MEANING AND EXPERIENCES OF SPIRITUALITY AND SPIRITUAL CARE AMONG PEOPLE FROM CHINESE BACKGROUNDS LIVING IN ENGLAND: A GROUNDED THEORY INVESTIGATION

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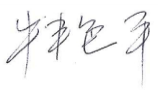
Declaration

This written dissertation is my own unaided work.

Signed



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Abstract

Spiritual care has become a topic of global interest, especially within healthcare context. Despite this growing interest, there is a sparsity of research conducted internationally exploring the understanding of spirituality and spiritual care among people from Chinese backgrounds, particularly those living in the UK. Therefore, there is a need to investigate the meaning of spirituality and spiritual care among this group of people to support the delivery of high-quality care for them.

The aim of this investigation is to understand the meaning and experience of spirituality and spiritual care among people from Chinese backgrounds residing in three regions of England. In order to achieve the aim, a grounded theory design was utilized, based on Strauss and Corbin's (1998) method to interpret the meaning of spirituality and spiritual care among this group.

Recruitment of participants was through Chinese community centres, using purposive and theoretical sampling methods. Twenty-five participants were recruited after which point data saturation was reached. Participants included 11 males and 14 females, aged between 20 and 82, originating from different regions in China, Taiwan, Hong Kong and Vietnam. Participants held diverse personal, religious and spiritual beliefs. In-depth interviews were conducted to capture the participants' thoughts and perceptions of spirituality and spiritual care. Transcribed digital recordings were translated into English and imported into NVivo for analysis. Data collection and analysis progressed simultaneously.

Data analysis followed the techniques of open coding, axial coding and selective coding, leading to the development of a substantive theory called '*Seeking a meaningful life*'.

The process '*Seeking a meaningful life'* comprised four categories: 'Motivation', 'Support', 'Maintaining standard values' and 'Achieving a meaningful life'. First, individuals using motivation and support resources were required for the purpose of seeking a meaningful life among people from Chinese backgrounds living in England. Next, individuals described how they usually utilise motivation and support resources that are essential for seeking a meaningful life. Following this, they needed to live by good principles, practice or work hard, to finally achieve a meaningful life. Two categories, 'Relationships' and 'Perceptions of spirituality', made up the support and influencing context for this.

The findings from this investigation provide unique understanding of spirituality and spiritual care from the perspectives of people from Chinese backgrounds living in the UK, which is reflected in the process of '*Seeking a meaningful life'*. The basic Chinese cultural concepts related to this group of people's understandings of spirituality could be put into teaching materials, such as leaflet, lecture or textbooks. This could facilitate nurses in clinical area or academic programme in providing the group culturally sensitive spiritual care. Importantly, the findings and cultural concepts emerged in this investigation offer healthcare professionals a way on how to find the meaning of spirituality and spiritual care by themselves, with the aim of providing patient-centred care to enhance this group's well-being.

Abbreviations

ASSIA	Applied Social Sciences Index and Abstracts
BAME	Black Asian Minority Ethnic Groups
BUA	Built-up area
CASP	Critical Appraisal Skills Programme
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DH	Department of Health
EAPC	European Association for Palliative Care
JBI	Joanna Briggs Institute
ICN	International Council of Nurses
IETS	International English Testing System
MEDLINE	Medical literature analysis and retrieval system online
NHS	National Health Service
NICE	National Institute for Health and Excellence
NSDSC	Nurses' Spirituality and Delivery of Spiritual Care
NMC	Nursing and Midwifery Council
ONS	Office for National Statistics
PCB	People from Chinese Backgrounds
QARI	Qualitative Assessment and Review Instrument
RCN	Royal College of Nursing
TCM	Traditional Chinese Medicine
UK	United Kingdom
WHO	World Health Organisation

CHAPTER ONE INTRODUCTION

Introduction

The aim of this investigation was to explore the meaning and experience of spirituality and spiritual care among people from Chinese backgrounds (PCB) residing in three regions in England. In a Western healthcare context, spirituality has been described in different ways, such as the essence of being (Narayanasamy, 2006), belief in God (Carson and Stoll, 2009), and meaning of life (Tanyi, 2002). In a Chinese context where Confucianism, Buddhism and Daoism prevail, spirituality is often referred as mental energy or a Higher being (Lin, Ma, Chen et al., 2012), a unidirectional process of mind (Chiu, 2000), and relationships (Chao, Chen and Yen, 2002). This difference suggests that there is a need to explore the understanding of spirituality among PCB residing in the UK context where Western and Eastern cultures converge, in order to generate new knowledge and insight.

Besides the difference in understanding of spirituality and spiritual care between Western and Eastern cultures, the subjectivity of spirituality and the absence of research studies reinforces the need for an investigation, focusing specifically upon these areas. Spirituality is a subjective concept and influenced by multiple factors, not only the circumstances in which people live, but also their cultural values and beliefs (Tanyi, 2002). Recently, there have been a rapidly growing number of PCB (387,584) entering and settling in the UK (Office for National Statistics (ONS), 2011), and their beliefs and values may be challenged and changed as they encounter cultural differences. Therefore, it is important that their voices contribute and inform the debates around spirituality and spiritual care generally and more specifically within healthcare. The current studies exploring the meaning of spirituality among PCB were mainly carried out in a small number of Chinese-speaking regions, such as Hong Kong (Chan, 2010), Taiwan (Yang,

Narayanasamy and Chang, 2012), Singapore (Tiew, Kwee, Creedy et al., 2013), and crucially there has been no such study conducted in the UK.

The above provides a clear justification and rationale for conducting an investigation into the meaning of spirituality and spiritual care among PCB residing in the UK. In the following sections, I outline the main issues of spirituality and Chinese culture, my professional experience in spiritual care, and the state-of-art of spiritual care in nursing, particularly in the UK. These issues are important to understand spirituality and spiritual care in nursing and healthcare from a Chinese perspective and my interest in the spiritual domain of nursing research in the UK.

Translation of spirituality to Chinese

In the English–Chinese dictionary, spirituality is *jingshen* (精神) or *lingxing* (灵性), and these two terms are used differently in Chinese-speaking regions, with *lingxing* in Taiwan and Hong Kong, and *jingshen* in mainland China. There is a slight difference between these two terms in Chinese culture. *Lingxing* usually means a Higher being, while *jingshen* is more related to an atheistic referent, for example mental energy or a counterpart of materialism. This could be the reason why *lingxing* is used in Taiwan and Hong Kong where believing in God or spirits has a position in society, and *jingshen* is used in China where atheism has been prevalent since 1949 when the Communist Party started governing the country (van der Veer, 2013). Although slightly different, PCB use these two terms interchangeably (Lin et al., 2012).

Currently, government documents presented in both English and Chinese causes some ambiguity in understanding the term spirituality (*jingshen* 精神). It indicates

jingshen as either ‘spiritual’ or ‘mental’. For example, taking the World Health Organisation (WHO, 2015) documents addressing palliative care and health; the document regarding palliative care states “Palliative care improves the quality of life of patients and their families who are facing problems associated with life-threatening illness, whether physical, psychosocial or **spiritual**”, and its Chinese version “姑息治疗能够提高那些面临危及生命疾病造成的问题的（成人和儿童）患者及其家人的生活质量。通过早期识别、正确评估和处理疼痛等身体、社会心理或**精神**问题，可以预防并减轻痛苦” in which ‘spiritual’ is the adjective form of ‘spirituality’ and is the Chinese version of the phrase *jingshen.* The WHO (2015) also indicates that mental illness is *jingshen* illness, and this can be seen in its on-line documentation on health in both English and Chinese. The document relating to health stresses “Health is a state of complete physical, **mental** and social well-being and not merely the absence of disease or infirmity”, and in its Chinese version “健康不仅为疾病或羸弱之消除，而系体格、**精神**与社会之完全健康状态” (WHO, 1948 p.100), ‘mental’ is *jingshen (***精神**)**.** In the Chinese context, *jingshen nursing* (精神护理) usually means ‘mental care’ or ‘psychiatric care’ for mental illness and it is used in a very narrow way, but it sometimes means caring for people’s well-being, as illustrated in the WHO’s documents.

I therefore encountered difficulty in translating the English ‘spirituality’ to Chinese *jingshen* (精神) or *lingxing* (灵性) at the start of the investigation. I consulted some nursing professionals who teach in a nursing school in mainland China regarding whether I should translate ‘spirituality’ as *jingshen* or *lingxing* in the investigation, and they suggested that I should use *jingshen* (精神) in mainland China. Based on the current WHO' (2015) documentation and academic opinions, I used the two terms during the data collection to explore and capture the participants’

understanding, with a focus on *jingshen* (精神) since it has a wider focus in human well-being.

Spirituality and Chinese culture

Translating 'spirituality' as *jingshen* (精神) requires a close examination of how this term is used in a Chinese setting. In Chinese, *jingshen* is a phrase consisting of two characters, *jing* (精) and *shen* (神). *Jing* is 'essence', and *shen* is 'spirit', which can be 'energy' or 'Higher Being'. These two words have been used separately in ancient Chinese scripts, for example, *jing, Qi, shen* (精气神) in Daoism and Traditional Chinese Medicine (TCM). TCM has been developed and applied for more than 2000 years in Chinese culture based on the principles of Daoism (Li and Shang, 2014). In TCM, *jing* (精) is the essence and source of life, *Qi* (气) is the vital energy of the body, and *shen* (神) is the vitality behind *jing* and *Qi*. In modern Chinese society *Jing* and *shen* are still used in the same way and are usually used in the phrase *jingshen* (精神) to indicate *jing* (精) as essence or *shen* (神) as energy. Based on the concepts 'essence' (*jing*) and 'spirit' (*shen*)', the phrase *jingshen* (精神) also derives its meaning within the development of Chinese society. For example, *jingshen* is used to indicate the unity of being, as *jing* (精) and *shen* (神) are unified under the *Yin-Yang* forces, which are the negative and positive forces that maintain a balanced world and body. With the influence of Confucianism, *jingshen* (精神) can mean 'spirit of the nation' (*minzu jingshen* 民族精神), a modern understanding of history as a sign of the nation by referring to Confucian social ethics. So *jingshen* is a product of language development, and is influenced by humanity in modern society which is related to the compassion of Confucianism and Buddhism in Chinese society.

The above discussion shows that although *jingshen* (spirituality) has its origin in Chinese history, it is a quite modern term in a Chinese context when used as the phrase *jingshen,* combining *jing* and *shen.* The traditional meaning and modern language development may be a reason for the ambiguity in the translation of spirituality to *jinshen,* as well as the confusion of spirituality (*jingshen)* as mental illness.

Spiritual care among PCB living in the UK

The continually developing meaning of *jingshen* (spirituality 精神*)* may evolve when social and cultural environments changes. For example, the meaning of *jingshen* for a person from a Chinese background may develop in response (Swinton and Pattison, 2010) to the UK healthcare system. This caused me to question whether there is an emergent meaning of spirituality in the UK which may have an impact on PCB's spiritual care. Moreover, I am a registered nurse who has worked in China where spiritual and religious care have no place in nursing practice and the profession. While working in the Middle East where Muslim prit appears, I realised that aspects of nursing practice observed Islamic prayer and rituals, and religious activities were respected and facilitated during patients' care in hospital. I noted the substantial effect of religious care on patients' spiritual life, and especially on their distinct attitude to death in the two regions, and this encouraged an interest in spiritual care in my profession. When I moved to the UK for an advanced nursing programme, this interest developed, because I realised that spiritual care is a topic that has generated much debate (Paley, 2008b; Newsom, 2008; Ross, 2008; Pesut, Fowler, Taylor et al., 2008) and has a close association with nursing education and practice (Narayanasamy, 1999a;

McSherry, 2007; Ross, 2006; Royal College of Nursing (RCN), 2011a). Driven by this interest, I wanted to explore the position of spirituality and spiritual care in current nursing practice and research.

Spiritual care and nursing practice

My focus on spiritual care within the nursing profession and my Chinese identity motivated me to explore the meaning of spirituality and spiritual care among PCB in the UK to raise awareness of its current position in nursing and healthcare practice. Molzahn and Shields (2008) state that openness to learning about the spiritual beliefs of individuals and attending to their nursing needs in a holistic way will enhance nursing care by reinforcing the attendance to patients' spiritual needs, which is as important as taking care of their physical and psychological concerns. Nurses can also use a range of assessment tools, which have been developed by scholars for use in diverse clinical settings (Anandarajah and Hight, 2001; Highfield, 1993; Puchalski and Romer, 2000; Larocca-Pitts, 2008; Girgis, Johnson, Currow et al., 2006), to assist them in identifying the spiritual needs of their patients and facilitate spiritual care. The Royal College of Nursing has developed a pocket guide on spirituality (RCN, 2011a), and an online resource (RCN, 2011b) to enable nursing staff to be better prepared and more competent to address spiritual questions within their nursing practice.

Besides the central position of spiritual care in holistic nursing, there has been a sharp rise in the research and literature addressing spirituality and spiritual care worldwide since the 1990s (Ross, 2006). The research confirms that patients' outcomes are improved through facilitating holistic assessment and care, in which

the spiritual dimension is highlighted (Cohen, Mount, Tomas et al., 1996; O'Connell and Skevington, 2005).

The current debate indicates that spirituality-in-nursing seeks to extend the nursing professional boundary to other professions, particularly chaplaincy and medicine (Gilliat-Ray, 2003). A professional boundary with chaplaincy arises because nursing is responsible for taking care of the holistic needs of the patient, including their religion, and faith which fall into the realms of chaplaincy. The professional boundary with medicine is due to the demands of patients and the supervisory role of the medical profession, so nursing aligns itself to medicine and questions its own professional autonomy (Gilliat-Ray, 2003). The purpose of a professional boundary is to establish and develop nursing as an independent discipline in which nurses have a role in providing spiritual care. The debate may also highlight a quest for something beyond the patients' satisfication with medical treatment (Swinton, 2006). For example, PCB's cultural preferences for dying at home, with Chinese death rituals being performed, may not be met because this requires healthcare providers to invest more in in terms of staff and facilities to provide care at the patient's home. Besides the financial reasons, working at the patient's home may affect the treatment, meaning the providers may prefer to treat the patient within a healthcare setting.

Debate on spiritual care in nursing

Despite the evidence suggesting that spirituality is often important to patients, Ross (2006) states that nurses can be less than willing to respond to spiritual needs. Not everyone supports the proposition that spirituality has a place in

nursing and healthcare. Arguing from a naturalistic viewpoint that the world available to human senses can be explained and amended by scientific studies, Paley (2008a; 2008b) argues that spirituality is an emergent, changing, universal and diffused concept, and spiritual care has not legitimate place in nursing practice. Paley (2008a) further argues that the existential concern evident in the spiritual domain can find theoretical and clinical explanations in health psychology, social psychology, neuropsychology and pharmaco-psychology. This standpoint opens up the nursing and healthcare professions to a much wider debate and dialogue with other classical disciplines (Gilliat-Ray, 2003; Swinton, 2006).

Although the importance of spiritual care is widely recognised by the nursing profession, some individual nurses and others outside nursing may not share this view, resulting in this area being neglected or overlooked. Engaging with the debate about the concepts of spirituality and spiritual care may provide greater understanding of the terms within nursing, and particularly for my investigation of the concepts among PCB living in the UK. This is important because a greater awareness of the range of views and arguments can make me more sensitive and balanced when exploring spirituality and avoid adopting extreme approaches, for example assuming it is absent in nursing or irrelevant, or seeing it in narrow terms just associated with religious care, or conversely, accepting that spiritual care is everything, making it too broad or universal to address (Paley, 2008a).

Spiritual care in the UK

Appreciating the development of spiritual care within the UK healthcare context is helpful in recognising that spiritual care has to be provided in a holistic way and is about attending to an individual's faith and beliefs in a culturally sensitive way.

As migrating populations have increased worldwide, the UK has become a nation where many ethnic groups converge (ONS, 2011). A multicultural and ethnically diverse society requires that healthcare professionals, particularly nurses, respond to this transition, and pay attention to the different factors specific to particular cultures, such as religious and spiritual customs. Moreover, holistic care requires nurses to integrate body-mind-emotion-spirit-environment principles into their clinical practice (Mariano, 2013), which brings the patients' spiritual dimension into focus. Holistic spiritual care is advocated at a governmental level; the National Health Service (NHS) constitution states,

> "The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status." (NHS, 2015 p.3).

Although the word spiritual is not used explicitly, it is implied in this statement, suggesting the need to support the personal, religious and spiritual needs of people from diverse ethnic backgrounds. The word 'spiritual' may be omitted because it is subjective or assumed to be incorporated into the other factors listed. Spirituality is not only influenced by the circumstances in which people live and receive care, but also by history/tradition and cultural backgrounds. This means that healthcare professionals should be sensitive to how spirituality may be expressed among diverse cultural groups. As the number of PCB residing in the UK increases (ONS, 2011), healthcare professionals should be more aware of the spiritual needs of this group in order to enhance their quality of life and well-being when receiving healthcare.

Map of the thesis

This thesis comprises ten chapters, each addressing a different aspect of the investigation. Chapter One provides the rationale for conducting an investigation into the meaning of spirituality and spiritual care among PCB residing in England. It also briefly outlines the main issues regarding the translation of spirituality to a Chinese cultural context, my interest in spiritual care among PCB living in the UK, and the current practice of spiritual care within nursing and healthcare the UK.

Chapter Two presents a conceptual literature review and analysis of the term 'spirituality' from a broad international perspective and that of the Chinese communities as well as describing the Chinese cultural values that provide the context for their spirituality.

Chapter Three presents an empirical literature review exploring the meaning of spirituality and spiritual care among PCB. These concepts enhanced my theoretical sensitivity around spirituality and spiritual care, providing an insight into the existing body of evidence.

Chapter Four presents a discussion of Strauss and Corbin's (1998) grounded theory methodology used in this investigation. It also describes the research process involved, including ethical approval, data collection and the analytical process. It also shows how the core category of 'seeking a meaningful life' emerged through the methodology, based on the preliminary findings from the pilot study.

Chapters Five to Eight present the findings of the investigation. Chapters Five to Seven describe the four main categories that make up the core category, showing

that the theoretical concepts are rooted in the data. Chapter Eight demonstrates the relationship between the core category and these four categories. It also describes how the two contextual categories support and influence the core category and how the substantive theory, *'seeking a meaningful life*', is integrated into the process for understanding spirituality and spiritual care among the PCB living in England.

Chapter Nine discusses the key findings of this investigation, placing them within the framework of current research and setting the direction for practice and future research. Chapter Ten explains briefly how the research aim and objectives were achieved, and reflects upon my achievements throughout this PhD journey, highlighting the implications for healthcare practice and future research.

Throughout the thesis, I use the first person as this demonstrates my role in and ownership of this grounded theory investigation.

CHAPTER TWO BACKGROUND

Introduction

In Chapter One, I presented the rationale for investigating PCB's perceptions of spirituality and spiritual care, and introduced some debates from the current literature regarding the understanding and meaning of these concepts. In this chapter I continue with this conceptual explanation of the terms. First, I present a brief overview of the role spirituality has played in nursing history to show how spirituality is changing, with a decline in the influence of world religions and the impact of the development of medicine and healthcare. Using a multi-perspective approach I critique the main current definitions of spirituality in both Western and Chinese healthcare, and their relevance for my investigation. In conclusion, I explain three basic Chinese philosophies influencing PCB's spiritual life, and clarify the terms in the Chinese context.

Spirituality in nursing

Before the 19th century when modern nursing was established by Florence Nightingale (1820–1910) (Dossey, 2008), nursing was inseparable from medicine. It was a holistic and intuitive response to people's health needs (Li and Shang, 2014), in relation to beliefs and daily living. Spiritual care was woven into caring activities in medicine. Prayer was often used throughout caring for the sick to rid them of evil spirits and to call more benevolent spirits to aid the healing process (Narayanasamy, 1999b).

Over time, nursing has become established as a professional discipline with well-educated intelligent nurses replacing the ill-prepared women who provided nursing care. Florence Nightingale incorporated spiritual, biological and emotional ministration into the service of nursing (Narayanasamy, 1999b). Modern nursing

was greatly influenced by Christianity based on its teaching of compassion and care for the poor and sick (Carson, 1989). This influence was intensified through nurses' commitment and compassion in nursing practice and education, and extended worldwide with the development of Western countries (Egenes, 2017) despite the influence of the local culture and social development. For example, the first nursing school in China, the Beijing Union Nursing School, was established by Christians in the early 20th century (Li and Shang, 2014) where originally Christianity had no influence upon the society. With the influence of compassion and caring in Christianity, the nursing students there have demonstrated their commitment to care by establishing and driving this forward throughout the nursing profession across China.

Although modern nursing has a religious and Christian tradition, the influence of Christianity has diminished due to the development of medicine and caring with science and technology (Greenstreet, 1999). Recently spirituality in nursing has been explained from an existential view, shifting away from classical theological traditions into secular explanations (Narayanasamy, 1999b; Paley, 2008a).

Ways of defining spirituality

The term 'spirituality' is too complicated to be captured within any single definition. In the current literature in nursing and healthcare, spirituality is explored from multi-perspective approach that recognises the diversity of definitions, in which healthcare professionals can work effectively within the field of spirituality by recognising its plurality (Swinton, 2010).

McSherry and Cash (2004) identify several subjective descriptors within the definition of spirituality and present these as 'a taxonomy of spirituality': *theistic,*

religious, language, cultural political social ideologies, phenomenological, existential, quality of life, and *mystical* (see Table 2.1 below). The descriptors are dynamic and reflect the diversity and subjectivity around the word ‘spirituality’ in both Western and Chinese culture. They are developed across a life-span according to an individual's worldview or religious belief. However, the post-modernist descriptors in the phenomenological and existential demonstrate that spirituality may alter when a person’s worldview and focus change (McSherry and Cash, 2004).

Table 2.1 A taxonomy of spirituality adapted from McSherry and Cash (2004)

Descriptors							
Theistic	*Religious*	*Language*	*Cultural, Political, Social ideologies*	*Phenomenological*	*Existential*	*Quality of Life*	*Mystical*
belief in a supreme being, cosmological arguments not necessarily a 'God' but deity	affiliation – belief in a God, undertaking certain religious practices, customs and rituals	Individuals may use certain language when defining spirituality such as inner strength, inner peace	an individual may subscribe to a political position or social ideology that influences their attitudes and behaviours dependent upon world faith – religious tenets	one learns about life by living and learning from a variety of situations, both positive and negative	a semantic philosophy of life and being, finding meaning, purpose and fulfilment in all of life's events	although quality of life is not explicit in definitions it is implicit	relationship between the transcendent, interpersonal, transpersonal, life after death
LEFT……..…RIGHT							
CONSIDERATION 1. The descriptors are not exhaustive 2. The taxonomy suggests two forms of spirituality the 'old' and the 'post-modern'. The old = religious and theist, while the 'post-modern'= phenomenological and existentially focused.							

Swinton (2010) also outlined three overlapping approaches to looking at spirituality: generic approach, biological approach, and approach from religion. These offer a valuable way of understanding spirituality and are relevant to the definitions in the current nursing literature.

The generic approach of spirituality is always applicable to all people in all cultures regardless of any religious or non-religious tradition. This universal understanding can be understood as an existing human reality which can be easily identified and assessed as part of the human experience. The generic understanding of spirituality focuses healthcare professionals' attention on the important aspects of a person if the disease and meaning of it are given priority, thus enhancing both the standard and the meaningfulness of caring practices (Swinton, 2010).

The limitations of the generic approach is that it does not actually describe what spirituality is as an identifiable and discrete entity (the ontology of spirituality), but addresses what spirituality does in describing spiritual well-being (Swinton, 2010). For example, in defining spirituality in such terms as the human search for meaning, hope, love, transcendence, purpose, value connectedness, and sometimes God, people are addressing the effects of a person's spirituality in terms of their experience, rather than considering spirituality as a mystery. This is because the terms explaining this mystery, such as 'a connection with the universe' and 'the essential life force', may be irrelevant to clinical practice, leading to people describing the experiential and material aspects of spirituality which are the consequence and effect that spirituality brings.

The definition of spirituality from the biological approach assumes that spirituality is a part of the brain, a biological basis for spiritual experience to receive religious and spiritual signals (Swinton, 2010). This biological basis is the source of our inherent awareness of things beyond understanding which is described as 'relational consciousness' connecting self and others, self and environment, and self and God. The biological approach indicates patients' need for relationship and it is important for healthcare professionals to recognise this and encourage patients to live well from individualism towards community (Swinton, 2010). However, this biological perspective of spirituality reduces it to a matter of neurological function alone. Furthermore, it raises a question about the biological basis of spirituality when a person's biology is damaged or destroyed in ageing, disability or illness.

The religious approach provides a traditional understanding of spirituality that God or 'transcendence' is the source of a person's spiritual experience and spiritual well-being. This traditional understanding also includes a more general form of the sacred in people's everyday lives. Transcendence refers to a sense of encountering something beyond the material norm and this may or may not be related to religion. This understanding of spirituality draws on specific religious traditions and practices, or the divine feature of objects and practice, to bring about healing and relief for patients. However, a focus on religion and religious transcendence can be considered irrelevant, even inappropriate and offensive for many who do not have religion or who do not believe in anything sacred or divine.

Definitions of spirituality in Western healthcare

Spiritual care is one of the four pillars in providing holistic care according to the WHO (2013). The concept of spirituality has been explored for several decades in nursing and healthcare (McSherry, 2007) in different ways, and various definitions of spirituality have been developed that reflect or incorporate Western culture (Murray and Zentner, 1989; Reed, 1992; Tanyi, 2002). In the following, I pull together the main definitions of spirituality used in Western healthcare. Table 2.2 below describes how these definitions have evolved over time across different countries or regions. In the table, I critique each definition by relating them to the main areas of healthcare relevant to nursing practice and review their suitability within a Chinese setting.

Table 2.2 Definitions of spirituality in healthcare in a Western context

Authors and region	Definitions	Comments and implication
(Stoll,1989 cited in Carson and Stoll, 2009) USA	It is who I am - unique, and personally connected to God. That relationship with God is expressed through my body, my thinking, my feelings, my judgments, and my creativity. My spirituality motivates me to choose meaningful relationships and pursuits. Through my spirituality, I give and receive love; I respond to and appreciate God, other people, a sunset, a symphony, and spring. I am driven forward, sometimes because of pain, sometimes in spite of pain. Spirituality allows me to reflect on myself. I am a person because of my spirituality – motivated and enabled to value, to worship, and to communicate with the holy, the transcendence. (p.5)	This definition is derived from a theistic worldview, particularly from a Judeo-Christian perspective. In this definition, spirituality is a personal relationship with God, including belief in God, undertaking certain religious practices customs and rituals. Personal motivation, pursuit, and transcendence are gained through giving and receiving love. This definition provides nurses with a way of caring from a theistic perspective, especially caring for those from Christian backgrounds (Narayanasamy, 1999a). It does not suit those who have no religious belief, and look at spirituality from existential philosophy (McSherry and Cash, 2004) or from a biological perspective (Swinton, 2010), because these people have no personal relationship with God.
(Murray and Zentner, 1989) USA	A quality that goes beyond religious affiliation that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any good. The spiritual dimension tries to be in harmony with the universe, and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death. (p.259)	I adopt the original definition because it highlights an individual without believing in any good has spirituality. This definition suggests spirituality is a universal concept and applies to religious and non-religious individuals, particularly for the existential search for meaning and purpose in life. It also stresses the need to explore the whole in which the body, mind and spirit interact. An illness, which can be a disturbance to the whole, can cause spiritual distress. Therefore, healthcare professionals should take care of the physical pain to improve patients' entire well-being. However, this generic form of spirituality is criticised as one definition fitting all (McSherry, 2005) and assuming homogeneity among human being (Lartey, 2003). It is also challenged as this definition is not rooted in any body of knowledge, religious tradition or philosophy, and does not have supporting scientific evidence (Swinton, 2006). Therefore, its utility for nursing practice and application in a different tradition, for example a Chinese cultural context, is questioned.
(Narayanasamy, 1999c) UK	Spirituality is rooted in an awareness which is part of the biological make-up of the human species.	This is a holistic definition of spirituality, incorporating its biological roots. It highlights the physical (biological make-up), psychological, social (relationship with reality), and spiritual aspects (inner peace and strength)

	Spirituality is present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a transcendent God or an ultimate reality or whatever an individual values as supreme. (pp.123-124).	of all individuals. Spirituality may manifest as inner peace and strength. This definition applies to religious and non-religious individuals (atheists and agnostics). However, the generic form of spirituality assumes that all people's spirituality is the same without considering their traditions and values. Thus, its application to PCB living in England needs to be examined.
(Tanyi, 2002) USA	Spirituality is a personal search for meaning and purpose in life, which may not be related to religion. It entails connection to self-chosen and or religious beliefs, values, and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace, and empowerment. (p.506).	This definition highlights spirituality from an existential perspective of individual searching for the meaning of life. The definition also stresses the importance of beliefs (religious and/or self-chosen), values and practices that enable one to search for the meaning of life. Searching for meaning in life and traditional values are helpful for healthcare professionals ito bring the patients' existential concerns and beliefs into healthcare practice. However, the definition does not emphasise the biological aspect of spirituality, and its usefulness for patients coping with physical illness is not obvious.
(Puchalski, Ferrell, Virani et al., 2009) North American (USA) consensus definition	Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. (p.888)	The North American consensus, EAPC and international consensus definitions of spirituality are similar and were developed by the same group of experts who specialise in religious and spiritual care in North America and Europe. These definitions suggest that spirituality is multidimensional, comprising existential challenges, value-based considerations and attitudes, relationships, and religious concerns and foundations. Although the North American version of spirituality has been criticised because it describes that spirituality as only a partial aspect of being human (Nolan, Saltmarsh and Leget, 2011), it forms the foundation of the other two definitions of spirituality. With some slight modifications to the North American version, the EAPC and international versions underline that spirituality is the dynamic aspect of human life, changing with their focus of life. The international version highlights that spirituality is expressed through the values, beliefs, culture and practice. It also makes the relational aspect of spirituality prominent in terms of the relationship with family, friends and society. However, the term 'transcendence' in the international version may cause objections because of its specific interpretations and meanings in a unique cultural context where 'transcendence' is located (Puchalski, Vitillo, Hull et al., 2014).
(European Association of Palliative Care (EAPC), 2010) The European consensus definition	Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant, and/or the sacred. (EAPC, 2010; Nolan, Saltmarsh and Leget, 2011)	
(Puchalski et al., 2014) The international consensus definition, held in USA	Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or	

	sacred. Spirituality is expressed through beliefs, values, traditions, and practices. (p.646)	The international consensus definition of spirituality was based on the North American (Puchalski et al., 2009) and EAPC (2010) consensus definitions of spirituality. This version advocates a sentence on how spirituality might be expressed and experienced (Swinton, 2010), demonstrating its practical utility (Swinton and Pattison, 2010). It is also a simplified statement that could be more amenable to research (Puchalski et al., 2014). Being developed under the consensus of experts in the field of spirituality and spiritual care worldwide, it could be termed authoritative when applied in practice and used in research. However, as there are no experts from China, Taiwan or Hong Kong where Chinese cultural values and beliefs prevail, and given that spirituality and care changes in different cultural contexts (Swinton and Pattison, 2010), its utility in a Chinese context may need to be examined. An empirical investigation might validate or modify the definition.
(Weathers, McCarthy and Coffey, 2015) Republic of Ireland	Spirituality is a way of being in the world in which a person feels a sense of connectedness to self, others, and/or a higher power or nature; a sense of meaning in life; and transcendence beyond self, everyday living, and suffering. (p.15)	The authors offer a secular version of spirituality by describing it in terms of relationships, meaning in life, and transcendence. The definition does not stress the role of religion, values and cultures but is useful in bringing the person's existential concerns into focus, including physical suffering. However, as the definition does not mention religion or belief and values, it may not be useful for people who have a religious affiliation or have a certain set of cultural values.

The table above demonstrates that Western healthcare definitions of spirituality have evolved chronologically over the past two decades from a theistic and religious perspective to a more general or eclectic approach that combines religious and non-religious understanding (Swinton, 2010). They then move to a secular or atheistic understanding incorporating a more humanistic and existential perspective (Tanyi, 2002), where religion seems to have no place. For example, the international definition of spirituality gives the humanistic aspect of spirituality in seeking ultimate meaning, purpose, transcendence, and relationships to self, family, others, community, society, nature, and the significant or sacred as human principles and activities (Puchalski et al., 2014). Furthermore, to connect spirituality to healthcare, the definitions appear to shift from a religious to a holistic view of health, incorporating the physical, psychological, social and spiritual or religious aspects of human beings. The shifting trend of spirituality is consistent with McSherry and Cash's (2004) view that there is a dynamic movement in the taxonomy of spirituality from different philosophical perspectives. In this movement, the religious connotation of spirituality is decreasing while holistic and spiritual definitions (not necessarily religious) are emerging. Although atheistic and humanistic definitions of spirituality are emerging, a generic form of spirituality is prevalent. This is consistent with Swinton's (2010) statement that a generic approach to spirituality, irrelevant to religious belief and applicable to all people in all cultures and at all times, is the most popular one within the British nursing literature.

However, the various definitions demonstrate that there is no consensus or authoritative definition of spirituality within the nursing discipline. As discussed, a

non-unified definition of spirituality may be the norm so that this can change and evolve in response to social, religious and cultural factors that impact upon the development of nursing and healthcare. However, this means that the concept of spirituality will always remain subjective and its meaning may vary according to individual and social political influences (Narayanasamy, 1993; Tanyi, 2002). Although the multiple definitions of spirituality may cause ambiguity around the absolute meaning of spirituality, Swinton and Pattison (2010) view this positively because the vagueness and lack of clarity around the term spirituality indicate that it can generate powerful political, social and clinical implications. For example, a claim that spirituality is linked with the cultural belief of a minority group in certain societies or countries may require policy makers to value this group of people, respecting their traditions and cultural beliefs within healthcare. So the application of a definition of spirituality could influence political and social changes.

Swinton and Pattison (2010) also argue that defining spirituality in a theoretical and abstract way is unrealistic because it is a quality that is not simply produced but emerges over time and responds to different situations and factors. Considering this complexity in defining spirituality, a simple explanation of spirituality in the Chinese context may be needed to capture an understanding of the term for PCB and its relevance to nursing and healthcare practice.

Definitions of spirituality in Chinese healthcare

As discussed in Chapter One, the spiritual dimension has its roots in Traditional Chinese Medicine (TCM) and health systems. Although the term spirituality is not new and has a developing meaning in Chinese society which has been influenced

by the West (Li and Shang, 2014), the spiritual dimension of nursing within a Chinese setting may be different from a Western cultural perspective. Researchers (Mok, Wong and Wong, 2010; Chiu, 2000; Chao, Chen and Yen, 2002) have recognised these differences and investigated the meaning of spirituality and spiritual care in some Chinese regions. Table 2.3 below presents examples of spirituality extracted from studies conducted in a Chinese context, with my comments on the key aspects on healthcare which are relevant to the understanding of spirituality and spiritual care for PCB living in the UK.

Table 2.3 Explanation of spirituality in health care in the Chinese context

Authors and region	Statement or description	Themes and sub-themes extracted	Comments
(Chiu, 2000) Taiwan	"The lived experience of spirituality in women with breast cancer is a developmental process, which is not a stage-by-stage process but, rather, unidirectional evolution to a larger realm. The women's experiences of their spirituality are unique to each of them, as each one lives with breast cancer in her individual way. The women's experiences are culturally specified." pp. 35-36	Living reality *Living with encounter* *Taking full responsibility* *Appreciation of life, people, and beloved things* Creating meaning *Purpose and meaning in life* *Finding alternative way of life/restructuring life perspective* *Religion* Connectedness *Relationship with self, others, God/deity/t'ien* *Power* Transcendence *Suffering* *Liberation* *Opening life and death* *Healing experience*	Spirituality is *Xin/Hsin* (mind/heart), a developmental process from facing reality by becoming conscious about their role and environment when encountering illness and taking responsibility for their existence, to finding meaning of life through religion or cultural values, then reaching transcendence by gaining harmony with others and an individual wholeness. The process of spirituality engages religious and non-religious belief. Spirituality is unique to each individual and is influenced by culture and beliefs, it also becomes prominent when experiencing a critical illness.
(Chao et al., 2002) Taiwan	None	Communion with self *Self-identity – spirituality is the discovery of self* *Wholeness – a human being is full of contradiction but still in wholeness* *Inner peace – spirituality is negotiating conflicts for self-reconciliation* Communion with others *Love – spirituality is a caring relationship but not an over-attachment to others.*	Spirituality is deemed as the relationships with self, others, and Higher Beings (Figure 2.1). This relationship is explained from a combination of a religious and atheistic perspective of spirituality, putting the person in the centre and emphasising the person's qualities in society and

		Reconciliation – spirituality is to forgive and to be forgiven. Communion with nature *Inspiration from the nature – spirituality is the resonance of the marvelous beauty of nature.* *Creativity – spirituality is conceiving imaginatively.* Communion with a Higher Being *Faithfulness – spirituality is keeping trust dependably* *Hope – spirituality is claiming possibilities.* *Gratitude – spirituality is giving thanks and embracing grace.*	nature, such as inner peace, love, inspiration, gratitude. However, it seems that the physical dimension of care is not emphasised. This prompts consideration of the physical dimension of spirituality in my investigation because spirituality is also understood from a biological perspective. It assumes that human bodies are designed to receive spiritual and religious information, forming the source of 'relational consciousness' which requires a connection with self, others, the environment, and God (Hay and Nye, 2006; Swinton, 2010).
(Mok et al., 2010) Hong Kong	"The lived experience of spirituality among the participants was a developmental process, which was not a stage-by-stage process but rather a unique process to each of them, as each lived in their own individual way." p. 363	Life is an integrated whole *Integration of mind and spirit* *A unique personal belief and experience* Acceptance of death as a life process *Harmony with self and nature* *Letting go* Finding meaning in life *Receiving and giving love in relationships and connectedness* *Having faith in God/higher power* *Being a good person* Having a sense of peace	This study presents a similar process to Chiu's (2000) study. It highlights that the spiritual experience of critically ill patients is a developmental process with different stages. The first stage is that critically ill patients face life reality by knowing that life is a unique experience in relation to the spirit, and death is a process of life. After accepting death and by reflecting and living harmoniously with the self and nature, letting go of illness and death, they find meaning in life through establishing compassion in relationships, commitment to religion and life principles. Finally, they attain

			transcendence by gaining a sense of peace with themselves, others, and a God or Heaven from one's inner consciousness in self-knowledge, self-worth, and a feeling of serenity. A framework was developed to help explain that spirituality is a holistic concept in nursing including body, mind and spirit (see Figure 2.2 below). However, it is not clear how the framework was developed because the concepts within it are not well explained in the relational statements based on the findings. Also, some of the concepts in the framework, such as 'responsibility' and 'hope', are not supported with evidence from the findings. This means its trustworthiness and usefulness are questionable.

(Lin, Ma, Chen et al., 2012) Taiwan	None	Spirituality is internal power *Spirituality is a true and existing spiritual power* *Spirituality is an abstract state which is difficult to articulate* *An expanding transformation like ripples* *A comforting and healing power* Having values of selflessness and fulfilment *Being competent and responsible* *Helping others and enhancing self (compassion, transcendence)* Refinement of tolerance and flexibility *Being both responsible and kind* *Mixture of feelings and rationality* *Withdraw feelings, transforming the mood and facing reality*	Spirituality is internal power which is true and existing. It is also good values, and transcendence. This is a secular interpretation of spirituality, with no mention of religion or a higher power.

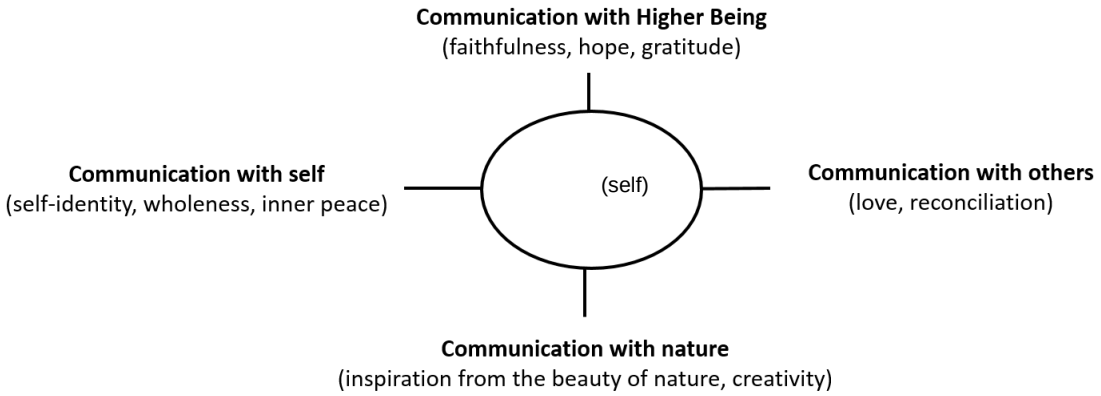

Figure 2.1 Essence of spirituality of terminally ill patients (Chao et al., 2002)

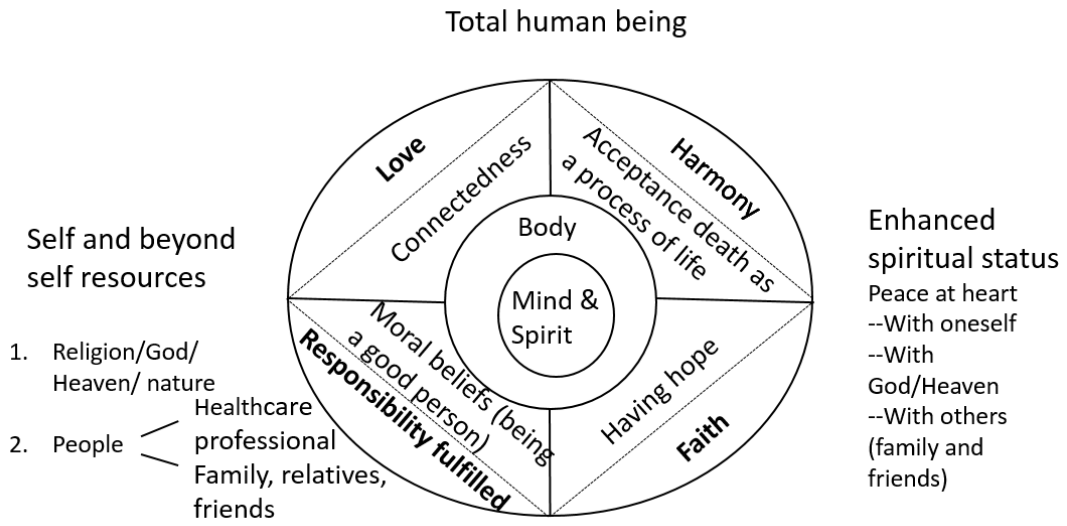

Figure 2.2 The meaning of spirituality and spiritual care among ill Chinese people (Mok et al., 2010)

Table 2.3 above suggests that during the past two decades there have been a few definitions or statements of spirituality developed within Chinese healthcare. These studies and definitions originate primarily from Taiwan and Hong Kong and are derived principally from a procedural explanation (Chiu, 2000; Mok et al., 2010), or are indicated through themes or sub-themes which may imply the attributes of spirituality (Weathers et al., 2015). For example, in Chao et al.'s (2002) study there is no definition or statement presenting an understanding of spirituality. The themes indicate that spirituality in Chinese culture can be understood as the concept of 'relationship', forming its attributes in association

with the self, others, nature and Higher Being(s). The sparse number of definitions and statements explaining spirituality as a concept indicate that spirituality in Chinese culture may not be well established within healthcare, highlighting the need for more in-depth understanding of the term.

Comparing spirituality in Western and Chinese healthcare

The above shows that the explanation of spirituality in some Chinese regions has similarities with those in the West. For example, the term is broad, ambiguous and complex, and with no unified understanding, influenced by cultural values. These definitions of spirituality have been provided at a conceptual and procedural level in both Western and Chinese contexts. However, the conceptualisation of spirituality in Western healthcare is evidently more developed, from the number and range of published definitions. These definitions also indicate a comprehensive range of attributes associated with spirituality such as relationships, belief, transcendence, higher power in religion and processes, for example, seeking the meaning of life and seeking transcendence unconsciously or consciously (EAPC, 2010). In comparison, the number of definitions of spirituality in the Chinese nursing literature is scarce, and they are either processed or conceptual in nature with a less comprehensive range of attributes focusing on belief, relationships and values.

The low number of definitions of spirituality present in the Chinese nursing literature highlights the need for a comprehensive understanding of the term. Thus, I needed to develop a holistic, integrated view of spirituality from the physical and psychosocial dimensions of spirituality. I also had to be sensitive to the diverse philosophical perspectives (McSherry and Cash, 2004; Swinton, 2010) PCB may adopt to express their understanding of this dimension.

Definition of spiritual care

There are few conceptual definitions of spiritual care in the nursing and healthcare literature. A commonly cited one provided by NHS Education for Scotland (2009 p.6) is:

> *That care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.*

This definition gives the critical elements of spiritual care as individual support in times of crisis, finding meaning of life in self-worth, religious need and compassionate relationships. This is very similar to the current definitions of spirituality which recognise religion, relationships (Narayanasamy, 1999c) and meaningful life, particularly during critical life events (Weathers et al., 2015). The similarity of these two concepts (spiritual care and spirituality) suggests that the spirituality guides the practice of spiritual care. For example, the focus of spirituality on illness in Weathers et al.'s (2015) definition is reflected in the NHS Education for Scotland's (2009) definition of spiritual care, which implies a spiritual care response to human crisis in illness.

Hummel, Galek, Murphy et al.'s (2009) definition of spiritual care details spiritual care interventions by pointing out the associations of these within different clinical areas. The authors classify spiritual care interventions within the function/roles of several disciplines: religion, spiritual support, counselling, emotional support,

advocacy, presence, respect, communication, and adjunct therapy (Hummel et al., 2009). This is representative of many similar explanations of spiritual care that provide information regarding what spiritual care needs to do (Puchalski et al., 2009). The interventions of spiritual care shown in different studies indicate that it can vary in different contexts or among different populations.

As discussed, the various definitions and explanations of spirituality in the nursing and healthcare literature may mean that a universal definition of spiritual care is not practical or indeed possible and any spiritual care interventions derived from these definitions will have a different focus. Furthermore, the delivery and implementation of spiritual care may only be applicable to the population in the specific cultural context where each study was conducted. I would therefore like to explore how PCB perceive the term spiritual care in nursing and healthcare so that an understanding can be identified for this population.

Chinese cultural values

Chinese cultural values are inseparable from Chinese philosophy and religion, which is a diverse and complex system that has been developing for more than 3000 years throughout Chinese history (Littlejohn, 2016). In mainland China, Hong Kong and Taiwan and other diasporic Chinese groups around the world, Confucianism, Buddhism, Daoism, and the mixed philosophy are the main traditions formulating the core of Chinese thought, cosmology, religious belief, and practice (Littleton, McGee, Rotem et al., 1996). These values have influenced and shaped PCB history, providing them with principles for living, developing their morals to establish a harmonious society while enabling them to gain peace and transcendence within their own personal lives.

Confucianism is a body of moral teachings that originated in China from the 6th century century BC when Buddha and *Laozi* (老子), the Father of Daoism, also flourished (Tan, 2014). Confucianism is the most influential system of thought in China, Hong Kong, and Taiwan (Tan, 2014). The founder of Confucianism is *Confucius* (551–479 BC) and his philosophical ideas are recorded in *The Analects of Confucius* (*Lunyu* 论语). The teachings of Confucius are principles for social order and family discipline, and set of rules to maintain society. Confucianism explains the basic moral standards of being human and forms the benchmark for spiritual development for PCB.

Daoism has existed alongside Confucianism and Buddhism in China for more than 2000 years, and has had a major impact on Chinese intellectual and spiritual life (Mou, 2012). *Laozi* (老子) is considered as the founder of Daoism in the 5th century BC, and the philosophy of *Laozi* is described in the *Dao de jing* (道德经) and *Yijing* (易经). Daoism concentrates on individual life, nature, and tranquillity, and is embodied in *Laozi*'s (老子) work the *Yijing* (易经) (Littlejohn, 2016), which has been one of the most influential books in the world. The basic ideas of *Laozi* provide a philosophical and a religious tradition for PCB to live a peaceful spiritual life and maintain good spirituality.

Buddhism began in India in the 5th century BC and was founded by Buddha Siddhartha Gautama (Park, 2009; Littleton et al., 1996). All forms of Buddhism share this root, and are motivated by the quest to attain a long-lasting state of contentment through mental, spiritual and moral development, following the enlightenment experience of Buddha Siddhartha Gautama (Deal and Ruppert, 2015). Buddha teaches that every individual is able to reach the state of

enlightenment and cessation of suffering. This is a state of true nature, full of happiness and wisdom. All forms of Buddhist teachings (Jingkong, 1991) are for people to gain different achievements in their spiritual life.

The Chinese context and Chinese diasporic communities

I need to explain several related concepts to make the research process clear in terms of the geography and study population participating in this investigation.

The term 'Chinese context' used throughout this investigation refers to a broad geographical area relevant to China including mainland China, Taiwan, Hong Kong and Chinese communities outside these regions where people consider they are connected to China or have Chinese origin (the diaspora). Based on this, the literature search I conducted covers studies worldwide with a focus on Chinese culture. In comparison, PCB is a population term utilised specifically outside of China, and PCB living in England means the population residing in England who consider they are connected to China or who have Chinese origin. As a result, 'PCB' includes non-Chinese citizens of different nationalities ('ethnic Chinese' and 'Chinese overseas') and 'overseas Chinese', which today is more accurately described as *Huaqiao* (华侨), a citizen of China residing overseas. Although the descendants of the early Chinese migrants, should not be considered as 'diasporic' community due to their cultural acculturation or assimilation (Suryadinata, 2011), this investigation maintains a flexible boundary to include the descendants of the early Chinese migrants. This is because they have a claim to Chinese origin and their understanding of spirituality and spiritual care may be influenced by Chinese culture.

Among PCB, the Chinese language dominates, consisting of Mandarin, Cantonese and other local dialects, for example Hakka and Hokkien (*Fujian* Dialect *福建话*) (Abraham, 2013). Although the Mandarin and local dialects share the same traditional Chinese and simplified Chinese characters, their pronunciation varies greatly, probably impeding the oral communication of different dialect speakers. It is possible that other languages, for example English, are also used in conversations among PCB, particularly for those who are second and later generations of the first-generation Chinese settlers. As a result of the variety of dialects of Chinese and different languages, there was a need to recruit interpreters for this investigation where my native language or dialect was different from that of participants. With an interpreter, the understanding of spirituality and spiritual care between myself and the participants could be enhanced.

Summary

In this chapter I have provided an overview of the history of nursing and the role of spirituality within it, emphasising how this dimension is important in today's healthcare service. I also outlined how spirituality is defined and examined from Western and Chinese perspective, showing that spirituality is important in today's health care service, and the concept of spirituality is broad, subjective and individual, informed by people's beliefs and culture. Western and Chinese definitions of spirituality were compared, outlining their relevance to this investigation. Finally, I defined what is meant by the terms 'Chinese context', 'PCB' and 'Chinese language' to clarify the population participating in this investigation, emphasising the importance of employing interpreters to facilitate the communication process.

In Chapter Three, I present the findings from a scoping literature review undertaken to gain further insights into the meaning of spirituality and spiritual care among people from Chinese contexts.

CHAPTER THREE LITERATURE REVIEW

Introduction

In this chapter, I present the scoping literature review conducted to gain further insights into the meaning of spirituality and spiritual care among people from Chinese contexts. Following the stages in Arksey and O'Malley's (2005) framework, I will present 1) the aim of the scoping literature review, 2) the search methods and inclusion and exclusion criteria, 3) the study selection, with characteristics of the included studies, and the appraisal process, 4) the extraction of data for analysis, and 5) analysis and reporting of the results. Finally, I will identify the relevance of the findings from the literature review for the practice of spirituality and spiritual care in current healthcare and research, and implications for the main investigation.

This literature review will follow the framework provided by the Centre for Reviews and Dissemination (CRD, 2008) to integrate the qualitative and quantitative findings.

Justification of a scoping literature review over a systematic review

Systematic and scoping reviews are two forms of literature review. Systematic review methodology is seen as the most effective for providing evidence in healthcare practice (Pope, Mays and Popay, 2007), and the process for undertaking a systematic review is well documented in CRD (2008) and The Joanna Briggs Institute (JBI, 2014a). However, a systematic review usually focuses on a specific topic, while a scoping literature review may concentrate on a broader topic which can be the ongoing process of a systematic review examining the extent, range and nature of research activity to assess the feasibility of a full

systematic review (CRD, 2008). As illustrated in the process of identifying the Chinese literature (p.45), I searched the international literature associated with spirituality and spiritual care. This enabled me to specifically focus on Chinese studies, establishing that a broad range of research had been conducted in this area in other cultures, particularly the West. Also, following the five-stage framework proposed by Arksey and O'Malley (2005) enabled me to develop the research question to identify and select literature and to chart and analyse the data. This scoping review provided valuable insight into the meaning of spirituality and spiritual care and issues concerning the implementation of spiritual care, in the current Chinese literature. It also confirmed that such reviews can be conducted independently to guide research and practice (Arksey and O'Malley, 2005).

The framework for the scoping review

Scoping literature reviews have increased in popularity since Arksey and O'Malley (2005) originally published their influential framework on how to conduct them. The framework consists of five stages:

Stage 1: identifying the research question

Stage 2: identifying relevant studies

Stage 3: study selection

Stage 4: charting the data

Stage 5: collating, summarising, and reporting the results

Additional Stage (optional): consultation exercise to inform and validate findings from the main scoping review.

The process is not linear but iterative, meaning that if necessary, steps are revisited to ensure that the literature is comprehensive. While using this framework as a guide, the techniques provided by JBI (2015) also ensure that the scoping review is undertaken in a comprehensive manner, applying the following: developing the title, objective(s) and question(s); background; inclusion criteria; search strategy; extraction of the results; presentation of the results; and conclusion.

Aim of the literature review – Stage 1: Identifying the research question

Arksey and O'Malley (2005) suggest that a research question for the scoping literature review should be broad so as to identify all the relevant literature, regardless of whether it is qualitative, quantitative, or mixed methods research. As familiarity with the literature increases, the researcher can redefine the search terms and undertake a more sensitive search of the literature. In this scoping literature review, the research question is:

'What are the meaning and experience of spirituality and spiritual care in healthcare within a Chinese context?'

The aims of the scoping review are:

1. To identify existing gaps in the evidence base, ensuring the originality of the proposed investigation
2. To gain insight into the size and nature of evidence in the current literature and body of knowledge

3. To disseminate findings in the area of spiritual care to guide nursing practice
4. To enhance the theoretical sensitivity of the investigation

Inclusion and exclusion criteria for the literature review

Based upon the research question and the aims of the scoping review, the following inclusion and exclusion criteria were set.

The review included only empirical studies to gain an understanding of Chinese people's experiences and understandings of the phenomenon (JBI, 2011). The research studies included were those exploring patients, nurses, medical and other allied healthcare professionals' understanding and experiences of spiritual care in mainland China, Hong Kong, Taiwan, and Chinese communities in other countries. Research on spiritual care in other contexts was excluded so that the scoping review was manageable, met the inclusion criteria and was relevant to PCB's understanding of spirituality and spiritual care.

Studies included were journal articles and dissertations, obtainable online, or through inter-library loan, or by contacting the researchers personally.

From a practical point of view, I decided at the outset to restrict the scope and coverage of the review to articles published in English and Chinese only. This was because English is my two supervisors' common language, and the language most frequently used in international publications. I am fluent in English and Chinese and could translate the relevant parts of articles for the team, although some translation work might be necessary on occasions. By including only articles in English and Chinese this avoided considerable time and finance being spent on

translation services. This review excluded studies without abstracts, or those where the full texts were unobtainable. There were no date restrictions. There was no date restriction. Table 3.1 outlines the inclusion and exclusion criteria.

Table 3.1 Summary of initial inclusion and exclusion criteria

No.	Inclusion criteria	Exclusion criteria
1	Empirical studies	Reviews, discussion papers
2	Studies that focus on exploring perceptions of spirituality and spiritual care	Studies mainly addressing other issues, such as quality of life, pastoral care, hope and compassionate care.
4	Journal articles, dissertations and studies available online, hard copy in libraries, inter-library loan, or by contacting authors	Textbooks, book chapter and other forms of publication
5	Studies published in English and Chinese	Studies published in other languages
6	Studies with an abstract, or without abstract but full text can be accessed online or through inter-library loan	Studies without an abstract and where full text not obtainable
7	No time limit	
8	Studies conducted in a Chinese setting, such as Taiwan, Hong Kong and Chinese communities in foreign countries	Studies conducted outside of a Chinese setting

Search method – Stage 2: identifying relevant studies

Prior to undertaking the main search, a pilot was conducted, using the key terms spiritual* AND Nurs* in two databases in nursing and medicine, the *Cumulative Index to Nursing and Allied Health Literature* (CINAHL) and *Medical Literature Analysis and Retrieval System Online* (MEDLINE), yielding a considerable number of studies. Following the initial pilot, a search strategy (see Appendix 3.1) was developed using all the identified keywords and index terms, to search six healthcare databases. The key terms ‘spiritual care OR spirituality’ AND ‘nursing OR nurse’ AND ‘perception OR experience’ were applied to these databases: CINAHL, MEDLINE, PsycINFO, Applied Social Sciences Index and Abstracts (ASSIA), ScienceDirect, and Web of Science, and the search results were presented (see Appendix 3.2).

Using the exact key terms and OR in searching ('nursing OR nurses'), rather than the truncated key terms (nurs*), offered an accurate search of studies regarding spirituality and spiritual care.

The search did not incorporate the keyword 'Chinese' during this phase so that the size and nature of the body of evidence and existing knowledge internationally could be gauged. Progressively applying search terms is in keeping with the scoping process recommended by Arksey and O'Malley (2005 p.22), "It is likely that as familiarity with the literature is increased, researchers will want to redefine search terms and undertake more sensitive searches of the literature."

Search results – Stage 3: study selection

The above database searches generated 5,261 results, which were initially stored in an Endnote library. After the removal of 1,271 (1,039 and 232) duplicates, 3,990 studies were obtained and scanned. The reason that Endnote could not identify 232 references as duplicates was because of slight differences between the references of the same article, with some titles uppercase and others lowercase, and the sequence of authors adjusted in different databases. Scanning the complete references in the Endnote Library, searching and scanning entire articles if there was no abstract, and applying the inclusion/exclusion criteria (without the Chinese context), led to the retrieval of 399 international studies addressing perceptions of spirituality and spiritual care. These were stored in the Endnote library as a pool for a more focused search. At the same time, 3,591 studies irrelevant to the proposed topic or that did not fall within the inclusion criteria were removed.

In order to identify studies conducted in a Chinese setting, the search terms Chinese', or 'China', or 'Taiwan', or 'Hong Kong', or 'Singapore' were applied to the identified pool of 399 studies. Other strategies were also used to find relevant studies, such as looking for a Chinese name in the authors list and reading the abstract to ensure that no studies included in the pool that were conducted in a Chinese setting were missed. This led to the identification of 33 studies that were assessed against the inclusion and exclusion criteria, to ensure that they were all from a Chinese background and the target population. Subsequently 15 studies were excluded – the reasons are listed in Appendix 3.3 – leaving 18 articles (see Figure 3.1 below).

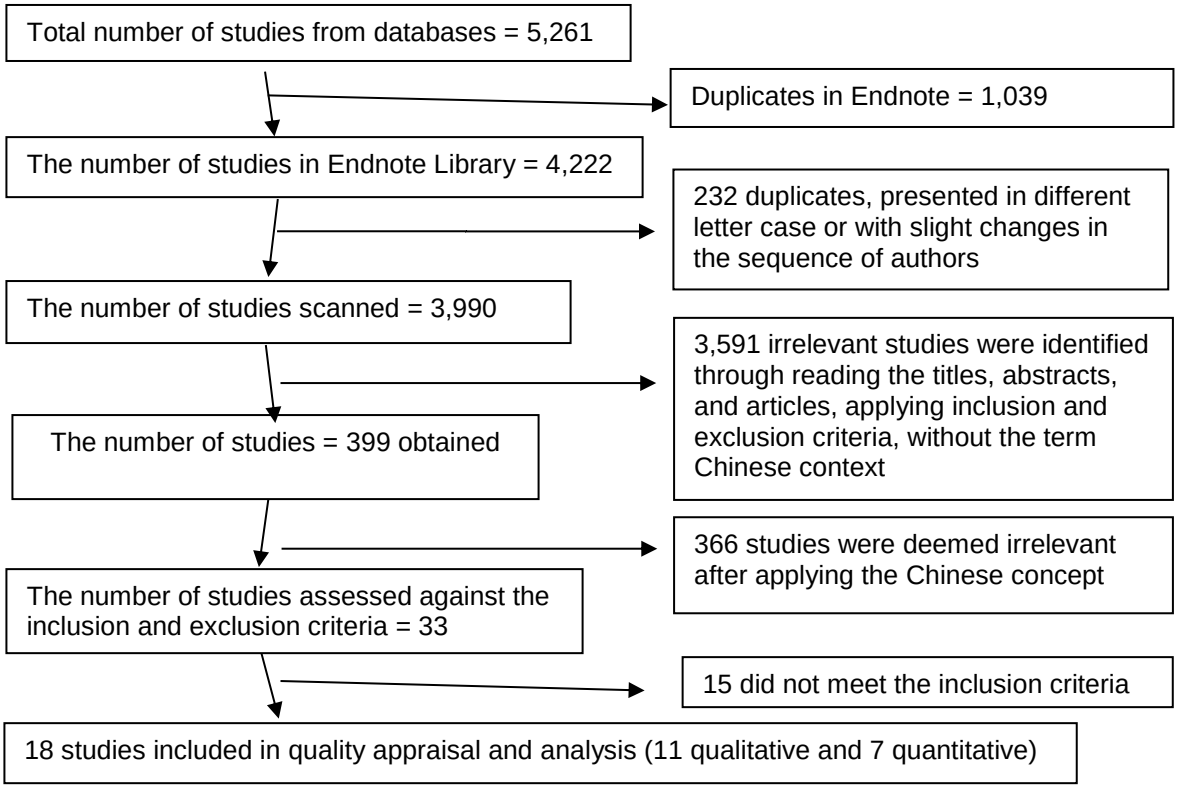

Figure 3.1 Summary of the search results

The above search was carried out in 2015 when conducting the initial review before the main investigation started. In December 2018 prior to submission of the thesis, I updated the search by identifying studies conducted between July 2015 and December 2018. Applying the same search strategy did not identify any

additional articles that met the inclusion criteria. The search result and excluded articles can be seen in Appendices 3.2 and 3.3.

Characteristics of included studies

Table 3.2 below shows the general characteristics of the included studies. It indicates that the nursing research exploring spirituality and spiritual care in a Chinese context, started before 2000 when accepting the manuscript for the earliest publication. No studies were published between 2013 and 2015. An updated search also confirmed that no further articles had been published between 2015 and December 2018. Among the 18 studies, there are 11 qualitative and seven quantitative, 16 written in English and two in Chinese. Eight studies focused on patients and 10 on nurses and nursing students. The attention on patients and nurses may have been because the articles were retrieved by applying the key terms 'spiritual care OR spirituality' AND 'nursing OR nurse' AND 'perception OR experience'. This meant that articles regarding spiritual care were relevant or had been conducted in the discipline of nursing where nurses and patients are the major providers and receivers of spiritual care. This approach also ensured that studies associated with other healthcare practitioners were included (Pike, 2011). The focus on nurses in 10 of the 18 identified studies might indicate the current importance of nurses' role within healthcare (Hummel et al., 2009). Many of the studies were conducted in Taiwan and Hong Kong. Only two quantitative investigations were conducted in China, and one qualitative study in the USA. Aggregation of the participants totalled 1,870, broken down as 249 in qualitative and 1,708 in quantitative studies. In the qualitative research, 87 participants were nurses and nursing students, and 162 were patients. In the quantitative studies, 1,708 participants were nurses. All the studies contributed to

an understanding of spirituality and spiritual care, because of their focus on exploring the perceptions of spirituality and spiritual care within nursing in a particular Chinese region or setting.

Table 3.2 Characteristics of included studies

Author and Year	Methodology	Focus	Geographical area	Language	Sample	Participant	Conclusion
(Chiu, 2000)	Qualitative, descriptive hermeneutic phenomenological research	Explore lived experience of spirituality in Taiwanese women with breast cancer.	Taiwan	English	15	Patients	Cultural spiritual care is needed for both patient and nurse.
(Chiu, 2001)	Qualitative, synthesis of ethnography and phenomenology	Investigate cultural-spiritual resources that are available to Chinese immigrants with breast cancer in the US.	USA	English	15	Patients	Spiritual resources
(Chao et al., 2002)	Qualitative, hermeneutic study	Investigate the essence of spirituality of terminally ill patients.	Taiwan	English	6	Patients	The essence of spirituality is addressed
(Chan, Chung, Lee et al., 2006)	Quantitative, descriptive correlational survey; inferential analysis - cluster analysis	Address the paucity of available information on nurses' spiritual care	Hong Kong, University programme	English	193 respons e rate (RR) 61.7%	Part-time nurses	Nurses lack spiritual care for patients.
(Yang, 2006)	Cross-sectional descriptive study: descriptive analysis, ANOVA, correlation, and regression	(1) Define the profile of nurses' spiritual intelligence; (2) examine the relationship between nurses' demographic characteristics and spiritual intelligence; (3) explore the mode of nurses' spiritual intelligence and related factors, among nurses in Taiwan.	Taipei, Taiwan, A conference	English	299 RR 89.25%	Nurses	Understanding nurses' spiritual intelligence.
(Chung, Wong and Chan, 2007)	Correlational design: descriptive analysis and inferential analysis – correlation matrix, nonparametric test on relation, multiple linear regression	Examine the relationship of nurses' spirituality to their understanding and practice of spiritual care	Hong Kong, University baccalaureate programme	English	61 RR not mention ed	Nurse students	The relationship between the demographic features (except for religion) and understanding and practice of spiritual care was not statistically significant. Inner resource of self-awareness and beyond the self will facilitate spiritual care provision.
(Yang and Mao, 2007)	Cross-sectional questionnaire survey: descriptive analysis, inferential analysis - T test, one way ANOVA,	Explore the profile of spiritual intelligence among nurses, and examine the effect of religions on nurses' spiritual intelligence in China.	Mainland China A conference in medical centre	English	130 RR 65%	Nurses	Understanding nurses' spiritual intelligence

	correlation, simple and multiple regression						
(Chio, Shih, Chiou et al., 2008)	Qualitative, phenomenological-hermeneutic	Explore the experiences of spiritual suffering and the change mechanism in healing processes among Taiwanese patients with terminal cancer.	Taiwan	English	21	Patients	Patients need spiritual care.
Author/study	**Methodology**	**Phenomenon of interest**	**Geographical area**	**Language**	**Sample**	**Participant**	**Conclusion**
(Wong, Lee and Lee, 2008)	Cross-sectional descriptive design: descriptive analysis, and inferential analysis – independent t-test and one-way analysis of variance	Explore Hong Kong nurses' perceptions of spirituality and spiritual care; investigate the relationship between their perceptions and their demographic characteristics.	Hong Kong, University programme	English	391 RR 91%	Practising enrolled nurses	Increasing nurses' spirituality in education and continuing development.
(Shih, Lin, Gau et al., 2009)	Qualitative, hermeneutic inquiry.	Explore the core constitutive patterns from the perspective of the older patient with terminal cancer, the major foci of spiritual needs, and professional actions that manifest tangibly as spiritual care.	Taiwan	English	35	Patients	Patients' spiritual needs.
(Yang and Wu, 2009)	Cross-sectional descriptive and inferential study: descriptive analysis, stepwise multiple regression	Compare spiritual intelligence between nurses in two different Chinese societies	Mainland China and Taiwan Nursing conferences	English	524 RR 74%	Nurses	Understanding nurses' spiritual intelligence.
(Chan, 2010)	Quantitative, descriptive analysis, and inferential factor analysis, stepwise regression	Examine nurses' attitudes to practising spiritual care and determine factors associated with nurses' attitudes to practising spiritual care.	Hong Kong, a public hospital	English	110 RR 61.7 %	Nurses	Perception and practice of spiritual care are positively related.
(Mok et al., 2010)	Qualitative, interpretive phenomenology	Explore the phenomenon of spirituality and spiritual care among terminally ill Chinese patients.	Hong Kong	English	15	Patients	Patients need spiritual care.
(Wong and Yau, 2010)	Qualitative, descriptive phenomenological study	Investigate the experiences of spirituality and spiritual care in Hong Kong from the nurses' perspective.	Hong Kong	English	10	Nurses	Barriers to providing spiritual care.
(Hsiao et al., 2011)	Qualitative, explorative qualitative enquiry	Explore the spiritual needs of patients with advanced cancer during their therapeutic process in Taiwan, and analyse the influence of Chinese culture in addressing their spiritual needs.	Taiwan	English	33	Patients	Patients need religious support.
(Lin, Ma, Chen et al., 2012)	Descriptive qualitative design	Explore perceptions of spirituality among ER nurses.	A medical centre in central Taiwan	Chinese	15	ER nurses	This study introduced the idea of spirituality as an inner power as perceived by ER nurses.

(Yang Narayanasamy and Chang et al., 2012)	Qualitative approach, naturalistic paradigm	How hospitalisation and diagnosis of schizophrenia have an impact on Taiwanese patients' spiritual life.	Taiwan	English	22	Patients	Nurses need to provide spiritual care.
(Sum and Leung, 2013)	Qualitative study	Investigate nurse students' understanding of spirituality and the learning needs for spiritual care.	Hong Kong	Chinese	62	Nursing students	Taking care of self holistically is crucial in life and future work.

Characteristics of the qualitative studies

Of the 11 qualitative studies, four studies were conducted using a phenomenological design (Mok et al., 2010; Chio et al., 2008; Wong and Yau, 2010; Chiu, 2000). Three studies adopted a hermeneutic (Chao et al., 2002; Shih et al., 2009) or naturalistic design (Yang et al., 2012), employing thematic analysis. Another study utilised a synthesis of ethnographic and phenomenological research approaches (Chiu, 2001), while the remaining three studies used qualitative design with a content analysis method (Lin et al., 2012; Hsiao et al., 2011; Sum and Leung, 2013). No studies used a grounded theory design which may have been due to the difficulties in conducting grounded theory and the requirements regarding data collection and analysis, such as theoretical sampling and theoretical saturation. The methodological aspects of grounded theory are detailed in Chapter Four.

Of the 11 qualitative studies, 10 used interviews (Mok et al., 2010; Chio et al., 2008; Shih et al., 2009; Chiu, 2001; Chiu, 2000; Lin et al., 2012; Yang et al., 2012; Hsiao et al., 2011; Wong and Yau, 2010; Chao et al., 2002), and one used a questionnaire with open-ended questions (Sum and Leung, 2013).

The sample sizes ranged from six to 62 in the 11 qualitative studies. Five studies (Chiu, 2001; Chao et al., 2002; Chiu, 2000; Lin et al., 2012; Wong and Yau, 2010) used a purposive sampling method. Five studies did not mention the sampling method, but detailed how participants were recruited by presenting the inclusion and exclusion criteria (Mok et al., 2010; Chio et al., 2008; Shih et al., 2009; Yang et al., 2012; Hsiao et al., 2011). The final study just stated that participants were recruited from a nursing class (Sum and Leung, 2013). All were in hospital

settings, apart from one that was conducted within a classroom setting (Sum and Leung, 2013), and one that was a community setting (Chiu, 2001).

Characteristics of the quantitative studies

All seven quantitative studies used the convenience sampling method. Four studies selected the eligible population from a single university programme (Chan et al., 2006; Wong et al., 2008; Chung et al., 2007) or a single hospital site (Chan, 2010), and three studies used a cross-sectional design in different conferences in mainland China (Yang and Mao, 2007), Taiwan (Yang, 2006), and both mainland China and Taiwan (Yang and Wu, 2009). However, the selection of enrolled nurses in a nursing programme in Wong et al.'s (2008) study offered a better representative source population than the other three studies, in which the eligible population were sourced from a single hospital or single university course setting (Chan et al., 2006; Chung et al., 2007; Chan, 2010). This was because the practising enrolled nurses spent their nursing careers working throughout Hong Kong. The sample size of these studies varied from 61 to 524 and they were all nurses, with four studies mentioning that there were more female nurses than male nurses (Chan et al., 2006; Wong et al., 2008; Chung et al., 2007; Chan, 2010). Three studies showed the nurses' ages ranging from 20 to above 40 (Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009), and a variety of religious beliefs were listed, including no religious belief, Christian, Catholic, Buddhism, Daoism, Islam, Protestant, Consistent Tao, and No Mention of religious belief. The response rate ranged from 61.7% to 91% in six cases, but one study did not report the response rate (Chung et al., 2007).

Data analysis of the quantitative studies

Seven of the quantitative studies presented demographic information exploring the concept of spirituality using different forms of questionnaire (Chan, 2010; Wong et al., 2008; Chung et al., 2007; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009; Chan et al., 2006). Six studies (Chan, 2010; Wong et al., 2008; Chung et al., 2007; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009) discussed the relationship between the nurses' demographic information and their understanding or practice of spiritual care using the t-test (Chan, 2010; Wong et al., 2008) and/or ANOVA (Chan, 2010; Wong et al., 2008; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009) or non-parametric alternatives, the Mann–Whitney U and Kruskal–Wallis tests (Chung et al., 2007), while one study utilised cluster analysis (Chan et al., 2006) revealing a positive relationship between perceptions and practice of spiritual care ($r = 0.62$). Chung et al. (2007), for example, compared the mean of spirituality among male and female participants using the Mann–Whitney U test. Wong et al. (2008) compared the mean of spirituality of three educational levels using ANOVA, and between subjects with and without religious affiliation in an independent t-test. Chan et al.'s (2006) study explored the relationship between nurses' perception and practice, and showed the nurses' understanding and practice of spiritual care in their profile groups in a cluster analysis. These seven quantitative studies identified how different demographic characteristics relate to spirituality and spiritual care (Chan, 2010; Wong et al., 2008; Chung et al., 2007; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009), and the association between an understanding of spirituality and spiritual care (Chan et al., 2006), utilising a questionnaire. The demographic characteristics included religious beliefs, age and professional seniority, nurses' educational level, working department, experience of hospitalisation, nurses' position, gender, and significant

life events. The relationships of these to spirituality and spiritual care are discussed later (see p.78). The use of different questionnaires indicates that there is currently no standard instrument for measuring perceptions and practice of spiritual care developed specifically for Chinese investigations. This supports the proposition that spirituality is subjective and influenced by specific contexts in which cultural values and traditions have an impact upon people's understanding of spirituality and spiritual care (Puchalski et al., 2014).

Quality appraisal of the studies

The quality of the 18 studies was evaluated using the Critical Appraisal Skills Programme (CASP, 2013) tool for qualitative studies, and the National Institute for Health and Excellence (NICE, 2009) appraisal tool reporting correlations and associations for quantitative studies. The CASP provides clear rating criteria for reviewers, while the NICE tool provides a version for reporting correlations and associations. An overview of the quality appraisal is presented in Appendix 3.4.

Trustworthiness of the qualitative studies

Nine of the qualitative studies (Mok et al., 2010; Chio et al., 2008; Shih et al., 2009; Chiu, 2001; Chao et al., 2002; Chiu, 2000b; Lin et al., 2012; Yang et al., 2012; Hsiao et al., 2011) were assessed as high quality by the two supervisors and myself, while the other two studies were deemed to be of lower quality (Sum and Leung, 2013; Wong and Yau, 2010). Saturation was reported as being reached in three qualitative studies (Mok et al., 2010; Lin et al., 2012; Hsiao et al., 2011), rigor had been maintained in 10 of the studies but not in the one by Wong and Yau (2010). Credibility was addressed in four papers (Shih et al., 2009; Chiu, 2000b; Hsiao et al., 2011; Chiu, 2001) by utilising member checking, whereby the

results were returned to participants for verification. For example, Shih et al. (2009) confirmed the interpretation with participants and their significant others, and Chiu (2000; 2001) took the essential part of the data analysis back to the individual participant for validation.

However, some of the qualitative studies had limitations. Sum and Leung's (2013) study did not cover ethical issues. Two studies mentioned strategies for maintaining rigour but they were not easy to follow in the data analysis (Chio et al., 2008; Shih et al., 2009). For example, the data collection process was not very clear in Chio, et al.'s (2008) study; the nursing staff collected the data rather than the researcher, and their potential influence or bias on the study was not discussed. Moreover, it was not clear whether the data were recorded or written notes.

Assessment of the quantitative studies

The seven quantitative studies (Chan, 2010; Wong et al., 2008; Chung et al., 2007; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009; Chan et al., 2006) were found to be weak using the NICE (2009) appraisal tool for studies exploring association and correlation. This tool is developed specifically for correlation or association studies to identify factors that are associated or correlated with positive or negative health behaviour or outcomes. The main reason for selecting this tool is that it was relevant for the seven identified studies which utilised a questionnaire design exploring the relationship between/among variables. Another reason for choosing this tool was the lack of appraisal tool for a questionnaire design in the field of spirituality studies. The mismatch between

these seven studies and the NICE tool in terms of research design and sampling led to them being scored as weak in the appraisal.

The response rates were reported in six of the studies (Chan et al., 2006; Wong et al., 2008; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009; Chan, 2010), but not in Chung et al.'s (2007). There was no detail on attrition rates, or discussion of how representative the sample was of the eligible or source population. The power of 80% at α 5% level of significance was discussed in one investigation by providing an adequate sample size of 110 (Chan, 2010). The expected sample size for Chan's (2010) study was 113, aiming to achieve a positive correlation ($r^2 = 0.26$) established in Chung et al. (2007) study. An inadequate sample size was reported in Chung et al.' (2007) study, and the adequacy of the sample size could not be determined in five studies (Chan et al., 2006; Wong et al., 2008; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009), although a sample size of 299 might be deemed adequate (Yang and Wu, 2009). Yang and Mao's (2007) study had a sample size of 130 with a 49-item instrument, which might be too small considering the number of variables (Burns and Grove, 2009) and raised questions about the representativeness of sample for accessible population and target population.

As a novice researcher, undertaking the quality appraisal enhanced my understanding and knowledge of research critique and design. All 18 studies were included in this review to generate a comprehensive understanding of spirituality and spiritual care.

Data extraction – Stage 4: charting the data

Following the strategy provided by JBI (2014a), I extracted the findings from 18 studies into the JBI Qualitative Assessment and Review Instrument (JBI-QARI) extraction form (see Appendix 3.5). The JBI-QARI form requires information on the author(s), the titles of the studies, the themes for the qualitative studies and the main points of the quantitative results, the supporting evidence and appraisal of the evidence. This provided me with an overview of the extracted findings, with the indicated sources and their credibility. This also facilitated the later coding process in NVivo11, in which the extracted findings were converted into nodes for further aggregation and analysis. Numbering the extracted findings enabled me to trace the original study when necessary to aid data analysis. Examples of extracted findings are listed in Table 3.3 below, showing broader and implicit themes against corresponding statements which I developed from the author(s)' original text (JBI, 2011).

If the article was written in Chinese, its theme or sub-theme and their supporting statements were extracted and then translated into English. Finally, the extracted findings were imported into Nvivo11 for data analysis and integration to generate themes and categories for a better understanding of spirituality and spiritual care in a Chinese context.

Table 3.3 An example for data extraction

(Yang et al., 2012) Transcultural spirituality: the spiritual journey of hospitalised patients with schizophrenia in Taiwan		
Findings (sub-themes)	**Illustration**	**Evidence**
F020 Taiwanese or Chinese ideology/Using Taiwanese or Chinese ideology to explain significant events	"After I got the illness and became hospitalised, I lost my marriage and I was separated from my family. All of the above are Ming. Ming arranges our lives. If I have to stay in the hospital and suffer from this illness, that is my 'Ming'." p.361 "Now I am hospitalised, I think I am also retreating from my life (Buddhism). Maybe I sinned against others; now living in hospital is atonement or a punishment." p.361	Unequivocal
F022: Disconnection or estrangement from the family	"I still feel hurt; why did my father abandon me here? Sometimes I hate my father and my brother. It is unfair, I am their family. They sent me away from home. I am angry and lonely." p. 362	Unequivocal
(Chan et al., 2006) Investigating spiritual care perceptions and practice patterns in Hong Kong nurses: results of a cluster analysis		
Findings (Main point)	**Illustration**	**Evidence**
F118 Demographic information and cluster analysis	Two-step cluster analysis yielded three clusters. Clusters A, B, and C consisted of 15.0% (n = 29), 44.6% (n = 86), and 0.4% (n = 78), respectively. Cluster A nurses were characterised by relatively negative perceptions of spiritual care and practices. Cluster C nurses reported positive perceptions, but negative practices; they mainly chose 'uncertain' for most items on both scales. Cluster B was a large group of nurses holding both positive spiritual care perceptions and practices. Significant differences towards spiritual care were found among clusters ($p<0.001$).	Unequivocal
F120 Nurses' perceptions were significant positively correlated with practices ($r = 0.62$, $p < 0.001$)	Nurses' perceptions were significant positively correlated with practices ($r = 0.62$). High positive correlations were found between the two scales ($r = 0.83$) for nurses in Cluster A. For nurses in Clusters B and C, low positive correlations ($r = 0.37$) were found.	Unequivocal

Data analysis – Stage 5: collating, summarising and reporting the results

After importing the extracted findings, each finding was converted into a node in Nvivo11, which could be moved and aggregated freely into a higher-level node according to the meaning. The process of converting the extracted findings to nodes and aggregating them into higher-level one(s) can be seen in Figure 3.2, in which the nodes represent extracted findings (F) and synthesised categories or sub-categories. The extracted findings were sequenced in number so that I could track them in each study for accurate interpretation when they were regrouped in the analysis.

Figure 3.2 shows that the lowest level qualitative findings (1st level node) from the primary eleven studies were assembled into higher-level nodes (2nd level node) on the basis of similarity in meaning (JBI, 2011). Some similar 2nd level nodes then grouped, forming the 3rd nodes. Eventually, the top nodes in each group were assembled as a concept or statement, and I manually aggregated them into a statement (or theme) according to their meanings (see the following section). In the same way, the quantitative findings were also analysed and grouped. Nvivo11 facilitated the data management and the process of regrouping qualitative or quantitative findings into higher-level concepts by utilising the nodes to code the extracted findings and move them freely (QSR international, 2014). However, for an abstract integration of higher-level nodes, in which some top nodes are regrouped into new themes and some are considered as themes, it is better to manually group them because the multi-level nodes in Nvivo may confuse the final integration.

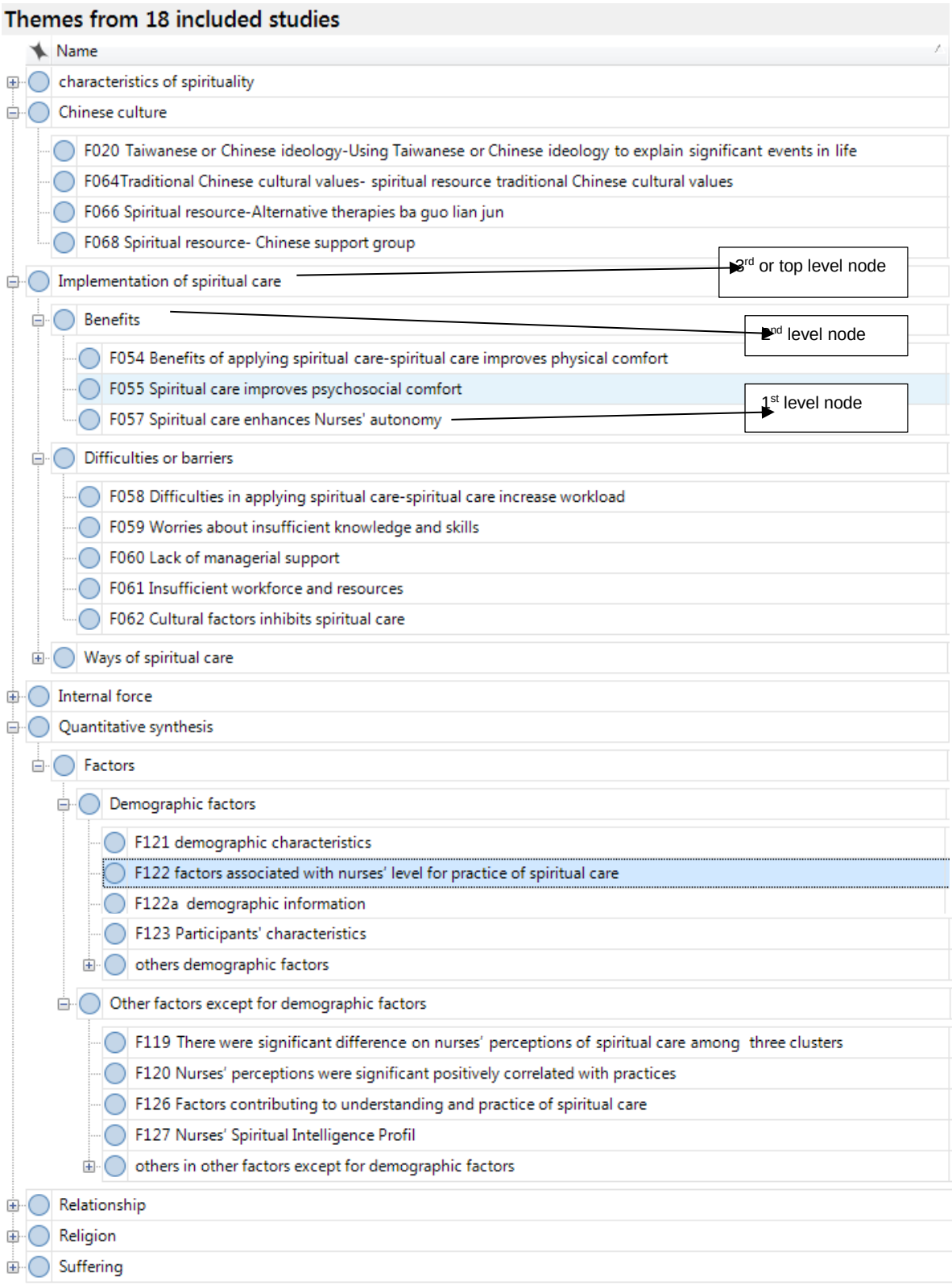

Figure 3.2 An example of data analysis in Nvivo11

Results – Stage 5: collating, summarizing and reporting the results

The synthesis of qualitative findings based on similarity of the meaning led to the development of two major themes regarding the perception of spirituality and spiritual care in the field of nursing in a Chinese context: *Meaning of spirituality*' and '*Implementation of spiritual care*'. The synthesis can be seen in Appendix 3.6. The quantitative category 'Factors influencing spirituality and spiritual care', which was grouped from the quantitative nodes (extracted findings from the seven quantitative studies) according to the similarity of their meanings, was integrated into the theme '*Implementation of spiritual care*' developed in qualitative synthesis (JBI, 2014b). This is because factors from the quantitative findings provide demographic and cultural factors at a personal, organizational and regional level, that may impact upon nurses' understanding of spirituality and spiritual care (Cockell and McSherry, 2012).

The findings present two major themes (Level 3), their affiliated categories, sub-categories, and supportive evidence extracted from 18 studies. The statements of the themes and categories represent the qualitative aggregation or synthesis through assembling the findings (Level 1) from the primary eleven studies and categorising these findings on the basis of similarity in meaning (Level 2) (JBI, 2011). The sub-categories further elaborate the way I assembled the extracted findings to generate categories by grouping similar nodes to form the dimensions of a category.

The two themes are synthesised comprehensive statements (JBI, 2011), regarding the spiritual pursuit of PCB during their life time, especially during illness when spiritual care may be required.

Theme 1: Meaning of spirituality

This theme comprises six categories and presents a general meaning or description of the term spirituality. Characteristics of spirituality are abstract, personal, and not easy to articulate. In Chinese culture, spirituality refers to an internal vital force. It also means an overall harmonious connection with the self, family, nature and God. For some people, spirituality is related to or described in terms of suffering they experience, and this highlights the importance of spiritual need and support for people facing life difficulties. Traditional Chinese cultural values provide a rich source of support during people's emotional turmoil. Additionally, spirituality in Chinese the context refers to religion.

Category 1.1: Characteristics of spirituality

The term 'spirituality' is unique and personal. It is abstract and not easy to articulate. A participant highlighted this in Mok et al.'s (2010) paper,

> *"Spirituality has to be interpreted from a person's own personal perspective; it is how a person defines it, and can refer to one's soul or one's beliefs. It is in the mind and soul, which are internal feelings."* p.364 (F110)

Being unable to articulate the term was considered by Sum and Leung (2013) as a reason to why enrolled student nurses were unable to offer a definition of

spirituality (F093). They also mentioned that spirituality is the integrity of all aspects of a person, including faith (F094).

The above characteristics of spirituality from a Chinese perspective are consistent with studies conducted in a Western context. For example, Bone, Swinton and Hoad's (2018) investigation into spiritual care shows that spirituality is individual and unique to each person. The similarity between the understanding of spirituality in Chinese and Western culture suggests that attributes may be transferrable especially with reference to unique and patient-centred care.

Category 1.2: Internal force

For PCB, spirituality is described as an internal force that provides them with vibrancy and energy. A participant in Lin et al.'s (2012) study stated that spirituality is a real and existing power,

> *"I think spirituality is a sound in the heart, which is deepest in the heart. Very few people can realise it because it grows with the person. It is like organs, such as the liver in our body; we cannot feel its existence. It exhibits when a person is weak, which a person probably cannot notice. A person needs to figure it out gradually. A person needs to pursue that power when he is in need and he is unable to go forward. It is this power to make people live since they have it. It seems like people are attractive to each other is because of spirituality."* p.225 (F109)

This suggests that from a Chinese perspective, spirituality is an entity akin to organ deeply inside a person, and spirituality comes into focus during times of weakness, acting as a living force to sustain life and provide motivation for people

to overcome difficulty. It is a biological understanding of spirituality, suggesting that spirituality is a part of humans and the source for their life, personal and social relationships (Swinton, 2010).

This Chinese understanding does not highlight spirituality as a source for relational consciousness for religion or Higher Powers, and this may be because religious influence was not evident at that time with the participants addressing spirituality. However, it highlights that relational support is important in spiritual care for PCB.

Spirituality as an internal force originating from the inner being is also described by participants in Sum and Leung's (2013) study. These authors present the key concepts of spirituality as 'inner', 'spirituality', 'in heart', and 'core' (F091). Spirituality encourages wisdom and this is highlighted in the same study (Sum and Leung, 2013) as being able to 'distinguish between good and evil' (F097).

Spirituality as an internal force also acts as a healing power for the self. This was illustrated in Chiu's (2000), with a participant saying that spirituality provides people with a view or lens to look at problems and illness to generate a good feeling which may be the best for their recovery,

> *"Viewing the problem from another angle, you are actually helping yourself in that you are giving yourself advice as well. You will be impressed by your own ability to become more philosophical. This is a really good feeling. I believe that this is really the best way to heal yourself."* p.44 (F090)

Another participant in Yang et al.'s (2012) study also stated that spirituality is the source of support which fosters inner peace and quietness through religious or cultural dimensions of practice,

> *"Religion is a method for me to commit my soul to God. Every day I read Buddhist scripture, which makes me realise why I suffer from the illness, and it gives me a new direction in life for how I view those difficulties in a positive way and how I get along with people. Now I find that I feel peace and inner quietness. Although in the hospital I feel lonely, I think it is a usual practice in Buddhism. My mother told me that I have to do some good deeds for others; it could accumulate Kong De [darshan] for me and others. I try my best to do that, because I know it is a way to diminish Karma. When one day I leave this world, my soul will go to nirvana [the paradise in Buddhism] and I will no longer suffer from schizophrenia."* p.363 (F026)

The above findings suggest that participants in these Chinese studies related spirituality to an internal force, which is an innate part of the human body. It may manifest as an internal energy that can provide wisdom to distinguish good and evil, while being a source of healing/power for recovery and a major source of support.

Category 1.3: A harmonious connection

Spirituality is described as a harmonious connection (F101). This connection is manifested within the self, with significant others and nature, and resides in mysteries such as God, the spirit, or soul. In Chao et al.'s (2002) paper, a participant stated,

> *"I found that I never loved myself. How can I love others if I hate myself? My last wish is to play a lovely old man to myself and hope my life has value to*

others. Now I accept myself as a worthwhile person with strength and vulnerability." p.240 (F071)

To establish a good relationship with the self, a person must be kind, diligent, tolerant, and have meaning and purpose in life. He or she will finally achieve transcendence which conveys a sense of being part of a greater whole and of communicating with Higher Beings (Chao et al., 2002). Being kind was depicted in Mok et al.'s (2010) study,

"It is important to be righteous and benevolent. If I give happiness to others, the feeling of helping others will make me feel happy too. My sense of wholeness in life is to shoulder my responsibilities to my family and my country." p.364 (F007)

It was also noted in Lin et al.'s (2012) study by a participant,

"I cannot always consider that much. Whether I am good at it, I do it very carefully. What I care about is whether I offered the chair to the older man to sit down, or put blanket on him, or put much thought into taking care of him." p.227 (F115)

Being diligent may be considered as encouragement for oneself, and was exemplified by a participant in Hsiao et al.'s (2011) study,

I'll try to learn from and follow other cancer survivors … I'm doing my best to stay optimistic and overcome it, otherwise I'd feel sorry for my children and health caregivers. p.954 (F010)

Being tolerant is also an aspect of a good connection with self. This was emphasised by a participant offering forgiveness (Hsiao et al., 2011),

> *"I recite Buddha's name to help me forgive my Daddy since he tortured me and didn't allow me to receive elementary education because I am a girl. I might have made mistakes and owed him a debt from my last life."* p.955 (F015)

Having meaning and purpose in life is essential and can direct a person's behaviour. This is described in Hsiao et al.'s (2011) study as a moral sense of duty,

> *"Sometimes I want to die; but, I owe others a lot of money. I should return the money then die innocently since I don't want to rebirth in the world again."* p.955 (F012)

Having a meaning and purpose in life was also presented in Chiu's (2000) study, with a participant saying their mission was serving people, when describing their spiritual experience,

> *"At first, I had a very strong feeling of God's will. . .. Everyone keeps praying for me. . .. Later, when the breast cancer group was formed, I suddenly felt that my preordained mission was to volunteer my services to this club."* p.38 (F082)

For some people the ultimate aim was establishing a good connection with the self and this was achieved by gaining self-transcendence through helping others and self-cultivation. A participant in Chio et al.'s (2008) study illustrated this, saying that the contributions to society provided him with a meaningful life,

> *"I have been making contributions to society for seventeen years, so my life is not meaningless. I have performed enough for my life."* p.741 (F039)

Connection is not only about connection with the self, it is also about having consideration for others. In Chiu's (2001) study, a participant stated how important her husband was when addressing spirituality,

> *"Since then, he did the laundry and cooked meals for me. He continuously encouraged me to live and supported my spirituality. We made decisions together for each treatment. He was always there and available to me. He never complained and never changed the way he did things for me."* p.179 (F063)

Being harmonious with nature is also a significant aspect of spirituality especially regarding connections. A participant in Chao et al.'s (2002) paper said,

> *"One day I felt very bored and tried to draw a picture of the sky and clouds through the window. Then I suddenly found that the clouds changed their shape within seconds. I threw out my pencil and felt greatly pleased. The beauty of nature cleansed my spirit."* p.241 (F074)

Having connectedness to God, religion or a Higher Power also inspires individuals in their understanding of spirituality and spiritual care. Two participants demonstrated this in Mok et al.'s (2010) research, with one saying that God had helped him out of an emotional crisis,

> *"I had been frustrated for a period of time but I sought the God of Mercy and asked for His help, and the God of Mercy held my hands and led me to the right path."* p.364 (F006)

The other stated that she now had hope because she knew she could expect a serene afterlife in heaven (F006).

Category 1.4: Suffering

For some participants, spirituality was related to suffering. A participant in Chio et al.'s (2008) study demonstrated this, saying spirituality was the physical torture of cancer which led to pessimistic thoughts about wanting to die,

> *"If I could die early, I would not experience the torture anymore."* p.739 (F031)

Another participant in Yang et al.'s (2012) study associated spirituality with mental illness, causing their sense of powerlessness,

> *"I think no one looks at us as normal human beings…no one…it is unfair. We also don't want to be psychiatric patients…it is very difficult. We are not criminals: why do they take away all our human rights?" (*p.362 (F021)

In the studies, participants also considered spirituality as a strategy that could release them from the suffering experienced. This was evident in Chiu's (2000) study, with a participant drawing on Buddhist practice, for example chanting,

> *"Chanting could reduce or erase the pains you are suffering and the hindrance of karma you have accumulated."* p.43 (F087)

Similarly, some participants in the Chinese studies explained spirituality from their cultural understanding of the concept regarding bad or negative experiences. For example, a participant in Chio et al.'s (2008) study said that his illness was pre-determined according to Buddhism because of his wrong-doing in a previous life,

> *"Suffering from this illness may be related to karma. This explains why I, not others, suffer from this illness. People say that fortune in the present life comes from doing good things in the past life. For me, probably I did something that I should not have done in the past life, so I got this illness…."* p.741 (F034)

Participants also related their understanding of spirituality to expectations they had when experiencing or encountering suffering. One participant in Shih et al.'s (2009) study expressed the need for companionship during a time of suffering but was reluctant to approach the children because of embarrassment,

> *"Although I feel lonely and scared because of my declining health (during the evening and night in particular), I am embarrassed to ask for my children's comfort and companionship because I used to be their leader and protector."* p.E34 (F044)

In addition to expecting companionship in time of suffering, some gain a positive perspective through interacting with family, friends, and other cancer patients, as well as searching for meaning in life through religious or cultural explanations. This was illustrated in Chio et al.'s (2008) study,

> *"We met in the hospital. Then, we encouraged each other and made fun of each other, which made us feel better. When you feel better, you feel less pain."* p.740 (F036)

> *"Belief in Yuan is the strength keeping me up. We do not have children, so our worry is different from others. To me, what I have is enough because I always take everything seriously, no matter how big or small it is…The meaning of my life is worthwhile because of the many things I have performed with my best effort…For death, everyone will go through this process finally. Cancer patients just meet with the issue of death earlier than healthy people."* p.741 (F038)

The above quotes show that participants in the Chinese studies related their understanding of spirituality and spiritual care to the experience of suffering. They address the negative consequences of suffering and provide positive reasons and strategies for dealing with it. This enables the individuals to develop a new outlook on life, having a source of meaning and purpose.

Category 1.5: Traditional Chinese cultural values

Spirituality in the Chinese context has a constant focus on Traditional Chinese cultural values using traditional religions, such as Taoism and Buddhism to explain life phenomena and suffering, especially when encountering disappointment and struggles. Two participants stated this in Yang et al.'s (2012) study,

> *"After I got the illness and became hospitalised, I lost my marriage and I was separated from my family. All of the above are Ming. Ming arranges our lives. If I have to stay in the hospital and suffer from this illness, that is my 'Ming'".* p.361 (F020)

> *"Now I am hospitalised, I think I am also retreating from my life (Buddhism). Maybe I sinned against others; now living in hospital is atonement or a punishment".* p.361 (F020)

Alternative traditional Chinese therapies such as *Qi-Kung* were also highlighted. For example, a participant in Hsiao et al.'s (2011) study stated,

> *"My doctor said this disease couldn't be cured, so I searched the web and learned Qi-Kung and other ideas from organisations that teach about hope and longevity."* p.954 (F011)

A participant in Chiu's (2001) study stated that they used Chinese medicine and herbs,

> *"Every morning, I make parsley juice and drink it slowly. Then I have some fruit to cleanse my bowels…"* p.180 (F066)

Category 1.6: Religion

The meaning of spirituality among PCB also refers to religiosity. For example, informants in Wong and Yau's (2010 p.243) study "expressed spirituality in terms of different religions". This was also stressed in Chiu's (2000) study,

> *"I often console myself that if I pass the period of torture, then I will be fine. It's only a religion, and it all depends upon how we believe it."* pp.38-39 (F084)

Another participant in Mok et al.'s (2010) study associated with religion, especially praying,

> *"I believe very strongly in the power of prayer, and I feel that everybody is praying for me. It is just something that encompasses me, a good positive feeling that lifts me."* p.364 (F006)

One participant in Hsiao et al.'s (2011) study demonstrated how spirituality was connected to the influence of religion upon their conscience,

> *"I killed a couple when I was 17, so I may get the retribution now. Recently, I approached different religious beliefs and wondered about the meaning of life and death. My quality of sleep has been troubled by the reflections of my deeds that were argued in my conscience. To me, waiting for death from cancer is more suffering than waiting for execution in the jail."* p.955 (F016)

The above highlight that spirituality for PCB within nursing and healthcare is concerned with several attributes, such as a positive life force, involving harmonious relationships and associated closely with traditional Chinese cultural values and religion. The findings also suggest that spirituality may come into focus during times of crisis.

Theme 2: Implementation of spiritual care

This theme comprises three categories: 'Ways of spiritual care', 'Barriers and benefits of spiritual care', and 'Factors influencing spirituality and spiritual care'.

Category 2.1: Ways of spiritual care

This category suggests there are several different ways of providing spiritual care, including the complementary therapy (F066), art (F067), restructuring life perspective (F083) and religious help (F065, F011). This is demonstrated in Chiu's (2001) study, with a participant saying that the source of spirituality is found in alternative therapies relating to the practice of spiritual care. Another stressed the importance of art, prose and literature in spiritual care,

> *"As long as these therapies might improve my illness and would not conflict against each other, we would try all of them. My husband called this ba guo lian jun (joint forces of the eight powers that occupied Peking in the wake of the Boxer Movement in 1990)."* p.180 (F066)

> *"What I read mostly is Chinese prose and literature. I especially benefit from Liu Shya's (who overcame her handicap and became a famous writer in Taiwan) Life Song. She wrote about how she lived day by day with her illness. Her suffering was never ending but she could overcome her disability.*

My suffering is only temporary, and I should be able to get through it. Her story is very much inspiring me." p.181 (F067)

Another participant in Chiu's (2000) study by the following participants,

"Sometimes, I wonder whether the benefits of the health products are only psychotherapeutic or if they are really effective. But when I think about the brand name Forever™, of health food, I would really like to know how long forever really is." p.38 (F083)

The religious and alternative approaches were also illustrated in Hsiao et al.'s (2011) when participants said implementation of spiritual care is seeking religious help and looking for some cultural explanations,

"When I feel pain, I recite the name of Buddha and feel better...I practised divination rituals and broke one cup accidentally before I was hospitalised. Then, I saw one patient die in the Emergency Room. That day I started to cough to death." p.954 (F011)

"Our future is destined by fate, fortune and Feng-Shu. My bed number is '514' and the opposite is bed '512' that sounds like 'let you starve' in Taiwanese; I decided to move to bed '513' although it cost me NT$300 (US$ 9.32) for this change." p.954 (F011)

Participants in Sum and Leung's (2013) study show that spiritual care is related to physical, psychological, social and spiritual methods (F105, F106, F107, F108). These authors illustrate that being physically healthy, having a positive attitude, communicating and sharing with others, and having religious belief and hope are the ways through which good results of spiritual care can be achieved.

The above findings suggest that spiritual care involves a comprehensive and broad caring approach, compromising with complementary help, art therapy, religious help, and restructuring one's life perspective. Importantly, spiritual care is holistic, integrating physical, psychological, social and spiritual aspects into modern nursing care (Narayanasamy, 1999c). The provision of spiritual care from a holistic perspective in nursing practice involves finding the meaning of spirituality for each person so that an appropriate person-centred approach can be developed. For some people this will mean utilising religious and cultural resources that may be helpful in dealing with difficulties in life and illness.

However, the Chinese literature does not provide a single definition of spiritual care like the one provided by NHS Education for Scotland (2009) which suggests it may be about individual support, relationships and finding meaning in life and religious need. Therefore, I would like to establish if PCB understand this concept in the same way.

Category 2.2: Barriers and benefits of spiritual care

The barriers and benefits of implementing spiritual care are outlined in Wong and Yau's (2010) study. For example, two participants indicated that spiritual care would increase their workload (F058), and they used the word 'burden' to describe their opinion on the difficulties they faced (Wong and Yau, 2010). Other barriers listed included insufficient knowledge and skills (F059), lack of managerial support (F060) inadequate workforce and resources (F061), and cultural factors inhibiting spiritual care (F062). For example, Chinese people generally avoided discussions

about death, and they were unlikely to discuss the meaning of life or death (Wong and Yau, 2010).

However, some nurses suggested that spiritual care might offer benefits to patients and nurses. Two participants said that patients improved their own physical comfort when praying, and reduced their psychosocial anxiety during meditation (Wong and Yau, 2010 p.243),

> *"Patients experienced less pain while praying to their God."* (F054)

> *"Spiritual care could improve psychosocial comfort because patients became less anxious after meditation."* (F055)

Spiritual care also enhances the nurses' communication with patients and families. One nurse said she communicated well with patients and families through providing spiritual care,

> *"More talking with patients and their families while providing spiritual help to them."* (Wong and Yau, 2010 p.243) (F056)

Through providing spiritual care to patients, the nurses' autonomy can be enhanced. For example, one participant said she was able to use her own time to support patients' needs, another was capable of determining the kind of spiritual care to provide, such as inviting the patients to worship and read the Bible (Wong and Yau, 2010) (F057).

These findings demonstrate something about the feasibility of putting different elements of spirituality into practice, for example, whether Chinese cultural

customs regarding attitudes towards death and dying could be put into practice when PCB avoid facing these issues.

The above barriers and benefits of spiritual care were derived from only one study (Wong and Yau, 2010). This may be because the search strategy did not focus on the key terms 'barrier' and 'benefit' of spiritual care. Therefore, a systematic approach with a comprehensive search strategy might lead to a deeper understanding of the feasibility of implementing spiritual care including the perceived barriers and benefits within existing Chinese research. This may help nursing and healthcare practitioners to maintain PCB's spiritual well-being.

Category 2.3: Factors influencing spirituality and spiritual care

The quantitative studies revealed that demographic factors and other factors, such as 'relationship with the self', 'religious belief', 'childhood spirituality' and 'social systems' can influence nurses' understanding of spirituality and their practice of spiritual care.

Demographic factors

The six studies (Chan, 2010; Chung et al., 2007; Wong et al., 2008; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009) provided evidence that different demographic characteristics such as nurses' religious belief, age, professional seniority, marital status, educational level, working department, position, gender, and life events influenced the understanding and practice of spiritual care.

Religious belief was the most frequently presented factor in terms of understanding and practising spiritual care (Chan, 2010; Chung et al., 2007; Wong

et al., 2008; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009). Five studies (Chan, 2010; Wong et al., 2008; Yang, 2006; Yang and Mao, 2007; Yang and Wu, 2009) (F122, F122a, F128, F130, F132, F135) revealed a significant positive relationship between religion and understanding spirituality/the practice of spiritual care ($p<0.01$). However, Chung et al.'s (2007) (F125) study revealed a negative relationship between religious affiliation ($p < 0.001$) and the dimension 'beyond self' ($p < 0.001$), which is about the understanding of spirituality in terms of a relationship with God or a Higher Being. The non-consensus of the relationship between religious belief and an understanding of spirituality and the practice of spiritual care may reflect that nurses do not see religious affiliation as a prerequisite to an individual's practice of spiritual care (Wu, Tseng and Liao, 2016). Therefore, nurses' religious beliefs may be irrelevant to their understanding of spirituality and the practice of spiritual care.

Age and professional seniority were positively related to nurses' understanding and practice of spiritual care (Yang, 2006) (F128). The older the nurses, the higher their spiritual intelligence scores tended to be ($F = 11.54$, $p < 0.001$), and the group with more than 10 years of seniority had higher scores of spiritual intelligence (16.46 ± 3.09) than other groups (3~5 years of 14.53 ± 2.95, 5~10 years of 13.94 ± 2.08, and <3 of 15.68 ± 4.42) (Yang, 2006). As for the variable marital status, only Chan's (2010) (F122) study revealed that it was significantly related to nurses' understanding and practice of spiritual care, with married individuals having a higher score than single ones. Four studies (Chung et al., 2007; Yang and Mao, 2007; Yang and Wu, 2009; Yang, 2006) (F125, F130, F135, F128) showed that marital status was not significantly related to nurses' practice of spiritual care and understanding of spirituality.

Nurses' educational level was considered significant in relation to their' practice of spiritual care in two studies (Wong et al., 2008; Yang and Wu, 2009) (F122a, F135). However, the results of these two studies contradicted each other. In Wong et al.'s (2008) study, the relationship with understanding and practice of spiritual care appeared positive in Hong Kong, for example a higher educational level equated with higher scores in understanding and practice of spiritual care (F122a). In Yang and Wu's (2009) study (F135), however, in mainland China nurses' educational level was negatively related to their spiritual intelligence. Those from vocational schools scored higher than nurses from junior college. Although the impact of educational level on nurses' spiritual intelligence in Hong Kong and mainland China may have relevance to spirituality and spiritual care in different social systems, two other studies (Yang and Mao, 2007; Yang, 2006) revealed that educational level was not significantly related to nurses' spiritual intelligence (F130, F128).

The working department and experience of hospitalisation were significantly related to nurses' practice of spiritual care in only one study (Chan, 2010)(F122). Those working in Obstetrics and Gynaecology had a higher score on the practice of spiritual care than those working in emergency room, ICU and surgical departments. This may be due to cultural factors in the Obstetrics and Gynaecology department, for example the requirement for tender care of new-born baby may creates a gentle atmosphere in which spiritual care is given thought and time for consideration. Also, the enjoyment and hope for new life from both parents and midwives may provide a pleasant environment for addressing spirituality and improving spiritual care. Those having hospitalisation experience

had higher scores in the practice of spiritual care than those with no experience. This may be because nurses who have been patients in the past have more understanding of their patients' needs based on their own experiences.

The nurses' position, grade or status (Yang and Mao, 2007; Yang, 2006) (F130, F128), gender (Chung et al., 2007; Chan, 2010) (F125, F121), and life events (Chung et al. 2007) (F125) had no significant relation to their spiritual intelligence or practice of spiritual care. Nurses' spiritual intelligence was measured by Wolman (2001) *PsychoMatrix Spirituality Inventory*, covering seven spiritual factors of divinity, mindfulness, extrasensory perception, community, intellectuality, trauma and childhood spirituality as part of a spiritual intelligence tool.

Other factors

'Other factors' were the variables or items in the questionnaires and study design that were relevant to an understanding of spirituality and spiritual care. For example in Yang's (2006) study, besides certain demographic variables being relevant to spirituality and spiritual care, 'childhood spirituality' was considered an other factor influencing nurses' spirituality and spiritual care, as this study revealed 'childhood spirituality' to be associated with nurses' spiritual intelligence (F130) using Wolman's (2001) *PsychoMatrix Spirituality Inventory*. In comparison, in Yang and Wu's (2009) study, 'childhood spirituality' and 'social systems' accounted for nurses' spiritual intelligence when applying step-wise multiple regression analysis in exploring this factor in Taiwan and China with the same spiritual intelligence tool (Wolman, 2001)(F135a).

Similary, the multiple linear regression analysis in Chung et al.' (2007)(F126) study revealed that a factor labelled ‘self’ (nurses’ relationship with the self dimension) contributed to an understanding of spiritual care and practice when using the *Nurses’ Spirituality and Delivery of Spiritual Care* (NSDSC) questionnaire. Multiple regression in Chan’s (2010)(F122) study also disclosed that the ‘perception of spiritual care’ is significantly related to the ‘practice of spiritual care’: the higher the score of the perception of spiritual care, the more likely to practise spiritual care (Beta = 0.25, $p < 0.001$). This study (Chan, 2010) utilised a modified version of NSDSC, with 10 items of the questionnaire considered critical to nurses’ spiritual care for patients. This is because these items measure nurses’ perceptions of spiritual care and evaluate nurses’ spiritual care practices, with established content validity of 0.92 by a panel of experts and reliability of 0.92 by *test-retest*. The factor analysis in Chan et al.'s (2006) (F120) study also showed perception of spiritual care was related to the practice of spiritual care ($r = 0.62$, $p < 0.001$) using a structured self-reported questionnaire: the higher the score in nurses’ perception of spiritual care, the higher score they gained in their practice of spiritual care.

‘Other factors’ influencing spirituality and spiritual care included nurses’ ‘relationship with self’, ‘religious belief’, ‘childhood spirituality’ and ‘social systems’. These factors are very broad and may also be seen as cultural factors which consist of personal, organisational, and other cultural settings in different regions or countries (van Leeuwen, Tiesinga, Post et al., 2006; Lucchetti, Ramakrishnan, Karimah et al., 2016). These findings are consistent with other studies conducted among multicultural groups which found that cultural values are important to spiritual care at either personal, organisational or regional level (Zhang et al., 2018; Pirkola, Rantakokko and Suhonen, 2016). Therefore, when providing

spiritual care to PCB or within a Chinese context, cultural factors should be considered.

Discussion

In this section, I discuss the concepts of an internal force, Higher Being(s) and suffering that were identified in this review, comparing them to Western understanding of spirituality, highlighting the implications for healthcare practice and research. I also explore the influence of demographic factors on nurses' and healthcare professionals' practice of spiritual care, while noting affirm that there may not be a single predictable factor that influences people's perceptions of spirituality and practice of spiritual care.

An internal force and Chinese spirituality

Participants in the studies related their understanding of spirituality and spiritual care to an internal force, describing it as an integral part of the human. This may be manifested as an inner energy from deep within the person. It may provide an inner wisdom, enabling the person to distinguish good and evil, be a force for healing and recovery, and a supporting resource. The Western healthcare literature also supports this premise of spirituality, using similar words such as motivation (Stoll, 1989; Tanyi, 2002), and empowerment (Reed, 1992) to indicate that spirituality is a driving force. However, the Chinese understanding integrates both the entity and internal force of human biology with spirituality, with an emphasis on the latter. The integration of the entity and internal force as spirituality may reflect their understanding of the *jing, Qi, shen* (精气神) which is rooted in the cultural values of Daoism and Traditional Chinese Medicine (TCM) in which, *jing* (精) is the essence and source of life, *Qi* (气) is the vital energy of the

body, and *shen* (神) is the vitality behind *jing* and *Qi* (Li and Shang, 2014). The *jing, Qi, shen* are usually used together as a phrase in Chinese cultures and TCM to demonstrate things related to essence, force and vitality. Thus the term spirituality, which is *jingshen* in Chinese (combined from *jing* and *shen),* has the meaning of an essence, force and vibrancy in the human body. The integration of *jing, Qi, shen* into the understanding of spirituality demonstrates their importance for spiritual care, where *Qi* appears evident.

Higher Being(s) and Chinese culture in spirituality

The importance of relationships to understanding spirituality within Chinese culture is consistent with Western definitions. These relationships involve connectedness with self and beyond self, including the sacred (Puchalski et al., 2014) or a Higher Being (Weathers et al., 2015) which may be either religious or mystical (McSherry and Cash, 2004). However, the religious and cultural boundaries regarding Higher Beings in the understanding of spirituality is obscure in Chinese culture. This is mainly because, as the findings of the review show, the participants were not clear whether to classify Confucianism Buddhism and Daoism as religion. For example, in Mok et al.'s (2010) study, the authors interpreted God/Higher Power as religious elements by categorising these concepts in the sub-theme '*Having faith in God/higher power through religious beliefs and practices*'. However, it is unknown whether the participants indicated God or Higher Beings in a religious or cultural sense. Although many authors, such as Mok et al. (2010), Yang et al. (2012) and Chio et al. (2008) considered Confucianism Buddhism and Daoism as religion, some studies such as Hsiao et al. (2011) and Chiu (2001) held the view that these were cultural values, interpreting them as both religions and cultural philosophies. Thus, there is inconsistency between participants and authors, and among authors

of different studies regarding the classification of Confucianism Buddhism and Daoism as religion or cultural values. This reflects there is vagueness in classifying God/Higher Beings as either religious or cultural domain in the studies conducted in a Chinese context.

The ongoing debate about whether Confucianism Buddhism and Daoism are philosophies or religion contributes to this confusion. In Western culture, religion must be a formal organised system, associated with a Higher Being, ritual and beliefs (McManus, 2006; MacKinlay, 2006). Jacques (2012) therefore argues that Confucianism Buddhism and Daoism do not qualify as religions because they are not organised and formal. This is further complicated when participants interpret their understanding of God/Higher Being as either religious or cultural when referring to spirituality.

Healthcare professionals therefore need to understand whether individuals from a Chinese background are referring to Higher Being(s) in a religious or cultural sense, because participants may be sensitive to whether spiritual care is implemented in a religious or cultural way and this will have implications for clinical practice. For PCB who claim a religious affiliation, this may make it a little more straightforward when assessing and implementing religious/spiritual care. This belief may be expressed more freely which will help direct support and related spiritual activities, so an individual feels their belief and values are understood and respected. Conversely, an individual who indicates that their beliefs in a Higher Being(s) is based on their cultural customs may require further exploration to assess the level of support required. Irrespective of whether PCB relate Higher Being(s) in religious or cultural sense, this whole area should be managed

sensitively to avoid PCB' feeling that they have been misunderstood or that their religious/spiritual beliefs have not been supported in a respectful manner.

Suffering, Chinese culture and spirituality

Participants in the Chinese studies related their understanding of spirituality and spiritual care to their experiences of illness. This may be because illness was their focus at the time the interviews were conducted and appears to confirm that awareness of spirituality is often raised or brought to people's attention during times of crisis or illness (Murray and Zentner, 1989). A focus on physical problems at difficult times of being ill reflects a generic understanding of spirituality, highlighting that spirituality is the existing reality participants experienced evidently (Swinton, 2010). This attention is helpful for healthcare professionals focus on the illness when implementing spiritual care.

When facing illness or crisis, relationships with the family and Chinese culture are important for PCB (Weathers et al., 2015) because they can gain strength from these connections. For PCB, Chinese cultural and religious customs appear important because these values help explain suffering, offering a way to cope with it. They also provide a foundation by transcendence of the situation may be achieved, providing a new way of finding meaning and purpose in life. Therefore, nurses and other healthcare professionals from different cultures need to understand these values to grasp PCB's perspective of suffering and utilise appropriate culturally sensitive spiritual care strategies. As this review shows, the role of Chinese culture in people's understanding of spirituality and its relationship with suffering have not yet been established in existing studies which indicates

that more investigation is required into PCB's understanding of spirituality and its relationship with Chinese culture in current healthcare and nursing practice.

This scoping review made me more aware of the importance of acquiring knowledge of different cultural perspectives with regard to suffering, especially when exploring PCB's understanding of spirituality and spiritual care in England.

Demographic factors in spiritual care

The results showed no consensus in the current Chinese literature regarding the demographic factors influencing participants' understanding of spirituality and spiritual care, which suggests that they are not major parameters influencing nurses' understanding and practice of spiritual care. Their understanding and competence in spiritual care needs to be developed professionally, supporting the finding that nurses with a higher perception of spiritual care tended to have higher scores in the practice of spiritual care in both the Chinese and international contexts (Chan, 2010; Chan et al., 2006; Turan and Yavuz Karamanoglu, 2013). However, this does not mean that the studies exploring the relationship between nurses' demographic factors and spiritual care were unimportant. The nurses' demographic characteristic(s) (Ozbasaran, Ergul, Temel et al., 2011) are relevant because they concern specific samples of people in different contexts. Each study's findings are valid for the participants in that specific setting. For example, Chan's (2010) study was conducted in a public hospital and it showed that the nurses who had a religious belief, were married, and had past hospitalisation experiences of being patients, were significantly more likely to practise spiritual care. Therefore, in this particular hospital, the nurses with these characteristics

were more likely to be involved in meeting patients' spiritual needs perhaps due to enhanced understanding of the importance of the concept in people's lives.

Implications

The significant findings of differences between a Western and Chinese understanding of spirituality and spiritual care highlight the need for further exploration of these concept within nursing and healthcare practice, education, and research. This exploration should have a focus on the importance of these concepts and their relationship to Chinese culture and values.

Nursing, healthcare practice and education

The findings highlight that it may be important that spiritual care is implemented in a cooperation with *Qi* related activities for PCB. This is because of the finding that spirituality is closely related to an internal force from a Chinese perspective and is rooted in *Qi*. In Hsiao et al.'s (2011) study, one participant highlighted *Qi-Kong* as a spiritual resource in illness, which is a kind of martial art or exercise to enhance the internal force and make it flow throughout the body to unblock the abnormal nodes of illness. Moreover, because participants referred to the essence, force and vibrancy of the concepts *jing, Qi, shen* with spirituality and Chinese medicine, such as Chinese herbs and treatment, it is important to integrate traditional Chinese medicine into spiritual care.

Also, this review has shown that there is no one specific demographic factor or cultural factor determining nurses' practice of spiritual care. Therefore, it may be necessary to educate nurses and healthcare professionals to increase their knowledge and understanding of spirituality and spiritual care.

Research

The findings of this review offer new directions for further research, for example, exploring the meaning of Higher Being(s) and how this may relate to understandings of spirituality and spiritual care based on either religious or cultural difference. This will be important for healthcare professionals with regard to providing religious and spiritual care that is person-centred and sensitive to the cultural values and needs of the individual.

Moreover, the requirement to develop cultural knowledge suggest the need to conduct a comprehensive investigation into how such knowledge may support the provision of care that is sensitive to the spiritual needs of PCB. This may also explain how PCB approach suffering from a Chinese cultural perspective and how this may inform their understanding of spirituality.

Furthermore, the inconsistency between 'factors influencing spirituality and spiritual care' and 'barriers and benefits of spiritual care' requires the development of a quantitative instrument to help measure the inhibiting and facilitating factors that affect spiritual care. This could be done through a comprehensive literature review or through a primary research exploring the barriers and benefits of spiritual care in Chinese culture. Conducting a literature review with a more systematic approach would also provide a greater insight into the barriers and facilitators of spiritual care to guide nursing and healthcare practitioners to maintain PCB's spiritual well-being.

In addition, the results suggest the need for a more detailed review involving studies published in other languages and grey literature to offer a deeper understanding of spirituality and spiritual care. This review was restricted to Chinese and English articles, excluding grey literature, due to the limited time and finances available to trace the unpublished studies and translate articles written in other languages.

Summary

This scoping literature review was undertaken in an inclusive rigorous and systematic manner, to answer the research question "What are the meaning and experiences of spirituality and spiritual care in a Chinese context?". By outlining all the steps involved this adds to the transparency and reliability of the scoping review (JBI, 2014a). Two themes the *Meaning of spirituality*, and *Implementation of spiritual care* were developed from the synthesis of the data. The *meaning of spirituality* in the Chinese context is multidimensional and based primarily on the Chinese cultural values of internal forces, connection, suffering and religion. The *Implementation of spiritual care* is derived from the categories of 'Ways of spiritual care', 'Barriers and benefits of spiritual care' and 'Factors influencing spirituality and spiritual care'. The findings arising from this review raise implications for future nursing, healthcare practice and research.

In particular, this review enhanced my awareness of the concept of 'Higher Being(s)' in a religious or cultural context. It also highlighted the need to acquire and develop knowledge about Chinese culture and how this may inform the understanding of spirituality and spiritual care in the main investigation. Thus, this early synthesis increased my theoretical sensitivity in terms of developing insight

into the concepts of ‘Higher Being(s)’ and ‘Chinese culture’ from a holistic perspective. This will help me avoid trying to forcing the data to fit into the existing knowledge (Glaser and Strauss, 1967).

From a general perspective, the concepts outlined in this chapter and the conceptual literature review in Chapter Two enhanced my theoretical sensitivity to the concepts of spirituality and spiritual care, and my knowledge in qualitative and quantitative research design. In particular, I have been able to maintain rigour in the main qualitative investigation and to identify the gaps, noting a lack of grounded theory investigation in the current Chinese research exploring the meaning of spirituality and spiritual care.

This literature review revealed gaps in the body of knowledge with respect to spirituality and spiritual care are: 1) whether the concept of ‘Higher Being(s)’ is raised in a cultural or religious sense in PCB’s understanding; 2) the need for the development of cultural knowledge to assist with the implementation of spiritual care for this group of people. By exploring these gaps, PCB’s perceptions of spirituality can be fully understood in order to address their spiritual care and needs adequately.

CHAPTER FOUR RESEARCH AIM AND METHODS

Introduction

In Chapter Three, I detailed the scoping literature review, identifying two principle gaps in comparing the Chinese and international literature with respect to knowledge in this field, which enabled me to explore: *How PCB perceive the concepts of spirituality and spiritual care in three regions of England.*

In this chapter I present the research question and objectives to give overall direction for this investigation. I introduce grounded theory research design and my reasons for choosing it, and present Leininger's cultural care theory (McFarland, 2014) to ensure this investigation is conducted in a culturally sensitive manner. I then outline the different processes involved in respect of its geographical focus, ethical considerations, the pilot, and data collection and analysis.

Research question and objectives

The aim of this investigation is outlined in the following research question:

How do PCB living in three regions of England perceive spirituality and spiritual care?

Objectives

1 *To compare the relevant concepts emerging from the data analysis to gain a deeper understanding of the term spirituality among Chinese groups, and how this is understood by PCB living in England*

2 *To identify how PCB who have been hospitalised perceive and experience spiritual care*

3 *To develop a theory of spirituality and spiritual care by investigating PCB living in three regions of England*

Grounded theory

There are different approaches of grounded theory, such as Glaserian, Straussian and Constructivist Grounded Theory. However, two of the schools, Glaserian and Straussian, are considered as early ones that inspired the others (Strauss and Corbin, 1990). For example, a constructivist grounded theory is based on an interpretive view that reality can be constructed in line with individual understanding of a social phenomenon, which was developed from Glaserian and Straussian grounded theory (Charmaz, 2014). In the following, I outline the philosophical views of grounded theory in different traditions and how they offer different ways of thinking about reality. I then focus on two major schools of grounded theory, Glaserian and Straussian, highlighting the reasons I chose Straussian to guide this investigation.

There are different ways of looking at social reality, including ontology (what the researcher believes is the reality), and epistemology (how to know the reality) (Cohen, Manion and Morrison, 2011; Sapsford, 2006). The various schools of grounded theory cover different philosophical views of reality ranging from positivism and traditional thinking that reality exists, to the modern pragmatism that reality needs to be found in the interaction of society, and the post-modernist view that reality is shaped by individual interpretation (Cohen et al., 2011). The

contemporary thinking is that reality needs to be found and the way to find it is by interacting with data. This is based on Straussian grounded theory that guided my investigation, stressing the need to enter the field, in this case to explore knowledge of spirituality and spiritual care with participants from Chinese society living in the UK.

Glaser and Strauss established grounded theory in 1967 with the publication of *The Discovery of Grounded Theory: Strategies for Qualitative Research,* which described the method of generating theory from data (Glaser and Strauss, 1967). This is often referred to as Glaserian, classical, or Columbia grounded theory. Barney Glaser came from Columbia University and was influenced by Paul Lazarsfeld, who was known as an innovator of quantitative methods (Strauss and Corbin, 1990). Thus, Glaserian grounded theory holds the view that theory and categories are inherent in the data, and this is considered a realist view of truth because "there is a real reality out there to be discovered" (Annells, 1996 cited from MacDonald and Schreiber, 2001 p.44). Based on this, it adopted a positivist paradigm, using reliability validity and generalisability to judge the products and process of the research, and adopting quantitative analytical methods (for example simple factor analysis) (MacDonald and Schreiber, 2001). As Charmaz (2000 p.512) states, Glaserian grounded theory was "founded upon Glaser's epistemological assumptions, methodological terms, inductive logic, and systematic approach".

Modified grounded theory is referred to as Straussian, or Chicago grounded theory. Anselm Strauss came from the University of Chicago which had a strong tradition in qualitative research and his thinking was inspired by people such as

George Herbert Mead (1934) who maintained that the self arises in social interaction with others through symbolic communication. Therefore, his experience was based on a more relativist and a pragmatic perspective that nature or reality comes from symbolic interaction with others, in comparison with the realist view of Glaserian grounded theory that a theory exists in the data and needs to be found. Straussian grounded theory demonstrates a shift from the realist view of Glaserian grounded theory (Hall, Griffiths and McKenna, 2013) considering a phenomenon from a naturalistic perspective.

Indeed, Straussian grounded theory is influenced by symbolic interactionist and pragmatist writing (Charmaz, 2014) which means that Strauss viewed society, reality and self as being constructed through interaction, and thus relying on language and communication (Charmaz, 2014). At the same time, the impact of pragmatism for him is related to the human or agents' action and interaction with others in a social process which is fundamental to human existence, and the construction of actions is central to identifying the process in solving a problem (Charmaz, 2014). These basic philosophical views on symbolic interactionism and pragmatism form the eight assumptions of the Straussian grounded theory which are: 1) the need to get out into the field to discover what is really going on; 2) the relevance of theory, grounded in reality, to the development of a discipline and as a basis for social action; 3) the complexity and variability of phenomena and of human action; 4) The belief that people are actors who take an active role in responding to problematic situations; 5) The realisation that persons act on the basis of meaning; 6) The understanding that meaning is defined and redefined through interaction; 7) A sensitivity to the evolving and unfolding nature of events;

8) An awareness of the interrelationships among conditions (structure), action (process), and consequences (Strauss and Corbin, 1998 pp.9-10).

A symbolic and pragmatic perspective, that considers nature as a reality arising from interaction with others and practical action in society, is consistent with my view of the nature of knowledge regarding the meaning of spirituality and spiritual care. This is because I doubt this kind of knowledge is inherent in the collected data, from a realistic perspective, or is an individual's mental construction of data, from a constructivist view. However, I believe that we act according to the meaning we give to data, and the meaning can change through our social interaction with others by using language and symbols. I therefore chose Strauss and Corbin's (1998) approach to grounded theory because the pragmatist and symbolic interactionist view of reality seemed the best way to investigate the phenomena of spirituality and spiritual care.

Since I perceive that a knowledge of spirituality and spiritual care can only be gained through interaction with others, I did not employ or consider any other qualitative methods because they would not allow for the construction of a theory with the same outcome as the approach suggested by Strauss and Corbin (1998).

The critiques of grounded theory

Currently there are some critiques of grounded theory in relation to the quantitative–qualitative realm, and the methods employed, such as the role of literature and the analytical tools which I highlight below.

Grounded theory in a quantitative–qualitative realm

Currently, grounded theory is considered as qualitative design (Burns and Grove, 2009). Qualitative researchers assume that reality is internal and subjective, and that they acquire the knowledge through active involvement with their subjects. In contrast, quantitative researchers assume that reality is external and objective and that they have to acquire the knowledge through a passive observational role, and align themselves in the natural science method. However, Savin-Baden and Major (2012) argue that it is problematic to categorise grounded theory as qualitative because of the broad range of philosophical views from different schools of grounded theory. For example, as mentioned above, Glaserian grounded theory within a realistic perspective and quantitative analytical method in a positivistic understanding may be contrary a qualitative design.

The philosophical perspective of grounded theory and its qualitative argument suggest that classifying grounded theory as qualitative or quantitative may be not important. This is because grounded theory covers a range of philosophical views including a pure realistic view or interpretive view which underpins both quantitative and qualitative research methodologies (Sapsford, 2006). The essence is to apply the philosophical view of grounded theory and its inherent method in data collection and analysis that will give a meaningful explanation of a phenomenon. Straussian grounded theory suggests that the knowledge of spirituality is relative, depending on my interaction with each participant. Therefore, when exploring the understanding of spirituality and spiritual care, I will not use a quantitative research design that assumes reality exists ‘out there’, employing natural science methods such as surverys and experiments (Cohen et

al., 2011), or using reliability validity and generalisability to judge the products and processes of the research (MacDonald and Schreiber, 2001) as in Glaserian grounded theory. Rather, I will choose a design with a more qualitative sense which supports the view that no absolute truth exists as social reality (Savin-Baden and Major, 2012), and will actively interact with the participants to understand their perceptions of spirituality and spiritual care by communicating and observing them.

Role of the literature review

There is some debate about the role of the literature review in the early stages of a qualitative research especially with regard to grounded theory (Elliott and Jordan, 2010). The researchers advocating Glaserian grounded theory claim there is a danger of imposing an existing theory and forcing the data to fit the theory and concepts from the literature, rather than allowing theoretical concepts to emerge from and be grounded in the data (Glaser and Strauss, 1967). However, Strauss and Corbin (1998) argue that it is difficult for the researcher to go to the field with a blank mind, and they suggest that the literature review is fundamental in grounded theory for increasing a researcher's theoretical sensitivities, and it depends on how the literature is used in developing a theory from the data. Strauss and Corbin's (1998) argument about the researcher's blank mind and the importance of literature is consistent with my own experience regarding knowledge of spirituality and spiritual care in nursing. I come from China where spirituality and spiritual care has no role in healthcare settings. Therefore, the literature review enhanced my knowledge of the Western and Chinese understandings of spirituality in healthcare, and thus my theoretical sensitivity to data analysis in this investigation. As shown in Chapter Three, the review heightened my theoretical sensitivity regarding the concept of 'Higher Beings' and Chinese cultural knowledge of

spirituality and spiritual care. Also, being a novice in grounded theory methodology, the literature review guided me in developing the investigation question for either new knowledge generation or to test existing knowledge in the field of spirituality and spiritual care. My experience of developing knowledge in the nursing discipline and constructing a research question highlighted the importance of conducting a literature review at an early stage in the research, particularly when employing Strauss and Corbin's (1998) school of grounded theory.

The analytical tools

Strauss and Corbin (1998) reformed the classic mode by developing analytic techniques and providing guidance to novice researchers. Strauss examined the data and asked "What if?" because he wanted to consider every possible contingency that could relate to the data, whether it appeared in the data or not (Stern, 1994). I agree that asking "what if?" provides a chance to search for possible data that have not been found. Strauss and Corbin (1998) provided a coding tool to identify an emergent grounded theory, which was slightly different from Glaser's. Glaser's coding tool comprised two levels of coding: substantive coding and theoretical coding (Heath and Cowley, 2004). Substantive coding includes two sub-phases: open and selective coding (see section on Coding p.103). In Glaserian grounded theory, induction is the key, compared with deduction and verification. This is based on Glaser's suggestion that grounded theory should be carried out in a flexible and simple way, and line-by-line analysis alone was enough to develop theoretical sensitivity through theoretical memo writing. Thus, in this approach all data are viewed as important and all other considerations are encompassed. Glaser also proposed that only by the use of

patience, tolerance of confusion, hard work, and going over and over the data using constant comparison would the concepts emerge (Heath and Cowley, 2004). The need to be flexible and tolerant in an extended way made me think that substantive coding and theoretical coding in Glaserian grounded theory would be very difficult to follow.

In contrast, Strauss and Corbin emphasised that induction, deduction and verification in the analysis process play their own roles, and claimed that the original grounded theory overplayed the role of induction. In their process of coding, the researcher is constantly moving between inductive and deductive thinking and that is the interplay between proposing and checking. Based on this, they developed three kinds of coding: open coding, axial coding and selective coding (see section on Data analysis). I felt this provided a more structured approach to guide novice researchers like myself.

Key components of grounded theory

There are seven key components in grounded theory which are openness/theoretical sensitivity, theoretical sampling, coding, constant comparison, theoretical saturation, the production of a theory, and reflexivity (Strauss and Corbin, 1998). I will briefly describe how each of these guided my investigation.

Openness/theoretical sensitivity

Theoretical sensitivity refers to the personal quality of the researcher to gain an awareness of the subtleties and meaning of the data. Theoretical sensitivity occurs in conceptual rather than concrete terms and sources of theoretical

sensitivity come from literature, professional experiences and personal experiences (Strauss and Corbin, 1990).

In this investigation, I used this technique to remain sensitive to the data, for example, in conceptualising the phenomenon ‘Difficulty in articulating’ the term spirituality in Chapter Eight (p.268). I described this category by detailing its properties and dimensions while grouping, interpreting and relating its subsidiary codes or concepts. Participants demonstrated this phenomenon by stuttering, hesitating or having nothing to say about the term, which coded as ‘action’, ‘Difficulty in articulating’. If they also stated that the term was difficult to explain, I coded their words in the transcript as ‘statement’, ‘Difficulty in articulating’. I then grouped the codes of the action and statements as the manifestation, indicating how the participant responded when trying to describe the term. I also grouped the reason for this being that the term is abstract, and people rarely think about it. Another reason is that spirituality is subjective and open to individual interpretation. It relates to personal privacy and covers a broad range of topics from the private to political life, presenting an issue when translating between spirituality and *jingshen* in the interviews. By using this method of grouping, I became more aware that spirituality is difficult to articulate.

Similarly, conducting a very brief conceptual literature review regarding the definition and explanation of spirituality in international and Chinese settings and the scoping review also enhanced my theoretical sensitivity to the phenomenon. For example, the religious understanding of spirituality is described as a relationship with God, religious practice, and the personal inspiration and

transcendent experience from this relationship (Stoll,1989 cited in Carson and Stoll, 2009). This provided a way of conceptualising religion in my investigation.

Theoretical sampling

Theoretical sampling means that data analysis guides the sample selection (Glaser and Strauss, 1967), based on the emerging concepts from the data that have relevance to the evolving theory. McSherry (2004) demonstrated that theoretical sampling not only responds to emerging data, it also depends on the characteristics information of the participants. However, McSherry (2004) notes that applying theoretical sampling assumes that potential participants possess the knowledge or experience required, which could present a limitation if the recruited participants do not have the required knowledge. The implications for my investigation are to recruit participants from a bigger sampling pool and to know each participant's background and the potential questions to ask to address further theory development. As theoretical sampling is the main sampling process used in this investigation, it will be revisited later in this chapter (p.140).

Coding

Coding is breaking down the collected data into small units of meaning and labelling them in order to generate concepts. Several authors recognise coding as a core process and fundamental analytical tool of grounded theory (Holton, 2007; Hoare, Mills and Francis, 2012).

When highlighting the reason for choosing Strauss' coding strategy, I explained that Glaserian coding is guided by inductive reasoning while Straussian follows the reasoning of induction, deduction and verification (Heath and Cowley, 2004).

Glaser developed selective and theoretical coding strategies in his grounded theory, while Strauss developed the coding strategies of open coding, axial selective, and selective coding (Heath and Cowley, 2004).

The major coding strategies are considered as three-stage procedures which have differences according to the different schools of Grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Strauss and Corbin, 1998; Charmaz, 2006). Table 4.1 below demonstrates the similarities and differences in the coding stages and tools of the three major schools of grounded theory, the Glaserian, Straussian and Charmaz' constructivist grounded theory.

Table 4.1 Coding stage and tools in different schools of grounded theory

Coding Stage	**Glaserian/Classic**		**Strauss and Corbin (1998)/(Corbin and Strauss, 2015)**	**Charmaz (2006; 2014)**
1	Open	Substantive	Open	Initial
2	Selective		Axial	Focused
3	Theoretical		Selective	Theoretical

The table shows that the coding tools in Glaserian, Straussian and constructivist grounded theory: open coding, axial selective or focused coding, and selective and theoretical coding (Engward, 2013). The first stage involves coding each line, word and segment. The second stage is about finding the significant concepts and relationships, and the third stage is sorting out the relationships of the main categories. There is no distinct boundary between stages one and two. Line-by-line coding in Straussian grounded theory leads to micro-analysis of data, word by word, making comparisons and asking questions, reflecting a multiplicity of perspectives and truths and actions/interactions of humans implied by Strauss. In

contrast, the line-by-line coding and continuous comparison of data in Glaserian grounded theory enables patterns to emerge, though it is more on the macro side. This highlights Glaser's positivism that theory and categories are inherent in the data. Line-by-line coding in constructive grounded theory using gerunds is considered useful in identifying a process because gerunds are usually associated with actions or processes (Charmaz, 2014), and the theoretical coding in constructivist grounded theory is similar to Glaserian (Engward, 2013). Axial coding is a special term used in Straussian grounded theory, where the relationship of the categories is established. Selective coding in Straussian grounded theory is to identify a core category under a paradigm of conditions, actions and consequences, while in Glaserian grounded theory it identifies a social process under a set of theoretical codes (Kelle, 2007).

These strategies and tools offered me some basic knowledge of coding in grounded theory in terms of their similarities and differences. This highlighted that the coding tool in Straussian grounded theory was easier to follow, with clear guidance on open, axial and selective coding, particularly the axial coding, to identify the relationship between categories. The coding tools provided in Straussian grounded theory guided the data analysis and theory generation process in this investigation. Importantly, exploring the analytical tools in the different schools enabled me to compare how these facilitated my investigation in the data analysis and theory generation.

Constant comparison

Constant comparison is comparing the emerging concepts in the data or literature to allow theory to emerge (Strauss and Corbin, 1998). Regarding 'Difficulty in

articulating' spirituality, for instance (p.101), showed that the term 'spirituality' is difficult to define, raising my awareness of the potential difficulty participants may experience with the term 'spiritual care' and trying to identify what the difference may be, because these two terms are both abstract and subjective. I felt it was easier to articulate, because participants were generally able to provide some practical examples or explanations in response to a direct question about spiritual care. However, for spirituality they required different kinds of prompts to elicit information, such as "*What is your perception on life?"* and "*What is important to you?*". Therefore, 'spiritual care' seems easier to describe than 'spirituality' so when a conversation regarding spirituality is difficult, a question about spiritual care may help participants to demonstrate their understanding of spirituality.

Describing spiritual care provided a way of exploring spirituality from a healthcare practice perspective. This highlights that the comparison of spirituality and spiritual care not only facilitated the identification of concepts around them, it also led to the development of questions that could be used in exploring the relationships between these two concepts.

To compare the emerging concepts with the existing themes identified in the literature, I used the term 'religion' mentioned above (p.101). Although the literature shows that religion is about a relationship with God, religious practice, and the personal inspiration and transcendent experience from this relationship (Stoll,1989 cited in Carson and Stoll, 2009), PCB's understanding of spirituality in the religious dimension is slightly different. This because their understanding is about their devotion to religious figures and a strong belief in Higher Powers rather than God. Comparing concepts around religion with the existing literature further

advanced the theory development from a Chinese perspective by establishing both a religious and cultural understanding of spirituality and their relationship to Higher Being(s).

Theoretical saturation

After 24 interviews, I felt that collecting additional data would be counterproductive, as the data collected could be grouped under the existing categories and located in their properties or dimensions (Strauss and Corbin, 1998). Therefore, I decided that the saturation of data had been reached, and I closed the data collection.

A substantive theory

The finding of this investigation generated a substantive theory from a narrower empirical area by focusing on a specific group of people in their own context (PCB living in England) and their understanding of spirituality and spiritual care. The findings did not intend to produce a formal theory with an emphasis specifically on the conceptual areas of spirituality and spiritual care within various conditions (Charmaz, 2014) to apply to a wider range of concerns in other groups outside of PCB living in England (Strauss and Corbin, 1990; 1998). This substantive theory is a set of concepts related to the core category in a cohesive way (see Chapter Eight), demonstrating a process of seeking a meaningful life, where PCB integrated their understanding of spirituality and spiritual care (Engward, 2013). It highlights the importance of developing an understanding of spirituality and spiritual care for practical purpose. Generating a purely theoretical and abstract insight may be unrealistic for practitioners (Swinton and Pattison, 2010), because the meaning of spirituality and spiritual care evolves over time and responds to

different situations and factors (Swinton and Pattison, 2010). Therefore a unified and formal understanding of spirituality that fits all cultures and contexts is probably not feasible (McSherry, 2005), and a practical understanding of spirituality suitable for certain cultures may be needed in healthcare.

Reflexivity

Being reflexive is demonstrated in my awareness of my background and knowledge including that from the literature review, and their influence on my research (McGhee, Marland and Atkinson, 2007), and finding strategies to limit this influence or differentiate my interpretation from others, such as those of the participants (Bolton, 2014). To better illustrate this, I provide a reflective account regarding my professional and personal background with a specific focus on my experiences with health and spiritual care.

I practised as a nurse in China from 1999 to 2003, and the experience of caring for terminally ill patients enabled me to observe patients' struggles at when receiving end of life care. I had sympathy for them but could do nothing except provide physical care. At that time I had a very vague understanding of the term 'spiritual care' because it was not used in the general medical settings in China. Spiritual/*jinghen* care seemed related to mental or psychological illness in mental hospitals, and it was not the nurses' responsibility working in general setting. Spiritual care in the Chinese sense can be anything, and therefore loses its meaning in a medical context. However, I was aware that spiritual care was being discussed as part of modern nursing at that time. When I worked in the Middle East, I observed that people facing death were very calm, observing the prayer provided by self, family and the religious services in hospitals, and this impressed

me greatly. The study undertaken as part of the Advanced Nursing Programme in the UK broadened my view on spiritual care in 2012, and I realised it was well implemented in Western nursing. I was interested in this kind of care because it is actual care that nurses can provide, and more importantly, care that can comfort people, particularly when facing death and other kinds of crisis.

As described above, these experiences enhanced my sensitivity in the field of spiritual care, raising my awareness of the impact of religion and nursing education. Also, they enabled me to develop strategies to question my own attitudes and values (Bolton, 2014), as my understanding of spiritual care could be termed as both wide range and narrow. A wide understanding is vague, aimless and unpractical. A narrow one, relating spiritual care specifically to mental care, may be beyond many general nurses' consideration. Being aware of my own understanding of spiritual care opened my mind to the international knowledge worldwide, enabling me to assess whether my understanding could bias the data analysis. For example, if a concept emerges from the data which indicated that spiritual care was mental care, I had to ascertain whether it was from the data rather than my own personal impressions or interpretation.

Theoretical framework

A theoretical framework and hypothesis development is not needed for a grounded theory research design (Glaser, 1998). However, because of the pioneering nature of this investigation, Madeline Leininger's cultural care theory, *Culture Care and Universality,* was used to guide the data collection and analysis. The theory takes account of a rapidly changing world and has been used and refined more than six decades since the 1950s (McFarland, 2014). Madeline Leininger, the

founder of the theory, put her life-time nursing practice and creative thinking into this theory for the field of transcultural nursing. The theorist transformed her cultural care theory into the *Sunrise Enabler,* a framework depicting its essential components and relationships (see Figure 4.1 below).

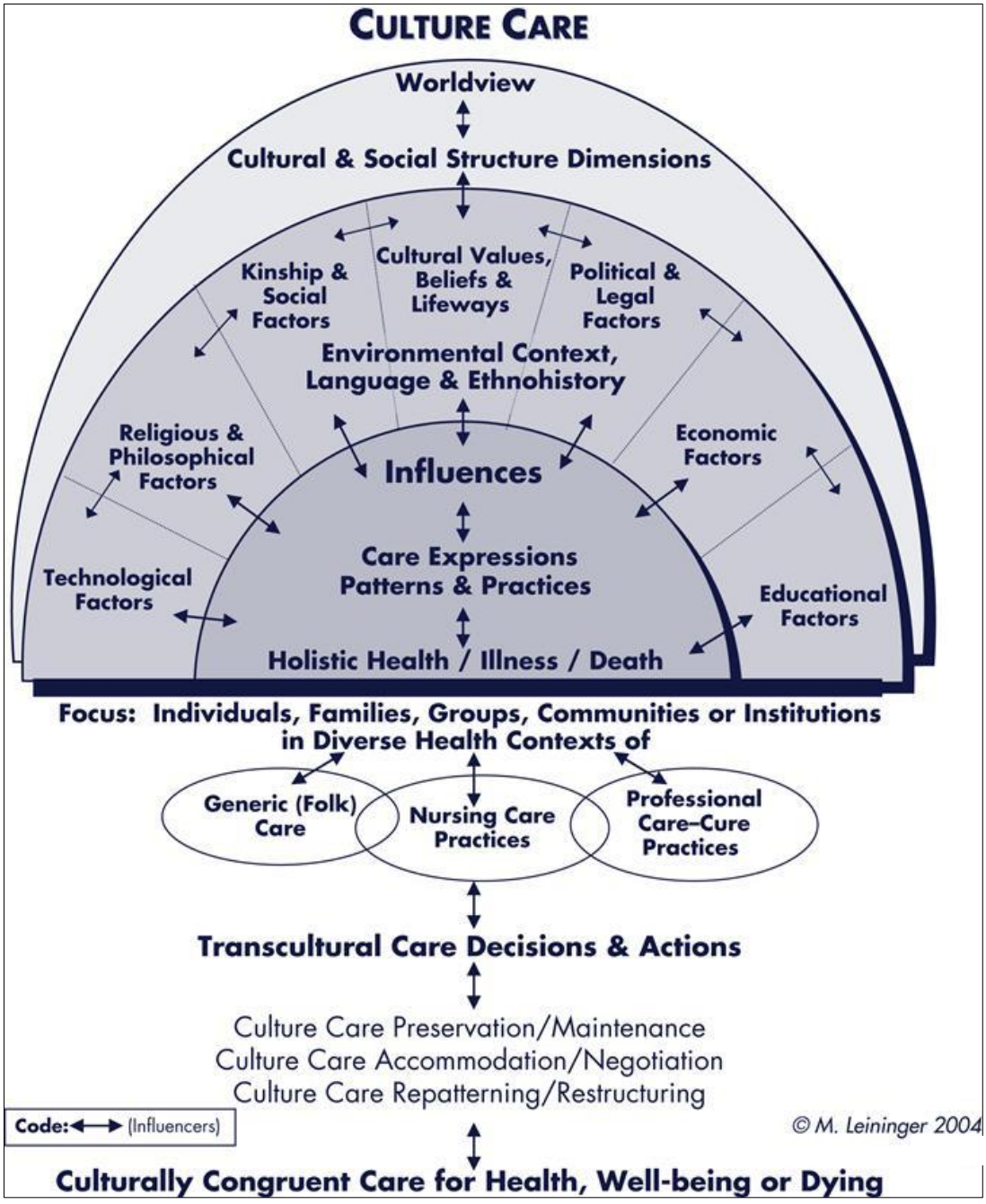

Figure 4.1 Leininger's sunrise enabler, adapted from McFarland (2014)

The figure above shows the many relationships that form part of the transcultural nursing theory and how this may be practised in the nurse–client relationship. The two halves together represent the universe that nurses must consider in appreciating human care and health. The upper half of the circle represents components of the social structure and worldview that influence care through the factors in the middle circle – the environmental context, languages and ethno-history, namely cultural values, beliefs and ways of life, kinship and social factors, religious and philosophical factors, political and legal factors, technological factors, economic factors, and educational factors. These factors in the two circles influence the factors in the middle part of the model – folk, nursing and professional practice, and the lower part of culturally congruent care occurring within the nurse–client relationship.

The cultural care theory highlights the important aspect of cultural care (caring) values, beliefs and practices of individuals or groups of similar or different cultures, with the goal of providing culture-specific and universal nursing care practices when promoting health and well-being. This is consistent with the current definition and understanding of spirituality, which casts light on the importance of personal beliefs and values (Puchalski et al., 2014). Moreover, its emphasis on the interaction between nurses and clients in providing culturally congruent care, reflects the epistemology of grounded theory that I, as a nurse researcher, interacted with participants to reveal their meaning of spirituality and spiritual care, to investigate providing culturally sensitive care. Finally, this conceptual framework highlights the importance of cultural factors, such as cultural values, relationships, finance and political considerations, which are deeply embedded in spirituality and spiritual care. Using this framework ensured that I undertook this

investigation in a manner that was culturally sensitive, capturing the diversity that exists concerning spirituality and spiritual care among PCB living in England.

Geographical focus of the study

This study involves PCB in three regions of England: London, Manchester and Birmingham. These three cities span England, including the North, West Midlands and South.

There are a growing number of people from Chinese backgrounds residing in the UK. In the UK at the time of the 2011 census (ONS, 2011), there were 387,584 people from 'Chinese or Other Ethnic Groups: Chinese' living in England and Wales. According to the 2011 census (ONS, 2011), the top three cities where Chinese populations live are London, Manchester and Birmingham, with figures of 137,623 in London (Greater London Built-up Area (BUA), 25,945 in Manchester (Greater Manchester BUA), and 17,751 in Birmingham (West Midlands BUA) respectively. The figures show large clusters of Chinese people living in these cities. Therefore, choosing them as research locations would facilitate the recruitment of participants ensuring representation from diverse Chinese ethnic groups.

Another reason for conducting this study in the UK is because the nursing practice here recognises people's beliefs and cultural values (NHS, 2015) and participants might feel free to express personal and sensitive feelings about spirituality and spiritual care. Also, investigating at a location where I am carrying out this PhD project facilitates the research process in terms of accessing participants, receiving support from supervisors, accessing library services and seeking the

research/ethical committee's suggestions around safeguarding the research process.

Ethical application

The Faculty of Health Sciences ethics panel (Staffordshire University) reviewed and approved the investigation (Appendix 4.1). A letter of introduction was sent to the administrators of each of the identified Chinese community centres in England, to seek help with recruitment and possible use of their facilities, if participants choose to be interviewed in these settings (Appendix 4.2). I received three letters of support from Chinese community centres (Appendix 4.3) and met with the manager to provide an overview of the investigation and their role prior to recruitment and meeting the potential participants. A covering letter and information sheet were given to all potential participants, outlining the nature of the study and what their involvement would entail (Appendix 4.4 and 4.5). Written informed consent (Appendix 4.6) was obtained from the participants by the researcher before data collection commenced. Participants were assured of total anonymity at all stages of the investigation, by keeping the participants' names confidential and not mentioning them during the recordings. No information about the respondents' identities was accessible to non-members of the research team, and all the information was stored in a locked filing cabinet, with all the electronic data on an encrypted and password-protected laptop, computer and portable disk. Participants were assured that they were free to withdraw from the study at any time. All the forms and information for participants were rewritten in English, traditional Chinese and simplified Chinese so that the participants could get the information in their preferred language.

Pilot study

Prior to commencing the main data collection and analysis phase, a pilot study involving six participants in five interviews was conducted to allow some basic concepts to emerge in the field of spirituality and for me to develop these in NVivo11.

During the pilot study, I ensured that I used the inclusion and exclusion criteria (below) to purposively select participants from Chinese community centres in the three regions. Participants were selected to provide their own unique understanding of spirituality and spiritual care thereby addressing the research aim (Pitney and Parker, 2009). The recruitment of participants satisfied the following criteria.

Inclusion criteria and exclusion criteria:

Participants were aged 18 years or above, and from a Chinese background. This meant that there was no need to seek permission from guardians for them to participate. Another reason for including these participants was because of the potential for them to have a greater life experience. Although including a broad range of ages made this investigation less focused, it assisted in capturing a comprehensive understanding of the concepts from various participants, across the life span including patients, healthcare professionals and nurses, and lay people employed in healthcare.

Because the investigation sought to explore PCB's experiences of spiritual care, I aimed for up to a third or half of the participants have utilised the health service or the NHS or been hospitalised in the past 12 months. This was to ensure that the

perceptions of spirituality and spiritual care could be compared between the two groups, people with recent experience of hospitalisation and those without hospitalisation.

I recruited both male and female participants. Participants had no cognitive impairment so there was no need to seek permission from their guardians or assess their mental capability. They had to be willing to participate in the study and able to give informed consent. These inclusion and exclusion criteria were deliberately wide in order to capture a broad range of views on spirituality and spiritual care.

The first six participants (one couple preferred to be interviewed together) varied in terms of their demographic characteristics, such as gender, age, religious belief, and country of origin, and I tried to ensure that the questions I asked in each of the interviews were derived or developed from the data analysis of the previous one. This ensured diversity among the recruited participants and followed the basic rule of theoretical sampling that the interview questions are based on previous analysis.

Pilot interviews

I used in-depth interviews for data collection in both the pilot and main investigation (Strauss and Corbin, 1998). This enabled individuals to talk freely about spirituality and spiritual care, so that their perception, understanding and experiences of the concepts could be obtained (Charmaz, 2014). I conducted each interview in a place that was convenient for the participant. These places included a room provided by the Chinese community centres, participants' own

houses, and a quiet place in a library. I used an interview agenda (Appendix 4.7), containing some prompts to guide the interview process (Holloway and Wheeler, 2010), particularly for the first few interviews. Due to the many accents/dialects that exist in PCB, for some interviews I used interpreters who had signed a confidentiality agreement (Appendix 4.8). At the end of the interview, I asked participants to complete a simple demographic form (Appendix 4.9) for basic information.

Issues raised in the pilot

The pilot study raised several issues that informed the early theory development on PCB's understanding of spirituality and spiritual care while living in England (p.119) (Strauss and Corbin, 1998). The pilot study also helped to refine the interview questions and enhanced my skill in conducting interviews, which built my confidence and competence on this aspect of the research process. Furthermore, the pilot highlighted several issues in relation to the interpretation services, thereby minimizing problems during the later data collection phase (Matthews and Kostelis, 2011).

<u>Refining of the interview question and process</u>

The pilot study helped to refine the interview questions. For example, an opening question developed in the original interview guide was *"Have you ever been provided with spiritual care?"* but this question seemed unsuitable in the pilot, as participants were embarrassed by it, and did not know how to respond. The participants' discomfort with the question led me to reword it to "*What is your perception on life*?" (In interviews 7, 9, 10, and 11), or "*What is important to you*?" (Interviews 12 and 13). The adjusted opening questions were simple and they

encouraged participants to provide information in a comfortable way (Holloway and Wheeler, 2010). Through these introductory questions, I was able to build rapport with the participants, obtaining their background information and laying the foundations for the more probing questions on spirituality.

Although the initial question and interview prompts were good at eliciting information, I did not use them rigidly. I sensed a participant was very knowledgeable and able to provide information on spirituality from the beginning, for example, a scholar with a PhD degree in religious care, I adapted the question to "*What is the meaning of spirituality?"*, thereby reflecting their understanding and ensuring that I responded with sensitivity, treating them with dignity and respect.

I also enhanced the interview process during the pilot stage by testing the adequacy of the interview agenda and prompts, becoming familiar and efficient with the interviewing process. However, this was an ongoing process because interview prompts had to respond to the data analysis covering all the emerging categories. For example, the provisional category of 'Chinese traditions' emerging from the pilot made me change the interview question to '*Speak about something in Chinese culture regarding spirituality.'* A sample of the initial questions addressing seven key initial themes is provided to demonstrate that questions were revised during interviews in response to the emerging concepts/theory (Appendix 4.10).

Interpreting service and arising issues

The pilot study also cast light on some key issues associated with the interpreting service. For better oral communication with participants in the Chinese communities, I used interpreters employed by them to provide an independent and professional service. Interpretation for the interview involved the interpreter translating between other regional Chinese dialects and official Chinese Mandarin so the cohesion and clarity of the translation from Chinese dialects to Mandarin was assured. Moreover, the interpreters were members of the Chinese community where participants were recruited, so they had an accurate understanding of the other members' language and dialect (Al-Amer, Ramjan, Glew et al., 2015), being familiar with the participants' daily life experiences and habits. However, several issues arose with the interpretation during the pilot interviews.

First, the interpreter avoided interpreting some sensitive topics that the participant raised, such as death, unpleasant feelings, which led to missing information. Second, the interpreter added to the information provided, editing or paraphrasing the participant's response, or using a higher level of rhetoric. This could have changed the original meaning and information (Temple, Edwards and Alexander, 2006). Furthermore, it was observed that both the interpreter and the researcher interrupted the participants when they were responding, resulting in them losing their 'train of thought' when disclosing their personal story. The interruptions influenced the dialogue and dynamics of the interview (Cohen et al., 2011).

Being reflexive on the issues arising during the pilot interviews resulted in me implementing measures to ensure the quality and accuracy of interpretation. This

involved meeting with the interpreter before the interview and laying out expectations, setting ground rules, reviewing the interview questions to ask during each interview, and ensuring appropriate interpretation. During post-interview meetings I sought clarification for any ambiguous meanings that had arisen during the interview. Pre- and post-interview discussions minimised the interpreting issues outlined above (Temple et al., 2006).

Findings from the pilot study

I utilised line-by-line coding and sorted the relationship of emerging codes/concepts by applying *condition, action* and *consequence* to relate the concepts when analysing the five transcripts. This led to the emergence of seven provisional categories, 'Religion', 'Chinese tradition', 'Good life', 'Relationships', 'Life events', 'Hope', and 'Spiritual care'. The basic analysing skills of open and axial coding (p.143) and the categories were checked and validated by two of my supervisors. These seven provisional categories overlapped with each other to provide an initial understanding of spirituality, and this relationship can be seen in Figure 4.2. The circles in different colours in the background refer to the provisional concepts, while the orange circle in the front centre represents spirituality where all the other surrounding concepts have collectively contributed to its meaning.

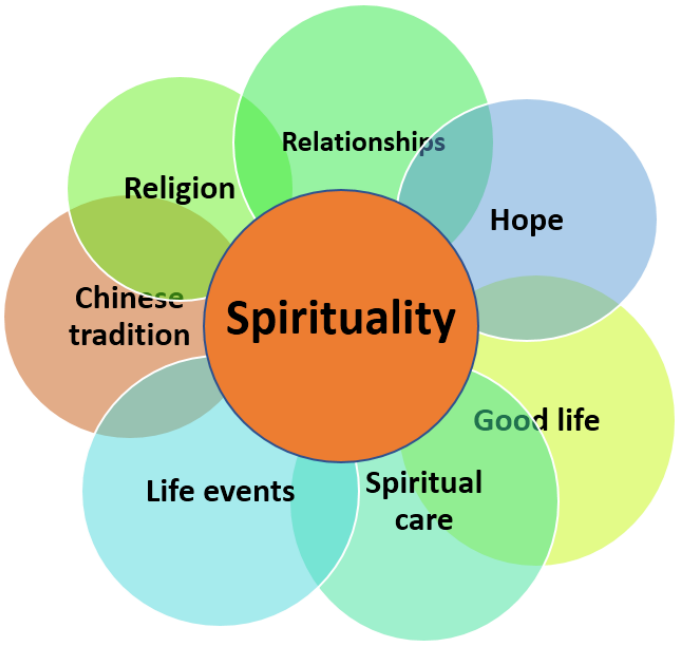

Figure 4.2 Seven provisional categories from the first five interviews

The above figure suggests that the first six participants held different views of spirituality and these views related to each other to support the meaning of spirituality. The seven provisional categories fall into two broad groups, from those who considered spirituality as being synonymous with religion, and those who felt spirituality was not religion but more rooted in Chinese tradition. The religious and non-religious understandings are consistent with the current literature that spirituality is a universal concept and applies to religious and non-religious individuals (Swinton, 2010). The literature notes that spirituality may be associated with religion (Stoll, 1989), cultural values (Puchalski et al., 2014), relationships (Narayanasamy, 1999c), hope, and living a good and meaningful life, and a resource during difficulty or critical times in life (Weathers et al., 2015). The multidimensional view of spirituality held by participants reflects that there is no standardised understanding of spirituality. It is subjective and its meaning emerges over time in different situations (Swinton and Pattison, 2010).

In Table 4.2, I present extracts of interview transcripts supporting these concepts in their dimensions.

Table 4.2 Provisional categories in the pilot stage

Provisional category	Aspects of provisional category	Participant's extract	Participant	My explanation
Religion	A Higher Being	"In our Holy Bible there are angels, the Devil and the Holy Spirit."	Azhen	Spirituality is about a Higher Being, the Holy Spirit in Christianity. This shows an understanding spirituality from a religious Christian tradition.
	Place of worship	"I can bring a person to the holy temple if he wants to seek *Dao* (求道)."	Maowai	Spirituality is related to going to a place of worship, stressing that spirituality is related to religion, and God or a deity.
	Religious practice	"In a case when encountering a big problem, because we are Christian we rely on prayers to solve problems."	Kunan	Spirituality concerns religious practice, such as praying and relying on God.
Chinese tradition	Responsibility for family	"Since I arrived in the UK, I have worked all the time in order to support my family."	Qiangjian	This is an indication that spirituality is closely related to one's responsibility to the family.
	Forgiveness	"If they… If they…we believe in Jesus Christ and learn to forgive."	Kunan	Forgiveness is considered as an aspect of spirituality.
	Being kind	"For example, this morning Miss Wang helped me to pick up my medication. She directly called the pharmacy and it was delivered to me."	Azhen	Treating others kindly through being positive is considered as an aspect of spirituality and spiritual care.
	Believing the theory of Karma	"It is like that you and I are predetermined (有缘) now and I will bring you to seek *Dao* (求道). Those who are not predetermined (有缘) will not believe despite all the talks."	Maowai	Using the theory of Karma in Chinese culture to suggest life is predetermined in a previous life, and this is related to spirituality.
	Traditional Chinese Medicine (TCM)	"After the operation, I was not awake for more than ten hours. During this time I dreamt about the Immortal Sage Huatuo (华佗圣师)."	Maoge	TCM is also important in Chinese culture in terms of spiritual care.

Relationships	Relationship with self in harmony	"If people live in this world without hope, then they will not live in peace."	Youhao	Emphasising a peaceful relationship with self is important in an individual's daily life.
	Relationship with family	"We have children and hope that they will study hard so that they can have good jobs, careers, a good future and good family life after their tertiary education."	Qiangjian	Qiangjian demonstrated that spirituality is the relationship with family
	Relationship with others in society/creation/nature	"One must get on well with everybody, even the animals".	Maowai	Having a harmonious relationship with everyone in society and with animals/nature is important to spirituality.
Good life	Living healthily and happily	"I wish I have good mental alertness, be physically healthy, be careful so that I will not slip and fall. This is spirituality to me."	Qiangjian	Spirituality is a part of good life by living healthily and happily. There are two dimensions of good life, being healthy and mentally happy.
	Living meaningfully	"I have done a good deed to another, which is also good for ourselves, then this is happiness, a good thing."	Youhao	Helping others contributes to having a meaningful and happy life.
	Gaining the truth about life	"Only through attaining *Dao* can human nature become good again, 'true nature' (本性) will return."	Maowai	Living meaningfully and seeking a good/positive purpose is to grasp the true nature of life. This can be achieved in practising *Dao.*
Hope		"I can't help them but I can pray for them. These are my hopes. People must have hope"	Youhao	In response to the question "Do you think hope is an aspect of spirituality?", Youhao indicated hope was an aspect of spirituality, which is demonstrated in praying to God.
		"From 1994 until the present time, I have been reading my Holy Bible. Spiritual/emotional sustenance (精神寄托) is very important to me."	Azhen	Azhen indicated spirituality is Christianity and this gives her hope and support.
Life events		"Spirituality…able to let go of everything."	Kunan	Spirituality is about letting the major event go. This offers an introduction to spirituality being related to suffering. The major events are grouped in the following related cells.

	Illness and health deterioration	"I have retired but I am losing my hearing too."	Qiangjian	Qianjian related illness and health deterioration to his understanding of spirituality, since these are physical suffering life events impacting on his spiritual well-being. Considering the major life event of being ill as an element of spirituality is consistent with Chiu's (2000) study, in which having cancer ignited women's understanding of spirituality by making them aware of their role as a human being in their spiritual journey.
	Losing a family member	"If something happens to my children, I can also understand it."	Azhen	'Losing a family member' is a life event significant to people's spiritual life.
	Death of self	"One day in the future I will go (die). But in my opinion, it is not me who decides when."	Youhao	Facing death is considered as a personal spiritual dimension.
	Political suppression	"If the Communist Party can say 'We are wrong and forgive us'. We Christians will forgive and pardon everyone."	Kunan	Political suffering is related to personal spirituality.
Spiritual care	Value of good care	"We also provided him with other support services, so the patient could become better spiritually, and he could feel warmer."	Jiangjian	Valuing spiritual care by saying if properly provided, it can have a good effect on a patient.
	Providers	"There was a huge difference (between spiritual care provided by the nurse and pastor)."	Azhen	An indication that non-hospital staff and hospital staff can implement spiritual care. For example, pastors in the community churches and nurses can both provide spiritual care.
	Implementing • Communication	"They have not talked to me about it. This may be because we can't speak English. But they may have interpretors to assist them in communicating with us. It may be because we cannot speak English."	Youhao	Indicating that effective communication could improve well-being.
	• Kindness	"All the doctors and nurses treated him really well."	Maowai	Helping clients with a good and sincere heart was desirable, since this shows the kindness from hospital staff.

	• Praying	“If the patient is a Christian, we will arrange the pastor from the church together with the church members to visit him and pray for him in the hospital.”	Qiangjian	Praying is also another care approach in providing spiritual care.

The table above shows that participants described spirituality differently in the seven domains of ‘Religion’, ‘Chinese tradition’, ‘Good life’, ‘Relationships’, ‘Life events’, ‘Hope’, and ‘Spiritual care’. They offered an explanation for some of the concepts. For example, to relate spirituality with religion, they described spirituality as an awareness of a Higher Being, place of worship, and religious practice. However, these concepts were not well-developed since they lacked variation in dimensions and were not verified by diverse groups of people. Some concepts started to emerge, such as ‘Hope’ and ‘Life events’, without any dimensions to support and explain them. Furthermore, the seven provisional concepts were identified among participants who claimed a religious affiliation (see Table 4.3 p.136), indicating that this may be different for participants without a religious belief. This highlighted the need to develop these initial concepts in dimensions among diverse groups of people, including younger participants because all were over the age of 60 in the pilot stage.

Spiritual care

Spiritual care is a term recognised in nursing literature when exploring spirituality (Hummel et al., 2009). As there is no definition of spiritual care given from a Chinese perspective, I wanted to test how this term emerged and developed in my investigation when participants from a variety of Chinese backgrounds particularly from mainland China, were involved.

The findings from the pilot revealed that an understanding of spiritual care among PCB is referred to as ‘good care’. This was supported by three concepts that

emerged: the value of good care, providers of spiritual care and implementing spiritual care.

As shown in Table 4.2 (p.122), Azhen indicated that spiritual care provision is different between a personal pastor and nurses in hospital. However, she was unable to articulate the difference when I asked what nurses can do to make a difference (Azhen1 below), just stated that spiritual care is provided by a religious leader, the pastor (Azhen2), signifying that there is an association between spiritual care and religion,

> *Interviewer "In which aspect did they (nurses) help?"*
> *Azhen: "The person I visited was in coma. Since we couldn't communicate, I cannot really comment on nurses." (Azhen1)*
>
> *"Before, when my husband was sick, it was not the doctor or nurse assisting with the spiritual care but the pastor from our church." (Azhen2)*

This implies that spiritual care for PCB is very personal, and they question whether nurses are responsible for providing spiritual care (Lang, Poon, Kamala et al., 2006). Azhen's inability to articulate the difference between spiritual care provided by personal pastors and nurses suggests that PCB living in the UK may not understand the term spiritual care as mentioned, and that spiritual care is linked closely to religious and pastoral support provided by the pastor.

Although Azhen was unable to elaborate or expand upon the types of spiritual care provided by nurses, analysing her data made me aware that spiritual care provided in general daily life might be different from that offered in a specific healthcare setting. This is because she connected pastoral care in daily life to that in a healthcare environment. The literature review indicated that spiritual care can be provided in other settings than healthcare (The five sponsoring organizations, 2000), and there are different spiritual care providers facilitating patients' spiritual needs along the illness trajectory (Daaleman, 2012), involving community care providers outside of hospital (Puchalski et al., 2009). The importance of spiritual care in both healthcare and daily life settings compared with healthcare literature indicated there was a need to explore these relationships and differences.

Moreover, in the pilot stage, it seemed that participants did not talk about the term spiritual care unless I specifically mentioned it. This may be because PCB usually do not relate spirituality to nursing, and the term 'spiritual care' is rarely used in the healthcare discipline. This finding is similar to Clarke's (2013) investigation where the term spiritual care was not mentioned by the participants because they did not perceive spiritual care to be a separate task to be performed by healthcare professionals.

Difficulty in articulating

During the first five interviews, I got the impression that the participants struggled to explain their understanding of the term. This is illustrated in their response to the question, "What is your understanding of the term spirituality?"

"Um…I do not quite understand what spirituality is." Youhao

"I am not sure about this at this moment. We do not know what the future holds. Everybody will have their explanation after the event." Qiangjian

The difficulty in articulating spirituality may be because the term is ambiguous and complex (Carson and Stoll, 2009). It may be because spirituality is a subjective term, and each individual has their own understanding of the concept (Bone et al., 2018) located in their specific cultural and traditional context (Puchalski et al., 2014).

The pilot stage developed my confidence and competence in managing the interview process, ensuring that the participant remained focused on the questions while addressing the emerging concepts from the previous interview. Importantly, the pilot led to the development of several basic concepts in their early stage, forming the bases for the following recruitment, data analysis, and category and theory development in line with the theoretical sampling (Charmaz, 2006).

Data collection

I collected data over a period of 16 months from July 2015 to October 2016. I had initially estimated to allow 9 months for this stage from July 2015 to March 2016. The prolonged period for data collection was because of the difficulties experienced in recruitment, trying to identify and recruit suitable participants to develop the emerging theory by being responsive to the emerging concepts and theoretical sampling.

As I previously mentioned, I was aware of the possible limitations of grounded theory associated with theoretical sampling and the assumption that I should recruit specific participants who possessed the required knowledge to advance the emerging theory and how this might delay theory development. As a result, I sought to limit this by maximising the number of potential participants so that I could interview them according to the arising concepts. In addition, I met with the managers in the Chinese community centres in person and contacted them by phone so that they could identify the required people for the subsequent recruitment.

Recruitment

The managers (gatekeepers) led the recruitment of participants at each of the Chinese community centres in Birmingham, Manchester and London, and they liaised closely with me. The main steps in this process were gaining access to the Chinese community centres then recruiting the participants. Participation in this investigation was entirely voluntary, and by enlisting the support of the 'gatekeepers' this meant that I did not directly influence this process thereby reducing any bias in the recruitment process. The recruitment of participants for the pilot and the main investigation followed the same inclusion criteria. These were participants being 18 or above, with some may having been hospitalised in the past 12 months and all participants having no mental impairment. The recruitment in the pilot did not strictly follow the theoretical sampling procedure. To allow all possible ideas about spirituality and spiritual care to emerge, participants were purposively selected to provide information about their understanding of the terms (Higginbottom and Lauridsen, 2014).

To secure access to the Chinese community centres, I sent a formal covering letter to each of the Chinese community centre managers via email, introducing them to the aim of the project and indicating how they could support the recruitment. I sent the initial emails to five Chinese community centres in Birmingham, Manchester, London and Liverpool on 11 February 2015. In the letter, I asked the managers from each of the community centres to provide a formal letter of support, indicating that they would be willing to support the investigation. I sent a follow-up letter to those centres that did not reply in April and May 2015. Eventually I gained access to four Chinese community centres in three cities (the fifth one in Liverpool did not respond to my request). After I had reached theoretical saturation by interviewing participants from the four centres, I did not need to enlist their support with recruitment. Therefore, I notified them that it would not be necessary to recruit at these sites and thanked them for their kind offer of support.

Once I had gained access to the Chinese community centres, it became necessary to renegotiate entry into the lives of the managers and participants (Okumus, Altinay and Roper, 2007). After consulting and discussing with my supervisors, I personally met each of the administrators, explaining again the nature of the research project, answering any questions they had, and briefing them about their role as gatekeepers in the recruitment process. At the same time, I scheduled time with the managers to meet the potential participants. The meetings took place on 25 June and 4 December 2015 in two Chinese social organisations in Birmingham, on 2 and 7 September 2015

in the Chinese community centre in Manchester, and on 19 February 2016 in the Chinese community centre in London.

The personal relationships established with the managers facilitated the theoretical sampling process with them identifying participants with specific characteristics that might support the development of the emerging theory. This was because the managers had a deeper understanding of each potential participant in their communities. Also, the personal relationships established enhanced our understanding and trust of each other and I was able to liaise with them to identify specific participants with certain characteristics, and they always responded in a supportive and timely manner.

With the administrator's introduction, I met the potential participants at the scheduled time. During the meeting, I briefed them about the investigation and provided them with the invitation letter and information sheet about the investigation; this also provided them with sufficient time to think about participating. I also collected some basic information from them, such as their country of origin, language, age, gender and religious belief. At the end of the initial meeting, I asked for their contact details, so that I could contact them to arrange the interview. Meeting with the potential participants before formal recruitment and interview enabled me to introduce them to my project, which facilitated recruitment. It also helped me in establishing a sampling pool by having an impression of the potential demographic information and

the possible areas of interest so that I could identify the correct participants to address the emerging concepts in later data analysis.

In addition, some participants were recruited through the recommendation of their friends who had already taken part in the study. Although these participants were not members of the Chinese community, they met inclusion criteria for this investigation. Therefore, their insights were also valuable to the understanding of spirituality and spiritual care. Recruiting them into this investigation had no conflict with the ethical consideration regarding their Chinese backgrounds since the Chinese communities only served as gatekeepers to help me with identifying potential participants. I received ethical approval to proceed with this slight deviation from the main approach to recruitment (Appendix 4.1).

Participants' demographic information

The final number of participants recruited for this research was 25. This was the point at which I had reached data saturation. For an overview of the participants see Table 4.3 below. The table shows that I recruited a broad range of people from a Chinese background. There are 11 males and 14 females with different marital status, and their ages range from about 20 to over 80 years old. Their countries of origin are China, Taiwan, Hong Kong and Vietnam, and with different ethnicity, such as Han, Hui and Hakka, which were defined by themselves. Fourteen indicated that they had a religious belief, such as Christianity or Buddhism. Eleven reported that they were atheist and/or believed in mixed philosophy. Their residency in the UK ranged from a

period of six months to over 20 years, and their backgrounds were student, housewife, restaurant worker, manager, and medical staff, with different educational levels. Of the 25 participants, six of them had experience of working in health-related sectors, including art therapist, social workers and care workers; three had medical backgrounds in hospitals as a nurse, a physician and a care assistant. The profile shows there were only four participants who indicated they had been hospitalised in the last 12 months, though it had been anticipated that a third (eight) of them would have had hospitalisation experience over this period. This figure was based on McSherry's (2004) experience of recruiting participants from different ethnic groups in the UK when he explored the meaning of spirituality and spiritual care. The participants in McSherry's (2004) study included patients, healthcare professionals and lay-people. The composition of his sample was very much like the participants in my investigation, with the exception that my recruitment focused specifically on PCB living in England. However, the under-representation of participants in this investigation who had been hospitalised signifies that PCB may have less access or be less likely to be admitted to a hospital in the NHS in England. This may be due to different reasons, such as language barriers or their social status of being immigrants, which I will discuss in later chapters.

The wide range of participants from Chinese backgrounds contributes to the quality and development of the categories and their properties, forming the key elements of the theory.

Interestingly, some participants labelled their religious belief as ‘Atheist and Mixed Philosophies’, indicating that it is difficult for them to specify a religion in Chinese culture due to their integration and use of Chinese cultural values as their religious or cultural belief.

Table 4.3 Demographic information

Informant	Age	Gender	Country of origin	Religion	Ethnic	In hospital last 12 months	Marital Status	Occupation	Qualification	Period in the UK
1-01 Youhao	Above 70	Female	Hong Kong	Christian	Han	Yes	Married	Housewife	Primary school	20-30 years
1-02 Kunan	82	Male	Vietnam	Christian	She	No	Married	Retired industry worker	Secondary school	20-30 years
1-03 Maoge	Above 60	Male	Hong Kong	Daoism	Han Hakka	Yes	Married	Retired restaurant boss	Primary school	20-30 years
1-03 Maowai	Above 60	Female	Meixian, Mainland	Daoism	Han Hakka	No	Married	Retired restaurant boss	Unassigned	20-30 years
1-04 Azhen	Above 60	Female	Hong Kong	Christian	Han	No	Widowed	Retired restaurant boss	Secondary school	20-30 years
1-05 Qiangjian	Above 60	Male	Hong Kong	Christian	Han	No	Single	Retired restaurant boss	Not specified	20-30 years
1-07 Boshi	40-59	Female	Taiwan	Christian	Han	No	Single	Art therapist and education	PhD	5-10 years
1-09 Sandi	18-39	Female	Jiangsu, Mainland	Atheist	Han	No	Married	Education and voluntary job	Undergraduate	9 months
1-14 Laoxiang	40-59	Female	Shanxi, Mainland	Mixed Philosophy	Han	No	Married	Health and social care manager	Master's	12 years
1-16 Shuaige	18-39	Male	Hong Kong	Atheist	Han	No	Single	Logistics transportation	Undergraduate	about 10 years
1-17 Xuezhe	40-59	Male	Macau	Buddhist	Han	No	Married	Voluntary job	PhD	half year
1-23 Shufa	40-59	Female	Shanghai, Mainland	Atheist	Man	Yes	Divorced	Housewife	Unassigned	about 10 years
1-24 Yisheng	40-59	Male	Unassigned	Mixed Philosophy	Han	No	Married	Scientist/surgeon (hospital)	Master's	10-20 years
2-06 Xieguang	40-59	Female	Guangzhou, Mainland	Daoism	Han	No	Married	Housewife/health related	High school	about 10 years
2-08 Wangxing	40-59	Female	Liaoning, Mainland	Atheist and Mixed Philosophy	Han	No	Married	Housewife/health related	High school	about 10 years
2-10 Maipian	40-59	Male	Fujian, Mainland	Communist and Mixed Philosophy	Han	No	Married	Restaurant worker	Secondary school	12 years
2-11 Aiwa	40-59	Female	Hong Kong	Buddhist	Han	Yes	Married	Taking care of elderly	Primary school	about 10 years
2-12 Linde	40-59	Female	Hong Kong	Mixed Philosophy	Han	No	Married	Retired restaurant boss	Primary school	about 10 years
2-20 Qinlao	40-59	Female	Henan, Mainland	Christian	Hui	No	Married	Nurse (hospital)	Bachelor	15 years
2-22 Chengshi	18-39	Male	Henan, Mainland	Muslim	Hui	No	Single	Care assistant (hospital)	College	about 10 years
3-13 Heping	40-59	Male	Hong Kong	Christian	Han	No	Married	Social worker	PhD	more than 30 years
3-15 Dianxin	Above 60	Male	Taiwan	Mixed Philosophy	Han	No	Married	Retired	Undergraduate	more than 30 years

3-18 Xiaojin	18-39	Male	Guangzhou, Mainland	Atheist, Agnostics, Mixed Philosophy	Han	No	Single	Student	In Undergraduate Programme	12 years
3-19 Pengchao	18-39	Female	Hunan, Mainland	Mixed Philosophy	Han	No	Single	Student	Master's	2 years
3-21 Mimang	18-39	Female	Meixian, Mainland	Christian and Buddhist	Han Hakka	No	Single	Student	High school	3 years

The Chinese community centres in Birmingham had the code **1**, for example, **1**-01 stands for the participants from Birmingham and the first person to participate in the interview

Chinese community centre in Manchester – code **2**

Chinese community centre in London – code **3**

In-depth interviews, digital recordings and field notes

All interviews were digitally recorded, and I made field notes of participants' observations during the interviews. I used these methods throughout the data collection phase, and these assisted me in identifying any missing data in the recordings, thereby enhancing the richness and quality of the data. I only made digital recordings and field notes after gaining permission and informed consent of the participants.

I made written field notes close to the time of the interview – during or right after each interview, so the detail of any observations would not be neglected or forgotten. However, this did not mean that the personal reflection ended here, as I undertook further reflection on relevant issues throughout the data collection and data analysis. Field notes are different to memos (Strauss and Corbin, 1998). Field notes are about the observation of informants in data collection whereas memos are analytical writing in the data analysis. I stored the field notes in NVivo11 to provide information for data analysis. A sample of a field note is provided in Appendix 4.11.

The interviews were the primary data sources for analysis. Informal data, such as field notes and the ongoing reflective diary were not analysed. They facilitated understanding of the interview context, supported the development of concepts and theoretical sensitivity, and took the role of secondary data sources for writing and developing the theory (Glaser, 1978).

Verifying interpretation, transcribing and translation

Although I adhered to the measures developed from the pilot interviews to ensure high quality interpretation there was still a chance that inaccurate interpreting could occur. After consulting my supervisor, I sought an independent review from an academic who held a position at Staffordshire University. His native language was Cantonese and Chinese and he was very fluent in English. According to Yom (1998), the first priority of translation should be the overall meaning of the words rather than linguistic structure. By adhering to this principle, I was able to verify the participants' transcripts where the interpreters were required. This mechanism added another layer of quality assurance, ensuring the accuracy of the translation and transcription services provided, adding to the rigour of the research. A sample of a verified transcript is provided in Appendix 4.12.

I transcribed each interview in full after conducting them. (A sample of transcribed and translated recording is provided in Appendix 4.13). This enabled me to capture what each participant had said or what the interpreter had relayed during the interview. If I found any ambiguities in the transcription, I clarified them with the participant by calling them or the interpreter. Alternatively, I sent them a copy of the transcript in digital or hard copy to clarify the ambiguity. As indicated above, to ensure the accuracy and quality of the transcription, I had a selection of transcripts verified by an academic from Staffordshire University, fluent in both Chinese and English. During the transcription and later translation, I gained a deeper understanding of the data, enhancing my theoretical sensitivity. This immersion in the data aided my interpretation of the meaning, which was further increased through the repeated interaction between the recording and transcript (Silverman, 2013).

I undertook the translation from Chinese to English. My native language is Mandarin, and I am proficient in English and gained a score of 6.5 in the *International English Language Testing System* (IELTS) in 2012 and a Master's degree from the University of Nottingham in 2013. Accuracy of translation was examined by the academic who was proficient in both languages (Partridge, 2012). Through dialogue with the academic, when there was doubt over the accuracy of a section of transcript, we reached a consensus, and this greatly facilitated the translation process. The transcribing and interpreting process immersed me in the data, which considerably helped my later analysis and interpretation, particularly in developing sub-properties of a concept because I could clearly identify the different supporting evidence from each participant.

After verifying the quality of the transcript and the translation, I formatted the English version of the transcript in a word document ready for open coding. I entered the English transcripts and field notes into the qualitative software programme NVivo10 (later changed to 11), ready for further detailed data analysis. All the original data will be kept for 10 years by the researcher or principal supervisor (Staffordshire University, 2015) and will be destroyed after this period.

Theoretical sampling process

After the first five interviews and based on the tested interview prompts, I commenced theoretical sampling. For example, the emerging category of 'Chinese tradition' from the pilot study guided me to recruit participants who knew more about Chinese traditions, with hobbies of practising art and traditional Chinese activities. The new theme of 'internal force' arising from interview 6 with

Xieguang required me to recruit participants who did not have religious beliefs, and who could probably provide sufficient information on internal forces relating to spirituality. I provide an illustration of the theoretical sampling process in Figure 4.3 below. The yellow squares show the characteristics that are required of each of the participants. The blue squares describe the aspect of the emerging concepts to be explored with the participants at interview, while the blue arrows indicate the process of how emerging concepts guided the next step in recruitment.

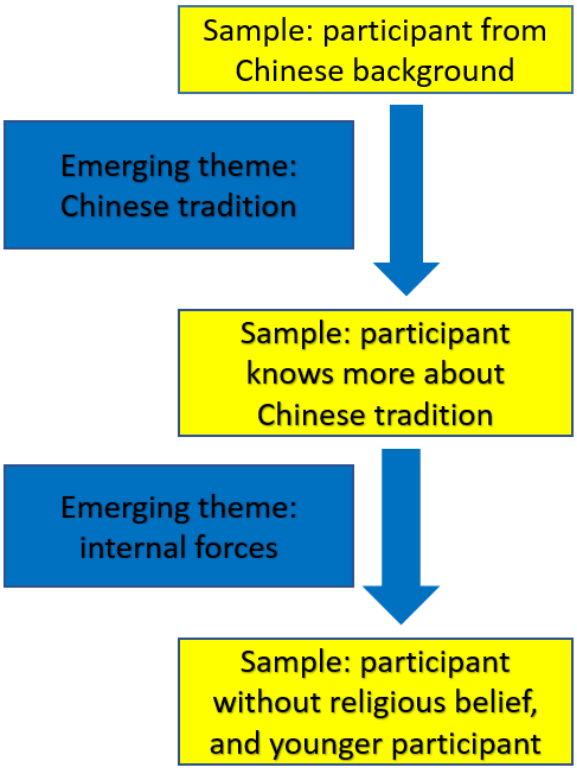

Figure 4.3 An example of theoretical sampling

I also had the impression that the participants recruited for the pilot study were a homogeneous group, and this led me to recruit participants with a variety of demographic backgrounds. The homogeneity of the six participants in the pilot meant they were all above 60 years old and had a religious affiliation, so the

findings from the pilot might not be inclusive or representative of PCB. I therefore needed to recruit younger participants, and participants without religious beliefs.

However, both the data analysing and recruiting processes demonstrated that there were problems in theoretical sampling. The first was that participants who were expected to provide information for the emerging theme could not do so. For example, I expected Xieguang to be able to provide comprehensive information on Chinese culture, but this proved not to be the case. I therefore carried out further theoretical sampling to explore the theme. As a result, I recruited Boshi as during the recruitment stage, she had demonstrated how she gained energy from Chinese art, one of the traditional Chinese elements.

This example shows that I was unable to identify a participant who knew specifically about 'Chinese culture'. Although another participant addressed this concept in a later interview, the data collected from this informant was not in line with the theoretical sampling to respond to the emerging concept of 'Chinese culture', but I had limited information about the knowledge possessed by potential participants. I will discuss this later to highlight its relevance for future research.

Another issue in related to theoretical sampling was that I could not recruit a sufficient number of healthcare professionals, particularly from nurses and chaplaincy staff in spiritual care. As a result, there is less supportive evidence from nurses and none from chaplaincy members. This again requires that further research to establish a bigger sampling pool involving a healthcare community of nurses, physicians and chaplaincy members.

In summary, I utilised the theoretical sampling method as a general guide in the recruitment of participants. I sought to recruit a range of PCB, in order to develop the emerging categories and their properties. This included people of different ages, gender, different regions of origin, and levels of care experiences, also those with nursing backgrounds, from a variety of professions, and different lengths of time living in the UK, as all these could affect the findings.

Data analysis

As described above, a grounded theory design is using a qualitative research to generate theory grounded in the data. The theory is generated on systematically analysed data gathered in naturalistic settings (Higginbottom and Lauridsen, 2014). As Strauss and Corbin write, “In this method, data collection, analysis, and eventual theory stand in close relationship to one another” (1998 p.12). This method guided my data collection and analysis.

In the following section, I describe how I used the analytical stages in Straussian grounded theory: open coding, axial coding, and selective coding. Figure 4.4 below indicates this process, with the double-sided bold arrow illustrating each stage moving back and forth during the analytical process. (An example of how I used Nvivo 11 to conduct line-by-line coding to generate a category in open coding and then to sort the relationship of categories during axial coding is provided in Appendix 4.14.)

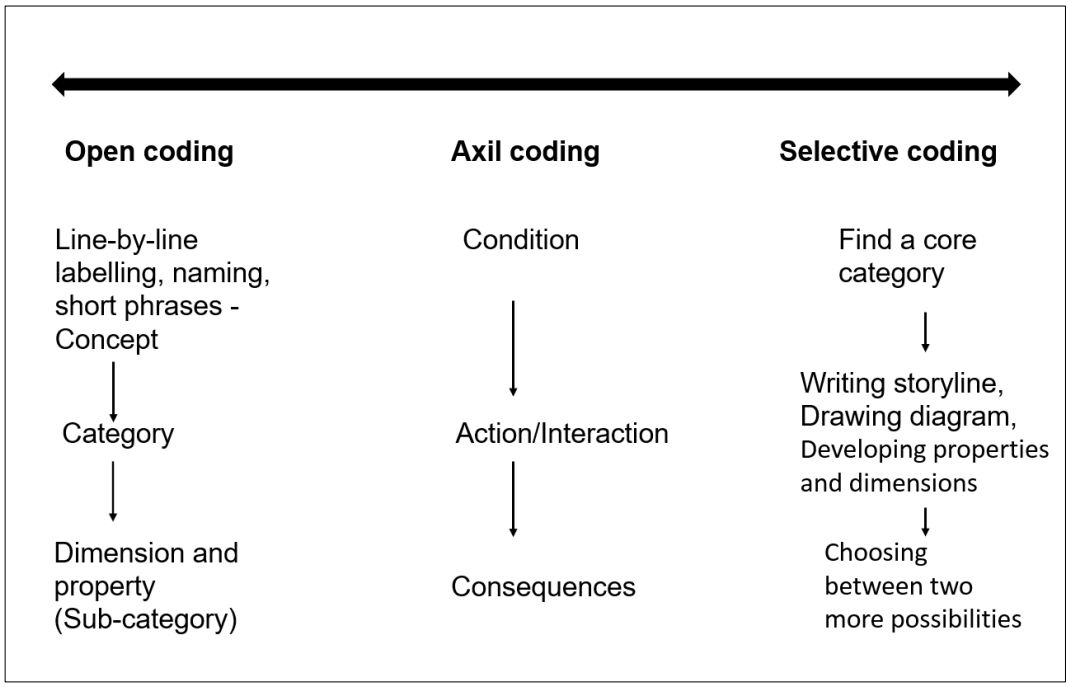

Figure 4.4 Coding process: open coding, axial coding and selective coding, adapted from Eaves (2001)

Open coding

The first step I followed in open coding was the line-by-line coding technique. After carefully reading each line in the transcripts, I labelled each sentence (giving it a name) in NVivo11 as first level codes. The first level codes with similar meaning were grouped into second or higher-level codes, which may be a code from the first level ones or a new label having an abstract meaning to present the accumulated lower level codes. As the lower level codes with similar meanings accumulated under an umbrella code, this umbrella code or label evolved as a concept. The concept does not describe and repeat the data, it arises from and is indicated by discrete characteristics, reasons, consequences, or other events concerning spirituality and spiritual care (Strauss and Corbin, 1990). As described previously, 'Difficulty in articulating' evolved as a concept based on its lower level codes describing how the term spirituality was difficult to articulate or explain, the reason for it and the consequences.

The second step was identifying categories. After comparing concepts against each another, I grouped the ones with similar meaning into a category. A category is a higher-level concept comprising a group of concepts derived from the data and representing the phenomena of spirituality and spiritual care (Strauss and Corbin, 1998). This is exemplified in the concept 'Difficulty in articulating' which can also be regarded as a category, because the code regarding the reasons for the difficulty in articulating spirituality is a lower level concept consisting of several labels, such as spirituality is a broad, individual and private issue. As a result, the concept describing the reasons for difficulty in articulating, together with the other labels indicating the manifestation and consequences of this difficulty, enable 'Difficulty in articulating' as a category.

The third step was developing the identified categories in terms of their properties and dimensions. In the category 'Difficulty in articulating', one of its properties is the 'reasons' for the difficulty. One such reason was because the term 'spirituality' is an individual subject. I therefore developed its dimension, from personal privacy to a broad range of topics. That is to say, the term spirituality is private for an individual, so they may have difficulty in expressing or discussing this in public. It can also relate to a broad range of other associated topics such as policy or health, making it difficult to express or articulate a precise meaning. As a result of developing these dimensions, the category 'Difficulty in articulating' was established in the respect that it indicates spirituality is a term based on individual understanding.

Axial Coding

In the axial coding stage, I related a category to its sub-categories to form a more precise explanation of the meaning of spirituality (Strauss and Corbin, 1998). I applied the paradigm of conditions, actions/interactions, and consequences to help sort out their relationship (Strauss and Corbin, 1998). This is demonstrated throughout the data analysis in this investigation. Again using the example of 'Difficulty in articulating', it was based on the manifestation of the difficulties, the reason for the difficulties, and the consequences of the difficulties, in line with the 'actions, conditions and consequences' process outlined in the paradigm.

Selective coding

Selective coding is the process of integrating and refining categories (Strauss and Corbin, 1998), and is the last stage of data analysis. I followed three strategies recommended by Strauss and Corbin's grounded theory (1990; 1998) to form a core category. The first was to identify a core category to pull other categories together, which should account for considerable variations. As Strauss and Corbin (1998) noted, selecting a core category is not easy; I thought about three concepts to use: 'Having a meaningful life', 'Living happily' and 'Having harmonious relationships' as the core category when trying to establish the relationships between these categories. After data saturation was reached, I decided to use only 'Having a meaningful life', because 'Living happily' is not able to explain concepts such as 'Suffering', 'Support', and 'Hard working', which seem at odds with 'Living happily'. 'Having harmonious relationships' seems appropriate for a core category but participants made frequent reference to spirituality as being 'Having a meaningful life'. As a result, I decided to use '*Seeking a meaningful life'* as the core category for this investigation.

The second strategy was to use a diagram to relate subsidiary categories around the core category (Strauss and Corbin, 1990). Guided by *paradigm condition, action, and consequences*, four properties of the core category are identified around the core: 'Motivation', 'Support', 'Maintaining standard values' and 'Achieving a meaningful life'. Figure 4.5 below demonstrates this relationship, with nodes highlighted in blue for *condition*, purple for *action*, and green for *consequences*. The relationships between the categories highlighted in grey and the core category need to be figured out, and the storyline strategy of describing the relationships will help with this.

Please note this figure is an earlier version of the diagram which helped me to identify the main categories emerging from the developed categories. It has evolved over time with the further integration of data taking place when I presented the main findings in later chapters (Five, Six, Seven, Eight). However, the diagram is helpful in relating categories with the core category in a conceptual way.

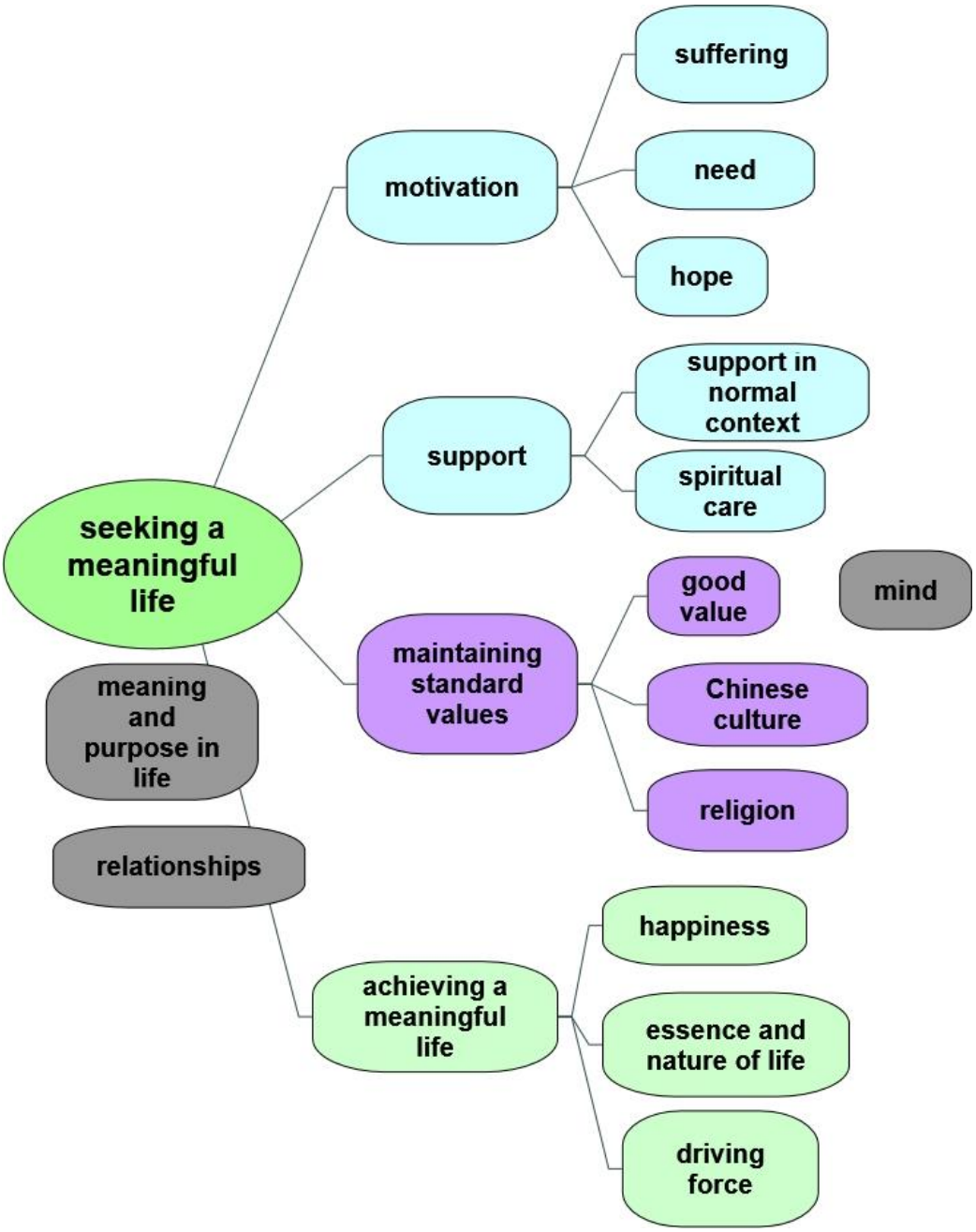

Figure 4.5 Diagram of the development of the core category

The third strategy was to formulate a storyline to integrate all the categories in a descriptive manner. In other words, it is about relating property and dimension categories to the core category, as well as relating other categories to the core category. This strategy helped me to further sort and refine the relationship between the core category and its related categories under the paradigm *condition, action* and *consequences*.

I felt that 'Seeking a meaningful life' was the core category because it related to all the developed categories. According to the meaning of the categories developed, such as 'Chinese cultural values', 'Spiritual resource' and 'Spiritual care', 'Suffering' and 'Driving force', I placed 'Chinese values' as *condition*, and 'Spiritual resource' and 'Spiritual care' as *action* in the phenomenon of 'Seeking a meaningful life' using the diagram strategy. This is because I interpreted 'Chinese cultural values' as the source and context for 'Seeking a meaningful life', and 'Spiritual care' together with 'Spiritual resource', as *action* in 'Seeking a meaningful life'. However, when I wrote a storyline using 'Spiritual care' as *action* my mind was blocked, and I was unable to relate the sub-categories under 'Spiritual care', such as 'good communication' and 'attending to patients' to the core. This is because the sub-categories did not show as action for the phenomenon 'Seeking a meaningful life' within the story; they have a tendency to just be a supporting resource for people gaining life meaning. As a result, I adjusted the category 'Maintaining standard values' (from 'Chinese cultural values') as *action*, and 'Spiritual care' as *condition* to the core category. 'Maintaining standard values' explains the phenomenon 'Seeking a meaningful life' because its sub-categories, such as Chinese cultural values in Confucianism, Daoism and Buddhism indicate a purpose or pursuit for a meaningful life if people act according to their principles.

(The relationship between the other concepts such as ‘Spiritual care’ and ‘Spiritual resource’ and the core can be seen in Chapter Eight). Adjusting the developed concepts demonstrates that using storyline-telling as a strategy facilitated the theory development by helping me to refine the relationship between the developed concepts and the core category under the paradigm *condition, action* and *consequences* (Strauss and Corbin, 1998). The storyline further developed the connection established at the conceptual level using the diagram.

The above three strategies were not a step-by-step process; they can be applied at the same time to allow the development of a core category at any point during the analytical process by integrating the categories.

Memos

In this investigation, I followed Strauss and Corbin's (1998) strategies of memo writing to record and direct the analytical process. The written memos were grouped as ‘open code, theoretical code, operational code’ as a tool to assist analysis. The open code is analytical thoughts arising during the open coding process. For example, the concept ‘Driving forces’ started to emerge in the interview with Xieguang. The written memo demonstrating this emergence was,

> **Being vibrant [Open code] 2015-11-28 Saturday #6**
> Spirituality means ‘being vibrant’, this is a new understanding arising from interview 6. This is indeed a very common understanding for PCB. I remember that Qiangjian mentioned spiritual care is ‘having mental alertness’ when explaining his understanding of spiritual care. This indicates that spirituality is a kind of driving force relating mental vigour and alertness. I need to identify other dimensions relating this.

The above memo for open coding also generates an operational code, highlighting which direction I need to develop and what type of participants I need to recruit,

> **Mental understanding of spirituality [Operational code] 2015-11-28 Saturday #6 from Being vibrant [Open code] 2015-11-28 Saturday #6**
> Understanding spirituality as a driving force is a non-religious understanding of spirituality. A participant without religious affiliation who is active by having different thoughts about social and family life may address this well. I need to explore the concept 'driving force' in the mental dimension by recruiting such participants.

Theoretical coding is about sorting relationship between categories, which is demonstrated in the way I found the relationships of all emerging categories,

> **Findings from the interviews [Core category code] 2016-11-14 Sunday**
> After reading the literature review on how the categories are structured, I grouped the categories by using 'mind map' function (Figure 4.5 p.148) in NVivo11 for all the identified categories into motivation, support, maintaining standard values, and achieving a meaningful life. This indicates the condition, action, and consequence for the process of 'seeking a meaningful life'. This mind map is called a diagram by Strauss and Corbin (Strauss and Corbin, 1998).

This simple approach to theoretical coding demonstrates the way I established and sorted the relationship of the categories under the core category, which I have detailed in the selective coding process. It recorded my original analytical thoughts in finding the relationship between categories in the core category and their individual relationships with the core, which I will demonstrate in Chapter Five.

Regarding the way to write memos, Charmaz (2014) advocated keeping a memo bank so the early memos can be mined. Corbin and Strauss (2015) recommended an on-going log for periodic reflection, separate from the memos. Overall, categorising the memos is not important. The essential point is to write something down to guide the data analysis.

Summary

In this chapter, I presented the research aim question and objectives for investigating the meaning and experience of spirituality among PCB. Following this, I introduced the philosophical perspectives and critiqued the main components of grounded theory, highlighting their relevance for my investigation. Also, I briefly presented Leininger's *Cultural Care Theory* and its relevance to this investigation, exploring the issue of cultural sensitivity. Importantly, I described process I followed in conducting this investigation in the respect of the pilot investigation, recruitment, data collection and analysis in keeping with Strauss and Corbin's grounded theory (1990; 1998), with a focus on the analytical techniques. At the same time, I presented the seven preliminary categories that emerged from the pilot to form the bases for theory development.

In the following Chapters Five, Six, Seven, I discuss the four sub-categories of the core category that emerged from the data and evolved from the preliminary categories. I will describe how collectively they contribute to the core category, even when a contradictory or alternative case is present, and demonstrate how they contribute to the understanding of spirituality among PCB living in England. Next, in Chapter Five, I describe the first category 'Motivation'.

CHAPTER FIVE FINDINGS: MOTIVATION

Introduction and an overview of findings

The selective coding techniques applied in Chapter Four led to the development of a core category *'Seeking a meaningful life'*, comprising four main categories 'Motivation', 'Support', 'Maintaining standard values' and 'Achieving a meaningful life' when data saturation was reached.

'Motivation' and 'Support' are *condition*s that enable PCB to seek a meaningful life. This is because an individual's experience of suffering, particularly physical illness, and the need for hope may motivate them to seek better living conditions and a meaningful life. This is in addition to the various resources required throughout daily life, especially those provided within healthcare settings which often support them at significant life events. 'Maintaining standard values' is an *action* indicating how PCB seek a meaningful life. This usually involves living in accordance with Chinese cultural philosophical values and religious beliefs and by incorporating them as life principles. 'Achieving a meaningful life' is the consequence of the phenomenon of seeking life's meaning, because living happily or vibrantly, reaching a state of transcendence and grasping the essence and true nature of life demonstrates the outcome of seeking a meaningful life.

In this chapter, I detail the first main category 'Motivation' which comprises three subcategories 'Suffering', 'Need' and 'Hope' under the structure of *condition, action,* and *consequences*, and they serve as conditions to motivate an individual's actions/behaviour to seek a meaningful life. This means that participants incorporate their understanding of spirituality and spiritual care into a motivating power, and the source for this may come from their daily experience of suffering. It can also arise from their need and hope for a better life, or for a change in their

current situation. In the following, I will explain these three sub-categories, indicating how they contribute to understanding the concepts of spirituality and spiritual care among PCB living in England.

Suffering

According to the Cambridge Advanced Learner's Dictionary & Thesaurus (2018), suffering is generally defined as physical or mental pain that a person is feeling or experiencing in their life. Participants' understanding of spirituality and spiritual care related suffering as life experiences that cause difficulties and stresses. The main reason for suffering was that participants encountered cultural barriers while living in England. It was also due to issues relating to health, family and their desire for material or self-fulfillment. Participants' experience of suffering depended on whether they accepted or rejected it.

Participants in this investigation related spirituality to the difficult times. For example, regarding the question about what matters in spirituality, Wangxing suggested it was about suffering,

> *"As a human being, there is a time he is weak and fragile when he is suffering."*

Boshi also stated her understanding of spirituality as 'spiritual impact', and she attributed the difficulties and distress that Chinese immigrants encountered in the UK to their cultural barriers,

> *"I have some cases of depression, which are the impact of culture and spirituality. Spiritual impact is within the cultural dimension. The distinction between the east and west on thought, life and habits can cause the impact.*

A person suffering from depression is due to his being unable to adapt to this difference between east and west."

Dianxin offered further explanation, suggesting that the older generation of Chinese immigrants in the UK were more vulnerable to cultural barriers than the younger ones,

"PCB in the UK, especially for the old generation and those who have no children, cannot involve themselves in the community. They feel they are helpless and their spirituality is depressed. Thus spirituality is more important to them."

While relating spirituality to suffering and explaining the reason for this, participants also illustrated different causes of suffering and how these may contribute to their understanding of spirituality and spiritual care. These causes could be categorised as health-related, family-related and desire-related, indicating that the term spirituality is an individual issue and responds to a person's own situation (Tan, Ozdelıkara and Polat, 2018) when their health, family, or desires come into focus. Regarding health-related suffering, participants in this investigation related their understanding of spirituality to the worries and sufferings associated with illness and death. For example, a terminal cancer patient Shufa stated,

"Sometimes my spirituality is not ok at all. As for today's interview, I promised to come. But indeed I can barely make this happen, since I just had the blood sample extracted according to physician's order this morning and I feel my bones are very painful."

Maoge also associated an understanding of spirituality and spiritual care with a scary experience encountered during a severe medical situation, and Xieguang with a fear of death and the unknown,

"I was very scared while I was bleeding." Maoge

"Sometimes I am very scared of death and I wonder what death is, whether I feel pain when my body is buried or burnt." Xieguang

In addition to health-related suffering, participants also referred spirituality to family-related issues. For example, Aiwa was worried about her children due to the burden her illness might have on them,

"*I am very worried that my deterioration will affect my children."*

She also related spirituality to the suffering which originated from her husband and his smoking and gambling habits, which hurt her most and affected her health,

"I cannot do anything if he plays with his own money. Every weekend he does not work, he comes back at 11pm. After he eats something, he goes out. You know I cannot do anything with him if he does not come back. I used to call him any time. When he wakes up next day, he says earning or losing money is gambling for the future… I can do nothing with him and sometimes he comes back in the morning (after a whole night gambling). I used to accompany him at the weekend when he took rest. Now I leave him alone."

"Everyone has sufferings... No matter for self or family, when you see they are in pain. I sometimes think that my husband is a time bomb because he has been smoking for decades and has no intention to quit... I am prepared

for an earlier death in the future as I am a passive smoker. I may die ahead of him and I am ok with my death or his health."

Suffering encountered during an unhappy marriage was also a common occurrence because of the couple's different preferences. Linde illustrated this when addressing spirituality,

"I have a friend who was probably healthy in the past. She has two daughters. The family came to the UK and the husband went back to Hong Kong for work. The wife did not like Hong Kong and stayed in the UK. I saw she was pretty healthy 20 years ago but now she has some mental problems."

In marriage, the family and children can be a source of suffering. Dianxin described this by illustrating a housewife's difficulties in taking care of her children,

"Once the children cry, she probably cannot bear the situation and is subject to depression. All these things are linked, such as the problem being unable to be resolved, issues related to children."

Besides health-related and family-related suffering, participants also referred spirituality to things that seemed unattainable. For example, participants associated spirituality with the distress they felt at not being able to eat Chinese food daily, the absence of effective communication, and the fear of not earning sufficient money for daily living,

"They liked to eat some Chinese food and they liked the family to send some food for them, (such as) soup, or something. They cannot get used to hospital food." Qinlao

"Life was very hard here due to the language. Besides, I was very lonely, not being to able to adapt to life, and the food was different from that at home. But the situation gradually changed later." Maipian

"I felt I was able to do a lot of things prior to this incident. I am scared now, which may affect people around me. I am very scared." Aiwa

These unpleasant feelings are reasonable and to some degree expected especially when a person is hospitalised and where there is a sense that the related services need to be enhanced. However, one participant referred their understanding of spirituality to the loss of control and being unable to attain their dreams or aspirations. For example, many people are becoming too materialistic and they have a great desire for material things, which sounds unreasonable to Maowai,

"But it has been polluted by too many worldly temptations (引诱)… Now the computers, a complicated and colourful world... People are helpless, indulging (沉迷) and losing their true nature in these places."

Maipian described how the complexity of relationships and providing for another person demoralised so he sought solace in gambling,

"I have an idea that it would be good to have a woman with me when I am lying down in the evening. The expense of having a woman is huge. I have no way for this, but watch the programmes and gamble a little."

Wangxing further confirmed the severe consequence of materialism that adds confusion to people's lives,

"Depression and gambling is the consequence of people's minds being confused by this colourful world, in which only money is recognised."

The explanation of spirituality as suffering originating from the inability to obtain what is desired, either for material things or a sense of control or satisfaction, can be classified into two broad categories. One is the feeling of being unable to obtain or achieve the necessary desires such as the fundamentals of daily living due to the difficulties associated with illness, communication and financial insecurity. The other is the personal feeling of being unable to attain what one desires, which may lead to the individual feeling demoralised compared with the virtuous values or standards of mainstream society. These two dimensions are not distinct, the difference is that the former is more on the right and moral side, while the latter is more on the immoral and insatiable. This reflects Hauerwas' (1986) understanding that suffering is a reasonable aspect of humans' need, arising from their mutual dependence on each other, and he argues that it is important to differentiate between needful and needless suffering. In this investigation, the demonstration that unpleasant experiences originate either from reasonable or unrealistic desires or rational wishes for the fundamentals in daily life may add some knowledge to the understanding of spirituality regarding suffering, especially for what are considered needful or needless experiences as put forward by Hauerwas (1986).

In this investigation, participants also demonstrated that spirituality was about strategies they used to deal with suffering. This was outlined by Boshi, who noted that some people cannot accept the bad experiences and engage in gambling,

"It is depression. Moreover, they have to deny themselves. Thus the more they deny, the more depression, resulting in illness eventually. Many Chinese in the UK are suffering from depression and they go for gambling…"

Yisheng also suggests that some people cannot accept bad experiences and lose control, offering this as an explanation of spirituality,

"But the majority of people are not in the same way (to cope), and they are overwhelmed by a serious situation, such as cancer. Their brain suddenly goes into blank and they do not know how to deal with it."

Besides responding to suffering negatively, participants also demonstrated their understanding of spirituality as positively engaging with bad experiences. Sandi illustrated this by describing her acceptance of suffering and her persistence as something positive,

"That is why I am persistent and I think all the suffering I experienced is worthy."

To a lesser degree of active engagement, Pengchao stated that a person has to accept the suffering and let it be, since it is a prelude to success and can enhance their tolerance,

"It is really like the saying in the classic Chinese that when Heaven is going to give great responsibility to a human, it must bitter his heart and will, make him hungry, exhaust his muscles and bones… I really believe the saying and I think it is reasonable."

Pengchao's statement suggests that finding meaning in suffering may soften any bad feeling (Wright, 2005; Emblen and Pesut, 2001), because suffering is

Heaven/God's plan for a person and they have to accept and adjust their life accordingly.

Viewing the experience of suffering positively also means that people accept the bad events but may not have an established coping strategy. For example, two participants described the importance of developing acceptance when encountering difficulties,

> *"There are many bad things taking place. But I cannot understand the thing happening to me. They are unfair and black and white reversed. I feel sad about it."* Aiwa

> *"They cannot bear the bad news when they first hear it. But gradually they have to accept it, knowing that nothing can change it."* Xieguang

The quotes describing how individuals may deal with suffering demonstrate that PCB in this investigation act either positively or negatively towards suffering experiences while addressing spirituality according to Chinese philosophies and traditions. In positive terms, it suggests that PCB living in England do not consider suffering as negative, rather they accept it and strive to see the positive side to it in an attempt to improve themselves through the bad experience. This may reflect a general way of dealing with suffering based on Chinese philosophies and cultures which I will discuss in Chapter Nine. Conversely, some participants may act negatively towards suffering, resulting in them losing control, being in a state of shock. An extreme reaction to this may result in individuals gambling or undertaking similar risk-taking behaviours, indicating the importance of good social support being in place.

The above evidence shows that the participants expressed their difficulties in life, and suffering, as a major concern of spirituality. This is consistent with the current understanding of spirituality in nursing that suffering is relevant to spirituality and spiritual care (de Castella and Simmonds, 2013). In both Western (Wright, 2005; Balducci, 2011) and Chinese contexts (Chiu, 2000; Chio et al., 2008), spirituality and suffering may be interrelated. A belief in God (Diaz-Gilbert, 2014) and a positive interpretation of suffering that it increases tolerance and self-cultivation as revealed in this investigation, may lessen or mitigate people's negative feelings and attitudes towards suffering. This indicates that spiritual care may be an important resource for people during times of suffering and have an impact on their well-being in terms of finding meaning in illness (Emblen and Pesut, 2001).

However, the concept of suffering appears more prominent in this investigation than in other studies. This may be because of PCB's familiarity with Chinese philosophy, recognising the value of suffering and how this may contribute to their spiritual growth. As this may be a useful strategy for supporting patients from Chinese backgrounds living in the UK, I will explore this further in Chapter Nine.

Participants frequently highlighted the suffering in their health and family-related issues recognising that these contributed significantly to their understanding of spirituality. As this has implications for family-supported care and may be linked with physical health, it will also be discussed in Chapter Nine.

Need

In this investigation, ‘Need’ is a broad concept used by participants in their understanding of spirituality. It is a requirement varying from physical health and safety, family closeness and community support to having a sense of accomplishment. Thus participants had expectations concerning health, safety, family relationships and accomplishments when describing spirituality and its related concepts. With reference to the concept of ‘Suffering’, when participants related this to spirituality, they implied a need. For example, when they referred to spirituality as illness-related suffering, they indicated a desire to deal with it efficiently or to obtain the necessary support to cope with situations. Hauerwas (1986) also highlighted that suffering is a reasonable aspect of human need which arises from mutual dependence on one another. Therefore, the concepts ‘Need’ and ‘Suffering’ are interrelated. ‘Need’ is a common understanding in spirituality, which can be seen in contemporary literature addressing spirituality related studies (Shih et al., 2009; Hermann, 2001; Taylor, 2003) .

Although ‘Need’ is a common concept in understandings of spirituality and spiritual care, it is not easy to elicit information about which aspect of need it is. As reflected in Maipian’s transcript, he has no spirituality but emphasised his feeling of being lonely. This feeling of loneliness was probably his focus at the time (Murray and Zentner, 1989 p. 259) or he may simply have had difficulty in articulating the meaning of the term,

> *Interviewer: “We all have need in a spiritual dimension. Could you say something about it? You can think for a while.”*
>
> *Maipian: “I have needs but feel lonely, and I have no spirituality.”*

The reason why identifying needs with reference to the spiritual dimension is difficult to express may be due to the abstract and broad nature of spirituality and spiritual care, or because participants have no awareness and low expectations, which is further explored in Chapter Six (p.187). The difficulty in identifying spiritual needs in this investigation is also reflected in Taylor (2003) study exploring the spiritual needs of patients with cancer and family caregivers. Because some participants had difficulty in identifying their own spiritual needs, the author provided a list of potential spiritual needs to allow them to provide comments on their own.

Participants in this investigation demonstrated they had a need for well-being when addressing spirituality, exemplified by Aiwa saying they needed health, family, financial security and safety,

> *"I think it is the best life that we all have physical and psychological health, that we are able to make a living and have a happy family without disasters."*

This shows that the participants' understanding of need in relation to spirituality may fall into *Maslow's Hierarchy of Needs* (Maslow, 1943) in five ways: physiological, safety–security, belonging, esteem and self-actualisation (see Figure 5.1 below). Because the theory is relevant in identifying people's motivations from low to high levels, these factors are associated with the motivating elements identified by participants in this investigation when addressing their understanding of spirituality.

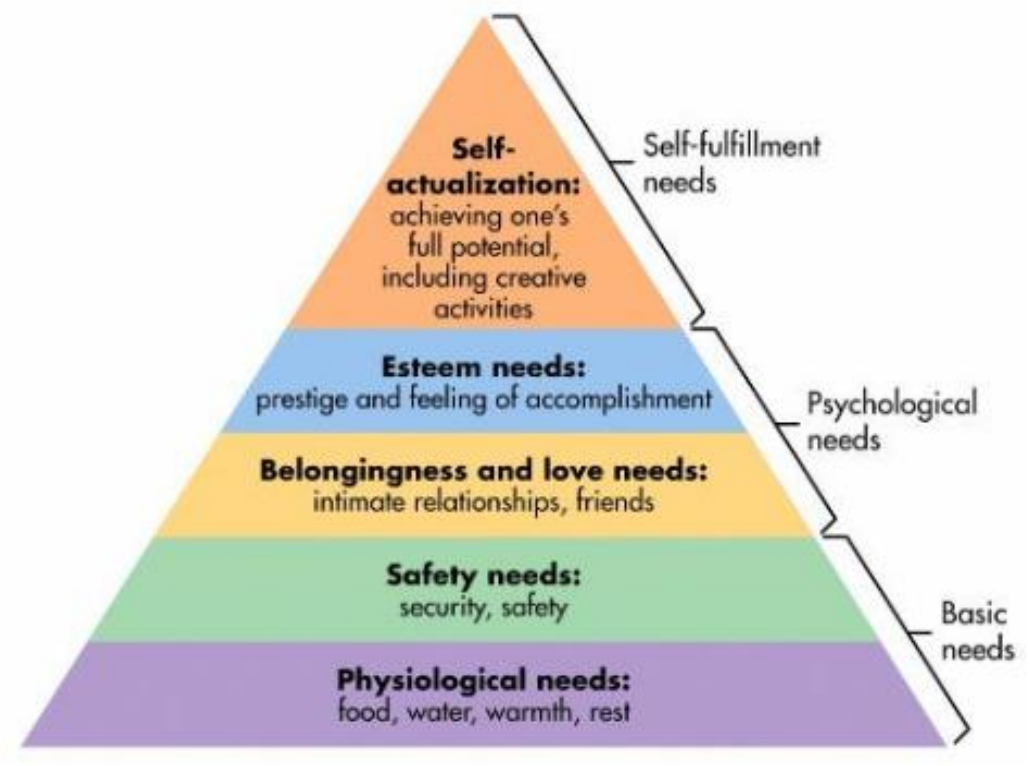

Figure 5.1 Maslow's hierarchy of needs, adapted from Maslow's Hierarchy of Needs (McLeod, 2016)

When addressing spirituality, participants expressed the need for material support such as money, clothes, food and accommodation, for everyday living. This was particularly evident during the hard times when there were insufficient resources and throughout times of illness. Sandi highlighted that a sustainable life is important, which was based on her husband's unstable profession and income,

> *"What he lied about to me was regarding his profession. Since he had no stable job, he knew that I would not have developed my relationship with him if he had told me the truth."*

Dianxin stressed that materialism is important in certain circumstances,

> *"People in the past valued money and clothes, and they used to say that if you have money, you can eat better food and wear better clothes."*

Chengshi, working as a nursing assistant, addressed the fact that proper

accommodation is important for certain patients in hospital,

> *"He may need an independent room because if he is admitted alone in a strange place and surrounded by foreigners, he will be affected more or less mentally."*

In addition to material support, participants also highlighted their need for health in their understanding of spirituality, describing how they exercise to keep fit and maintain health and well-being,

> *"We do not prioritise money anymore and it is ok that we just have enough to live. We have to exercise very often."* Linde

The above extracts show that participants' understanding of spirituality may correspond to the first level of Maslow's hierarchy of needs. This implies that participants relate their understanding of spirituality to the material and financial resources necessary to meet physical needs and the need to be healthy and feel safe, reflecting that physiological need are the basis for survival (Cutler, 2014). This verifies that taking care of physical illness is a priority for patients. As shown previously, participants emphasised the dominating role of physical illness in their spiritual suffering. It also shows that when providing spiritual care, caring for physical needs, such as offering culturally appropriate food and comfortable accommodation, is an important part of this. Therefore, it may be important for healthcare professionals for PCB to think first about the physical needs, because these are fundamental to life and existence, contributing to health and a sense of safety, rather than prioritising religious or spiritual needs or other dimensions of care.

Besides the need for physical health and safety, participants also related spirituality to psychological needs. This was demonstrated by Sandi, saying people need good mental health and to have positive thoughts and attitudes, when describing her understanding of spirituality,

> *"You have nutritious food and everything is alright in the family, but if your thoughts are bad, worrying and being anxious about work, being jealous of the money people earn and so on."*

Specifically, participants emphasised the importance of family in their understanding of spirituality. Maipain highlighted this because he felt lonely abroad, and talking to the family supported him,

> *"In the UK, I do not have spiritual needs when I am alone but communicating with the family, so they can support me sometimes."*

Mimang also stated that an individual living overseas needs the love from family members in their home country,

> *"It is about you needing your family support when you are abroad. Then you can go ahead. Yes, it should be called family support."*

The need for family is essential for the elderly PCB living in England as they are hungry for their children's support. Aiwa explained that she needed her son's support during her mental turmoil,

> *"My eldest son then told me to send him a voice message if I need to talk to him…As soon as I send a message to him, he immediately replies."*

Qinlao also related spirituality and spiritual care to patients' need of family at the end of life,

"When patients are at the end of life, they need to calm down and feel comfortable. If the family visit them, comfort them and talk to them, they will get comfort from this kind of spiritual care."

Participants' strong desire for family confirms that it can become a concern because they worry about close ones. Their desire for family is because they can get love and support from family members. This desire in their understanding of spirituality indicates that family can be a powerful supporting resource in spiritual care.

Participants also felt that spirituality related to the need for interaction in a wider context, such as friendship, social support and healthcare. For example, Dianxin stated that he needs friendship within the community,

"You can go to the Chinese association where the Chinese get together to find and make new friends who have the same interests. Then you will live very well in the same way."

Yisheng illustrated that PCB need healthcare from society,

"If you have a traffic accident and report the case at the hospital, a telephone number will be provided to you by an automatic system, or a doctor will ask you whether you need physiological help or not."

Shufa highlighted that she preferred the hospital facilities provided in the UK,

"I am used to staying alone overseas so I dislike going back. The facilities are very good here. Why do I need to go back?"

In addition to experiencing physical and psychological needs, participants also referred to a higher level of need associated with love, contentment and achievement. For example, Boshi stated that people need contentment and a sense of success from and helping others,

> *"Sometimes we also need love and care mentally and then need to enjoy the spiritual contentment."*

Kunan also described the need for a peaceful life in his understanding of spirituality, which is a common aspect of a mature person's achievement,

> *"Why do we need to have protests nowadays at the Embassy every year etc., creating a chaotic situation?"*

Maowai and Mimang associated spirituality with the need for spiritual guidance in achieving a way of life and overcoming difficulties,

> *"But it has not been publicised and you need the treasure guider and guarantor (引宝师) to bring you to seek Dao (way)."* Maowai

> *"At this time, one needs a strong faith to support oneself and remember that God or Buddha can help him or her out of the difficulties, or minimise his or her suffering."* Mimang

The above reveals that participants' understanding of spirituality was founded on a wide range of needs associated with physical health and safety, family closeness and community support. In addition, participants highlighted a sense of accomplishment, demonstrating that life is not just about material needs and that

the spiritual dimension may be related to the need for a philosophy to guide daily thought and behaviour.

These needs also ranged from person-focused needs, such as daily necessities, being safe, and a sense of accomplishment, to community-focused needs, such as connection to the world. This broad range of needs associated with the spiritual dimension signifies that for PCB in England they should be addressed within a person-centred approach as each person has a different understanding and expression of their needs. The person-centred approach will ensure the identification of needs that may be related to spirituality.

Hope

Hope is defined as an expectation for some future good and an effort towards achieving this desired end (Kristiansen, Irshad, Worth et al., 2014). In this investigation when discussing the concepts of spirituality and spiritual care, participants indicated that hope was a longing or expectation for basic material things and good health, fundamental for well-being. They also expressed a hope for filial piety in maintaining family closeness, and with regard to personal achievements for the benefit of their family and society.

Participants related spirituality to a belief and longing for the future. According to Mimang,

> *"Sometimes, you have a hope in spirituality. It is about what could happen in the future. This kind of future is similar to a kind of hope. Or it is not hope but yearning."*

The expectations of hope ranged from what might be a normal desire to a strong yearning for the future. In answer to the question "What is your understanding of the term spirituality?" Qiangjian referred to it as a wish for health, because health is the most essential requirement for a normal life,

> *"I wish I have a good mental alertness, to be physically healthy, to be careful so that I do not slip and fall."*

Qinlao indicated that spirituality is about a willingness or readiness for something wished for, and Pengchao stated that spirituality is related to offering hope and sustenance, for oneself or for others,

> *"Spirituality is soul and willingness, soul and willingness."* Qinlao

> *"In my opinion, spirituality is giving encouragement, comfort, sustenance and hope."* Pengchao

Mimang suggested it is a deep desire, something that a person pursues with all their heart,

> *"Um…there is certainly…um… a pursuit in a person's deep heart. It is a spiritual sustenance in a person's deep heart. It can also be a kind of desire."*

The above quotations show that some participants' understanding of spirituality was grounded in hope, varying to different degrees from normal wishes to deep desires, in terms of the intensity of expectation.

Participants also related spirituality to what they hoped for, including daily necessities and physical health. For example, Dianxin stressed the importance of having sufficient food, for some people,

"At the time, the expectation was lower as long as there was food to eat."

In response to the question "Could you say something about hope?", Azhen expressed her hope for the "gift of good health", and Qiangjian said it was "being healthy and helping others", while Pengchao spoke about the longevity of life that people hoped for,

"The encouragement from family and physicians may make his life expectation much longer."

Participants also stressed the importance of a death without suffering, or a dignified death when addressing spirituality,

"But people around them feel these dying people are in severe pain, which is beyond description. I have see people in severe pain. It is important to seek better death rather than a better life." Aiwa

"So the patient got his/her wish for peace and comfort, and died with dignity." Qinlao

Participants' understanding of spirituality as being about hope for both material needs and health is also in line with the first level of Maslow's Hierarchy of Needs (Maslow and Frager, 1987). In this theory, material and physical health are the basic needs for people to have a sense of safety. This shows the similarity of participants' understanding of spirituality.

In addition to hope for health and material possessions, participants also considered spirituality to be associated with family closeness, as for Pengchao, who was responsible for taking care of her parents,

"I hope I will accompany and take care of my parents in their way. Certainly, it is the thing I greatly expect."

Parents also shared the same view,

"In the past, people were responsible for their family, and older people relied on their children, but now these traditions are outdated." Qiangjian

Filial piety is an important value to maintain the role of the family in a Confucianist-dominated society (Leung and Shek, 2016) and I will show in Chapter Eight that participants associated themselves with this value. The teaching of filial piety to younger generations might be useful in family-assisted spiritual support for patients from Chinese backgrounds.

Furthermore, participants expressed an understanding of spirituality as hopes for achievement in both academic and personal development. Pengchao observed that parents have high expectations for their children's achievements,

"The student's parents had great expectations of him. Since his mother was a faithful Buddhist, she went to the temple to pray, hoping her son would achieve a good score."

Boshi wanted to continue her personal development when addressing spirituality,

"Meantime I will try to change, adjust, and improve by learning from my past mistakes…My personal creed is to break my bottleneck through more contacts and learning so that I can pursue more knowledge."

There were hopes embracing a wider perspective, rather than focusing on an individual and family. For example, Maowai in discussing spirituality indicated that it may be associated with forgiveness and how she had hopes for world peace,

> *"If this person can forgive, the other will be alright. If everybody can tolerate and endure, and do good deeds, this world will be peaceful and there will be no more wars."*

Participants indicated that the way to realise hope was not to take life too seriously and keep expectations low so that people will not become frustrated if those things that are hoped for cannot be achieved. Dianxin addressed this,

> *"One must not take things too seriously but enjoy oneself. Anyway it is better not to have high expectations but be content with a basic livelihood. Do not take things too seriously."* Dianxin

Another way of turning hope into reality is keeping hope practical. This was demonstrated by Youhao, who recognised that not every wish can be realised,

> *"We live in this world we can't have everything we wish every day."*

The notion of having low expectations reflects the Confucian philosophy of staying practical and not letting oneself down, in line with the principle of self-cultivation in an individual's family and social life and setting realistic and ambitious aims (Eno, 2016). Participants recognised that personal expectations and ambitions for personal development in a practical and achievable way might be an aspect of spirituality.

However, some expectations may not be very practical, requiring effort to be accomplished. For example, Heping related his understanding of spirituality to the prospects for independence and freedom for their children,

> *"Sometimes, a mother pays great attention to her child, but the child does not want excessive attention. He wants independence and his own space from his own perspective."*

The striving for non-parental interference with personal issues may present a challenge for young people because parental authority over them has long been established in the Chinese tradition (Eno, 2016).

The above suggest that participants may relate their understanding of spirituality to hopes and expectations for basic material needs and health, filial piety to maintain family closeness and achievements in personal and social life. This is in line with the concept of 'Need' developed in the previous section, with different levels of need from physiological necessities to psychological closeness and accomplishment. These aspects of need and hope demonstrate that the two concepts overlap to support participants' understanding of spirituality. They also complement each other to provide a deeper level of understanding of spirituality by highlighting the different dimensions and yet shared components. For example, family closeness is highlighted as a common need, while in 'Hope' filial piety is seen as a deep desire that participants yearn for, and these are crucial elements in participants' understanding of spirituality. The overlapping relationship between hope and need is also demonstrated in the current literature on spirituality and spiritual care within nursing and healthcare. For example, 'Need' and 'Hope' can be seen in Anandarajah and Hight's (2001) spiritual assessment tool, identifying that sources of hope facilitate spiritual needs identification.

However, the participants demonstrated that hope is different from need because hope is the longing or desire for something possible to occur, requiring belief and persistence in achieving the desired goal. Hope indicates a person's aspirations and goals for life. By comparison, a need is something required or wanted, and it may have a focus on requisition. The two concepts add different understandings to the term 'spirituality'.

Participants explained their hope in terms of the intensity of desire, with a variation in intensity ranging from average wishes to deep desires, from practical and basic requirements to the achievement of desires that may require considerable effort to accomplish. The faith and effort placed in pursing the desired goals may act as "an inner power that facilitates the transcendence of the present situation and movement towards new awareness and enrichment of being (Department of Health (DH), 2010 p.22).

Summary of motivation

This chapter presents participants' understanding of spirituality and spiritual care in relation to motivation in their daily life, and particularly in healthcare settings. The concept 'Motivation' consists of three sub-categories: 'Suffering', 'Need' and 'Hope', which emerged and were presented according to the paradigm *condition, action* and *consequences* in grounded theory, as suggested by Strauss and Corbin (1998). These sub-categories enriched the theory of seeking a meaningful life because what people suffer, need and hope for may motivate them to seek their life's meaning. The next chapter will describe the category 'Support'.

CHAPTER SIX FINDINGS: SUPPORT

Introduction

Chapter Five discussed how ‘Motivation’ and its subsidiary categories contributed to an understanding of spirituality and spiritual care in the process of seeking a meaningful life. This chapter in turn examines the concept ‘Support’, which emerged in line with grounded theory as another condition for seeking a meaningful life.

The concept ‘Support’ consists of two sub-categories, ‘Spiritual resource’ and ‘Spiritual care’. ‘Spiritual resource’ was developed as supporting resources with a focus on normal, everyday contexts or settings. In contrast, ‘Spiritual care’ was established with a specific focus on healthcare settings. These two sub-categories emerged in response to participants’ understanding of spirituality and spiritual care with regard to accessing support. They also tested and developed further insights into the points raised by Azhen at the pilot stage that spiritual care can be provided in participants’ everyday lives (p.126). The results provide further understanding of spirituality in terms of the different types of support available in everyday settings and particularly within healthcare. This may inform future practice by offering simple and practical ideas of nursing activities that could enhance the provision of spiritual care.

Spiritual resource

‘Spiritual resource’ in this investigation focuses on the support that PCB get or expect in their daily lives, when relating this to their understanding of spirituality and spiritual care. The resources for this kind of support were referred to as: family; self; Chinese culture and philosophy; others and society; religion and a Supreme Being; and material and financial support. The consequences or

impacts of support are wide ranging and may include an individual's personal and professional development, the quality of family life, and one's health and well-being. They may also include values and dignity, emotional help, giving hope, and showing gratitude to others. In the following, I explain these different avenues of support to reveal their relationship with spirituality and spiritual care among PCB and how this is manifested in their daily lives.

Participants related their understanding of spirituality and spiritual care to the different types and forms of support available in everyday life. For example, Laoxiang associated spiritual care with the support gained from her own experiences, friends and parents, and highlighted its importance for a person's professional development,

> *"When you have a development opportunity at work, your support from your own experience and your colleagues is important. As for a younger person, parental support and peer support are important. Otherwise, I think many people will withdraw."*

Participants frequently linked the term spirituality with family support, as Shufa illustrates:

> *"I think it important a person has good spirituality… My utmost spiritual sustenance is my child and my parents, and I have to live for them."*

While explaining the understanding of spirituality, Linde said that family support resulted in feeling warm and being loved,

> *"You have a warm feeling and feel loved when you have a husband and family."*

Similarly, Pengchao illustrated the severe consequences for children who lose parental care and support,

> *"After his wife's death, there was nobody to take care of and encourage the children, since he needed to work as a teacher and earn money. The children had lost their mother, which greatly affected their confidence and esteem. They were defeated… Their children did not develop as well as others. They did not complete their studying, nor enter university. Thus, the family has a huge impact on children."*

For many PCB living in England, their meaning of spirituality is expressed in material terms such as financially supporting the family, as with Maipian,

> Interviewer: *"There is a term called spirituality in China. What is your thought on this?"*
>
> Maipian: *"I think it is earning money and sending it back to the family when I am abroad."*

The participants' responses associated with family revealed that they relate their understanding of spirituality to family because the support can make them feel comfortable and substantiate their life. One reason could be the influence of Confucianism, in which the family is considered the basic unit of society and the cradle for individual development. This could have implications for PCB's spiritual wellness in general and particularly in the healthcare setting.

In addition to family support, participants also related their understanding of spirituality to the support gained from their own thoughts and faith,

> *"Of course…the main things lie in your objective perspective and your own thoughts."* Sandi

"I have no religious faith, but I have a relative stable and solid faith that a person has to grow up or mature continuously in practice." Laoxiang

The support gained from one's own thoughts and life experiences enabled the participants to grow and gain resources to fulfil their life purpose. It also made them stronger in their daily life and during times of illness. For example, Pengchao indicated that the hope a patient gained by not being told a terminal diagnosis could provide them with the will to live,

"In my opinion, a person usually should not be told his real health situation by family and physicians in China, especially a cancer patient. The purpose of this is to give hope to the patient to live and then keeps the will to live."

Similarly, Boshi stated that her belief in helping others constantly motivated her to work for the benefit of others, therefore she grew in her own sense of value and self-belief,

"I like to do such things (helping others) constantly because it has formed the inner motivation and belief."

The above statements relating to one's own resources suggests these are important in their understanding of spirituality.

This comfirms the notion that spirituality is the establishment of self-identity (Chao et al., 2002) as discussed in Chapter Two, contributing to the knowledge of spirituality and spiritual care from the perspective of PCB living in England.

Furthermore, participants related their understanding of spirituality to the supporting resources gained from Chinese culture. References were made to the

Chinese traditional concept of ‘Heaven (*Tian* 天) which are the gods Chinese people worship, for their emotional support,

> *“Yes, I am very grateful that the heavenly being cares about me.”* Wangxing

> *“Yes. That is the reason I do not have resentment. You know, Heaven is very good to me and lets me survive.”* Shufa

Besides providing the feeling of being taken care of and giving power for survival, Chinese cultural values are also a catalyst for achievement and a sense of pride. Pengchao illustrated that a charm guaranteed an academic achievement. This is a Chinese custom and many people follow this for a better outcome in their studies or other aspects of life,

> *“…his persistent desire was to enter university in the 985 or 211 project (the universities with a high rank in China)… This was the reason his mother came to accompany him and she gave him another charm for scholarly honour (功名符), saying the charm guaranteed her son’s entry to university and it would ensure her son obtained a good examination score. She encouraged her son to be relaxed during the exam.”*

Boshi also stated that Chinese opera ignited her feeling of satisfaction and admiration for Chinese history and tradition. Appreciating traditional art provided her with asense that the nation was beautiful, and she gained pride from this,

> *“Some programmes were about Yue’s emperor Goujian and the beauty Xishi, who washed her silk in the river. They are related to our history of tradition. I love to watch the figures, costumes, make-up, and decorations in the opera. I feel China is a graceful nation. I really love opera.”*

While relating spirituality to Chinese culture and philosophy for support, participants also indicated spirituality was gaining support from religion and a Higher Being,

> *"From 1994 until the present time, I have been reading my Holy Bible. Spiritual sustenance (精神寄托) is very important to me. It is the corner stone of the mind."* Azhen

> *"Huatuo, he sometimes… some people have seen his revelation, Sage Huatuo (华佗圣师). This time when my husband was hospitalised, I prayed to Sage Huatuo for assistance such as, 'go to the hospital to save my husband'."* Maowai

The above extracts show that Chinese culture and philosophy provide a means of spiritual support for PCB in their daily life, because these sources offer a feeling of being taken care of, a power or force for survival, assurance of achievement, and a sense of pride. Inseparable from Chinese culture and philosophies is religion and supreme beings, from which some participants gain support, which suggests it is important to their understanding of spirituality and spiritual care. Therefore, considering the role of Chinese culture, philosophy, religion, and belief in Higher Beings may be a helpful source of spiritual support for PCB living in England.

Gaining support from other people and UK society was also relevant to participants' meaning of spirituality. The example provided by Shuaige highlights the relevance of seeking support from others,

> *"My understanding of spirituality… Let us return to the example I gave just now, which is about sharing difficulty between two people… If you face a*

difficulty, the way and the thoughts to handle it come from yourself. If another person shares it with you and offers his suggestion, he gives you opportunity to let you express your own idea and provides feedback on it. Then the way to handle it will be different from the way you handle it by yourself."

Youhao demonstrated that spirituality is reflected in the support provided by others. She recalled how her friend's help in calling a doctor and interpreting enabled her to receive proper treatment, thus avoiding a further deterioration in health,

"I have a friend who is a nurse. She knew that removing fluid reducing tablets was not right; she helped me and called the doctor (in English) straight away to come."

Although a friend's help is beneficial for participants sometimes, it raises alarm that using friends or family as an interpreter may have potential risks for people's health because of their non-professional interpretation of medical information. I will discuss this later.

Kunan described how he gained social welfare provided by the UK government and he was very grateful for it, when talking about the concept of spirituality,

"We must understand we receive very good welfare in the UK, the government gives us pension. We have welfare payment as well as pension… everything is sufficient."

The above show that gaining support from others and society is relevant to PCB's understanding of spirituality. This is because it provides resources for them to deal with difficulty and crisis and provides security through the provision of social

welfare. Therefore, friends' help and social groups can provide play a role in spiritual care for PCB living in England.

Kunan's quote mentions the state pension, explaining that the financial support received from the UK government allowed them to maintain a reasonable standard of living. This is to say, in addition to the above spiritual resources, participants reveal their financial concerns and how this may impact on their understanding of spirituality and spiritual care. The evidence for material and financial relevance to spirituality can be seen in Maipian's explanation regarding the effect of money on him,

> *"I am thrilled and feel energetic if I win at gambling, like winning a lottery. I feel exhausted if I lose money. I feel energetic even in walking if I can gain a little, which is the same as winning the lottery."*

Aiwa expanded on the role of money, saying that the pension helped her during her mental illness because she did not need to work in order to survive,

> *"From last October, I have been receiving a pension for my problem. Now I get some money without working. I do not need to spend money on visiting the doctor and renting a house. I do not need to work (to earn money) now."*

These participants' experiences highlight that PCB are aware of the need for material and financial support, recognising this as part of their understanding of spirituality. This is because it enables them to maintain their lives, particularly when they lose the ability to work. This recognises the need for financial and material security which is a motivating factor in the process of seeking a meaningful life. The material and monetary understanding of spirituality adds to the definitions in the Western and Chinese contexts (Chapter Two) where

spirituality is not usually explicitly related to material and financial matters. Therefore, being aware of the importance that PCB place on these elements of spiritual support provides greater insight into the cultural differences in accessing different forms of support.

Spiritual care

'Spiritual care' in this investigation is defined as the support for an individual's spiritual well-being especially within a healthcare context. The supporting resources provided within healthcare emphasise the importance for healthcare professionals to address and engage with this aspect. However, there is also recognition of family help and the patients' own inner strength/resources in maintaining their own health. The healthcare professionals' support for patients in this area was articulated as 'identifying patients' need for support', 'facilitating good communication' and 'attending to patients with love and respect'. Crucially, it was about ensuring the quality of spiritual care by taking PCB's personal, religious and spiritual needs into account. I address these points below.

Identifying needs in the spiritual dimension

Qinlao refers to the admission process stating that spiritual care relates to asking patients if they have any specific religious needs,

> *"In the admission process, we already…nurses have already assessed patients' spiritual needs by asking the question, 'do you need religious support?' If they said yes, we would arrange this."*

Qinlao's example involves asking a direct question to identify religious needs so that the appropriate support can be provided. This may require gaining consent to

refer patients to a religious leader, but this should be done in a timely manner to meet the patients' personal needs.

Mimang also noted that spiritual care is associated with the various needs of individuals during illness. A patient may need help to overcome the initial shock and disappointment of a diagnosis. Mimang stressed the need for a listener, and support from family, friends and healthcare professionals,

> *"When a person is sick and he suddenly learns that he has a serious illness after he is hospitalised, his first response is disappointment. During the illness, he needs strong belief and confidence to help him come through the disaster. He may indeed need a listener to listen to the suffering inside him, as well as supporting strength which can come either from relatives or friends, or the physician, who can support him mentally if he has no relatives or good friends."*

Mimang's extract demonstrates that identifying the needs restores patients' confidence which can be devastated by the experience of illness.

Participants in this investigation also referred to spiritual care as the formal way that assessment can be used to identifying spiritual/religious need, for example, as Laoxiang notes, using a form to identify patients' religious needs,

> *"In these circumstances (religious aspect of care), they attempt to inquire (what patients need), because I think a patient has to fill a form where information about religious belief is also asked. However, I think many Chinese might provide some information or might say nothing regarding this."*

Laoxiang raised the issue that using assessment may not be effective for PCB because most of them will not state or express their needs in this way. This

further reflects that spirituality and the need for spiritual support may be related to cultural issues (Mok et al., 2010). Therefore, assessment needs a more attentive and subtle way to identify spiritual care-related needs for this group of people. Shufa offered an alternative form of assessment, suggesting that responding quickly and appropriately to patients is an effective method of identifying patients' needs rather than filling in a formal assessment form,

> *"As soon as you fluctuate slightly in your feeling, they (nurses) will come back to you. They ask you, serve you water and tea… once they find your blood pressure is high and assess that you may have difficulty going to the toilet, they will come over to support you and bring things to you."*

Being responsive to patients' needs requires healthcare professionals, particularly nurses to have time to accompany or be present with patients, suggesting that more nursing staff and time may be needed to provide adequate spiritual care.

A major consideration when identifying these kinds of needs was raised by participants. This was because patients from Chinese backgrounds appear to have limited awareness and low expectations about receiving spiritual care due to their focus on medical treatment. Laoxiang demonstrated this,

> *"So I think if Chinese people are hospitalised in the UK, the majority of them have no awareness of spiritual care, nor expectations about the level of spiritual care. When they are sick and hospitalised, they lower their standards to a very basic level. Their key issue is about medical treatment, getting a clear diagnosis, and getting treatment. As for the care in hospital, or the emotional support in the hospital, or spiritual care, many people, I think, have no expectation."*

Communication

The essential and important role of communication was highlighted during the process of spiritual care. For example, Yisheng mentioned that his understanding of spiritual care was good communication,

> *"Spiritual care is surely about communication, rather than administrating medicine and something else."*

Similarly, Shufa indicated that spiritual care is related to effective communication through using an interpreter,

> *"The only thing is it would be better if the interpreter was available at any time. I can communicate without an interpreter. Considering others who do not understand English, there is no way to make contact. This aspect is very important."*

Participants also highlighted different communication skills in their understanding of spiritual care. For example, Maowai noted that having a sense of humour and speaking pleasantly enhances the communication, and makes for a harmonious relationship between staff and patients,

> *"The senior doctor then laughed. There was one doctor speaking Mandarin and Cantonese, and he interpreted for us. He said, 'You have been sick for such a long time, you have such a speedy recovery'. They all joked with him (my husband)."*

Mimang explained that the pace of conversation is an important requirement of clear communication,

"It (spiritual care) is about the speed the medical staff talk. For example, some of them talk very fast and so the patient may not understand. It is ok if they can speak a little slowly… Speaking clearly and patiently will be good."

Xuezhe stated that another aspect of communication in spiritual care is for healthcare professionals and nurses to use words that are appropriate and respectful,

"Yes, in terms of acceptance, clients are described as emotionally unstable rather than having mental illness. Using a different expression."

The essential skill in communicating spiritual care is speaking with love and sincerity as Qinlao demonstrates,

"I talk with patients once I see them, I touch and hug them if they cry, saying 'What is the problem, and could you tell it to me?'."

Having a loving heart as the essence of care is not only demonstrated in participants' understanding of spiritual care relating to verbal communication, it is also confirmed in the process of attending to patients.

Although communication appears as an important issue in participants' understanding of spiritual care, Youhao demonstrated how, as a patient in hospital, they lacked support in communication and the interpretation service, stressing how this may impact on the provision of spiritual care,

"They have not talked to me about it, may be because we can't speak English. They may have had assistance. It may be because we cannot speak English…I did not know what a kidney dialysis was. Was it painful? Was it calm during the procedure? Nurses said nothing to me."

Chengshi, as a healthcare professional, also confirmed that an adequate interpreting service can have a good effect on the overall quality of care,

> *"Yes, explaining clearly to them. In this aspect (language support), professional interpreters are arranged for the patients to explain what the doctor is saying. If every foreigner can get language support, it will be very good in my opinion."*

Laoxiang, from a social care manager's perspective, also illustrated a distressing consequence of the lack of communication and interpreting services with regard to providing spiritual care,

> *"The old woman went to hospital to visit her husband in the early morning the following day and found her husband could not move his hand. As you can imagine, the old woman was very anxious. But the staff in the hospital could not offer her any information about what had happened rather than smiling at her, smiling at her. She then cried, sitting in corridor."*

When facing a shortage of interpreting services in the NHS, Linde indicated that family members could provide a service as interpreters, but pointed out that the interpreting service must be independent and professional, therefore bringing into question the appropriateness of using family members as interpreters,

> *"We were able to use our family as interpreters before but it is not the case for the time being. A certified interpreter must be hired. They do very well in this aspect and their medical service is good as well. They can ease the tense situation."*

Qinlao indicated that staff from Chinese backgrounds' may act as interpreters, supporting the patient while in hospital, but pointed out that this may affect their normal nursing activities by taking up time and increasing their workload,

> *"They (feel) very close (with Chinese nurses). Even when I see Chinese (patients in hospital), I pay attention to them because I think they need (something). Once I met a young man during my work time, and he was holding a piece of paper and wondering… After I (helped him and) handed him to the X-ray technicians, my break (time) was finished and I had to go back (to work)."*

Yisheng also suggested that staff from Chinese backgrounds were more effective in communicating with Chinese patients. This is because of their understanding of Chinese culture, which enables them to grasp the essence of information and requirements for this group of people,

> *"Because even if a British nurse really likes Chinese culture, their understanding of Chinese culture is very limited. They probably have little understanding of the basic knowledge of Chinese culture. But for a nurse with a Chinese background, they would probably find out the patient's context, his birth context and growing-up context, and his educational level, through a simple conversation."*

Both Qinlao and Yisheng demonstrate that staff from Chinese backgrounds are more effective with communication, as they grasp the meaning of a situation and develop a close relationship between the patient and staff. They may share and recognise the importance of cultural background. They may also speak the same language. Both effective communication and close relationships are important for caring activities.

The above points reveal that the participants closely related their understanding of spiritual care to good and effective communication, by illustrating the different channels of communication. Communication is recognised by PCB living in England as a fundamental aspect of caring and an essential skill in the provision of spiritual care (Swinton, 2002). The apparent shortage of, or access to, professional interpreting services in current healthcare settings may be a problem for PCB living in England.

Care with a good attitude

As mentioned above, love and kindness were considered key aspects of communication in the participants' understanding of spiritual care. These values and attitudes are also important for healthcare professionals to communicate that they are attending to the needs of PCB. For example, Laoxiang described her understanding of spiritual care as kindness and love, behaviour that touches the bottom of her heart, adding that kind attendance of healthcare professionals can support frail patients,

> *"I know an English man who has had a voluntary job for 10 years. His job involves transporting the frail people on a wheelchair and pushing them to a little chapel at a ward in the afternoon once a week…This is typical spiritual care for patients."*

Not only does loving care support the frail, it is also essential for the dying. Wangxing explained that this is because a dying person has limited life left and needs compassion and empathy during this final journey,

"When a person is dying, you can accompany him and show your enormous compassion to him, because he has very limited time left. During this special period of dying, the love to him… it will be very much appreciated if there is such kind organisation in our society."

Although caring for patients with love, kindness and empathy is important, participants highlighted that healthcare professionals should not be sentimentally involved in patient care. Qinlao said that she controlled her emotions and feelings when providing nursing care following the death of a patient,

"It is said that you have to be mentally strong during the course. You cannot… if a patient dies, you cannot cry while doing your job. I am able to control myself in this aspect. I am able to control myself while sympathising with patients."

Qinlao's keeping a balance between compassion and not being overly emotional reflects a basic Chinese philosophical value of keeping a balanced mind in personal and social activities (Eno, 2016).

One way of providing care with a loving heart (Penman, Oliver and Harrington, 2013) is done through close and frequent contact with the patient, illustrated by Qinlao,

"She treats me as a close friend. Because I feel she is isolated, I go to her room every day, asking her what she wants to eat and does she need a wash or a turn. She is still very close to me even though she can't understand why."

Another way of loving care is spending time with the patients, as indicated by Qiangjian,

"Some nurses spend as little time with you as possible."

Spending more time with patients ensures that nurses and other healthcare professionals are responsive to their needs, values and expressed preferences, demonstrating their compassion and empathy when providing care (Care Quality Commission, 2018).

Love in patients' care also requires healthcare professionals to be sincere, indicated by Yisheng in his understanding of spiritual care,

"How to provide spiritual care is beyond my knowledge. I think it might be…the key is enlightening the patient with reason and emotionally moving him, which is about treating him honestly."

However, Pengchao was concerned that telling the truth to patients may harm them, and suggested that medical staff and the family should hide the truth from the patients,

"In my opinion, a person usually should not be told his real health situation by family and physicians in China, especially a cancer patient. The purpose of this is to give hope to the patient to live and then keeps the will to live."

Pengchao's concern about hiding the truth highlights an ethical conflict with regard to patients' medical information disclosure between Western and Chinese cultures (Dong, Zheng, Chen et al., 2015; van de Bovenkamp and Trappenburg, 2012).

Participants in this investigation also mentioned that respecting patients is crucial in the provision of spiritual care. For example, as Aiwa said,

"Spiritual care is about knowing how to respect a person, which is most important."

Treating patients with dignity, in conjunction with other professional values such as compassion and sincerity, highlights the importance of the human aspect of the person's principles and activities, and these have to be assured in the delivery of spiritual care (Puchalski et al., 2014).

Xuezhe suggests that one way of respecting patients is to use terms that patients prefer,

> *"…who (Chinese) should not be called patients… Chinese are hypocritical (虚伪). They get antipathy (反感) as soon as they hear words related to their mental illness."*

Yisheng provided another approach, respecting patients choice even for the withdrawal of treatment,

> *"It is to say that the patient's will has to be respected, no matter if it is to get treated or not, because everyone has to decide his own treatment."*

Chengshi highlighted a specific situation where respect is also needed, when caring for a patient in a coma, stressing the importance of communication,

> *"For the spiritual aspect… although they cannot speak, before each nursing action, we explain to them what we are doing to relax them since I feel they can understand my explanation."*

Chengshi's view on treating patients in a coma and deceased patients with love and respect affirms the human aspect of caring, because patients need to be treated with dignity and respect (NICE, 2012).

The above examples indicate that PCB associate their understanding of spiritual care with caring activities. One key element of caring activities is compassionate and kind attendance of patients. This is because compassionate care supports and comforts people in their frail and dying times when attendance is most needed. Respecting patients is achieved in various ways, such as using patients' preferred terms in communication and respecting their treatment choices.

Xieguang mentioned the requirement for sufficient staff to ensure good quality care, and said that nurses were unable to provide care with a pleasant attitude if they were tired due to staff shortages or an increased workload,

> *"How can nurses smile at patients when they are very tired and still have much work to do? They have to be unhappy because they are too tired, wanting to go home, but have to take care of patients."*

Also, Dianxin expressed his wish for a medically staffed Chinese nursing home,

> *"However, it would be better if we could have this. Nothing but a nursing home… There are some medical staff, such as doctors and nurses, who are Chinese, help to resolve problems."*

Shufa demonstrated her appreciation for the free and convenient healthcare service provided by the UK NHS in the delivery of spiritual care,

> *"You see I came back alone, and all my family are living in Shanghai. I must be strong. I told them it is meaningless to live in Shanghai. If I were there, I would have to pay 300,000 Yuan for treatment a year."*

Similarly, Laoxiang suggested that spiritual care is related to satisfaction and gratitude for the free healthcare,

"The Chinese have very grateful hearts for hospitals in the UK since they do not need to pay, and all the services are free. The food is free too. They should be very grateful."

Although patients from Chinese backgrounds are grateful for a free service, using it also causes them to consider whether they are entitled to this because they have feelings of being discriminated against. This feeling was illustrated by Dianxin,

"But I feel that racial discrimination is not very serious in the UK. It is not too serious to tolerate. I think there should be no such degree of racial discrimination."

Spiritual care was not only related by participants to satisfaction with the free NHS service, but also to NHS support for dietary, living space and daily recreation activities, as seen in the following transcripts,

"When you are hospitalised, the food is important. The food and sleep should be good since they are certainly related to your mood. Eating toast every day will make people sick." Mimang

"He may need an independent room. Because if he is admitted alone in a strange place and surrounded by foreigners, he will be affected more or less mentally. It could be better that his family members can visit him frequently if he is provided with a single room…Thus an independent room and the family's frequent visits might help him a lot mentally." Chengshi

"Nowadays you can bring your own music or get your friends to bring some Chinese newspapers and magazines for you. If hospitals are able to… but it is unlikely that they can provide Chinese TV programmes. However, it would be better if we could have this." Dianxin

Participants felt there was a need to educate and train nurses and healthcare professionals in spiritual care, to enhance their competence in this aspect of care. For example, Heping indicated that nurses must have knowledge to be competent in dealing with medical issues,

> *"First, nurses should have professional knowledge, medical and healthcare knowledge. A nurse should have conduct which is loving to others, and be dedicated to her profession, which means medical and nursing staff should do their part…It is necessary that they understand and care about the causes and the symptoms of the illness, that they know some handling methods."*

Xiaojin also suggested there was a need for healthcare professionals to improve their knowledge in the provision of spiritual care,

> *"To keep the patient's psychological/mental situation at a good level, what nurses and physicians can do is a big portion. However, it is still limited."*

While Heping emphasised the effect of professionalism and competence on quality of care in his understanding of spiritual care, Qinlao indicated that one way of gaining professional medical knowledge was through university education, saying the knowledge she obtained in her nursing programme as a student greatly enhanced her skills and quality of care,

> *"The (nursing knowledge) level I reached is attributed to the good education in the UK. I studied ethics and social care first instead of studying anatomy, nursing or pharmacology, etc…. The education is very good and I am educated to help others."*

It seemed this participant did not address spiritual care in education in general as she did not mention spiritual care or a specific course or programme that dealt with spirituality or spiritual care. But she mentioned the effect of ethical knowledge and communication skills in her nursing education and subsequent nursing practice. This shows that spiritual care education received at university may not always be obvious in the nurse's practice of spiritual care. Similarly, Lewinson's (2016) study found that third year nursing students failed to identify the education of spirituality and spiritual care in the first year of their programme due to the implicit and discontinuous way these concepts were addressed. Both the findings of this investigation and the literature review indicated that continuous professional education may be needed so that nurses can improve their knowledge on spiritual care interventions.

Religious care

As indicated in Chapter Two, the definition of spirituality includes religious and non-religious care. Participants in this investigation indicated that spiritual care is closely related to or may involve religious care. This was also highlighted by Xuezhe who added that spiritual care was the responsibility of the chaplaincy services in hospital,

> *"If your topic approaches the religious dimension, you may suggest that several chaplaincy services be set up in the mental hospital."*

He further explained that spiritual care as religious care was more complex in a Chinese context. This may be due to the fact that there are various philosophical and religious branches in a Chinese setting, influenced by the cultural and social

development in Chinese history (Park, 2009). Xuezhe considers these philosophies as religion.

> *"Spirituality in a religious context is simple and easy to be taken care of, no matter if it is Christianity, protestant or catholic, it is relatively simple. In China, religion among the Chinese is more complex. So, you need to find a way to change this situation."*

The effect of religious care on patients' well-being is exemplified by Qinlao, who says religious care is important and good for patients' well-being, particularly in providing them with a peaceful feeling at the end-of-life stage,

> *"It (religious care) is very important and I really like it…because when patients die they are not frightened. They will think they are going to another land, and to die is just to move their house (to another place and) join another family. So, they are not frightened…they die in peace... I think spiritual care is very important."*

Besides the chaplaincy service being responsible for religious care, spiritual care is also supported at the institutional level. Laoxiang illustrated this by saying that spiritual care relates to the facilities and places, such as a chapel or mosque, provided by the hospital,

> *"In the hospitals I know, there are some facilities or places for people with different religions, such as Catholics, Muslims, and Christians, to practise their religious activities, such as praying, etc.."*

Friends and pastors in community religious institutions and volunteers can also provide religious care. Nurses and other healthcare professionals may invite them and facilitate their activities for the patients' spiritual care,

"At the weekend, volunteers go to every ward and ask the patients, "Do you want to go to church or chapel? Do you want to go there?" If the patients say yes, they will bring the wheelchair and push them to the service." Qinlao

"If the patient is a Christian, we will arrange for the pastor from the church together with the church members to visit him and pray for him in the hospital." Dianxin

Nurses can also help arrange private spaces for personal prayer and places for religious activities which are part of providing spiritual care. Laoxiang commented,

"In this hospital, if you require a private space from nurses, for example, a private room for meditation or prayer, they will surely arrange it for you."

Furthermore, nurses may provide spiritual care by asking questions regarding whether patients require religious support,

"You ask them, 'do you need to go to church and have spiritual support?' When admitting the patients, we ask them these questions as part of the admission, such as 'What is your religion?" and "Do you want this kind of service?' If they say yes, we will inform the church. If they say no, we do nothing." Qinlao

A universal method of providing spiritual care is caring for patients with specific religious concerns, and Chengshi offered an example of being conscious of patients' taboos,

"The purpose is to see whether there are taboos in these religions. Some religions are very confidential and cautious about their bodies, and permission must be gained…. nurses must be clear about it by asking in terms of nursing care."

Chengshi's concern was that nurses had to gain knowledge of major religions and cultures to understand what was prohibited, in order to provide appropriate spiritual care.

Spiritual care: patients themselves

Spiritual care from the patients themselves refers to the spiritual support patients gain mainly from their own strength and thoughts in hospital. During interviews, participants associated spirituality and spiritual care with the approach of the patients themselves. For example, Youhao stressed the importance of keeping oneself calm in a crisis,

> *"The person who helped me to make the phone call comforted me. I said to her, 'Do not be so panicking, I do not need to go to see the doctor so quickly'."*

In addition to keeping calm when encountering illness, a higher level of openness was demonstrated by showing gratitude or being grateful to Heaven for the illness not growing worse. Shufa said that being positive and grateful made her a happy person,

> *"But I am content with my situation. I do not complain about anything. I feel Heaven has taken good care of me for this illness. At least, he does not let me die. I am very grateful. A person has to have a good mindset."*

Besides the relatively static strategy of keeping calm and having gratitude, participants' own spiritual support in illness was also exhibited by actively interacting with others. For example, Shufa shared her experience of gaining

confidence from her friend who had similarly suffered from a life-threatening illness and how they were encouraged with positive thinking,

> *"She visited me in the hospital and said to me, 'Do not look at others but me. Everything will be ok if you follow my case.' I asked her if she had dietary restrictions (due to lupus erythematous) and she said she did not have any. She just let it go... She said anyway she had experienced many things knocking her down to death (but she was still alive)."*

Youhao also indicated seeking information through learning as a way of spiritual care when dealing with personal illness,

> *"Several years ago, there were seminars next door. If a person got sick, depressed, they had information about this. Their seminars were helpful to us."*

While searching for different solutions for illness, participants demonstrated that a person needs to have some pursuit or belief in life. As mentioned above, Shufa believed that Heaven helped her to survive. This was also illustrated by Mimang regarding pursuing a particular belief in a health crisis,

> *"I believe that the Buddha in heart is the only way…"*

The above examples suggest that spiritual care from the patients themselves can be implemented in various ways, from a passive state, for example keeping calm, to a more active approach of seeking others' help. These approaches may have an impact on a patient's illness such as gaining confidence and obtaining the right solutions for one's own spiritual health.

Spiritual care: family and friends

The interviews revealed that the participants saw spiritual care as being the support gained from family and friends especially when admitted into hospital. This is evidenced by Xiaojin,

> *"As for general spiritual care or psychological assistance, I think the most important thing is that family and friends are present. I think this is the most effective and the most commonly used."*

Qinlao suggested a way that a family member can provide spiritual care is through close body contact with their sick relatives especially when they are in the final stage of life, and this may result in a peaceful death,

> *"A dying person is accompanied by their family, and family members touch them on the head and hold their hand. They touch and kiss the patient every day and the patient dies in this way very peacefully."*

Similarly, Qiangjian indicated that spiritual care was supporting his friend in hospital so that his friend felt warm from having a sense of value and worth, aiding his recovery,

> *"We also provided him with other support services so patient spirituality can become better, and he can feel warmer."*

Shufa highlighted the benefits of family and friends' support for patients from healthcare professionals,

> *"I was hospitalised due to a high fever and my family in Shanghai were very worried as they noted my critical condition. My sister then flew here and I told the nurses that she had nowhere to live. They then arranged a bed in the room so my sister could settle down with me. I had a very spacious room,*

and they put another bed for my sister, and ordered and served meals for us, even for my sister."

However, when addressing spiritual care, Heping questioned the appropriateness of family and friends supporting spiritual care for patients in hospital. This was because he doubted they gave the necessary patience, strength and love when caring for the sick person. He also referred to the knowledge individuals require of the illness and the attitudes and disposition to provide care,

"But generally speaking, for frontline nursing staff and family members, who have frequent contact with the patient, it is necessary that they have more patience and love than others who are not in the frontline of caring. It is necessary that they understand the causes and the symptoms of the illness, that they know some handling methods...Additionally, the proper attention… the attention certainly should be proper. For example, it should be proper for sentimental issues, which is difficult for others to mediate."

His uncertainty about family and friends providing spiritual care is also related to issues around whether they can provide selfless, powerful and consistent care.

Despite some reservations, the above descriptions highlight that spiritual care from family and friends was a valuable source of support for individuals who had experienced hospitalisation, because it helped them in their recovery and provided them with a sense of value and worth. This was of special importance for those who were receiving end of life care. However, implementing family-assisted care raised issues about resources especially the family members' ability to care, to have relevant knowledge about the disease process, and their attitudes and disposition to provide care. Due to the great benefits of family-assisted care, it is

very important for the voices of family members to be heard so that they can improve the patients' quality of care and experience. It is fundamental that the family should be provided with time and space by both healthcare professionals and healthcare institutions to express their concerns.

Spiritual support gained from the participants themselves and the family in healthcare settings, in conjunction with everyday sources of support, appears to shape their understanding of spirituality and spiritual care. This is consistent with the perceptions of spirituality in Western literature (Carr, 2006; Nixon and Narayanasamy, 2010) and Chinese literature (Chao et al., 2002), confirming their relevance and importance for PCB living in England.

However, it seems the process of seeking inner help and external support is particularly prominent in a health crisis, more than in daily life. This is because participants emphasised a change in their attitude when dealing with or facing a critical illness. It changed from keeping calm to actively seeking others' help in the course of their illness. Through using an inner and reflective approach of being calm and cherishing the positive, they opened the door to obtain external help for spiritual support (Swinton, Bain, Ingram et al., 2011).

Perceptions of spiritual care

In this section I briefly explore the holistic perspective of spirituality. This may be why participants had difficulty in articulating what spiritual care was. I highlight how it is an individual issue and an important one for the participants.

Holistic care

Participants associated spiritual care with holistic care in the hospital setting. Heping demonstrated this, saying that spiritual care covers the dimensions of physical, mental and cultural care. The cultural domain relates to caring about Chinese immigrants' social and political issues,

> *"Holistic, I will talk about something which is holistic. At first, holistic care is surely about whether a patient suffers from pain physically. Then it is about considering his psychological experiences and his physiology. This also includes his specific cultural background, language and social status… In the1960s or 1970s, many immigrants came to the UK without a legal status… Some people could not be provided with welfare and houses, due to political or social reasons, and they were put into mental hospital as patients with mental problems, so that they could get welfare, such as food and housing."*

Heping's quotation suggests that PCB's personal circumstances are important and these include the fundamentals or basic necessities such as food and housing. He indicates how all these are interrelated and interact with their social status, cultural background, language and immigration status (legal or illegal). If these are not recognised and supported then individuals may experience mental illness, requiring welfare aid and support. This reflects that PCB social and personal issues are woven together constantly, influencing their health and spiritual well-being.

Boshi also suggested that spiritual care is related to religious care for different social groups. She indicated that these resources that exist within wider society supporting people's different personal and spiritual beliefs could be drawn upon to provide care for individuals from these groups while in hospital,

"There are also different religious groups from outside who are invited to go to hospital to practise religious activities together with patients."

Laoxiang extended the scope of spiritual care to the funeral director in a hospital setting, but wondered whether their service was spiritual care because, in her opinion, spiritual care has to be provided in a hospital setting, suggesting that spiritual care in hospital settings and everyday settings is closely related. This implies that nurses may need to know more about this service so that they can provide patients with the information,

"The service related to after-death is provided by a funeral director, and it is not the responsibility of the hospital anymore. In my opinion, the hospital should not do anything in this respect."

Participants indicated that spiritual care not only related to the different services provided by hospitals, but also to the activities and programmes taking place in other external institutions such as schools. For example, Boshi indicated that spiritual care is a programme regarding life education in schools,

"Alright, I will give you examples taking place in Taiwan. I feel… in Taiwan, the term spiritual care is called life education. This discipline has been popularised in schools."

She further explained that life education is about teaching people in Taiwan the way to live and face death when in primary school, and it connects life education in school to the end-of-life care in hospital. Also, she suggested that life education in school and end-of-life care support were similar because they had the same purpose, which was to teach people to cherish life and take care of their spirit,

"It is about how to live and face death. Life education is initiated in primary school, and children are taught and guided to cherish life. They are repeatedly taught that life is precious and they should cherish life by way of taking care of their body, mind and spirit. In hospital, this kind of service is provided to the patients at the end of life… Probably the content is slightly different. But both are about cherishing and respecting life. In hospital, the end-of-life care is applied. But I think they are all about spiritual care, which is about life starting and ending in good way, a person's whole spirituality…"

Laoxiang's explanation of spiritual care relating to funeral directors and Boshi's account that spiritual care is a life education programme indicate that spirituality and spiritual care cover the full lifespan involving children and care at the end of life. They also support the view that the concept is very personal, and different individuals have different understandings.

The participants' responses indicate that PCB associate spiritual care with holistic care specifically within a hospital setting. The scope of spiritual care is broad, covering the fundamental major aspects of physical, psychological, mental and religious care including relevant services in cultural care. Participants highlighted how individuals may be educated in these matters through education programmes extending the concept further into the wider community and society.

Participants also demonstrated that the boundary between spiritual care in the hospital setting and the general everyday setting may be blurred, showing that there is a broad range of interpretation of spiritual care and some confusion in understanding the concept. This reflects the current criticism concerning definitions of spirituality, that the term 'spirituality' is used in loose ways and there

is a lack of clarity and consensus around it (Fradelos, Tzavella, Koukia et al., 2015).

Although the broad and individual understandings of spirituality cause confusion and risk giving direction on how to practise spiritual care (Pattison, 1990; Clarke, 2009), participants could point out their expectations of spiritual care interventions and related services in different areas including legal and cultural issues. This is consistent with Swinton and Pattison's (2010) argument that the confusion and lack of clarity around the term spirituality is a strength, and that spiritual care has political, social and clinical influence in nursing practice.

Difficulty in articulating

Participants had difficulty in articulating what spiritual care meant to them. This was exemplified by Xiaojin, in answering my question "What do physicians and nurses do when providing spiritual care?"

> *"Well, spiritual care…"*

Azhen demonstrated her difficulty in addressing what constitutes spiritual care by saying she had no knowledge of spiritual care from her own or others' hospital experience,

> *Interviewer: "In which aspect do they help in terms of spiritual care?"*
>
> *Azhen: "The person I visited was in coma. Since we couldn't communicate, I cannot really comment on the nurses (for spiritual care)."*

Similarly, Xieguang also struggled to explain the term, relating it to physical care,

> *"Spiritual care… It was… about caring for my wounds and scars when I gave birth to my babies. Other kinds of care…"*

Mimang was also unclear with regard to spiritual care, questioning what nursing can do in relation to providing spiritual care, showing that she was uncertain whether this is actually the responsibility of nurses or other healthcare professionals,

> *"In the future, what level of spiritual care could nurses reach?"*

Participants' difficulties in offering a meaning or explanation of the term spiritual care demonstrates some confusion between spiritual and other dimensions of care. This may be because they have no direct experience of spiritual care. Or it may be due to cultural differences because the term is not used in Chinese culture and healthcare.

Individual and important

Participants recognised spiritual care as an individual issue, meaning different things to different people depending upon their own life experiences. Qiangjian said his understanding of spiritual care related to his individual worldview especially his own personal and family life,

> *"With regard to spiritual care, everybody has his individual idea and therefore has a different view. I personally am getting old now as my life has already passed the halfway mark. We have children and hope that they will study hard so that they can have good jobs, careers, a good future and good family life after their tertiary education."*

Yisheng also explained that spiritual care should be responsive to individual needs,

"The caring and nursing provided are different when facing different difficulties. The key is that you are caring and nursing according to the needs of the individual who receives the care."

This means for the purpose of meeting individual needs, spiritual care should be personalised, placing the patient at the centre of care. This could therefore present a barrier for healthcare professionals and hospitals, considering these are primarily institutions that focus upon physical illness and have limited staff resources.

Spiritual care must be personalised according to patients' individual and personal needs. However, patients from Chinese backgrounds living in England are unwilling to disclose this aspect of need as they consider spiritual issues to be personal and private. Laoxiang indicated that Chinese patients may be unwilling to disclose their spiritual information on the assessment form when first admitted into hospital, which might be due to their cultural reluctance to express this sensitive information, as discussed above (p.187). This means that healthcare professionals will be unable to identify their religious needs, or needs for spiritual support,

"In these circumstances (religious aspects of care), they attempt to inquire (what patients need), because I think a patient has to fill in a form where information about religious belief is also asked. However, I think many Chinese might provide some information or might say nothing regarding this."

Some participants also felt that healthcare professionals should not enter the field of spirituality and spiritual care because they thought spiritual care was not their responsibility. Xuezhe said,

"They should not be responsible for this aspect of care, since this is a very personal issue and it is beyond many others' consideration."

Although some participants were unwilling to talk about spiritual care, they still felt that caring for patients' spiritual needs was important for people's well-being. Yisheng made reference to statistics and scientific facts to confirm that spiritual care helps patients' recovery from illness,

"…when a person is sick, the care on a spiritual level should be offered, as it may greatly help his recovery and the treatment. This has been proven in many cases and by scientific statistics…., if a patient can be inspired from a spiritual dimension, from a medical perspective his whole body will be in a very positive state, from which his immune system can take the further role to fight against all kinds of illness."

The characteristics of spiritual care are similar to the concept of spirituality outlined in Chapter Eight that shows the term is difficult to define because of its subjective and individual nature. Participants felt that both spiritual care and spirituality were important to their lives. The similarities in understanding spirituality and spiritual care are important for the purpose of nursing and the practice of spiritual care.

I felt it was easier to elicit information about spiritual care from participants than the concept of spirituality because the majority of participants were able to explain spiritual care but had difficulty in describing spirituality. This may be because I explored spirituality with them first and this familiarised them with the term 'spiritual care' which concerns the practical aspects of an individual's spirituality. It might also be that participants had expectations of spiritual care in their daily lives particularly when entering healthcare settings. The degree of difficulty in eliciting

information about spirituality and spiritual care is demonstrated in the questions I applied. As an interviewer, I was very cautious about asking different questions to explore the concept of spirituality. Therefore, I used a combination of direct questions such as “What is your understanding of spirituality” in conjunction with other indirect types of questions. For example, indirect questions were “What is your perception on life?” and “What is important to you?”, as shown in Chapter Four (p.116) to gain an in-depth understanding of the concept. The reason I was cautious and approached participants with these indirect questions was because the majority of participants were unable to talk about spirituality if I raised the questions directly with them. But for spiritual care, I inquired in a relatively direct way, with questions such as “Could you tell me something about spiritual care?” and “What can nurses do in this aspect of care?”

Overall, PCB had difficulty in articulating about spirituality and spiritual care because the terms may not be recognised in the general healthcare of Chinese culture. However, they did appear more confident and comfortable when discussing aspects of spiritual care than spirituality. Nonetheless, it was found that an understanding of spirituality is important for the practice of spiritual care.

Summary

This chapter presented PCB’s understanding of spirituality and spiritual care in relation to support in their daily lives, particularly in healthcare settings, with ‘spiritual resources’ originating from daily life and ‘spiritual care’ from a hospital setting. The different aspects of spiritual care identified that healthcare professionals need to address included recognising the need for spiritual support, communication, caring with a good attitude and with good values, and providing

religious care. Spiritual care provided by the family and derived from the individuals' own inner resources were seen as important supporting resources for PCB. The term 'spiritual care' was difficult to articulate because it is a broad and individual aspect of care which may not be recognised in Chinese healthcare due to issues of culture and because of the cultural sensitivity surrounding the concept. 'Spiritual resources' in PCB's daily lives were varied and included family, self and societal support. 'Spiritual resources' and 'Spiritual care' enriched the theory of 'Seeking a meaningful life' by highlighting the supporting resources from daily life and particularly within healthcare settings.

In the next chapter, I will present the categories: 'Maintaining standard values' and 'Achieving a meaningful life', which are the next two steps in the process of seeking a meaningful life.

CHAPTER SEVEN FINDINGS: MAINTAINING STANDARD VALUES AND ACHIEVING A MEANINGFUL LIFE

Introduction

Chapter Six discussed the sources of support and resources available in the daily life and particularly healthcare settings and how these contributed to the understanding of spirituality and spiritual care. In this chapter, the discussion is about the categories 'Maintaining standard values' and 'Achieving a meaningful life', which are the action and consequences in the process of seeking a meaningful life in line with grounded theory.

The category '*Maintaining standard values'* is made up of two sub-categories, 'Chinese culture', and 'Religion'. This suggests that PCB maintain Chinese values and principles of Confucianism, Buddhism and Daoism as cultural traditions or religious beliefs to achieve a meaningful life. These two sub-categories are not separate but interrelated, sharing similar values, such as filial piety and Higher Power/Heaven. The cultural and religious understandings of these values are important for healthcare professionals to implement culturally sensitive spiritual care for PCB living in England.

The category 'Achieving a meaningful life' incorporates three sub-categories, 'Happiness', 'Driving forces' and 'Essence and nature'. This shows that the outcome of adhering to the standard values is attaining happiness, an internal motivating force and grasping the essence and nature of life as a human entity. The sequence of these sub-categories demonstrates a level of contentment or joy when participants consider a meaningful life to be achieved. This is because 'Happiness' is a common feeling of being content and applies to every individual. 'Driving forces' is a higher level of being joyful, which may be specific to a certain group of people who can apply *Qi*. 'Essence and nature' in Chinese culture

sometimes means attaining the ultimate level of happiness, which is a term widely used among PCB, particularly within a Buddhist-dominated society (Jingkong, 1991). These three sub-categories are the components that PCB relate to their understanding of spirituality and are central to the achievement of a meaningful life. As a result, they may be helpful in guiding healthcare professionals to find ways to develop measures to establish if PCB have attained a meaningful life by applying the Chinese standard values in either a cultural or religious approach.

Therefore, in the following I present these two categories. The first part addresses 'Maintaining standard values', comprising the two sub-categories, 'Chinese culture' and 'Religion'. The second part focuses on 'Achieving a meaningful life', and this includes the three sub-categories of 'Happiness', 'Driving forces' and 'Essence and nature'.

Chinese culture

Participants in this investigation related spirituality and spiritual care to Chinese culture. For example, Boshi described spirituality as very much part of a national identity that is rooted in history and tradition, suggesting that spirituality equates to Chinese tradition, Chinese origin and the basic core of Chinese tradition,

> *"You have asked me about our spiritual matter. I think the reason is that every nation has its own deep-rooted national ideals, that is, they have a root in their agreement, in their every cell, and in their group consciousness."*

Laoxiang also referred to spirituality as a cultural pursuit,

"In the context of spiritual civilisation and material civilisation, I think spirituality (jingshen, 精神) in spiritual civilisation refers to the pursuit of a culture."

Participants further related spirituality and spiritual care to the values and traditions in Confucianism, Buddhism and Daoism.

Confucianism

Participants related their understanding of spirituality and spiritual care to the values in Confucianism, such as family responsibility, filial piety, ancestor worship, individuals' social role and keeping a balanced mind and being genuine to reach self-perfection for a better social and family role.

Participants talked about the relationship of spirituality to Confucianism in terms of family roles. For example, Qiangjian mentioned the responsibility for the family as parents,

"Because I have been working all the time from a young age in order to support my family, and ran a small business, I do not have a good education."

Responsibility for family is an important cultural value in Confucianism (Eno, 2016). This is because family was the basic unit of Confucian society in the past through assuming social responsibility for educating children and taking care of older people. Also, family is important in Confucianism because social relationships are viewed in the context of the family. For example, in Confucianism, the relationship between the ruler and their subjects was viewed as the relationship between parents and children in terms of parental authority and children's obedience. As a result, the ruler has authority over their subjects and the subjects have to obey the ruler.

Besides parental responsibility, participants also spoke about siblings' responsibility within the family when discussing spirituality. Aiwa states that she took care of her younger sisters to fulfil an elder sister's responsibility within her family,

> *''I am the eldest daughter of my parents and I took good care of my two younger sisters when I was able to.''*

Participants also related filial piety to spirituality, which is another important value showing children's responsibility, support and respect for parents or ancestors. For example, when addressing spirituality Aiwa emphasised that it meant supporting their parents when they grew older. Therefore, she instilled this value into her children as part of their childhood education,

> *"I tell my children that they should take care of their parents when we are too old to move, and too old to care for ourselves. As for myself, I left my parents when I was very young and cannot take care of them myself now."* Aiwa

Maipian indicated that being filial is to show respect to ancestors by worshipping them so that the activity of ancestor worshipping will continue across generations.,

> *"Usually the next generation worship the last one. If you do not worship the previous generation then the next generation will ignore you."*

Worshipping the dead family is an activity in both Confucian and Daoist tradition, and shows that Confucian and Daoist thoughts are blended together, influencing PCB's daily life (Littleton et al., 1996).

Participants also related spirituality to the family role between couples. For example, Sandi indicated the inferior position a divorced lady experienced when losing the support of a husband and marriage,

> *"But my friend was very different after divorce. Her father thought that she had lost the family's face and he could not go out to interact with others. He then insulted her with words so badly that she nearly killed herself. She could not respect herself and did some negative things… you understand what I mean."* Sandi

While relating spirituality to the Confucian values in terms of family roles, participants also related spirituality to an individual's social role within society. Laoxiang stressed that the most important thing for her was to play a good role in her personal life when interacting with others,

> *"Currently, I think the most important thing for me is to realise the value of my life, to play a good role in my personal life."*

During the time of Confucius from *Han* (202 BC) to the *Qing* (1911) dynasty when Confucian thoughts dominated education and people's daily lives (Tu, 1996), an individual's social contribution was important because it was a stage of personal development in the process of self-perfection, setting up an ordered family, and establishing a peaceful society (Eno, 2016).

Linde also emphasised her social role, saying she respects everyone in society, to maintain a harmonious social relationship irrespective of personal or religious belief,

> *"I respect everyone, as well as religion."*

The findings of this investigation did not demonstrate specifically how participants fulfilled their social roles in relation to past Confucian teaching. However, they did highlight the importance of respecting their leaders' authority, but not in the way of unconditional obedience to parents (Tu, 1985). This shows that although participants recognised the importance of an individual's social role due to cultural influences, they may not have adhered rigidly to Confucianism.

One important way of maintaining family and social roles in Confucianism is to have a balanced mind, and participants related this to their understanding of spirituality. For example, Linde connected her understanding of spirituality to keeping a well-adjusted mind or not over-stressing oneself when dealing with family or social issues,

> *"One must try his best to help others within his ability. Do not pressure self in helping others."*

Aiwa also mentioned that a modest attitude was important in balancing family and social life, showing humility in the interview. When she was given a compliment, she redirected it or gave the praise to her mother-in-law,

> *Interview: "You have taught your children a lot, and I think you are successful."*
>
> *Aiwa: "I do not think I am successful. I attribute the good result of teaching my children to my mother-in-law. She taught me to fulfil my responsibility for the next generation."*

Linde and Aiwa's examples illustrate that their understanding of some fundamental values are derived from one of the Chinese classics, *The Doctrine of the Mean*

(*Zhongyong* 中庸). This offers insight into the thought of all early Confucianism which is about the unlimited potential for human self-perfection and social transformation (Eno, 2016). In this classic, having a balanced mind is one of the principles for self-cultivation in an individual's family and social life. It motivates one's sustained effort and addresses a key feature of personal and social maturity that can help people leverage personal discipline and become socially authoritative (Eno, 2016).

Being genuine is another of the values listed in *The Doctrine of the Mean* (*Zhongyong* 中庸), which participants related to spirituality. This was reflected by Sandi saying she had to be genuine by following her heart and thoughts to do her own thing,

> *"After this, I think my life is about my own life journey and I must follow my heart. That is to say I do things by following my own thoughts, so that I live in my own way."*

Maowai also illustrated that being genuine was important to one's spirituality by emphasising its relevance to conscience,

> *"Nowadays, you see, the true nature of people in the world is becoming evil, without a conscience. There is a saying on scolding someone, 'his conscience has been eaten by dogs'. Why is there such an expression?"*

The above findings show that participants related their understanding of spirituality and spiritual care to the values in Confucianism.

Buddhism

In addition to Confucianism, participants also related their understanding of spirituality and spiritual care to principles in Buddhism. For example, Kunan associated it with the 'salvage ritual' in Buddhism by stating the ritual was important to the dead person and is demanded among overseas Chinese in certain festivals,

> *"15 of July is the Zhongyuan festival. The Chinese overseas went to the Chinese embassy to request the Sangha, the monks to salvage the dead (Chaodu, 超度)…"*

Maipian also related spirituality to the tradition of worshipping Buddha in Buddhism and souls in Daoism,

> *"We worship souls and Buddha at festive times and the New Year, with incense burnt and sacrifices offered."*

Maipian's example suggests he may not be aware of a distinction between worshipping souls or Buddha in the Buddhist or Daoist traditions, and he blends these traditions together with the word worshipping.

Xieguang also associated spirituality with the Buddhist tradition of Karma and she explains that the tradition is about the cause and effect of life,

> *"It is about Karma, the causes and effects about this life and the next."*

Beside Buddhism customs or traditions, participants also related spirituality to Buddhist thought. For example, Maowai illustrated that spirituality is true nature,

> *"This is spirituality, the true nature, the original of which is good."*

Maowai's quote shows that she equates spirituality with a fundamental concept in Buddhism which is gaining enlightenment, reaching the status of Buddha and acquiring the essence and nature of life and the world (Deal and Ruppert, 2015).

Wangxing linked spirituality with suffering and tolerance because these are predetermined by fate,

> *"But I think a person's personality, fate, and experience is predetermined and arranged in an unseen world… I believe that fate determines everything."*

This shows that she applies a basic concept of Buddhism in her life, Karma theory, meaning one's situation in this current life is predetermined by what he or she may have done in the past when life cycles. Therefore, tolerance of suffering is a way of paying a debt for the evil they have done in a previous life, to gain a better next life, or ultimate intelligence/enlightenment in this life (Jingkong, 1991).

Another illustration of Buddhist thought that participants related to spirituality is the concept of 'letting go'. Kunan exemplified that his understanding of spirituality was letting go of everything,

> *"Spirituality…able to let go of everything"*

The concept of letting go is based on the Buddhist philosophy that the world is formed from a state of emptiness. This emptiness can turn into different things and life styles in different situations (Deal and Ruppert, 2015). As a result that one's possession including the life is a state of emptiness in this world, he or she should let it go.

> *"Spirituality…able to let go of everything"* Kunan

Linde demonstrated a similar notion about letting go of sad things,

> *"Do not always keep the sad issue in mind."*

Sandi also expressed a way of letting go through forgiveness, after she forgave her former husband and relinquished the hate she had for him,

> *"I forgave him because hatred tortures me in my spirituality, when as a couple we had already separated. Hating him does nothing to him since we are not in touch anymore. Hating him is torturing me. I said to myself there is no reason that I cannot get along on my own, and then I forgave him."*

The above examples show that participants equated spirituality with Buddhist customs, figures and thoughts, such as *Chaodu* (the salvage of the dead), worshipping Buddha, applying the concept of Karma, and ideas about true nature, tolerance of suffering, letting go, and forgiving.

Daoism

Participants also related spirituality to principles in Daoism. Maowai related spirituality to traditional Chinese medicine (TCM) by referring to a famous physician *Huatuo* (华佗) in Chinese history (Sun, Yao, Chen et al., 2009).

> *"Traditional Chinese medicine also has (spirituality). There is famous Sage Huatuo, specialising in healing people. (Husband laughing). Sage Huatuo has also become a celestial being…".*

Empowering historical figures and assuming they have a specific role to play according to their contribution when alive is a characteristic of Daoism (The Splendid Chinese Culture, 2015). In this case, as *Huatuo* was a famous

physician, he is regarded as a celestial being in Daoism, responsible for preserving people's health.

Maoge stressed his closeness to figures in Daoism and Buddhism, saying *Sage Huatuo* and other celestial beings (in Daoism) and Buddha (in Buddhism) came to visit him,

> *"After the operation, I was not awake for more than ten hours. During this time, I dreamt about Sage Huatuo (华佗圣师). He looked at my beard, and then I slowly awoke. I also dreamt about others, Buddha and Gods. They wore clothes in various colours, such as red for prosperity, or green for the Taoist. They all came out to protect me."*

Maoge's quotation demonstrates that figures in both Buddhism and Daoism influence his life.

Qiangjian also demonstrated a preference for TCM based on the fact that Chinese herbs are more natural and milder than Western treatments, and the fact that the traditional Chinese physicians are more considerate and give a more comprehensive examination than the physicians utilising Western medical treatments,

> *"Western medicine is completely different and they are not conscious of people's feelings. TCM has its advantages and the Western medicine has its own."*

The principles in Daoism form the foundation of TCM focusing on the integrity of the human body and the harmony between humans and the environment (Sun et al., 2009). Moreover, the main principle of *Wuwei* (无为) in Daoism requires

people to act naturally and effortlessly in alignment with the flow of life (Mou, 2012). As a result, in TCM, a comprehensive and natural physical examination without the help of modern medical instruments is undertaken, and they observe patients' symptoms, inquiring about their illness history and discomfort, and palpating their pulses. TCM also provides treatment focusing on the wholeness of the body, mind/spirit and the environment, and natural treatment remedies such as massages and Chinese herbs. Qiangjian's association of TCM with spirituality reflects the influence of Daoist principles on his understanding of spirituality.

Besides relating spirituality to Daoist thought which is the theoretical foundation of TCM, participants also refer to Daoist fundamental values. Maipian said he preferred a peaceful and quiet life to avoid busy bustling places, reflecting the Daoist concept of *Wuwei* (无为), which means 'non-doing and non-action' of struggles or excessive effort,

> *"I prefer to be alone for quietness and I do not like bustling (热闹). I felt… I used to bustle at home. I have adapted to the life and feel more comfortable by being alone than being together with others."*

Qiangjian also expressed *Wuwei*, highlighting that it is important to follow the natural process of life in terms of age and the way of daily living,

> *"I have become old and do not think too much about spirituality. What I am doing is shopping, cooking, eating, and sleeping. Sometimes, I visit friends and we chit-chat."*

Participants therefore relate spirituality to Daoist principles including philosophical figures, traditions and thought.

Integration of Confucianism, Buddhism and Daoism

Participants also linked spirituality to traditional Chinese education, including that outlined in Confucianism, Buddhism and Daoism. As Maowai suggested, the study of the principles of the classics is to gain knowledge and spiritual growth,

> *"We read the Sutra of Mind from Taishang (太上心经, one of the Daoist scriptures), Zhongyong (the Doctrine of the Mean), Lunyu (Analects), etc. We read the books written in ancient times, handed down by Confucius and Mencius from the past."*

An important source of learning traditional Chinese culture is watching and practising Chinese art. Boshi said that she practised and enjoyed Chinese art because it was recreational and instructional,

> *"I feel I am also uplifted substantially by the artistic music in our traditional culture. I paint in a traditional style. I love traditional Chinese painting and Chinese calligraphy very much. I also love Chinese Gu Zheng music, or those folk instruments like erhu or flute. I especially love Chinese opera, shown on the TV opera channel…"*

and Aiwa was interested in Chinese opera,

> *"Thus it is better for old people to spend their time in Li Yuan (a place for opera performances), and enjoy good food."*

Participants also spoke about how they followed the Chinese cultural values in their daily life. For example, Youhao followed a Confucian saying in dealing with death,

"Confucius once said 'if one did not know living, how would one know about dying?' That is why I never want to think about it."

Here, Youhao provides a new understanding of the famous saying in Confucianism, '未知生, 焉知死?' (*wei zhi sheng, yan zhi si*?) which is different from its original meaning. In the *Analects,* one of the Chinese classics records the words and thoughts of Confucius; the above should be understood as "While you are not yet able to serve men, how could you be able to serve the spirits?" (Eno, 2016a p.53). Youhao's application of Confucian sayings demonstrates that she intuitively followed Confucian thought, but not in an academic way.

In the same way, Maoge applied one of the famous sayings of Confucius as his daily behavioural rule, and Maipian utilised Karma ideals from Daoism and Buddhism as his instructional principle,

"I have to introspect three times daily". Maoge

"Otherwise you will be cursed to death by suffering from retribution according to old people's sayings." Maipian

Youhao and Maoge use terms and sayings from traditional Chinese philosophies to illustrate their understanding of spirituality and spiritual care.

Participants unconsciously following the classic Chinese cultural values affirms that these values deeply affect their thoughts and actions influencing their understanding of spirituality. When participants describe Chinese cultural values or figures as spirituality, many of them may not be aware that these values belong to Confucianism, Buddhism or Daoism, and some of them provide a new

understanding or interpretation of the old sayings and traditions which are different from the originals.

As well as integrating traditional Chinese cultural values into their understanding of spirituality, participants also incorporated religious figures from Confucianism, Buddhism and Daoism. For example, when talking about a person's spirituality, Xieguang related it to religious or historical figures, mentioning the figures she worshipped including *Guanyin* in Buddhism and other deities in Daoism though she said she was unable to distinguish whether these figures were from Buddhism or Daoism,

> *"Our family have worshipped Bodhisattvas Guanyin since I was very young. As for my current religion, it may be a branch of Daoism, but I am not sure whether it is Buddhism or Taoism. Anyway my husband's family worshipped many deities such as ancestors, Guanyin, heavenly deity, gate deity, land and water deity, kitchen deity etc."*

Shufa also integrated religious figures and cultural concepts in Buddhism and Confucianism into her understanding of spirituality and spiritual care. She believed that prayer in Buddhism could be answered through establishing a relationship with Bodhisattva. At the same time, Shufa submitted herself to 'Heaven', which is a concept in Confucianism as a Higher Power or nature (Littleton et al., 1996),

> *"… and I do not believe religion. I sometimes pray to Bodhisattva but I am content with my situation."*

"I am very optimistic and I gain an extra day if I survive a day. I said, 'Heaven, help me. Please let me see my child and see my grandson grow up a little'."

Shufa shows a contradiction in allocating herself a religious belief by claiming that she has no religion but believing in Bodhisattva of Buddhism and Heaven in Confucianism. This indicates blending Chinese cultural values into her understanding of spirituality and spiritual care, without thinking of these as religion.

Participants also integrated other good values and religious figures from other cultures and religions into their understanding of spirituality. For example, Azhen outlined the good values and God in Christianity as her understanding of spirituality and spiritual care,

"Be happy (快乐现在), ask God to lead your daily life (求神七日引), ask God to endow wisdom (赋予智慧), choose the right path to follow (择善而行), praying for the gift of good health (祈赐健康).

Azhen's extract shows that spirituality is Christianity, which I will discuss in the section on religion.

Participants' integration of the values in Christianity in Western culture reflect that they integrate the good values they see as spirituality and spiritual care in a broad way. This means they not only connect spirituality to Chinese cultural values, but also values in Western cultures impacting on their life and understanding of spirituality. Although participants integrate Western cultural values, Chinese culture still deeply influences their lives. For example, Azhen's work was cooking and selling Chinese food to support her family,

"I came to the UK to make a hard living in a take-away business in 1966. We were very busy earning a living. I had to take care of the children and worked very hard."

Azhen's responsibility for the family demonstrates the Confucian tradition. This suggests that regardless of religious belief, Chinese cultural values are deeply rooted in participants' daily lives informing their understanding of spirituality and spiritual care.

The fusion of cultural values and religious figures from Confucianism, Buddhism and Daoism resulted in some participants providing contradictory information during the interview when exploring spirituality. As Shufa's example shows, she did not belong to Confucianism, Buddhism or Daoism (see p.136), but believed that Heaven was helping her with her grandson's growth.

Similarly, Wangxing indicated she was an atheist (p.136), but believed in the existence of fairies and Buddha, which are religious figures in Daoism and Buddhism (The Splendid Chinese Culture, 2015).

"On the contrary, I am an atheist. As an atheist, I believe that Gods, fairies and Buddha exist. Many people say that the fairy and Buddha are in me."

Similarly, participants provided contradictory information about religious beliefs when completing this section on the demographic characteristics form during the interview (p.136). As mentioned in Chapter Four, some participants labelled their religion as multiple beliefs, such as 'Atheist and Mixed Philosophies', 'Communist and Mixed Philosophies' or 'Christian and Buddhist'. This suggests a fusion of

beliefs as they assimilate values from these philosophies or religions, particularly traditional Chinese values, into their daily lives. They refer to this fusion in their understanding or interpretation of spirituality.

This fusion of values and beliefs not only resulted in participants providing inconsistent information regarding religious belief, but also caused them difficulty when providing religious information. Participants were hesitant to tick a religion, or changed their religious information when filling in the demographic form. For example, during an interview, Xiaojin ticked his religious belief as 'Atheist'. Later he restated his religious belief as "Atheist, Agnostics and Mixed Philosophy".

This difficulty in labelling religious belief for participants meant a label of 'Atheist' or 'Communist' among PCB could cause concern. This is because ticking 'atheist' is easy and not sensitive to personal or political challenges. This has implications for healthcare professionals that a difficulty or a single religious indication of atheist or communist, may indicate a hidden belief in the cultural values and figures of traditional Chinese philosophies among PCB.

Attitude to Chinese culture

Not all Chinese people have the same attitudes towards Chinese culture and tradition. Some of them are enthusiastic, whereas others are less interested. For example, Qiangjian showed his disappointment that Chinese tradition seems to be missing in the UK when discussing this within the context of spirituality,

> *"Chinese traditional education has been kept in my home village and in China, but it has disappeared overseas."*

Boshi has a strong wish that wherever people with Chinese backgrounds live, their Chinese traditions are continued,

> *"I do not know what the situation is in China, but I know the Chinese culture in Hong Kong is lost, where people do not know Confucius and Mencius at all, and they do not understand the Classics and even the Three Characters."*

Conversely, Maipian said he had no thoughts on connecting Chinese values to spirituality,

> *"The old values, I do not have thoughts about this."*

And Azhen seemed less enthusiastic about the Traditional Chinese education, saying that she had no experience of this, without any further mention of the term,

> *"I was educated in Hong Kong and I did not learn the Ancient Sage Education there at that time."*

The different levels of interest in Chinese cultural values in relation to their understanding of spirituality may reflect that spirituality is a sensitive and abstract term that participants are either unwilling or do not know how to address. It may also be that participants have become less aware of some Chinese traditions since they have been residing in the UK for many years and have been exposed to and influenced by Western customs. However, as some of the findings suggest, some of the participants have assimilated a broader range of values from some Western culture into their understanding of spirituality, particularly religious values, though their way of life is still influenced by Chinese tradition.

Religion

In this investigation, some participants had a way of associating spirituality with religion. Maowai when speaking about spirituality suggested that there is no conflict or in practising Daoism and Christianity stating,

> *"You can go to a holy temple even if you are a Christian. There is no contradiction. We are alike, talking only about one thing, same spirituality only in different countries, and different ways of preaching to people."*

Also, Laoxiang's initial response for her understanding of spirituality was religion,

> *"My understanding of it is mainly religious belief, when the word first comes into my mind."*

And, Xuezhe pointed out that spirituality is religion in a traditional way,

> *"According to the understanding of the older generation, spirituality is related to religion."*

Interestingly, participants were able to provide appropriate and prompt responses indicating that spirituality is equated with religion. They also illustrated this by showing their conformity with religion when speaking about spirituality. For example, Linde referred to an individual's adherence to religion by speaking about her religious observance and practice,

> *"She goes to temple every day to worship and burn incense."*

Also, Xieguang disclosed her affiliation to religion by describing her admiration for the religious founder and explaining the influence and benefit of the founder's thoughts for human beings,

"We are very faithful to our founder of religion, the person we pray to, who predicted many years ago that food for future human beings would not be as healthy and organic as it was before (due to the use of pesticides and high technology such as transgenosis)."

Maowai illustrated her pursuit of *Dao* by highlighting the benefits of Daoism stressing that human beings achieve inner peace

"After attaining the Dao, you will definitely achieve inner peace gradually. I can't talk much about the Three Treasures."

In addition to constant prayer, proclaiming the benefit of their religion, and showing admiration for religious leaders, participants also demonstrated their conformity with religious observance. For example, Maoge followed strict Daoist vegetarianism, not eating meat even during his hospitalisation,

"I am a vegetarian, and in the hospital I insisted on not eating meat and eventually I was given a sandwich. I did not lose my temper, nor insult people. I cannot make a mistake by insulting other people, which is not allowed in Daoism. I smiled at them, and they were all good to me."

Furthermore, participants revealed their devotion to God, or the higher powers. Azhen expressed her strong adherence to Christianity, saying she prayed to God in any location, either formally and publicly in church or privately and informally at home. She pointed out that the benefit of formal prayer to God is reinforcing their faith in Christianity and fellowship with other church members,

"I believe in the existence of God. God will guide me on my path. I go to church to have fellowship with God. I also pray to God as well as thanksgiving at home. Even without going to church, I still believe in the

existence of God. Another benefit of going to church is to have fellowship with other church members and to share our experiences concerning God."

This suggests that adherence to religious belief may be expressed through a constant and uninterrupted devotion to God.

Wangxing when discussing spirituality clearly showed her faith in the soul by outlining its importance for human survival. She also indicated that the soul is a kind of Higher Being like a spirit that can live in and out of the human body and has magical powers in people's lives,

"I think spirituality is about the soul and there is a soul in every person. Spirituality would be lost without the soul. In my opinion, spirituality and the soul are the same. For example, a person looks vitalised which is our everyday expression, or a person looks dull. A person is severely ill and has no energy, meaning his spirit is not in him, and then this person is… just like a flower withers."

The above examples suggest that some participants viewed spirituality synonymously with religion. However, some demonstrated that these two terms were different. Xiaojin was unsure that spirituality (*jingshen*) was the same as religion,

"However, jingshen (精神) seems not like religion."

Laoxiang also indicated this by defining spirituality as the meaning of life, adding that spirituality is not necessarily connected to religious belief,

"Therefore, I define spirituality as, I think the meaning of spirituality is, to a person without religious belief, how you define the meaning of life. That is to

say, even if I do not believe in religion, I have my orientation to the meaning of life and this is my spiritual dimension."

Both Xiaojin and Laoxiang's transcripts indicate that some participants do not see spirituality as religion or even having a close connection.

While participants had different understandings about the nature of spirituality, viewing it either as religion or Chinese culture, some held a dual understanding of the concept, seeing it as a blending of both religion and Chinese culture. For example, in response to the question "What is the meaning of the term spirituality?" Xuezhe indicated it is a mental state or a religion,

"I am wondering if the understanding of spirituality is based on a person's mental/psychological state or his religious perceptive. Excluding religious perception, spirituality refers to a mental state, which is about one's psychological dimension."

The above examples demonstrate clearly how some participants expressed their understanding of spirituality within the context of religion. The devotion to God and religion for some participants was revealed through their public acts of worship in religious places (temple, church) and in hospital. A strong belief in a Higher Being was reflected in participants' claims that this played a part in the survival of humanity.

Participants' association of spirituality with God is consistent with Stoll's definition of spirituality, where the term is a personal relationship with God, which allowed Stoll to pursue God, overcome difficulty and achieve life transcendence (Carson

and Stoll, 2009). These expressions of religion as a part of spirituality may offer strategies for healthcare professionals to provide religious care as part of spiritual care to improve the spiritual well-being of individuals. This can be achieved by ensuring healthcare is given according to participants' religious affiliation, or religious activities, enabling them to pursue their relationship with God, and accessing the perceived benefits of their particular religion.

The information provided in the category 'Maintaining standard values' suggests that some participants related their understanding of spirituality to the Chinese philosophical principles outlined in Confucianism, Buddhism and Daoism. It also shows that many participants applied a fusion of these philosophies. Participants' association of spirituality to each philosophy respectively or a fusion of them was demonstrated in the way that they applied these philosophical figures, traditions, thoughts, values and terms into their own worldview. By comparison, participants associated spirituality with the context of religion by illustrating people's religious conformity in the observance and practice of religion. MacKinlay (2006) states that religion must be a formal and organised system, and associated with a Higher Being, ritual and beliefs. In a loose way that religion is associated with a Higher Being, ritual and beliefs, the above philosophies of Confucianism, Buddhism and Daoism could be deemed as religion (Mok et al., 2010). This is because the philosophical figures are thought to have transcendent powers or influence over humanity and other creatures in the natural world. These philosophical traditions include some rituals and influence thought and values and specific beliefs. The cultural and religious approaches are the two major understandings of spirituality and spiritual care among PCB living in England.

Happiness

The above sections describe how participants related their understanding of spirituality to maintaining standard values in Chinese culture or religion. In this part, participants reveal their understanding of spirituality and spiritual care in the activities and actions involved in seeking a meaningful life, which are expressed in terms of gaining happiness, driving forces, and essence and nature of life.

In this investigation, participants related spirituality to happiness, suggesting they live in a positive and meaningful way. Mimang when discussing spirituality demonstrated that happiness is manifested as a good mood and an energetic outlook,

> *"If a person has good spirituality, this means he may be in a good mood. If his spiritual appearance is very bad, we guess he might be ill or be disturbed, which makes him different in mood or expression."*

While addressing spirituality, Xuezhe illustrated that the way of gaining happiness for certain people is through performing recreational activity, indicating this could result in them feeling that life is meaningful,

> *"But people who are not intellectuals think that playing Majiang (a Chinese gambling where the loser needs to pay a certain amount of cash to the winner) is a kind of activity in spirituality."*

Shufa felt that her life was full of meaning, especially when speaking or being connected with her grandson,

"I have a lovely grandson. He is my spiritual support. He chats with me by video and they send his photos to me every two or three days. The child is very lovely and is 21 months now."

Dianxin also indicated that a way of gaining happiness is enjoying family living close or nearby,

"One main reason (I am happy) is that my parents and siblings are all in the UK."

Besides enjoying recreation and experiencing family closeness, participants highlighted that another way of gaining happiness was by keeping healthy. For example, when explaining spirituality and spiritual care, Qiangjian stated the reason for keeping healthy is that being healthy is basic, and the method of keeping healthy is to be alert to mental and physical problems and the potential dangers of slipping and falling, for older people,

"I wish to have good mental alertness, be physically healthy, and be careful so that I will not slip and fall. This is spirituality to me."

To stress keeping healthy as a way of gaining happiness, Sandi also demonstrated the importance of physical and mental health and the value to her life. This was an integral part of her understanding of spirituality, implying that good heath was fundamental for happiness and achieving a meaningful life. She also provided examples of keeping healthy, indicating that being healthy is fundamental for people's spiritual well-being in terms of achieving meaning and purpose in life,

"Spirituality is internal thoughts. From my experience, our physical health is... People cherish their lives because they have life once. Chinese

especially advocate nourishing health (养生) for living longer. I think health includes the following points. First, diet is important. A supplement may be unnecessary or harmful. It is important to adjust what you eat to improve your health. Second is your thoughts."

In addition to enjoying recreation, appreciating family closeness and keeping healthy, some participants highlighted another way of gaining happiness which was having sufficient financial resources. Kunan was content with the amount of welfare support received from the government,

"We have welfare payment as well as pension… everything is sufficient."

Kunan's example suggests that a feeling of financial sufficiency and security may also contribute to a sense of happiness and these material aspects of life may be relevant to understanding spirituality because they are important for some people in achieving a meaningful life.

The feeling of happiness was also associated with individuals feeling free to do things according to their own thoughts. This was explained by Sandi, saying that she is free to do things to gain what she wants by following her own heart and intuition,

"After this, I think it is about my own life journey and I must follow my heart. That is to say I do things, follow my own thoughts, so that I live my own way."

Qiangjian indicated that being happy involved a number of factors, having an open-mind, being healthy and having friends,

"In my opinion, being open-minded is most important, as well as being free, being happy, being healthy and having friends. Things will be ok if everybody is healthy and happy."

Heping used the example of Nelson Mandela to suggest that having social and political freedom are important to happiness and that equality may be an important aspect of spirituality,

"For example, Mandela was in prison in South Africa for more than 30 years, which meant he lost many material things, especially freedom. But he preserved some things, for example, equality, which is the spiritual aspect in him."

The above quotations suggest that happiness may be a central aspect of spirituality which is expressed through good moods and a positive outlook. Therefore, happiness is an important feature of achieving a meaningful life and is central to the participants' explanation and understanding of spirituality.

Driving forces

Besides happiness, participants associated spirituality with internal driving forces, implying that a person lives energetically for a meaningful life. Shuaige demonstrated this, saying that spirituality is the engine of the human body which generates energy to drive people's lives, giving a life filled with meaning,

"I think spirituality is something within people to make them alive… this part can be seen as an engine and spirituality is… for example, a person is the engine, and spirituality is the meaning of living, the driving force."

Shuaige implies that spirituality is essential and a central part of the person, demonstrating that it plays a vital role in attaining a meaningful life.

The driving forces were expressed as health, alertness and vitality. Xieguang illustrated this saying that spirituality is being healthy and vibrant,

> *"Spirituality…Generally I think it is about being healthy, being mentally vitalised… If the words are, 'he is healthy and vibrant,' it means he is very alert."*

Xieguang's example implies that spirituality is associated with the mental dimension of a person.

Kunan extended the mental dimension of spirituality to mental illness, saying that spirituality was related to an individual's mental state and mental illness,

> *"It (spirituality) is about everything being normal and no mental illness. If (spirituality is abnormal for a person, they) must have mental illness."*

In relating spirituality to mental illness, Xuezhe implied that a consequence of having mental illness is that people may become hostile or even angry about the term when expressed within the context of spirituality,

> *"Chinese are hypocritical (虚伪). They get antipathetic (反感) as soon as they hear words related to their mental illness."*

The association of spirituality with mental illness may imply that spirituality is more to do with the mental dimension. It also suggests the term (spirituality) can be understood by PCB as being related to mental illness.

Here, participants' indication of spirituality as a mental state reflects an understanding of spirituality from the Chinese cultural perspective, originating from

the basic Daoist concepts of *jing, Qi, shen* (精气神). As indicated in Chapter One (p.5), these three concepts are very much related to people's energy and a state of mental alertness, with *jing* (精) as essence, *shen* (神) as energy, and *Qi* (气) as driving forces in the human body. The understanding of spirituality *(jingshen)* as a mental state demonstrates a modern understanding of *jingshen*, which is distinct from its original meaning in Daoism and TCM, but deeply rooted in the understanding of traditional Chinese philosophy.

While relating spirituality to a mental state in relation to illness, participants also made reference to a positive and energetic mental state. Xiaojin illustrated this, saying spirituality is being high in spirit, which is *jingshen hao* (精神好) in Chinese,

> *"I know how to apply jingshen (精神) in such context. You can use being in good spirits (精神好) or lifting spirits (打起精神) and this is a casual application."*

This further confirms that a driving force is the manifestation of being healthy, alert, and vibrant in spirituality.

Besides describing spirituality as an 'engine' which enables people to be vibrant, participants also related spirituality to a driving force with regard to energy. When providing an explanation of spirituality, Maipian illustrated this by emphasising the importance of recreational activities (gambling) and earning money. For him this was a driving force that made him feel thrilled and energetic,

> *"I am thrilled and feel energetic if I win at gambling, like winning a lottery. I feel exhausted if lose money. I feel energetic even in walking if I can gain a little, which is the same as winning the lottery."*

Maipian's example indicates that the outcome of some driving forces is that they

can provide a person with energy, although this kind of driving force can have a negative or destructive impact on people's lives.

Similarly, Wangxing used the analogy of spirituality as a driving force and energy. This was evidenced in the way she implied that her courage had been strengthened when facing death through understanding mixed philosophy,

> *"That is why I have another kind of perception of a person's life in this world and I am not afraid of death. If I encounter the issue of being sick and death one day, I will be open and face it."*

These findings illustrate how some participants' related spirituality to specific driving forces. This was explained by referring to spirituality as the engine and core of a person. This provided them with a driving force and made them alive. It also drove them to live a life filled with meaning, to be vibrant and full of energy. For some participants, spirituality gave them power and courage to face life crisis and ultimately death.

Furthermore, participants thought of spirituality as a mental state, which can either manifest positively as being vibrant and in high spirits, or the opposite, as mental or psychological illness.

Understanding spirituality as being associated with one's mental state or mental illness is consistent with previous findings that spirituality and spiritual care should be viewed holistically, embracing physical, mental and social aspects of a person.

Essence and nature of life

In this investigation, participants related spirituality to the essence and nature of life indicating how these may contribute to attaining a meaningful life. Qinlao demonstrated this by doubting the existence of spirituality, seeing it as human nature dwelling inside the person,

> *"Spirituality? Inside you... is human nature? You can Google it."*

Qinlao indicates that spirituality is associated with the true nature of the person's inner self, which is very abstract and difficult to articulate or explain.

Maowai confirmed this in a clearer way, pointing out that spirituality is true nature, an innate part of humans. She further highlighted her point by explaining one basic characteristic of true nature which is its overall virtue. She emphasised that the way to gain it is through attaining *Dao,* and the benefit of the true nature is changing one into a new person to lead a new life,

> *"This is spirituality, the true nature, the original of which is good. So after we have attained the Dao (*the way in Daoism)*, we know where it comes from, what we should do to change ourselves."*

Aiwa demonstrated that spirituality is the true nature of humans by highlighting another characteristic which is stability and resistance to change,

> *"A person's nature is very difficult to change unless he has suffered substantial setbacks."*

Laoxiang when discussing spirituality extended the idea of human nature to trusting in oneself and humanity with reference to wider society,

"… it is a trust of human nature, of people themselves, of humans, of society, namely a trust in humanity."

Besides human nature, participants also suggested that spirituality was the essence, another attribute that is built into one's body and life, indicating spirituality is an essential part of human life and existence. This was demonstrated in Shuaige's extract above (p.246), that spirituality is something within the person, referring to this as the engine, the driving force,

"I think spirituality is something within people to make them alive… the part can be seen as an engine...."

Participants also used words such as soul or spirit as the entity central to their understanding of spirituality. For example, Wangxing described spirituality as a soul or spirit, explaining that the soul exists in the human body and it only leaves the flesh after death and it exists forever,

"You can tell him that death is not scary and everybody has to go through this. You can also tell him that his soul is within him, it only leaves his flesh body behind, and he has his soul with him and his spirituality exists forever."

Mimang represented the spirit as an entity to address the meaning of spirituality, saying spirituality was a spirit that is inherent in a person and can be manifested as energy and solidarity at a national level,

"The simplest example is that the ongoing Olympics expresses a nation's or a person's spirit."

Summary

In this chapter, I presented two categories in the understanding of spirituality. The first category was ‘Maintaining standard values’, regarding PCB’s actions in the process of seeking a meaningful life, which they integrate into their understanding of spirituality. In this process they usually act in line with Chinese cultural and religious values to pursue a meaningful life. This is because some of them equate these values to spirituality, with a direct reference to religion. The second category is ‘Achieving a meaningful life’, indicating the consequences of this process. This is demonstrated in three ways: gaining happiness, driving forces, and essence and nature.

In the next chapter I will discuss the main findings in relation to participants’ understanding of spirituality and spiritual care.

CHAPTER EIGHT FINDINGS: A SUBSTANTIVE THEORY - SEEKING A MEANINGFUL LIFE

Introduction

In Chapters Five, Six and Seven, I presented the main categories ‘Motivation’, ‘Support’, ‘Maintaining standard values’, ‘Achieving a meaningful life’, and their relationship to the core phenomenon *‘Seeking a meaningful life’*. In this chapter, I collectively demonstrate and verify these relationships by pulling together the core, main categories, sub-categories and individual supporting extracts. I also illustrate the two contextual categories, ‘Relationships’ and ‘Perceptions of spirituality’, because they support and influence PCB’s understanding of spirituality and ‘*Seeking a meaningful life’*. Further, I present how the core category and its subsidiary categories evolved into a substantive theory in the process, called *‘Seeking a meaningful life’*. This shows that the theory was developed systematically, and deeply rooted in and validated by the data.

Core category: Seeking a meaningful life

The elements of the core category in the previous chapters are summarised in Table 8.1 below. The table illustrates how I organised the core category, its categories and sub-categories. The categories ‘Relationships’, ‘Perceptions of spirituality’ and their relationship to the core category are explained later in the chapter.

Table 8.1 Core category, categories and sub-categories

Core category	Category	Sub-category
Seeking a meaningful life **(Contextual category)** Relationships Perceptions of spirituality	Motivation	*Suffering* *Need* *Hope*
	Support	*Spiritual resource (spiritual support in a normal/everyday context)* *Spiritual care (spiritual support* *in a hospital/health context)*
	Maintaining standard values	*Chinese culture* *Religion*
	Achieving a meaningful life	*Happiness* *Driving forces* *Essence and nature of life*

The core category ‘seeking a meaningful life’ has the analytical ability to organise the subsidiary categories and other categories in an ordered and related manner (Strauss and Corbin, 1998). That is, it must be central and frequently appear in the data and its subsidiary categories, and all other categories must be related to it. The relationships outlined here demonstrate how the core category can be seen within the categories.

Relationship between the core category and its subsidiary categories

As indicated in Chapter Four, while conducting the data analysis I felt that the meaning and purpose of life was the connection across all the categories, because

it featured everywhere in the data and was able to pull them all together. At the data saturation stage, I developed four categories around the core category under the structure of *condition, action* and *consequence*, using a diagram (see p.148). These categories were constantly refined during the writing stage of the thesis when I related them to the established concepts, indicating that the diagram I used in the selective coding stage was an ongoing process within which some concepts kept evolving and developing. The diagram helped me to establish relationships in the development of concepts (see p.148) by considering them as *condition, action* and *consequence*, while the writing-up further refined and developed the concepts and their relationship to the core. The sub-categories 'Suffering', 'Need' and 'Hope' which emerged from the data evolved into the conditions motivating individuals' action for a meaningful life, so were grouped under the category 'Motivation'. An individual's experience of suffering, particularly physical illness, along with need and hope may motivate them towards a meaningful life. The sub-categories 'Spiritual care' and 'Spiritual resource' constituted supporting resources for achieving a meaningful life, classified as the category 'Support'. The various resources gained from daily life, especially in healthcare settings, support quality of life. The sub-categories ('Chinese culture' and 'Religion') relating to Chinese cultural and religious values represented required actions in seeking a meaningful life and formed the category 'Maintaining standard values'. Maintaining the Chinese cultural philosophical values and religious beliefs (Park, 2009) as life principles is the way that PCB seek life's meaning. The consequences of seeking a meaningful life are shown in the three sub-categories: 'Happiness', 'Driving forces', and 'Essence and nature of life', considered essential for developing a meaningful life. I labelled the consequences of this category 'Achieving a meaningful life', because living happily or vibrantly, reaching a transcendent state

of grasping the essence and true nature of life demonstrates the outcome of the process of seeking life's meaning.

The above demonstrates that the core category is related closely to its four categories and I describe this relationship below by pulling together the core, main categories and sub-categories. I also quote from participants' transcripts to demonstrate this integration.

The category 'Motivation' and '*Seeking a meaningful life*'

As mentioned, 'Motivation' involves three sub-categories 'Suffering', 'Need' and 'Hope' with situations motivating an individual towards a meaningful life. Motivation is important for a positive life, as Boshi said,

> *"The motivation… the motivation of life is also another indicator. That is to say, I am happy today and I want to do lots of things. I then have a positive attitude to each aspect of a thing…"*

Suffering also appears to motivate PCB. For example, Wangxing indicated that suffering is a common life experience, but may be the starting point to achieve motivation for a better direction in life,

> *"As a human being, there is a time one is weak and fragile when one is suffering. I considered killing myself before… But when the time came to end myself, I always felt a person was praying for me, then I was guided to live again…"*

Motivation can also begin from a sense of need. Aiwa exemplified that her need to take care of herself in the future motivated her to take up Chinese opera,

"I am now studying opera performance with them. I feel they are motivated they can live alone and take care of themselves even when they are old, in their 70s, 80s and 90s."

In addition, motivation can originate from hope. For example, Pengchao equated spirituality with hope and people gaining motivation to achieve their dreams,

"Ur…spirituality… I think it is that a person has a strong belief, he has hope and support from family and friends. With these, he is very powerful and it is possible to create miracles and succeed, no matter what difficulty he is in, either illness or personal dreams."

The category 'Support' and '*Seeking a meaningful life*'

'Support' comprises two sub-categories 'Spiritual care' and 'Spiritual resource'. As mentioned in the pilot, 'spiritual care' is a term recognised in the nursing literature and it was established in my investigation by testing participants' understanding with those who had experience of healthcare settings. 'Spiritual resource' emerged when participants indicated that the supporting resources may be derived from daily life and healthcare settings. 'Spiritual care' and 'Spiritual resource' form the sources and conditions from individuals' daily lives and healthcare services, to support PCB living in England in realising their life purpose. 'Spiritual resource' is the support PCB gained from family, society and religious communities, and the patients themselves, as well as Chinese cultural and religious values, and the materials and finances available to sustain their well-being in daily life. Supporting resources are fundamental to achieving a fulfilled life and this was demonstrated by Boshi,

"Anyway, if they get enough support, they will step forward and grasp the opportunities if the opportunities are pushed in front of them."

Sandi said that she lived meaningfully after she received support from her husband on a daily basis,

> *"But now I probably can reside here permanently with my husband's support. The people and things I am in contact with, and the things I do, are different from before."*

'Spiritual care' is healthcare professionals and family, as well as patients acting as a self-resource, supporting their recovery and improving their well-being in a healthcare/hospital setting. Healthcare professionals' support in holistic nursing and attentive care and communication, is particularly important for patients' recovery during a time of illness. Yisheng confirmed that healthcare professionals' therapeutic attendance in a holistic way, including spiritual help, is essential for patients' recovery,

> *"When a person is sick, he may get treatment. It is important to have the detailed treatment. However, spiritual care is more important than the detailed treatment…Particularly when a person is sick, care on a spiritual level should be offered, as it may greatly help his recovery and treatment."*

Qinlao said that spiritual care, especially religious care, encourages a person to live peacefully and keep hope at the end of life,

> *"I found religious people… I like talking to them. They are very peaceful. They treat… They are not frightened of death. Even their body condition is not very…it's poor, but they still have a lot of hope, not disappointment, not hopelessness."*

The category 'Maintaining standard values' and '*Seeking a meaningful life*'

'Maintaining standard values' is based on two sub-categories: 'Chinese culture' and 'Religion'. These are Chinese cultural and religious values that PCB living in England act upon in the process of seeking a meaningful life, and they are essential in searching for a life purpose. Boshi stated that Chinese cultural and religious values are the core of each nation and these provide an identity and foundation for every person's life, particularly for their life meaning,

> *"You have asked me about our spiritual matters. I think the reason that every nation has its deep-rooted national idea in them, is that they have a root in their agreement, in their every cell, and in their group consciousness."*

The category 'Achieving a meaningful life' and '*Seeking a meaningful life*'

'Achieving a meaningful life' was developed from three subcategories 'Happiness', 'Internal forces' and 'Essence of human nature' and is the outcome of seeking a meaningful life. That is being happy, being vibrant and realising the essence of life are considered essential for a meaningful life for PCB living in the UK.

Linde said she gained happiness by living meaningfully through fulfilling responsibilities and disciplining herself,

> *"Do not fuss (计较) too much. When we were young, we prioritised work and children. When the children grow up and become independent, we are relaxed. We now just take care of ourselves and keep healthy, (I smiled and nodded.). We live happily every day. Money and wealth are not important anymore."*

The provisional category ‘Good life’ identified in the pilot study developed into the sub-category ‘Happiness’ by emphasising the importance of joy in life and how this contributes to their understanding of spirituality.

Sandi demonstrated that the internal force is an important energy to help people live meaningfully and positively,

> *“I summarised that spiritual care in your research can be understood as positive energy, which is ideological, it’s about teaching people to be positive.”*

Maoge highlighted the importance of the true nature for meaning and purpose in life, and said that the teaching of Dao – attaining the true nature in Daoism, has changed him into a good person,

> *“I used to go gambling frequently. I was an addicted gambler, out of control. After starting to believe the Dao teaching, I do not go gambling anymore.”*

Qinlao stated that human nature is to live meaningfully by being kind, forgiving, and confident, extending the concept of ‘True nature’ in the pilot stage by explaining what true nature is,

> *“Human nature is patience, forgiving others, tolerating others, tolerating others’ bad side, benevolent heart and broad mind…True nature is confidence, self-confidence.”*

Relationships among the four subsidiary categories

The overall relationship among the four categories shows a directional process, indicating that ‘*Seeking a meaningful life*’ follows a specific direction: from ‘Motivation’/’Support’ to ‘Maintaining standard values’ to ‘Achieving a meaningful

life'. This means that the different kinds of motivation and support a person gains from experience can affect their interpretation of a meaningful life.

For example, Boshi said that motivation from life experiences leads to a different meaning of life,

> *"Each person may put forward a response and dimension based on his personal experience in life and hence it will be different."*

Sandi, in her example, suggested that experiences in the different stages of her life, particularly the suffering she had experienced, enabled her to realise a different meaning and purpose in life. In her childhood she felt the meaning of life was about having happiness and receiving love from her parents. Later, the suffering she experienced during her marriage helped her gain a grateful heart for everything in life, enabling her to make sense of her own life.

> *"I have been happy and lucky 80 to 90 per cent of the time since I was born. My family loved and cared about me tremendously and I have had no challenges except my previous marriage I have told you about. The period of two and half years' marriage was the darkest period in my life, and this certainly taught me a lesson. It is … I do not regard this as my suffering. Now I think it is a very meaningful lesson I had, from which I have learned a lot."*

The categories 'Motivation' and 'Support' have an overlapping relationship in the process, demonstrating linkages interacting with each other. Spiritual support in daily life or illness enables PCB living in England to have an expectation of a better situation or improvement in their well-being. This was demonstrated by Youhao, saying her worries and difficult life experiences raised her expectations

and she started to seek ways of overcoming her worries. The expectation and seeking a solution motivated her for a better life,

> *"What worries me most is if something happens to me, because all my children are not around me and not staying here, only I and my husband live here. Compared with other people, I am very scared, very worried because here, there are many old folks dying all the time... Need someone to help. Furthermore, our English is not good. We need others to help us…"*

Also, the 'suffering' experience, which may motivate people to seek a meaningful life, is often the context for the support they are seeking. For example, Laoxiang explained that the challenges her friend encountered in the UK enabled her to seek support, thereby achieving a meaningful life,

> *"The research did not go well for quite a long time at the beginning when she came here. Additionally, she had a language barrier. These distressed her. She was very vulnerable and lost her confidence in her study…Following bible study, she started to orientate the value of life. For many things in her life, she then started to analyse and treat them from a Christian perspective, which played a huge role in her life. In my opinion, the people in the church supported her greatly."*

The linkage between 'Support' and 'Motivation' can be summarised as follows. Good 'spiritual resources' and 'spiritual care' usually provide an individual with hope, fulfil their need, and motivate them to seek a better life. The 'suffering' experience often forms the context or reason for a person to look for the support from spiritual resources in daily life and spiritual care in hospital, during their journey of seeking a meaningful life.

Verifying the core category

The above description shows that PCB integrate their understanding of spirituality and spiritual care for the phenomenon of seeking a meaningful life. In Table 8.2 below I offer some participants' extracts, together with my explanations, to describe how PCB equate spirituality with a need to find meaning and purpose in life.

Table 8.2 Statements indicating spirituality as meaning and life purpose

Extract	Main point	My explanation	Participant
"Well, that is about the understanding of the term *jingshen* (精神), which is spirituality in English. I have just talked about it. I think it is important to orientate the overall meaning of life either consciously or subconsciously."	Definition	Defining spirituality as the meaning and purpose of life, and Laoxiang explained this in response to the question 'what is spirituality?'	Laoxiang
"We now have a clear understanding with this spirituality (灵性). What is the purpose of our existence in this world? I started to understand now."	Purpose of life	Spirituality is understood as the purpose and meaning of life in this world.	Maowai
"A person anyway should pursue something when he is alive. There are many kinds of pursuits and the way of pursuing is different."	Life pursuit	The meaning of life is a person's life long pursuit.	Wangxing

The above demonstrate that participants referred to spirituality as seeking the meaning and purpose of life. The citations in the table and the integration in the previous section indicate that 'seeking a meaningful life' is closely related to PCB's understanding of spirituality in a direct or indirect way. Importantly, the individual extracts in the table verified the development of the core category and demonstrated the application of seeking a meaningful life to the understanding of spirituality.

Contextual categories

The core category developed shows that PCB living in the UK equate their personal striving with the meaning of spirituality and spiritual care. This phenomenon is also supported by two other contextual categories: 'Relationship' and 'Perceptions of spirituality' (Table 8.1 p.255). In the following, I describe the linkage between the core category and the two contextual sub-categories.

Relationships

While '*Seeking a meaningful life'* emerged from the data as a core category in understanding spirituality and spiritual care among PCB living in the UK, the category 'Relationships' also evolved as a major category. The process of '*Seeking a meaningful life'* interacts closely with 'relationships'.

Boshi indicated that the ultimate goal of life is looking for harmonious relationships. This verified the provisional category 'Relationship' that emerged in the pilot stage.

> *"Our spirituality craves harmonious relationships among people, between human beings and our natural environment, in addition to that between human beings and God".*

The category 'Relationships' was developed from its sub-categories as presented in Table 8.3 below. I also present the extracts of the participant transcripts along with my explanation in this table. The sub-categories, 'with self', 'family', 'Higher being', 'society and others', and 'other creatures and nature', represents the different dimensions of relationships from a narrow setting to a wider or broader context, or from self-focused to family focused, or society focused. A more focused dimension of relationships may determine an individual's process of

seeking a meaningful life. For instance, if a person focuses on the dimension of 'with self', he or she may seek a meaningful life by focusing on self-development. Similarly, a focus on the dimension 'with family' may lead to a meaningful life concentrating on the family, such as the family's happiness and having harmony within the family. The interaction of different relationships in the process of seeking a meaningful life means that diverse dimensions in relationships affect or influence the process.

Table 8.3 Category of 'Relationships' and its properties and dimensions

Category	Sub-category	Extract	Participant	My explanation
Relationships	With self	"I think if I have tried my best to do things, I do not need to worry and consider others…Then I will say to myself that I will not worry, and let things go with nature and be obedient to Heaven if I have done my best."	Sandi	Being able to let things go if one has done things to the best of one's ability. This shows that PCB hope to achieve harmony with self.
	Family – Couple	"She looked after me."	Maoge	People live happily and are proud to say that their spouse attended when they were ill.
	– Parents and children	"But my parents and all the relatives objected to this marriage."	Sandi	Parent and child relationships are also important. Filial piety is fundamental and expected within the Chinese community and mentioned in Chinese culture. For example, Sandi says she had to consider her parents and relatives' decision in her marriage to show her filial piety.
	– Siblings	"When my eldest son was in middle school, he took care of his younger brother until he was 11 years old, sleeping with him, washing his feet, and sending him to kindergarten, and taking him back home after school."	Aiwa	Sibling relationships are an extension of the parent and child relationship. Sibling responsibility reflects this relationship in people's lives.
	Higher being	"We and spirits are in the same space. We can get along with each other."	Xieguang	The importance of transcendence or having a relationship or connection with a higher being or God, is stressed. In this case, Xieguang says that spirits and human beings exist in the same space and live alongside each other.
	Society and others	"They help each other and get along with each other very well."	Linde	Relationships with friends and other people in society are also important. Being in harmony with society is a broader interpersonal relationship. PCB demonstrate that they cherish good relationships in society. Linde explains how this is helpful in religious society.
	Other creatures and nature	"No matter where a person lives, he cannot be separate from this universe and his roots are still in the cosmic and nature. Thus, everything should go with nature.	Wangxing	Stressing the importance of the relationship between an individual and nature, showing a relationship between humans and the whole of nature.

The relationships with ‘self’, ‘family’, ‘higher being’, ‘society and others’, and ‘other creatures and nature’ emerged from the data, highlighting that this was a major theme in the understanding of spirituality in both Western (Weathers et al., 2015) and Chinese contexts (Chao et al., 2002). Having a good relationship with the family is of great importance for PCB. These relationships include those between couples, parents and children, and siblings, and reflect the basic ‘five relationships’ (*wulun* 五伦) in Confucianism.

Overall, the participants emphasised the relational aspects of spirituality, expressed in the different levels of relationship they had experienced, describing how these contributed to their understanding of spirituality.

Perceptions of spirituality

Participants revealed their perceptions of the term spirituality by describing its characteristics, and they demonstrated that the term is difficult to articulate. Azhen illustrated this by saying it is difficult to vindicate or prove,

> *“Spirituality is very difficult to vindicate.”*

Kunan also demonstrated this by stuttering and struggling to define the term, reflected in the non-cohesive reply,

> *“If ….(speaking in a non-cohesive manner) must have mental illness.”*

and Qinlao also displayed this through stuttered words and suggesting searching on the Internet,

"Spirituality? Inside you... is human nature? You can Google it."

The reason the term is difficult to articulate may be due to its abstract nature. For instance, Heping referred to the opposite of spirituality, materialism, to explain spirituality because material is visible and sensible,

"In my opinion, it is dualism which means that spirituality and material are separate."

Shuaige also felt the word was abstract and said he never gave it consideration,

"I rarely consider it."

Another reason for the difficulty in defining the term is because it is subjective and open to individual interpretation. For example, when explaining spirituality, Azhen said each person had different feelings about it,

"That is, everyone has a different feeling for it."

While relating spirituality to the meaning of life, Laoxiang explained that spirituality is a person's subjective explanation, which keeps changing in different times and places according to an individual's life and experience,

"He will then keep having different perceptions on the spiritual dimension. He will feel his pursuit is changing at different times, and feel the things he cannot acquire are more important. As a result of this, he cannot grasp the direction of life."

This shows that the meaning of spirituality is based upon individual interpretation. It is an individual issue related to one's privacy and essential concerns. For example, in

response to the question “What is your understanding of spirituality?” Xuezhe described it as a private and unique topic and he could not reveal it to others,

> *“This is a very personal issue and it is beyond many others' consideration. How can you share your meaning of life…? I cannot open my meaning of life to the public.”*

Spirituality was also described as a sensitive topic which may be related to an individual’s political concerns. Some potential participants refused to take part in the interview for this reason. One lady, who wanted to remain anonymous, explained that she’d had some political suffering in the past and therefore would not participate.

The political sensitivity attached to spirituality was also expressed by Kunan, who asked me (the researcher of this investigation) to remove the part of the interview related to politics,

> *“You better not…… could you delete those not relevant?”*

The characteristic of spirituality as being individual is also the reason for the concept having a broad, almost inexhaustible meaning. Laoxiang demonstrated this, saying spirituality had different and various meanings,

> *“But I think spirituality has a different meaning literally…”*

Xuezhe indicated that spirituality could be explained from two main directions, the mental/psychological and the religious domain,

> *“I am wondering whether your understanding of spirituality is based on a person’s mental/psychological state or his religious perspective?”*

Furthermore, the concept of spirituality is also difficult to translate directly from English into Chinese. As described in Chapter One, I encountered real difficulty when translating the English 'spirituality' into the Chinese *jingshen* (精神) or *lingxing* (灵性) and made a final decision to translate spirituality from *jingshen* (精神) by consulting with some nursing professionals in mainland China, and based on the current documentation (WHO, 2015) in both English and Chinese that uses spirituality in English and *jingshen* (精神) in Chinese.

Doubts about using 'spirituality' for *jingshen* were also expressed by participants in this investigation. For example, when answering a question regarding his understanding of the term *jingshen* (精神 spirituality), Xiaojin questioned the accuracy of the translation of *Jingshen* as spirituality, as these terms were presented on the information sheet in English, traditional, and simplified Chinese,

> *"Well. I think spirituality is not a direct translation for the word 'jingshen' (精神). I am not very clear on the definition of 'jingshen' (精神). But spirituality is a more narrowly defined concept to me. I cannot adequately address what 'jingshen' (精神) is."*

Laoxiang also suggested that *jingshen* and spirituality were different,

> *"In my opinion, spirituality in religion and 'jingshen' in spiritual civilisation and material civilisation are different concepts."*

The confusion in the translation between spirituality and *jingshen* is further evidence that the term spirituality is subjective and everyone has a different understanding and interpretation. It also reflects a cultural understanding of spirituality which changes with cultures. In Laoxiang's transcript, spirituality is a non-religious concept in the Chinese context when referring to *jingshen* but a religious one in the UK context.

Despite spirituality being a difficult concept to articulate, the majority of the participants considered it important in people's lives. For example, Dianxin compared it to food and clothes which are essential for daily sustenance,

> ***"****It is certain that spirituality is more important than materials. People in the past valued money and clothes, and they used to say that if you have money, you can eat better food and wear better clothes. But you can live happily without good food and clothes if you do not care in your mind. Thus, spirituality is the most important thing and it can dominate everything."*

Maowai supported this, saying that spirituality helps a person live with clear direction, and with meaning and purpose,

> *"Only from then have I had a clearer understanding, i.e. very meaningful with spirituality."*

Despite spirituality being difficult to articulate, it is considered important in people's lives, because it is as essential as people's daily needs and directs them to a meaningful life. All of these issues relating to the definition of spirituality mean that, for healthcare professionals, there is a need to clarify the term spirituality as *jingshen* or *lingxing* for PCB when implementing spiritual care, to avoid confusion. Also,

implementing cultural and person-centred care is important for this group of people as they may have different understandings of spirituality in a UK culture.

Substantive theory: *Seeking a meaningful life*

The construction of the core category and relating it to the contextual categories, 'Relationships' and 'Perceptions of spirituality' led to the development of a tentative substantive theory labelled: *'Seeking a meaningful life'*. This was achieved by adhering to the analytical methods provided by Strauss and Corbin (1990; 1998), as discussed (Chapter Four). The theory was tested and substantiated throughout the main data collection phase and through theoretical sampling until theoretical saturation was reached.

I presented the theory visually (Figure 8.1 below), highlighting the main elements and their overall relationships. The theory (the orange square) consists of a core category (the large orange circle), and its subsidiary categories: 'Motivation', 'Support', 'Maintaining standard values' and 'Achieving a meaningful life'. These subsidiary categories are integrated under the paradigm: *condition* (the two blue circles), *action* (the purple circle) and *consequences* (the green circle). The dark arrows indicate that the core category 'Seeking a meaningful life' is a directional process and follows a specific direction: moving from 'Motivation'/'Support' to 'Maintaining standard values', and finally 'Achieving a meaningful life'. The theory also includes two contextual categories in ovals, with arrows pointing to the core category to indicate that they support and influence the core category.

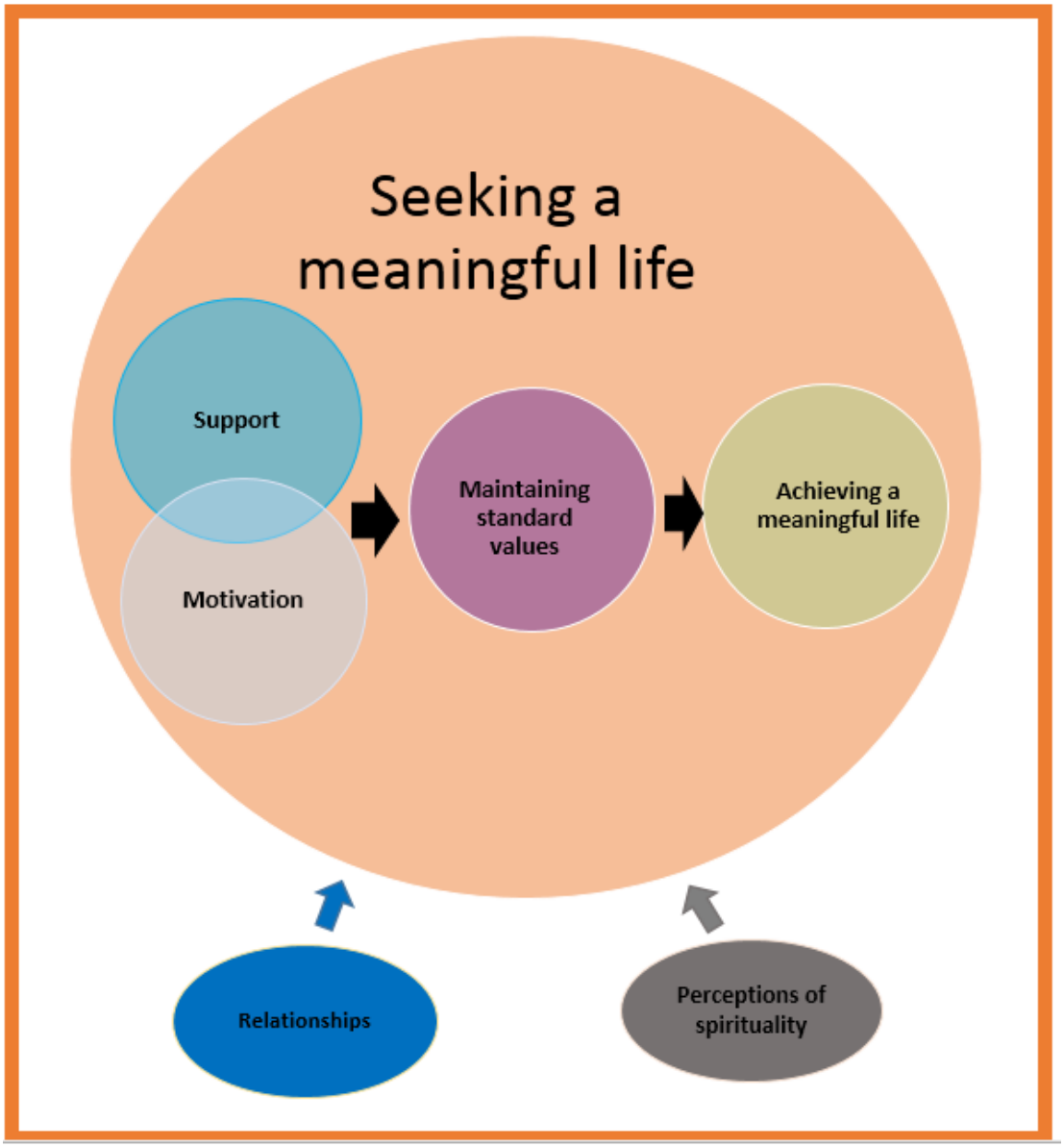

Figure 8.1 A substantive theory called '*Seeking a meaningful life*'
Note: The paradigmatic condition is in the light blue circles, action in the purple circle, consequences in the green circle. The supporting category is in the dark blue oval and the influencing factor in the grey oval

The core category developed above shows that PCB integrate or reflect upon their understanding of spirituality and spiritual care in the process of seeking a meaningful life. For the purpose of seeking a meaningful life, PCB living in the UK are usually in motivating and supported situations. Motivation comes from suffering experiences, particularly physical illness, and the need and hope for better situations. A variety of

supporting resources come from daily life, especially the support gained in healthcare settings. Once they gain the motivation and supporting resources, they start practising good principles, including Chinese cultural, philosophical values and religious beliefs. The consequence of this practice is that they achieve a meaningful life by living happily or vibrantly, or by reaching a transcendent state, grasping the essence and true nature of life. Relationships with self, others, the environment and a Higher Being(s) may facilitate this process.

Due to the difficulty in articulating the term spirituality because it is abstract and based on individual understanding, it can cause some confusion and present a challenge when translating 'spirituality' into Chinese. As explained in Chapter One, based on authoritative documents and expert opinion in China, and crucial evidence derived from this investigation, 'spirituality' has to be translated into *jingshen/lingxing(精神/灵性).* Therefore, it is necessary to explain what the terms 'spirituality' and 'spiritual care' mean, using an accurate Chinese equivalent, for PCB living in the UK to establish their initial impressions of spiritual care.

Summary

In this chapter, I have explained the relationship between the core category and its four properties and the relationships among them. I also describe the components of the theory: the core category and its two contextual sub-categories and their relationships. Finally, I have outlined the development of the substantive theory: "seeking a meaningful life", to provide a provisional understanding of spirituality and spiritual care among PCB living in the UK.

In the next chapter, I will discuss the main findings in relation to the literature.

CHAPTER NINE : DISCUSSION

Introduction

Chapters Five to Eight describe the findings from 25 Chinese participants residing in three regions in England regarding their understanding of spirituality and spiritual care. The process, '*Seeking a meaningful life',* is presented with its sub-categories. In this chapter, I will present key points that feature within these categories and appeared significant for the participants in terms of their understanding of spirituality and spiritual care. I also discuss and compare each point against the key themes identified in the scoping literature review and the general literature presented in the background information. I first discuss the issue of 'seeking a meaningful life'. Then I consider two points relating to 'Motivation' – 'find meaning in suffering' and 'identifying PCB's need of support'.

'Seeking a meaningful life' and spirituality

Participants in this investigation highlighted that seeking a meaningful life related specifically to their understanding of spirituality. They used a variety of terms, such as the 'overall meaning of life', the 'purpose of our existence', and 'pursuit' to describe 'spirituality' and 'spiritual care'. Also, life's meaning forms their core understanding of spirituality by pulling together the other concepts in the process of *'seeking a meaningful life'.*

The element of finding meaning and purpose in life as an attribute of spirituality can also be seen in Western literature (Weathers et al., 2015; Tanyi, 2002). For example, Frankl's (2014) experience in the war camps enabled him to develop a theory about finding meaning and purpose of life. He accomplished this by consolidating his

relationship with God in religious faith. In the Chinese literature (Hsiao et al., 2011; Chio et al., 2008; Sum and Leung, 2013; Chiu, 2000; Mok et al., 2010; Lin et al., 2012), spirituality also includes seeking life's meaning as one of its key attributes. Some studies integrate both 'relationships' and 'life meaning' into spirituality (Wong and Yau, 2010; Chung et al., 2007) by explaining spirituality as being concerned with meaning and purpose in life by connecting with the self, others, nature, or a power greater than oneself (Wong and Yau, 2010; Chung et al., 2007). The current literature signifies that spirituality relates to the meaning of life, but it is NOT all about the meaning of life in a non-religious context (Edwards et al., 2010; Rykkje et al., 2011; Chao et al., 2002). In comparison, the findings from my investigation highlight that PCB integrate their spirituality into the process of seeking a meaningful life by utilising motivation and support, maintaining good values and achieving their life meaning. This signifies that seeking life meaning is important for their understanding of spirituality. Thus, healthcare professionals may need to understand the relevance of this process in the delivery of healthcare and more specifically in the practice of spiritual care.

Finding meaning in suffering

The concept of 'suffering' appears more prominent in this investigation than in other understandings of spirituality (Narayanasamy, 1999c; Lin et al., 2012). This shows that participants relate their understanding of spirituality and spiritual care to the suffering they experience in life. In the following, I will compare the meaning of suffering in the West to that used in Chinese culture. In order to achieve this, I will highlight the Chinese cultural knowledge that PCB draw upon to explain their

attitudes, indicating how this may support them in dealing with suffering and illness. I will also reinforce that it is common in both Western and Chinese culture to prioritise physical illness over spiritual care. This section will highlight how spiritual struggles may manifest, demonstrating how these may cause individuals to reassess themselves and their life, recognising sources of support. In addition, I will offer reasons why the family is considered by PCB as a major source of suffering, outlining implications for the approach to delivering spiritual care for the purpose of relieving and overcoming family-induced suffering.

Suffering in Western and Chinese cultures

The findings in this investigation reveal that PCB relate their understanding of spirituality and spiritual care to suffering, and they attempt to find meaning for it. This is also reflected in Western literature which suggests that spirituality and suffering are closely related (Wright, 2005; Balducci, 2011). Finding meaning can soften suffering and the illness experienced (Frankl, 2014; Emblen and Pesut, 2001). As Wright (2008) points out, perceptions of suffering are distinct between Eastern and Western cultures. In Western culture, suffering is a part of living and it must be promptly removed or overcome (Wright, 2008). But in Eastern and Chinese thought, particularly in the Buddhist tradition, all life is believed to be suffering and misery occurring in birth, aging, illness and death (Wright, 2008). This may explain why the concept of suffering appears to be more prominent in this investigation as, for PCB, suffering takes place throughout the whole of one's life. Understanding this difference will be useful for healthcare professionals, explaining why PCB view spirituality as suffering.

Moreover, the results of this investigation show that many PCB are seeking a meaning for their suffering, in accordance with Chinese philosophy. This means they will usually accept and seek to live with it. They address suffering by working hard in times of difficulty, rather than trying to eradicate or remove it. They perceive suffering as payment for wrongdoings, as one side of the balance of nature, or as something one accepts as Heaven's or nature's rule (The Splendid Chinese Culture, 2015), explained in Chinese philosophy within Buddhism, Daoism and Confucianism.

Karma theory which is a basic rule in Buddhist philosophy (Jingkong, 1991) believes that life goes in cycles, and people must pay a debt for the evil they have done in a previous life, to attain a better next life, or ultimate intelligence/enlightenment in this life. This means a person's suffering in this current life is attributed to one's wrongdoings, and no one can change the suffering experience but oneself. This view of suffering enables PCB to relieve their suffering by examining their own behaviour. Thus, they have an attitude of acceptance because they are the only ones able to change this (Chio et al., 2008) .

The *Yin–Yang theory* is the foundation of Daoism (Mou, 2012) and participants in this investigation highlighted the balance of positive and negative attitudes which can be understood as *Yang* and *Yin*. According to *Yin–Yang theory*, the world is composed of the two opposite sides of *Yin* and *Yang* and these two forces keep moving and converting to each other to maintain a balance. *Yin* encompasses the qualities of darkness, softness and femininity, while *Yang* represents brightness, hardness and

masculinity. The *Yin–Yang* theory emphasises that everything in the world must be balanced between good and bad (Jing and Van de Ven, 2014). Suffering and failure on the *Yin* side are the hidden forces of enjoyment and success of *Yang* and will be converted to it. Guided by the Daoist life principle that good and bad things constantly convert to each other, suffering is the turning point and basis of happiness, and it is the way of nature. Thus, people should 'let it be' and obey nature's rule, since experiencing suffering may be a source of happiness and may not be as dire as it appears.

Confucianism is concerned with principles for social order and family discipline, formed in line with Heaven's way (Tu, 1985). Heaven's way here means nature or God's way. In Confucianism, suffering is the trial and cultivation of a person by God or in nature's way, serving the family, society and the world. One participant cited the old saying of *Mengzi* (Eno, 2016b), an important developer of Confucianism after *Confucius* in about 400 BC, that suffering is a trial from Heaven to mould a person, so that a great task can be allotted once they are capable of assuming it. *Mencius'* saying about suffering for endurance to success and achievement, is also well known among Chinese and taken as a motto to influence their lives. Therefore, following Buddhism and Daoism, PCB believe that suffering should be accepted and tolerated because it is nature's way of testing and training a person. Besides accepting suffering, they also act upon it by working hard during difficulties, perhaps to prepare for a harder test, while hoping for success.

As the meaning of suffering in Buddhism, Daoism and Confucianism is deeply rooted in the lives of PCB, many of them said that finding meaning in suffering was a way of life and the rule of nature. Thus, they accept, tolerate, and work hard when experiencing or enduring suffering. Having an understanding of Chinese philosophy with respect to suffering may be useful for healthcare professionals to appreciate the meaning an illness may have for PCB living in England (Chan, 2010), and this may account for the different actions and attitudes they adopt in times of illness.

Physical illness related to suffering in spiritual care

The results of this investigation show that suffering related to physical health was a major concern for participants' and this informed their understanding of spirituality and spiritual care. This is consistent with Chio et al.'s (2008) understanding that suffering is an emotional, physical, or spiritual anguish, distress, or pain and affirms biological understanding of spirituality (Swinton, 2010). As Wright (2008) highlighted when addressing spiritual care practice, suffering occurred to her when she had cancer and when her family members experienced physical pain. Participants in this investigation mirrored the same, observing that their own and their family members' health issues were a cause of their suffering and occupied their mind, reflecting the dominating and important role of physical care in an individual's spiritual care (Lewinson, 2016). Therefore, healthcare professionals should assess PCB's symptoms, and prioritise their physical needs when implementing spiritual care.

The findings of this investigation revealed that participants' emphasis was on their physical illness as one of their suffering sources. Participants also highlighted the

significance of physical health in their spirituality by speaking openly about their own experience of physical illness and that of their close family members, describing how this was a major concern. Their perceptions of suffering and illness were closely related to spirituality. The importance of physical illness and suffering in people's perceptions of spirituality is reflected in the results of the scoping literature review in Chinese cultures, conducted between 2000 and 2013 (see Chapter Three). It is also consistent with Koenig's (2012) findings in a systematic review study exploring quantitative research conducted between 1965 and 2009 within a Western culture context. The result of this study (Koenig, 2012) found that among 63 studies reporting a relationship between spirituality/religious (S/R) belief and physical disorders, 36 (57 per cent) reported lower blood pressure or less hypertension in those who were more S/R or received S/R interventions.

Although not all quantitative studies showed that (S/R) belief was related or positively related to patients' illness, this figure provided strong statistical evidence, highlighting the position of physical illness and suffering in people's spirituality and spiritual care. The studies conducted in Chinese (Chapter Three) and Western culture from 1965 to 2009 (Koenig, 2012), including this investigation, demonstrate a consensus on the importance of physical illness in their spirituality/spiritual care across diverse cultures and different timespans. This again affirms the importance of healthcare professionals' priorities in assessing the impact of PCB's physical illness, ensuring their physical needs are met.

The findings of this investigation revealed that some participants became stronger in illness, highlighting that the suffering from an illness or cancer enabled them to find positive ways to cope with their diagnosis. This was in keeping with Chinese philosophy where spirituality and religion play an important role. In Chiu's (2000) study, encountering terminal cancer enabled Taiwanese women to face reality by becoming conscious of their roles and responsibilities. They also created meaning for life by realising their own purpose in helping others and being needed, by finding alternative ways of life such as attending painting classes, and by using Chinese religion to boost their hopes for survival and healing. For example, some religious figures such as Mercy *Kuanyin* (观音) had great compassion for people and would listen to their prayers. This suggests that the current spiritual care practice in England should be in line with Chinese cultural and religious values, focusing on creating meaning for life. It also needs to recognise PCB's roles and responsibilities, and build their harmonious relationships with others and self when looking at this group's spirituality.

Family as a source of suffering

Suffering from issues that arise within marriage and the family were a major concern for participants in this investigation. This is consistent with the findings in the current literature (Villagomeza, 2005; Exline, Pargament, Grubbs et al., 2014), that show breakdown in family and personal relationships is one of the main contributors to stress, impacting upon people's spiritual well-being. In this investigation participants provided several reasons why the family can be a source of suffering, affecting their spiritual life, reflecting findings in the published literature (Chio et al., 2008;

Villagomeza, 2005). The first is that a lack of family support contributes to patients' pessimistic attitudes towards life (Chio et al., 2008) and spiritual distress (Villagomeza, 2005). Therefore, healthcare and social care professionals may need to act on patients' behalf to seek family support to alleviate their suffering.

The second stems from a loss of trust within relationships between participants and family. This may cause individuals to feel embarrassed about taking the initiative to ask their significant others for support and companionship. This applies particularly to seeking assistance in relieving physical discomfort and psychological insecurity, because they feel their neediness may change their identity within the family (Shih et al., 2009). Moreover, trusting relationships are considered a foundation of spiritual care, because it is within positive relationships that the concerns of patients can be expressed to health and social care professionals (Shih, Lai, Lin et al., 2001). The importance of a trusted relationship between patients and family requires health and social care professionals not only to liaise and communicate with significant others but they may also need to build trusting relationship by treating patients like their own relatives (Shih et al., 2009).

The third reason why suffering may originate within the family is due to the closeness of the family to participants, which makes them worry that their illness may place a burden on family members, thus making them unwilling to express their difficulties to their family (Hsiao, Klimidis, Minas et al., 2006; Villagomeza, 2005). Wright (2008) further demonstrates that patients' suffering affects their family members' life experiences, suggesting that family members may also suffer along with the patients

due to their closeness. In this situation, both patients' and family members' experiences of spiritual and emotional suffering may need to be considered. To relieve the suffering caused by an unwillingness to inform family members because of the perceived impact this may have on family dynamics and relationships, health and social care professionals may need to adopt an inclusive approach to care, taking into account the needs of the patients and other family members. In addition, they may also need to seek other avenues of support for patients' spiritual health. For example, nurses may need to take care of a patient's religious needs which he or she usually practises within the family, as suggested by Villagomeza (2005). It is also necessary that health and social care professionals explain to patients that family involvement may be beneficial for them and the family if their involvement is possible. This is because the family taking care of members who are ill are fulfilling their responsibilities, particularly in Chinese culture (Dong et al., 2015). They may be willing and feel they can manage the situation if informed or involved.

Although a lack of family support may contribute to spiritual suffering in both Chinese and Western cultures as mentioned above, participants in this investigation and those from Chinese backgrounds (Shih et al., 2009; Hsiao et al., 2006) explained this from a specific Chinese cultural perspective. In a Chinese setting, family support plays a central role in an individual's life, particularly during their spiritual distress. This may make the degree or seriousness of patients' suffering relating to family issues more obvious among this group of people. In the past, under the influence of Confucianism, the Five Relationships (*wulun* 五伦), which inform the basic social norms and guide family relationships in people's daily behaviour, still have an impact

on modern Chinese society. The Five Relationships are between the ruler and their subjects, parents and children, siblings, husband and wife, and between friends (Eno, 2016b). Of the Five Relationships, three of them are about family, showing its great importance within Chinese society. The importance of the family's role shows that the family is an essential unit within Chinese society. It is a great source of support for individuals, including those who are experiencing illness or health problems.

As a result of the central and important role families play in Chinese societies, PCB may still have great expectations about the support they should receive from them. This will still apply even when they reside in countries outside of China and where healthcare services are provided by government institutions and other organisations. When this expectation is unmet, they may experience distress and become pessimistic due to the lack of family support that they expect to be available during a time of illness because these expectations have been instilled through Chinese cultural values. This is not unique to PCB because people from Western backgrounds may also feel angry and distressed if they feel neglected, lacking support from the family (Wakefield, Drew, Ellis et al., 2014). However, due to the accessibility of other avenues of support such as utilising the services provided by government health and social care, their degree of distress caused by a lack of family support may not be felt as deeply as by those from Chinese backgrounds.

Therefore, an awareness of the important role that family support plays in the lives of PCB because of the influence of Chinese cultural values is essential for those caring

for people from such regions. This knowledge may not only enable health and social care professionals to provide appropriate care for this group of people but it may also alleviate their sense of suffering. This highlights the importance of eliciting family support and engagement, involving them in any care activities.

Overall, participants in this investigation referred to health problems and family relationships as the source of suffering. Because of the frequency with which they made the reference, this reinforces the link between health and family relationships in their understanding of spirituality. Therefore, having a basic understanding of Chinese cultural knowledge and the centrality of family may help health and social care professionals from the Western world to understand how PCB react when encountering illness, and their expectations with regard to the family.

Identifying needs for spiritual support

The findings show that participants associated their understanding of spiritual care with identifying patients' needs in terms of spiritual support. They demonstrated this can be done through asking patients questions, using assessment forms, interacting and being sensitive and responsive to patients' needs. They also show that the issues with identifying patients' needs for spiritual care lie in their cultural reluctance to express sensitive requirements, or their neglect of such matters to focus on the medical treatment. Participants' understanding of spiritual care as the identification of the need for spiritual matters is consistent with Nixon, Narayanasamy and Penny's (2013) UK study that identified spiritual need as a major aspect of spiritual care. This

confirms the importance of identifying religious or spirituality related needs in the implementation of spiritual care from a Chinese cultural perspective.

However, when identifying spiritual need, healthcare professionals have to be aware that PCB are unlikely to reveal their spirituality needs during admission due to their cultural sensitivity, their limited awareness and low expectations about receiving spiritual care, and their focus on the medical treatment. Therefore, healthcare professionals, particularly nurses, need to have time to accompany or be present with patients in identifying their needs when implementing spiritual care.

Family involvement and gaining support for spiritual care

Family involvement in participants' care activities has been a feature of this thesis. This suggests that participants relate their understanding of spirituality and spiritual care closely to family involvement in their care. This finding is supported by the literature, which highlights the benefits and challenges of using family support as a resource in health and social care. Also, participants in this investigation and findings from the current literature describe how family involvement in spiritual care is informed and shaped by Chinese culture. This section highlights those areas that health and social care professionals need to pay attention to when caring for people from a Chinese culture, particularly associated with involving family in the care of a dying patient.

Benefit of family involvement in spiritual care

The results of my investigation clearly show the benefit of family involvement in the delivery of care both generally in terms of daily life and particularly within a hospital setting. The findings confirm that family involvement can be a source of great comfort to PCB, enabling them to recover and feel better during times of illness. This is consistent with Chiu's (2001) study that showed Chinese immigrants in the USA with terminal cancer gained or drew strength to live from their family members' encouragement and support. Presently there is a scarcity of literature regarding the engagement of family caregivers in spiritual care (Edwards, Pang, Shiu et al., 2010), but there is a great deal of literature addressing family caregivers' involvement in the specifics of nursing in end-of-life care (Murray, Kendall, Boyd et al., 2010) and care of older people (Dehghan Nayeri, Gholizadeh, Mohammadi et al., 2015), as shown in this investigation.

The overlapping relationship between spiritual care and general everyday care provided at end of life and the care of old people (DH, 2010) indicate that the benefits of family involvement in these domains are the same for family involvement in spiritual care. For instance, Dehghan Nayeri et al. (2015) indicated that the presence of the family in hospital and their involvement in providing care contributed to the overall quality of older patients' experience in terms of safeguarding them from harmful interventions. This benefit was highlighted by participants, that spiritual care can protect elderly and ill patients from harmful or devastating news. Also, in my investigation and Chiu's (2001) study, participants considered the benefit of family care in providing patients with their preferred Chinese meals. Although this does not

seem to fall within the spiritual domain, it offers patients comfort and care, enabling them to have peace of mind. The involvement of family will probably benefit patients' spiritual care in the same way, because an overall improvement in the patients' experience may enhance spiritual well-being because they are more likely to be satisfied and connected with those they love. This is particularly important if one considers the multidimensional nature of spiritual care.

The findings of this investigation also reveal that family members are a primary source of support for PCB experiencing spiritual suffering, and they are beneficial to the healing process during times of illness (Chio et al., 2008). This is because individuals can feel empowered by their family members' encouragement, and the enjoyment family members bring (Chio et al., 2008). Moreover, family closeness manifested itself in this investigation as a desire to maintain close relationships with different family members, such as between wife and husband, parents and children, and among siblings. This is in keeping with the Five Relationships displayed in past Confucian society (Tan, 2014), and participants emphasised these relationships when addressing family involvement in support.

Challenges of family involvement

Despite the perceived benefits of involving family members in the delivery of care, consideration must also be given to the potential negative effects upon family members. Murray et al. (2010) found that family carers showed clear patterns of social, psychological and, interestingly, spiritual well-being and distress that mirrored the experiences of those for whom they were caring, with some carers also

experiencing a deterioration in their own physical health that impacted on their ability to care. As family carers, participants experienced psychological and spiritual distress, with their spiritual well-being fluctuating between highs and lows at different stages, from a patient's illness diagnosis, returning home and recurrence, to the terminal stage. As these key time points are the same for most patients, the needs of patients and carers should be dealt with in parallel at these significant time points. Similarly, the findings of this investigation also describe how family involvement in patients' care while in hospital may damage family caregivers' well-being due to working too long through continued involvement in the lives of loved ones, and lack of appropriate respite and carer support (Gaugler, Anderson, Zarit et al., 2004). Therefore, adequate support services are needed for family members from healthcare professionals in order to improve their general and spiritual well-being (NHS Choice, 2015) by reducing the carers' workload and enhancing their knowledge when needed.

Participants indicated that support for the family may include the identification of those at risk by using tools to identify, for example, family members' needs in spiritual support and by providing appropriate and timely spiritual care. Since the identification of need in spirituality is difficult to articulate and the requirement for spiritual care interventions remains obscure, tools to facilitate family caregivers' initial communication and clear direction for spiritual interventions may need to be in place. Some tools that may be used are, the *Patient Dignity Questionnaire* (PDQ) tool for initiating spiritual communication (Ellington, Billitteri, Reblin et al., 2017), the *Faith or Beliefs, Importance and Influence, Community, and Address* (FICA) Spiritual

Assessment Tool for taking spiritual history (Ellington et al., 2017). Also, The *Fellow Traveller Model for Spiritual Care* (Holloway and Moss, 2010) and the *Framework for Social Work Practice* (Furness and Gilligan, 2010) can be used by health and social care professionals in taking care of family members with reference to their spiritual dimension.

When using these tools for PCB, cultural factors may also need to be added or adjusted in each question or intervention to facilitate assessment and information gathering or spiritual care implementation. This is because the findings from this investigation affirm that Chinese cultural and philosophical factors have a profound influence on PCB's spiritual and daily life (Yang, 2006; Yang and Wu, 2009; Yang and Mao, 2007) as discussed in Chapter Two. When asking questions about personal spiritual and religious beliefs, using cultural elements in the inquiries and implementation may enable family caregivers/patients to establish a close relationship with healthcare professionals, helping them to provide valuable information and responses.

Participants in this investigation highlighted the importance of the NHS support and showed their disappointment when unable to gain useful and relevant information for health-related issues from improving their spiritual well-being. In the UK, government support for family and patients' care with specific reference to the spiritual dimension can be found on the NHS choice (2015) website. This website is funded by the NHS and is designed for the UK population from diverse cultural backgrounds to enhance their health and well-being, and holds valuable information regarding physical,

mental, social and religious care in different areas. For example, it provides information on how to seek home care assistance to support family involvement in patients' care, including religious and spiritual support.

As this website is an important resource for diverse ethnic groups living in the UK, it is important that the essential information on the website is designed to take account of the multiple languages spoken by BAME groups to meet their language needs. By doing this, those from BAME groups, including PCB who act as family carers, can contact the NHS when individuals request information in other languages. Therefore, it is recommended that the important websites and documents providing information regarding people's health and domestic welfare are established in the languages utilised by the main ethnic groups in the UK, rather than just thinking this is the responsibility of social workers who specialise in cultural care.

As previously stated, there is a shortage of literature addressing family involvement in spiritual care, and this may explain the absence of guidelines regarding family engagement in the provision of spiritual care. ICN (2012) stresses it is important to address patients' and families' spiritual beliefs in its code of ethics and the RCN (2011a) has developed a pocket guide for nurses, raising awareness of the importance of spiritual care and signposting them to different ways to support patients' spiritual needs. This includes making appropriate referral of patients to agencies who can provide family support. However, there is no mention in either of

these documents of how the family should be involved in the delivery of care. Therefore, the findings from this investigation may offer some direction around family involvement in spiritual care to ensure a multidimensional approach to family support leading to an overall enhancing of spiritual well-being for the patients and their carers. To ensure such guidelines are grounded in robust evidence regarding family involvement in spiritual care within a Chinese context, there is a need for further research exploring patients, carers, and health and social professionals' perceptions on family involvement in the cultural aspects of spiritual care (for example communication) among PCB in England. With such guidelines in place, the regulation of family involvement in the delivery of spiritual care can be implemented and monitored to ensure that this leads to the improvement of both patients' and carers' spiritual well-being and quality of life for PCB living in England.

Family involvement in the cultural aspects of spiritual care

The findings of this investigation show that participants related their understanding of spirituality and spiritual care to family members' involvement in supporting patients' care needs. This is consistent with Chiu's (2001) study findings that family support was the main spiritual resource for Chinese immigrants in the USA suffering from breast cancer. The study (Chiu, 2001) reveals a pattern that Chinese immigrants have a heavy reliance on family and friends as spiritual resources, and the author attributed this to the nature of Chinese culture in problem-solving that individuals seldom go outside of their families to seek assistance or connections. Seeking support and assistance outside of the family, such as from the government and society is common in the UK where health and social support for individual care is

well established and convenient for access (Houses of Parliament, 2014). The heavy reliance on family found in Chiu's (2001) study is similar to the point I discussed on suffering, that it may be related to issues arising within the family which reinforces the central role of family in a Confucianist-orientated society. The family's central role in Chinese society may be one of the main reasons why PCB rely on family support and rarely access support provided by other statutory or voluntary organisations. Because of these values and beliefs, PCB may implement their own problem-solving approach to resolve the challenges they face, meaning they will only utilise support from close family and friends.

The findings from my investigation reflect those of Chiu's (2001) study, which show that participants have a heavy reliance on family and friends. This may be partly because PCB become marginalised or viewed as strangers in a new society. Thus, marginalisation and cultural background may be factors that increase their reliance on close family and friends. Alden, Friend, Lee et al. (2018) also revealed that family involvement in decision-making is related to patients' acceptance of social hierarchy and a personal tendency for interdependence. This is mirrored in my investigation where participants had a feeling of being a stranger in mainstream society, which meant they relied on interpersonal relationship within their family (Chiu, 2001). Based on the literature and my findings, family involvement in spiritual care regarding decision-making has to be considered in the spiritual care implementation. However, shared decision-making may also need to be considered (Davidson, Powers, Hedayat et al., 2007), in which patient and family cultural attitudes and needs are addressed and respected. Some participants in this investigation demonstrated a preference for

making their own decisions on their treatment and care, based on their belief in Chinese cultural values of making a contribution to the family and not putting a burden on family members.

As Chiu (2001) described, patients' reliance on family members in decision-making and caring activities during illness impedes the process of identifying this group of people's spiritual needs. She also points out that this is due to them having a tendency to hide their spiritual needs from those who are not closely involved in their daily lives. Participants in this investigation showed their reliance on family for decision-making in illness and their tendency to hide their spiritual and religious information and requirements. This means that PCB may be reluctant to disclose spiritual needs to healthcare professionals because they consider they are far from these staff (not related or friends) and only interact with them on a professional, superficial level in public when they are ill. This is important when considering the role of the family in decision-making and involving them in caring activities. Therefore, it is necessary to consider these issues when supporting PCB as they may have a tendency to hide their spiritual needs from healthcare professionals (Wang and Nolan, 2016). Therefore, a close therapeutic relationship based on mutual respect should be established with patients and family so that they will be comfortable about disclosing and expressing their spiritual needs.

Four participants (Qinlao, Yisheng, Shufa and Wangxing) made specific reference to caring for PCB dying at home and in hospital. The importance of involving family in providing support in this situation has special cultural meaning, especially for PCB

(Shih et al., 2009). This can be explained from the perspective of Chinese customs for a dying person. Just before an impending normal death, a dying person's daughters or comparable persons have to wash the body to keep the person clean in the next world (The Splendid Chinese Culture, 2015). The daughters must put special clothes on their parents when they are still alive. Of special note here is that the dying person's clothes must be made according to specific Chinese customs. For example, the sets of clothes should be odd in number to avoid death in pairs among the family. Right after the person dies, the body of the dead person will be placed on a board by the sons and placed in front of the ancestral family shrine, with the dead person's head pointing towards the shrine (Yan鄢, 2013). In an abnormal or sudden death, these traditions may be followed in a slightly different way.

Dying at home and placing the dead in the ancestral shrine reveals what traditional Chinese culture teaches about family and how the souls of the dead will reunite with their forebears' family and will not be lost (Tang, 2000). The family of the dead perform different Chinese rituals to comfort the soul of the dead and show their respect and mourning for them. There are many kinds of cultural rituals for the dead and these must be completed by family members. For example, these may include wailing the dead (*kushi* 哭尸) (Bryant, 2017) with daughters speaking out what the dead did when alive, and the male descendants accompanying the dead during the night (*shouye* 守夜) to have the *xiaoge* (the songs to show filial piety 孝歌) and *qifu* (the songs for blessing 祈福) sung by particular individuals (Yan鄢, 2013).

Dying at home with substantial family support makes the dying feel more comfortable and a sense of wholeness by connecting with the family and the place they lived their whole life. However, transferring patients from institutions to their homes for palliative care can be challenging (Hu, Chiu, Cheng et al., 2004). Participants presented the major barriers for this, including insufficient caregivers, a poorer quality of care, and familial concerns regarding knowledge in emergent medical support. Therefore, an effective referral/discharge system, which may include in-patient care and homecare programmes for dying patients (Shih et al., 2009)**,** is suggested. Nurses should also discuss with patients and their family personal preferences for the place of death so that they die comfortably. In addition, as family involvement in patient care has cultural meanings for PCB, they may need to employ a professional from the chaplaincy team/department or other resources who has specialist knowledge of Chinese customs to work within the healthcare team who can advise on family involvement in patient care and treatment.

PCB's supporting resources of spiritual care

Participants in this investigation highlighted the importance of support in their life experience and how this contributed to their understanding of spirituality. They indicated that supporting resources were derived from aspects of self, family and friends, Chinese culture, society, religion, and hospital services. This is consistent with findings in the current literature (Chao et al., 2002; Swinton et al., 2011; Edwards et al., 2010; Sum and Leung, 2013). Chiu (2001) conducted a study to identify those aspects of spiritual support that Chinese immigrants living with breast cancer in the US usually relied on. Chinese culture and art, religion and Chinese society were

found to be the main resources of support they drew upon when addressing spiritual matters. The kinds of spiritual resource in Chiu's (2001) study are similar to the different types of support identified in this investigation, reinforcing their importance and relevance to how PCB understand spirituality and what may be considered important to them when providing spiritual care.

Similarly, Swinton et al.'s (2011) study revealed the different relationships people turn to, when exploring the ways that spirituality may be beneficial in coping with illness and enhancing quality of life for women with breast cancer. To highlight the relationships, Swinton et al. (2011) pointed out that breast cancer is not only a biological condition, it is equally a social and relational experience. The relational experience consists of proximate relationships with family and a broader connectedness within participants' social circles when patients move outwards (horizontally) in cancer crisis. Moreover, the relationships also included one with a Higher Power as an extension of social relationships where patients start moving upwards (vertically). In addition, it also encompassed the relationship with self. As Swinton et al. (2011) suggest, the findings highlight the importance of self as a resource, which is the way of moving inward (introspection) by reflecting upon what lies within self. Therefore, it is important for healthcare professionals to explore what resources PCB have available to them to improve their spiritual well-being. This could be undertaken at several levels. First, encouraging the individual to reflect upon themselves, identifying those inner resources that they can utilise, such as patience and resilience. Second, the individual may identify and utilise those proximate relationships within their family, and broader relationships existing in their

wider social circles. Finally, this may extend to include the social relationship with a Higher Power.

PCB's lower awareness of social support in spiritual care

While highlighting the relationships with family, society and a Higher Being as the resources of support women turn to for spiritual support with a diagnosis of breast cancer, Swinton et al. (2011) stress the importance of their social circles. This is because social relationships with friends, others in society and workplaces is a resource they turn to for help to enhance their spiritual well-being in times of crisis. In comparison, although participants in my investigation mentioned the benefit of support from within their social circles for their spiritual well-being, it seems they did not value this type of support as there was less mention of social support as a resource for spiritual care.

Participants' lower use of social support in spiritual care might be due to having less awareness of social care services available in the UK. This is similar to Wah-Yeung et al.'s (2015) findings, when exploring the experiences of PCB with physical disabilities, that they generally had low expectations of social care. The authors identified the cultural factors of Chinese customs and traditions and structural factors in the UK's healthcare system as contributing to this phenomenon.

As the findings of this investigation reveal, among the structural factors, the inadequacy or limitations of interpreting services, participants' limited English

language skills, and their cultural backgrounds which led them to seek support from their families, were major barriers for individuals influencing their perception of the quality of social and health care. These barriers can cause uncertainty among PCB about the role of different professionals working in both health and social care, for example when to seek the perspectives or expertise of social workers. In hospital and other healthcare settings, inadequate interpreting services or lack of effective communication can impact on the provision of spiritual care and may affect patients' health or cause family members desperation and despair, as shown in this investigation.

Also, as the findings show, the above factors can mean that the family take on the role of interpreter. Participants showed their willingness to use family and friends as interpreters to facilitate their communication and improve their understanding of the illness to better cope with healthcare professionals' treatment and care by following their instructions and suggestions. However, they realised that the family providing an interpretation service in healthcare may be unprofessional and cause negative effects on patients' health and spiritual well-being. This is evidenced in the current literature (Butow, Goldstein, Bell et al., 2011). For example, Butow et al. (2011) revealed that family interpreters had a significantly higher rate of non-equivalent interpretations than professionals ($p=0.02$), when exploring the rate and consequences of non-equivalent interpretation in medical oncology consultations. Here equivalent interpretation means the accuracy of messages conveyed by interpreters, while non-equivalent interpretation is the opposite. The high rate of non-equivalent or inaccurate interpretation in medical consultation reflects possible errors

and omissions in the medical interpretation provided by the family which may affect the health of the patient. Additionally, using family and friends as interpreters in healthcare settings may also lead to them having low expectations of health and social care.

In summary, the limited evidence from the literature in conjunction with the findings from this investigation suggest that PCB have low expectations of the support received in social care in England. This is primarily due to their language barrier and cultural backgrounds, highlighting the importance of having interpreting services provided by the UK healthcare system. As the lack of confidence and low expectations could affect PCB's physical and spiritual well-being while receiving healthcare, it is important for regulatory bodies, such as the *Department of Health and Social Care* and NMC, and also healthcare professionals to improve the professional interpreting services.

Inner resources in spiritual care

The findings show that utilising or drawing upon one's own inner resources was a source of support participants used both in everyday life and while receiving care within a hospital setting. This reliance on self was considered a key attribute of spirituality. Generally, the different types of support and resources for individuals' spiritual well-being in this investigation were related to their internal resources or strength, because it is only through their motivation and dynamic role that other supporting resources can be put into effect. For example, a patient's family may be considered as a form of external support and resource for the patient's individual

spiritual well-being. However, the family's support is closely related to the individual's own resources because it is only through the patient's acceptance of the help offered from the family that they can access and gain inner strength provided by the family's encouragement and support. The combination and interaction of inner and external support and resources may lead to quicker recovery or improvement in illness, ultimately leading to enhanced spiritual well-being.

In this investigation, self as a resource was used in a narrow sense as an internal resource or support rather than external, with individuals gaining support from their own thoughts and beliefs. Examples of this were the inner power to sustain one's life, resilience in gaining the power to live, and motivation to help others. Yang et al. (2012), exploring the spiritual journey of hospitalised patients with schizophrenia in Taiwan, revealed that self-reliance is a way of coping with feelings of loneliness or helplessness. They further added that PCB believe that only their own power and belief is real and more trustworthy, and that self-reliance can be gained by keeping control of themselves and being independent. Chio et al. (2008) also found that Taiwanese patients relied on themselves to get explanations of suffering from Chinese philosophy and read books about how other cancer patients survived with their strong will, thus becoming more tolerant to suffering and illness, and inspired by others. Similarly, in Western culture gaining support from self is stressed as turning inward to seek strength from within (Swinton et al., 2011).

However, in this investigation, it seems that PCB focused on inner consciousness when reflecting on self and moving inwards. This is consistent with Chiu's (2000)

study exploring the experience of spirituality for Taiwanese women with breast cancer; the author revealed the patients realise that the core of the relationship with self is inner consciousness. PCB emphasised a person's inner consciousness through peaceful thinking about why things happened (Chiu, 2000). They also stressed this through expressing their feelings of self-worth by appreciating what they were pursuing (Chiu, 2000).

The above discussion shows that gaining support from self is important for people coping with feelings of loneliness or helplessness in difficulties when their spiritual well-being is jeopardised in crisis. There are different expressions of seeking supporting resources from within self in both Western and Chinese cultures, and they are about 'moving inwards' (Swinton et al., 2011), 'self-consciousness' (Chiu, 2000), and 'self-reliance' (Yang et al., 2012). The ways of seeking support from within self in Chinese culture are also diverse. Besides finding proximate relationships between self, family and close ones (Swinton et al., 2011), it is important for PCB to gain an explanation of suffering from within Chinese philosophy, and get energy from other resources such as reading books and listening to stories of other cancer patients, to become more tolerant in times of suffering and illness, and gain motivation from others (Chio et al., 2008). Moreover, for PCB, self-reliance can be gained by keeping control of themselves and being independent (Yang et al., 2012). The Chinese cultural norm of cultivating self and fulfilling responsibility for family may influence these cultural habits (Littleton et al., 1996). Therefore, being aware of the importance of gaining support from self will be helpful for healthcare professionals in implementing spiritual care. Also, as using self as a supporting resource and PCB's

self-consciousness in their understanding of spirituality could be the influence of Chinese philosophical thought: self-cultivation (Eno, 2016), it might be useful to use the related principles to guide people's lives or support patients for better spiritual care.

Integrating traditional Chinese philosophies as spirituality

The findings show that participants apply integration of good values, particularly from different Chinese philosophies within their understanding of spirituality and spiritual care. The integration of Chinese cultural values of Confucianism, Buddhism and Daoism (including TCM) within their understanding of spirituality is consistent with Chiu's (2001) study. Although they applied these values in a free way, they might be unclear about the association of these values with the philosophies of Confucianism, Buddhism and Daoism, or might have different or new understanding of the values or old-sayings from the originals. Understanding PCB's sub-consciousness in integrating these Chinese cultural values may be helpful for healthcare professionals in understanding any inaccuracies in PCB's explanation of the Chinese cultural values. Healthcare professionals also need to be aware that the classic Chinese cultural values deeply affect PCB's thoughts and actions and they may use them without thinking about or exploring the exact meaning of the values or sayings.

The results reveal that not only do participants relate the cultural values in traditional Chinese philosophies to their spirituality, they also connect Western cultural and religious values to their understanding of spirituality and spiritual care. Therefore, healthcare professionals should integrate both the Chinese cultural values and their

highlighted Western values in providing person-centred spiritual care to PCB in the UK.

Religious care in spirituality

The findings demonstrate that PCB associate their understanding of spirituality and spiritual care with religious care as they noted the benefits of religious care, and different religious providers such as hospitals, nurses, ministers and volunteers in healthcare settings and daily life. Religious understanding of spirituality is one of the major approaches to understanding spirituality in the literature (Swinton, 2010; Wong and Yau, 2010) and it is also an element of spirituality in both Western and Chinese contexts (Carson and Stoll, 2009; Chiu, 2000). Therefore, it enriches the theory of 'seeking a meaningful life' regarding religious support in hospital settings, and the support gained for health and well-being may motivate PCB to achieve their life meanings. The providers and general ways of providing religious care in hospital are common in investigations which mainly focus on Westerners (McSherry, 2004), for example assessing religious needs, supporting patients' religious activity and using chaplaincy services. This may be because these participants mainly illustrated their experience in a Western hospital setting. As PCB use a religious understanding of spirituality, religious care may require that the services related to Chinese religion such as Buddhism and Daoism are in place for PCB in the UK.

However, participants' religious understanding of spirituality was complicated in this investigation. They had a spectrum of understanding of spirituality from cultural values to religion. This may suggest that among PCB there is no distinct boundary

between whether spirituality is about religious or cultural values, or a tendency for spirituality to be understood through two opposing positions of Chinese culture and religion.

Participants related spirituality to cultural values in the way they associated spirituality to religions. That is, they used historical figures and cultural values in Confucianism, Daoism and Buddhism as their base for understanding spirituality, which is the way they expressed religion as their understanding of spirituality (MacKinlay, 2006). As a result, the cultural understanding of spirituality may be deemed as indicating spirituality as religion in an indirect way. The spectrum of spirituality from culture to religion, and indirectly indicating cultural values as religion, may remind healthcare professionals that PCB may have either religious or cultural understanding, or a fusion of this as their understanding of spirituality.

Holistic understanding of spirituality

A holistic notion of spiritual care is shown in the participants' perceptions of spirituality and spiritual care as they state that the scope of spiritual care is broad, covering the fundamental aspects of physical, psychological, mental and religious care including relevant services in cultural care**.** This holistic notion of spiritual care supports Narayanasamy's (1999c) definition of spirituality consisting of physical, religious and social aspects, enriching the understanding of spirituality being broad and holistic within both Western and Chinese cultures (Sum and Leung, 2013; Wong, Lee and Lee, 2008). This suggests that multi-disciplinary cooperation in hospital settings is important for the organisation of spiritual care, and this cooperation could be

extended to patients' spiritual support in their daily lives when they are not hospitalised.

As the findings show, a broad understanding of spirituality and spiritual care arose from the attribute of spirituality that each individual has their own subjective understanding of the term. This highlights that patient-centred care is important (Balducci, 2011) for healthcare professionals when a certain aspect of care is highlighted among a broad range of needs.

Mental health in spirituality

The results of this investigation show that participants specifically related spirituality to a mental state which was indicated as a force of being vibrant or mentally ill. The force was expressed in two ways with regard to achieving health. When the driving force was in or out of balance, this meant being vibrant or in high spirits or being in a condition of mental or psychological illness. The association of mental state with spirituality suggests that mental health is an important aspect of spirituality among PCB, and this is proved by quantitative evidence among different cultures (Salsman, Pustejovsky, Jim et al., 2015; Koenig, 2012). For example, Salsman et al.'s (2015) meta-analysis of 148 studies worldwide provided statistical evidence that spirituality/religiosity is related to mental health (Fisher z=0.19, 95% confidence interval=0.16-0.23), with a higher score in spirituality/religiosity towards better mental health. This suggests that people's mental aspect is also their main spiritual concern. The association of spirituality with mental health and its positive effect on people's

mental health highlights its important position in people's spiritual well-being, regardless of the culture and traditions they have lived with.

However, the findings of this investigation provide another explanation for this association. PCB perceive spirituality as a mental state which may be shown as being vibrant, with a high mood and energy in activity and thoughts. This explanation is derived from basic traditional Chinese health concepts, which see people's health originating from their internal vibrancy or a moving force (Li and Shang, 2014). Therefore, healthcare professionals in England may need to bear in mind this understanding of spirituality in Chinese culture. Since this understanding is also related to mental illness if the vibrancy or force exhibits as mental mania with great excitement and overactivity in psychiatric patients, healthcare professionals may need to be cautious when explaining spiritual care to PCB due to the stigma of mental illness.

Essence and human nature in spirituality

The findings reveal that some participants related spirituality to an entity within the body and they made reference to words such as 'human nature', 'essence' and 'soul' or 'spirit'. To further explain that spirituality is associated with these entities, they provided characteristics or explanations, such as 'human nature is good', and 'the essence inherent in every human body' likening it to an engine in a machine. They also commented that the soul is everlasting in the universe and the spirit is within a person. Participants additionally noted that the way to achieve the essence of spirituality was to follow the guidance in Daoism by observing its principles and

doctrine, claiming that attaining this is beneficial for their life. They added that people needed to trust human nature in self and others to build confidence within oneself and humanity in society, because this innate part of humans is good.

By relating spirituality to driving force, essence, human nature, and soul or spirit, participants indicated that spirituality was a human entity. This entity was inherent, virtuous, energy-generating and everlasting. This means that humans are born with a good nature, therefore believing in this entity is like a person regaining the essence of life or a new way of living. Because humans are born with a trusting nature, helping others is following this human principle of being virtuous. The everlasting attribute of this entity means that although death is the disappearance of the human body in this world, their entities or souls still exist in a metaphysical world. Therefore, believing in it enabled people to have hope for life when facing illness or crisis. Being energy-generating means that human nature is a source of energy for a person, and this energy enables people to have power and courage to face life crisis and death (Lin et al., 2012). This energy is also collectively demonstrated as a national spirit if a group of people cherish it and display this energy and its virtue.

Participants' association of spirituality with a human entity reflects David Hay's argument that human spirituality is partially their biological gene inherent in their body. Participants in this investigation did not specifically explain that spirituality was essential for relational consciousness and designated to received spiritual and religious information to connect with self, others, the environment and God (Hay and Nye, 2006; Swinton, 2010). However, they emphasised the importance of this human

entity for personal development and well-being by highlighting its attribute of being virtuous, innate, and moving them forward. Understanding spirituality as a part or entity of the human body is important for healthcare professionals, to realise that spiritual care is a vital part of care.

Summary

This chapter discussed several factors that are important to PCB's understanding of spirituality and spiritual care. Seeking a meaningful life was the key understanding of their spirituality, through attaining motivation and support, maintaining good values and achieving their life meaning. Finding meaning in suffering and identifying their need of spiritual support were important elements for the implementation of spiritual care for this group of people. Also, family involvement and gaining support for spiritual care for the family was pivotal for these people's spiritual well-being. Beside these, the resources of spiritual support in daily nursing care, including the inner resource of spiritual care, provide the way and direction for practice, in gaining support for PCB. However, there is a need to pay attention to the low awareness of social support when providing spiritual care. While spiritual care needs to be considered for integrating traditional Chinese philosophies into spirituality, other important factors are religious care, mental health and a holistic understanding of spirituality. Finally, for PCB, understanding the element of 'essence and human nature' is crucial to grasp their perceptions of spirituality.

In the next chapter, I conclude this investigation and make recommendations for nursing practice based on the findings.

CHAPTER TEN : CONCLUSION, RECOMMENDATIONS, AND REFLECTION

Introduction

The research question '*How do people from Chinese backgrounds living in three regions in England develop their perception of spirituality and spiritual care?*' led to the development of a substantive theory, titled *'seeking a meaningful life'*. Collectively each chapter of the thesis has outlined in detail the whole research process. In this chapter I provide some final reflections and conclusions. First, I revisit the research aim and objectives, demonstrating how these have been achieved during this investigation. Second, I highlight the implications of the main findings for healthcare practice and future research. Finally, I provide a reflexive account of my research journey, evaluating this PhD experience and offering some plans for my future ongoing development.

Addressing the research aim and objectives

The overall aim of the research was to investigate the perceptions of spirituality among PCB living in three regions of England. By capturing and exploring the meaning and experience of spirituality and spiritual care among this group of people, a substantive theory titled *'seeking a meaningful life'* was developed. This aim was achieved by addressing three objectives focusing on conceptual development around two groups of PCB, those with and those without any hospitalisation. To achieve Objective 1: *Compare the relevant concepts emerging from the data analysis to gain a deeper understanding of the term spirituality among Chinese groups, and how this is understood by PCB living in England*, I used the constant comparative method to constantly develop the emerging concepts in conjunction with in-depth analysis, paying attention to those related to each other and that were of a similar nature, and

comparing these across different dimensions. For example, I compared 'Spirituality' and 'Spiritual care' in terms of their characteristics and the way participants described them, thereby demonstrating that the way participants described spiritual care could be a way of explaining spirituality from a practice perspective. This was because 'spiritual care' seemed easier to describe than the concept of 'spirituality'. Constant comparison of these two concepts allowed their differences and similarities to emerge. These demonstrated how 'Spirituality' and 'Spiritual care' support each other to enhance an understanding of PCB's resources in seeking a meaningful life, particularly within healthcare settings when asking individuals from this culture what spiritual care they may require.

For Objective 2: *Identify how PCB who have been hospitalised perceive and experience spiritual care*, I recruited four participants who had been hospitalized in the UK and identified how they perceived and experienced spiritual care within a healthcare setting. Their perceptions of spirituality and spiritual care advanced understanding of the concepts and contribute to theory development when they communicated about spirituality/spiritual care during their illness. For example, Maowai and Youhao expressed how they used Chinese cultural values in dealing with illness, detailing physical sickness as a source of suffering which allowed them to investigate cultural values for a meaningful and comfortable life. Shufa also, from a patient's perspective, stated that friends' help is relevant in spiritual care when she is hospitalised, by delineating her friend's encouragement in eating and sharing of going through the difficult life experience for living on (p.204). This makes her live on with a free mind without following specific restriction from her illness and hopeful for a longer

life. Furthermore, she used her own experience to illustrate the importance of friend for a patient, which makes her information more impressive because she used her own experience to illustrate the importance of friend for a patient, in comparison to those without hospitalisation experience who generally identify that a friend's help may be a source of support in spiritual care.

To address Objective 3: *Develop a theory of spirituality and spiritual care by investigating PCB living in three regions of England*, I explored the concepts of 'spirituality' and 'spiritual care' by recruiting a broad range of PCB into the investigation, and through in-depth analysis of the interviews, closely following the methods outlined in grounded theory. The wide range of participants contributed to the quality and development of the categories and their properties, forming the elements of the theory. It also helped to address the process involved in understanding spirituality and spiritual care by capturing a wide variation of understanding among PCB living in England. The process showed that PCB usually utilise motivation and support resources by following good principles to achieve a meaningful life.

Implications for practice

The results of this investigation suggest that finding meaning in suffering, involving family in healthcare, and improving communication services in hospitals are considerations for the advancement of spiritual care for PCB living in England. Additionally, the integration of Chinese philosophies in the understanding of spirituality and the association of mental health with spiritual care from a Chinese

cultural perspective need to be considered in the practice of spiritual care for this group of people. These suggestions could be developed as a tool for specialist spiritual care services to take care of PCB spiritual needs.

Finding the meaning of suffering for PCB

The results of this investigation suggest that healthcare professionals from Western contexts need to have a better understanding of Chinese culture, especially regarding the role of health-related suffering, in order to support this group of people and help them find meaning and relationship during times of suffering and illness. The theoretical knowledge of Chinese philosophy found in Buddhism, Daoism and Confucianism forms the foundation for PCB to understand, interpret and respond to suffering and illness. The knowledge and traditions embedded in these philosophies are the core through which PCB find meaning and relationship in their suffering. Therefore, healthcare and social care professionals should have an awareness of this knowledge which may enhance their competence in providing culture-based spiritual care to this group of people. This knowledge could be integrated within education dealing with cultural dimensions of care, and within teaching resources to raise awareness both with nurses in clinical practice and within different programmes of health and social care education.

As PCB living in the UK tend not to consider suffering as bad, due the Karma theory that suffering in this life is paying the debt for the previous life and to have a better next life or become a Buddha or deity in this life, they may have more tolerance in

their suffering experience. Healthcare professionals should understand that PCB's suffering experience is helpful for their health and well-being in two ways. First, noticing the negative side of suffering enables healthcare professionals to identify health problems and relieve patients' suffering in a timely way. Second, being aware that suffering is the way PCB pay 'the debt from the previous life' and the way they follow the rules of nature may facilitate clinicians to help them in reaching life transcendence when the debt is paid or harmony and peace within nature is gained.

Besides understanding the theoretical base which forms PCB's attitude to illness, healthcare professionals should also be aware that caring for the physical illness is a priority for this group's spiritual needs. This means that healthcare professionals should be aware of this cultural tendency of PCB, be actively involved in identifying their pain and physical discomfort, and relieve the symptoms and suffering as soon as possible.

Family-related issues and family members are factors contributing to PCB's worries during illness, and these factors may have a negative effect on their healing and spiritual well-being. This requires nurses and other healthcare professionals to differentiate which family situation is causing their suffering, and take an appropriate caring approach. If the patient's worry and health deterioration is caused by a lack of family support, healthcare professionals may need to take care of them with warmth and closeness. If it is due to patients' feeling embarrassed to ask for family support, this may require the nurses to liaise with family members and support the patient to

access their family members' involvement. If the suffering is related to the patient's worry and concern for family members, an explanation by nursing staff may be needed regarding the bad impact that worrying about the family can have on their health, and an exploration of other resources from which the family usually provide patient support. The explanation and suggestions may be as simple as, "I understand your worries about your family, but your improvement and health are very important to them. I would suggest you don't worry about anyone while you're ill but get enough rest to help recover from the illness". In terms of looking for support resources that the family usually provided, it will depend how participants express these concerns. For example, if patients indicate a need for family companionship to support their spiritual health, nurses might spend time with them so that they can express their worries and burdens.

Family's involvement in getting support for spiritual care

This investigation suggests that healthcare professionals need to consider family involvement in care when providing spiritual care to PCB. This can be in different contexts of nursing practice, such as at hospital and in primary care, and family involvement should include every aspect of caring, including physical, social, psychological and spiritual. Moreover, the manner and level of family involvement should be discussed with both the patients and family, and a decision made based on the individuals and their family situation.

In addition, when involving family members in spiritual care, healthcare professionals need to pay specific attention to the different kinships of patients, particularly those for couples, parents, children and siblings, because these relationships are considered as basic supporting resources in Chinese society. Just as Confucian cultural factors shape the meaning of suffering and spirituality for PCB (p.280), having an understanding of the relationships of the Chinese family under the influence of Confucianism is also helpful for educators to develop curricula with regard to family involvement in care and how this may improve the spiritual well-being of patients (Lin, Gau, Lin et al., 2011).

However, healthcare professionals should be aware of two hidden issues related to PCB's reliance on family members in health and spiritual care. First, due to their reliance on their family and close friends, patients and families of PCB tend to hide their feelings from clinicians, resulting in healthcare professionals being unable to identify their need for spiritual support. Second, their own standards also contribute to their behaviour in seeking family support. Therefore, it is important for healthcare professionals to care for these people with close and warm attention as if they are family. In doing this, these people may feel they are not marginalised and will be able to express their own needs to enhance their spiritual well-being.

With reference to receiving end-of-life care, healthcare professionals may need someone from the person's community who has knowledge about Chinese customs

pertaining to death and dying. This will enable the caring team to meet the person's and their family's cultural and spiritual needs in the final stage of their life. This is because family-assisted care and care provided within family settings has a special cultural meaning and significance for PCB facing death. Also, at an institutional level, the hospital needs to establish an effective referral system, including integrative in-patient care and homecare programmes for dying patients (Shih et al., 2009) to meet both patient and family needs. Certainly, nurses should also discuss with patients and their family their wishes and preferences around end-of-life.

The support to address the spiritual dimension of the family and patients can be found in existing tools developed for spiritual assessment and spiritual care interventions within traditional Chinese cultural and philosophy. For example, when utilising the tools of the FICA (Ellington et al., 2017) in spiritual need assessment, the question *"What is your faith or belief?"* could be followed up with questions addressing important teachings within Chinese culture, "For example, do you have any belief in Confucianism, Daoism or Buddhism?" Using a modified question within the FICA assessment tool to address cultural factors pertaining to Confucianism, Daoism or Buddhism will make PCB feel more comfortable with the enquirer, because they are demonstrating knowledge of their traditions and culture. This sensitivity may encourage the person to respond and provide the information that is sought. When utilising the *Fellow Traveller Model for Spiritual Care* (Holloway and Moss, 2010) to interact with the family of PCB, it is suggested that a Chinese cultural expert in religious and spiritual care or a Chinese cultural expert in healthcare could work

collaboratively with the care team to provide spiritual care for the families from Chinese backgrounds.

Communication service to improve PCB's health and spiritual well-being

Participants in this investigation highlighted that enhancement of their oral communication with healthcare professionals was essential for their spirituality and spiritual care. Regulatory bodies should improve interpreting services in healthcare structures, and recognise and address PCB's low awareness of social care in hospitals and everyday life. To address the low level of awareness of social support, Wah-Yeung et al. (2015) suggest the use of cultural organisations such as day centres or community groups for accessing and learning to navigate the healthcare service. In a hospital setting, healthcare professionals, particularly nurses, doctors, and social workers need more awareness of the importance of this support for PCB in England and other ethnic minority groups. They also need to ensure there is access to adequate independent (professional) interpreting services that are provided in a timely manner to help with the provision of high quality information regarding their health and social care needs.

In addition to the utilisation of Chinese welfare organisations to help PCB access and navigate the healthcare service in the UK, there is a need for the NHS to provide sufficient financial and human resources to improve professional translation in hospital settings. This investment would enhance PCB's expectations with regard to treatment and social care in hospital settings. There needs to be an increase in the

interpreting workforce and the number of professional interpreters available to enhance the existing service, ensuring that patients from minority groups can easily access interpreting services at any time, particularly on the wards. Finally, recruiting more Chinese staff to work in both health and social care would help PCB to feel less isolated in healthcare settings. This is because the findings of this investigation revealed that the presence of healthcare professionals from Chinese backgrounds helps patients emotionally, leading to effective communication and interventions.

Spirituality and the Traditional Chinese philosophies

Healthcare professionals need to be aware that PCB, like other groups of people, may express their spirituality either directly or indirectly. The most direct way that PCB may express their spiritual or religious beliefs is through stating their affiliation to a particular religion. They may also express this through the use of prayer, stating the benefits of their religion, showing admiration for religious leaders, strictly following religious teaching and having an evident strong devotion to God or a deity/higher powers. This direct expression of belief provides healthcare professionals with a clear way to provide spiritual care with religious methods to improve PCB's spiritual well-being according to their particular religious affiliation, or religious practices used to worship God, or help to access the benefits of their particular religion.

The indirect way is similar to the way that participants indicated spirituality to be about Chinese culture and philosophies, relating spirituality to Chinese philosophical principles in Confucianism, Buddhism and Daoism respectively or in combination. Therefore, healthcare professionals will need to care for these people's spiritual

needs in line with the values and customs of traditional Chinese culture. This culturally sensitive approach will mean that care is provided according to the teachings of each of the Chinese philosophies or an integration of them.

Healthcare professionals need to have a basic understanding of each of the philosophies in order to provide bespoke spiritual care. This will help establish a trusting and close relationship with PCB by showing their appreciation of the main cultural values and beliefs of this group. The application of these philosophical principles may include an awareness of the key historical philosophical figures, traditions, thoughts, values, terms and some of the written works.

In Confucianism, these are included in the classics regarding the Confucian thought, for example, *The Doctrine of the Mean*. The key principles or illustrations of these values are 'Heaven', family responsibility, filial piety, ancestor worship, individual social roles, and self-perfection by keeping a balanced mind and being genuine, to provide a better social and family role. For the philosophies in Buddhism, examples are *Chaodu* (the salvage of the dead), worshipping Buddha, Bodhisattva or *Guanyin*, and applying the concept of Karma. Buddhist thought encompasses true nature, tolerance of suffering, letting go and forgiveness. In Daoism, the philosophical figures may be celestial beings and empowered historical/ancestral characters. The Daoist thoughts are concepts such as inner peace, quietness, and obedience of nature in following a natural living process of becoming old and sick and encountering life difficulties. The Daoist tradition can be illustrated as a preference for TCM. These concepts and traditions represent *Wu wei* in Daoism, indicating 'non-doing' to avoid

struggle and effortless engagement. At the same time, they focus on the integrity of human being and environment and the integrity of the human body, therefore suggesting relatively natural and comprehensive diagnosis, treatment and care, especially within TCM.

Understanding the main principles of Confucianism, Buddhism and Daoism will therefore be very useful for healthcare professionals, providing them with a framework and vehicle to provide culturally sensitive spiritual care for PCB in England.

The results show that participants also integrate Chinese philosophies into their own understanding of spirituality and spiritual care. Therefore, healthcare professionals need to integrate the values and traditions outlined in the Chinese philosophies to implement spiritual care. This requires them to be aware of the main tenets and integrate these philosophical traditions where possible into the conversations or activities they engage in when caring for PCB, especially when addressing spirituality and providing spiritual care. Healthcare professionals also need to bear in mind that PCB sometimes associate Chinese cultural values with spirituality in an unconscious way. They may apply or express Chinese culture as spirituality with their own understanding, being unaware of a direct affiliation with Confucianism, Buddhism or Daoism, or they may provide an intuitive understanding of old sayings, which may be different from the original. Also, they may be unaware of the influence that Chinese culture has on their spirituality when addressing the term, but they may provide enough explanation once they realise this or are given some guidance.

In addition, healthcare professionals need to pay close attention to three issues relating to the integration of Chinese philosophies within the concept of spirituality. The first is healthcare professionals may find that PCB provide contradictory information regarding their religious beliefs when addressing questions about spirituality. This may occur at three critical time points: during their admission conversation; during the process of identifying religious belief when providing demographic information; or a combination of these two processes. The second issue is that participants sometimes have difficulty in identifying their religious belief. This may be observed in their hesitation about ticking an option on a form about religious belief, or replying with a simple/single answer, and through wanting to change or add a different religious belief. The third is linked with the second one; because of difficulty in identifying their religious belief, PCB may simply state 'atheist', 'communist' or 'none' to simplify the process.

Spiritual care in mental health

The results of this investigation demonstrate the close association between spirituality and mental health for PCB. Koenig's (2012) study supports this, showing that spiritual intervention is beneficial for people's mental health in reducing stress and has a general positive impact on their mental health. This indicates that spiritual care is interrelated with the practice of mental health and psychiatry, and this may be because both spiritual care and mental care share similar benefits in helping people to gain positive emotions and achieve meaning and purpose in life (Koenig, 2012; Tanyi, 2002). The interrelatedness of spirituality and mental health requires

cooperation from these disciplines when necessary. Furthermore, the benefit of spiritual activities such as meditation or praying for people's mental health (Koenig, 2012) suggests that spiritual care is important for people generally in everyday life and more particularly in contributing to their psychological and mental well-being by relieving tension and helping to input meaning and purpose in their lives.

In addition, as participants have suggested that people may show hostility towards those experiencing mental illness, healthcare professionals need to pay attention to the close relationship PCB ascribe to mental health and their perceptions of spirituality. The perceived lack of distinction between mental health and spirituality may be one reason why PCB show resistance towards spirituality-related topics. Therefore, for healthcare professionals and nurses, there is a need to explain to PCB that spiritual care and mental care are two different concepts within healthcare. This may help to reduce the resistance and fear associated with spiritual care due to its close connection to mental health.

In Chinese culture, this association is influenced by the basic Daoist concepts of *jing, Qi, shen* (精气神), which mean essence, energy, and driving forces in the human body. A finding of this investigation was that spirituality is considered a driving force, which manifests as a mental state of being vibrant and of high or good spirits. Another finding was that spirituality is considered as the essence and nature of all life, an entity that is hidden and inherent in the human body, which generates the energy and power to drive human life. Therefore, healthcare professionals may be able to explain that spirituality and spiritual care are comparable to the basic traditional

Chinese concepts of *jing, Qi, shen* in order to provide PCB with reassurance about spiritual care.

Limitations of the research

The recruitment process revealed that making assumptions that participants possessed the required knowledge was a setback for this investigation because the criteria for the theoretical sampling was somewhat affected if the supposed participant(s) could not be identified. However, this issue could not be avoided with regard to my investigation for several reasons. First, due to my limited time and financial resources for conducting this PhD investigation, I could not engage with and attend all four Chinese communities for a prolonged period. This involvement might have enabled me to recognise all the potential participants with specific characteristics and knowledge across the four communities who may have contributed to the development and testing of the emerging theory. Second, there was always the possibility that potential participants might change their mind and make the decision to withdraw from the investigation based on their personal circumstances, thus affecting the research process. Third, the support from the Chinese communities might diminish if a long-term engagement and commitment was required, due to their busy schedules and the alteration of staff, also delaying or affecting the recruitment. Based on these factors I could not avoid making assumptions that a participant might possess certain knowledge, and had to recruit them into the investigation. It is suggested that further research might be conducted in the future establishing a bigger sampling pool with adequate funding, and a stable

participant population. However, this would involve more resources and financial support.

The number of recruited participants was 25, which is a small number for this kind of investigation given the number of Chinese British living in the UK and this may have contributed to the limited numbers of healthcare professionals recruited. For example, among the 25 participants there were only three participants practising in UK healthcare: one lab technician who had surgical experience in China, one UK registered nurse, and one care assistant. The recruitment process revealed that the developed theory might lack involvement and contributions from chaplaincy staff involved in the delivery of spiritual care. Again, this suggests the need for further research with a bigger sampling pool involving perhaps the whole healthcare community including allied health professions, nurses, physicians and representatives from chaplaincy services.

The second limitation of this investigation lies in the broad research question that sought to explore the meaning of spirituality among PCB living in the UK. Bluff (2005) suggests that the research question developed in a grounded theory investigation should have a broad focus to help formulate a theory in later stages. In this investigation, a substantive theory applicable to all the participants was developed to capture and reflect their diverse backgrounds and experiences. Although this could be considered a major advantage of this investigation, it also presented a challenge because it did not concentrate on a specific group of people, such as patients in hospital. Therefore, a future research study might focus purely on participants from

Chinese backgrounds in a hospital setting, applying a strict inclusion criterion. For example, it could include PCB who are currently hospitalised. This would provide the opportunity to gain insights on spirituality and spiritual care which were not relying on individuals to recall and reflect on past experience, as was the case in my investigation.

The third limitation is about the vagueness of the term 'people from Chinese backgrounds' (PCB) that I applied to recruit participants for this investigation. This is because I used the term to define both the early migrants and their descendants as PCB or those living in the 'Chinese diaspora community'. This is to say, the second or third generation of the immigrants, who become acculturated and assimilated within local communities eventually becoming native to the area, are also included in this investigation. Besides this, I also included those who had recently moved to the UK, such as an international student. Therefore, the findings of this investigation might be influenced by the participants' native perceptions of spirituality without the impact of UK society and the healthcare system. For example, a participant who studies as an international student from China or Hong Kong may have a lower immersion or exposure to UK culture and have had limited need to access the services of the National Health Service. Therefore, a recruitment criterion that considers the degree or depth to which an individual has assimilated the UK culture is suggested, because this kind of study could lead to the focus of spirituality and spiritual care being upon PCB who have been living in the UK for a long time as frequent and resident healthcare users. This could be accomplished through

establishing the criterion to include PCB who are UK citizens or permanent UK residents or who have been living in the UK for more than five years.

Reflection on the PhD journey

This four-year PhD journey has been very challenging but at the same time rewarding. I have developed my knowledge based in the field of spiritual care by exploring PCB's understanding of spirituality and comparing it with existing knowledge. I have also enhanced my knowledge of research methods, particularly by applying Strauss and Corbin's (1998) grounded theory within the research process. While completing this research investigation, I enhanced my skills with regard to conducting literature searches and by utilising and applying Endnote I was able to conduct a comprehensive scoping review. In addition, by developing my skills in the use of NVivo, I have learned how to manage and analyse large qualitative data sets. In addition, I have completed several modules in research skills as part of the programme, *Post-Graduate Research Method Certificate* (PgRMC), and *Research Methods and Data Analysis in Public Health*. This furthered my interest in conducting research in areas beyond the discipline of nursing. Throughout my PhD journey I have developed my skills and competence in the English language both written and spoken, as well as skills in analysis and critique.

Furthermore, I developed personal effectiveness through remaining enthusiastic and maintaining my personal commitment even when I experienced difficult times. My confidence developed as I improved my research skills, such as utilising new

software and using grounded theory analytical methods. I also used reflection to explore my strengths and weaknesses, and I strove for excellence in everything that I undertook. To achieve personal effectiveness, I developed and prioritised my project plan to meet the research objectives, including addressing supervisors' comments and feedback. As for future career development, I understand that I may be able to apply for a position in either clinical or educational settings. With the transferable skills and competency gained as part of my PhD research, I feel confident to interact with others in order to conduct further research for the improvement of people's health and spiritual well-being, and share the knowledge and skills I have gained to educate students about different approaches to research.

In addition, my awareness of the importance of good research governance, organisation, and administration has been developed throughout this entire research investigation. I have ensured that the research has been conducted in accordance with the highest standards of professional conduct. While recruiting participants, I acted according to ethical principles and legal requirements in the UK, for example to keep and respect participants' confidentiality. My project management and time management skills were enhanced by the setting and monitoring of goals that I had set in a Gannt chart detailing the key stages in the investigation. An area that I feel I need to learn more about is income generation and funding so that I can continue to conduct future research activities.

At the end of this PhD journey, I developed my skills in liaising and working with managers in the Chinese communities and in negotiating my research activities. I

have also benefited from regular supervision which has increased my awareness of different approaches to supervision and research management styles. Additionally, I have enhanced my knowledge about the importance of disseminating my research findings and have presented a poster and used PowerPoint presentations. I am currently working on publishing the findings in international peer-reviewed journals.

However, I need to develop my ability to work within a team as these skills are key to taking on a leadership role and developing mentoring skills to support future students.

In summary, all these activities and processes mean that I have gained valuable insight and experiences in organising a research investigation and particularly in conducting grounded theory research. More importantly, they have convinced me that I can do research and have encouraged me to achieve higher levels of research skills.

Concluding remarks

The aim of this investigation was to develop a theory of spirituality and spiritual care among PCB living in three regions of England. This was achieved through the establishment of a substantive theory called '*seeking a meaningful life',* by capturing and exploring the meaning and experience of spirituality and spiritual care among this group of people using a grounded theory approach. Health and social care professionals in England need to be aware of this process in order to gain an understanding of spirituality and spiritual care for PCB living in the UK. PCB usually utilise motivation and supporting resources that are essential for seeking a

meaningful life. Following this, they need to live by good principles, practice and hard work, to finally achieve a meaningful life. This process is not related to an individual's cultural identity and beliefs in the Chinese philosophies, but generally apply to PCB when addressing spirituality and spiritual care. Also, the theory may not be applicable to specific individuals who think that seeking a meaningful life is irrelevant to spirituality and spiritual care.

This investigation is significant and unique because there has been no other research conducted focusing specifically on the meaning of spirituality and spiritual care for PCB living in the UK. The findings reveal that by integrating the process of '*seeking a meaningful life'* into their lives, PCB may enhance their knowledge and understanding of spirituality and spiritual care. It is suggested that being aware of the importance of family involvement and the application of traditional Chinese philosophy has relevance for the provision of spiritual care within nursing and wider healthcare practice. Furthermore, the findings reveal that it may be appropriate when explaining spiritual care to this group to do so within the context of traditional Chinese concepts. The theory also affirms the importance of removing fears arising from the association of spirituality with mental illness for PCB. The importance of the theory and knowledge will be disseminated to educate health and social care professionals to enhance their understanding of spirituality and spiritual care for PCB living in the UK, with the ultimate aim of enhancing this group of people's spiritual well-being.

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APPENDICES

Appendix 3.1 Search strategy

This is a general search strategy for six databases: CINAHL, MEDLINE, PsycoINFO, WEB of Science, ScienceDirect and ASSIA.

TOPIC	The meaning and experiences of spirituality and spiritual care in nursing from 2005: a scoping literarure reivew
Key concept	Synonyms/ related terms/alternative forms for key words (Index terms)
Spiritual care or Spirituality	spiritual care, spirituality (spiritual*)
Nursing or nurse	nursing, nurse* (nurs*)
Perception or experience	perception*, perspective*, concept*, view*, opinion*, attitude*, meaning*, experience*
Chinese[1]	Chinese, China, Taiwan, Hong Kong, Singapore
Key databases	1. CINAHL 2. MEDLINE (PubMed) 3. PsychINFO (Ovid) - covers PsycARTICLES (Ovid) 4. Web of Science - Science Citation Expanded®, Social Sciences Citation Index®, and Arts & Humanities Citation Index™. 5. ASSIA (ProQuest) - Applied Social Sciences Index and Abstracts 6. ScienceDirect - is a large scientific, technical and medical (STM) database provides full-text journals from Elsevier Science

("perception" OR "experience") AND ("spiritual care" OR "spirituality") AND ("nursing" or "nurse")

[1] Concept Chinese was not initially combined in searching strategies for the purpose of gaining size and nature of evidence of the body of knowledge in a wider context. It was applied after the studies regarding meaning of spirituality and spiritual care worldwide were identified.

Appendix 3.2 Search result

Search history and result in "CINAHL" (2042 findings 30 June 2015)

Search ID#	Search Terms	Actions
S16	S3 AND S6 AND S15	(2,042)
S15	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	(595,518)
S14	"meaning*"	(29,392)
S13	"attitude*"	(204,119)
S12	"opinion*"	(22,259)
S11	"view*"	(63,735)
S10	"concept*"	(111,729)
S9	"perspective*"	(71,665)
S8	"experience*"	(206,125)
S7	"perception*"	(85,871)
S6	S4 OR S5	(690,431)
S5	"nurse*"	366,239)
S4	"nursing"	(550,332)
S3	S1 OR S2	(13,809)
S2	"spirituality"	(11,643)
S1	"spiritual care"	(3,479)

Search history and result in MEDLINE (1274 findings on 30 June 2015)

#	Searches	Results
1	spirituality.mp.	6791
2	spiritual care.mp.	907
3	1 or 2	7157
4	nurse*.mp.	269925
5	Nursing/ or nursing.mp.	454944
6	4 or 5	557273
7	perception*.mp.	297136
8	experience*.mp.	683716
9	perceptive*.mp.	1539
10	concept*.mp.	353732
11	view*.mp.	318118
12	opinion*.mp.	76252
13	attitude*.mp.	315517
14	meaning*.mp.	76820
15	7 or 8 or 9 or 10 or 11 or 12 or 13 or 14	1813371
16	3 and 6 and 15	1274

Search history and result in PsycINFO (571 findings on 30 June 2015)

#	Searches	Results
1	spiritual care.mp.	571
2	spirituality.mp.	17748
3	1 or 2	17890
4	nursing.mp. or exp Nursing/	48134
5	nurse*.mp.	53203
6	4 or 5	78879
7	perception*.mp.	379999
8	experience*.mp.	497844
9	perspective*.mp.	214657
10	concept*.mp.	370533
11	view*.mp.	251354
12	opinion*.mp.	44491
13	attitude*.mp.	351632
14	meaning*.mp.	131623
15	7 or 8 or 9 or 10 or 11 or 12 or 13 or 14	1578911
16	3 and 6 and 15	614

The three databases, ASSIA, WEB of Science and ScienceDirect do not have search engines as do CINAHL and Medline. The index terms in the key words, which produced most results in CINAHL and MEDLINE, were used for ASSIA, WEB of Science, and ScienceDirect. The index term 'perception' produces the most result, followed by 'experience' in second, and 'meaning' third for key term 'perception or experience'.

Search history and result in WEB of Science (188 findings on 30 June 2015)

Searches	**Results**
(spiritual*) *AND* TOPIC: (nurs*) *AND* TOPIC: (perception*)	188

Search history and result in "ScienceDirect" (917 findings 30 June 2015)

Searches	**Results**
(spirituality spiritual care perception) and nursing.	917

Search history and result in "ASSIA" (226 findings on 30 June 2015)

Searches	**Results**
spiritual* AND (nursing OR nurse) AND (perception OR experience) AND (spirituality OR spiritual care)	226

Search result in December 2018

Search result in six databases: CINAHL, MEDLINE, PsycINFO, PyscARTICLES ScienceDirect, and ProQuest Nursing and Allied Health Database (ProQuest)

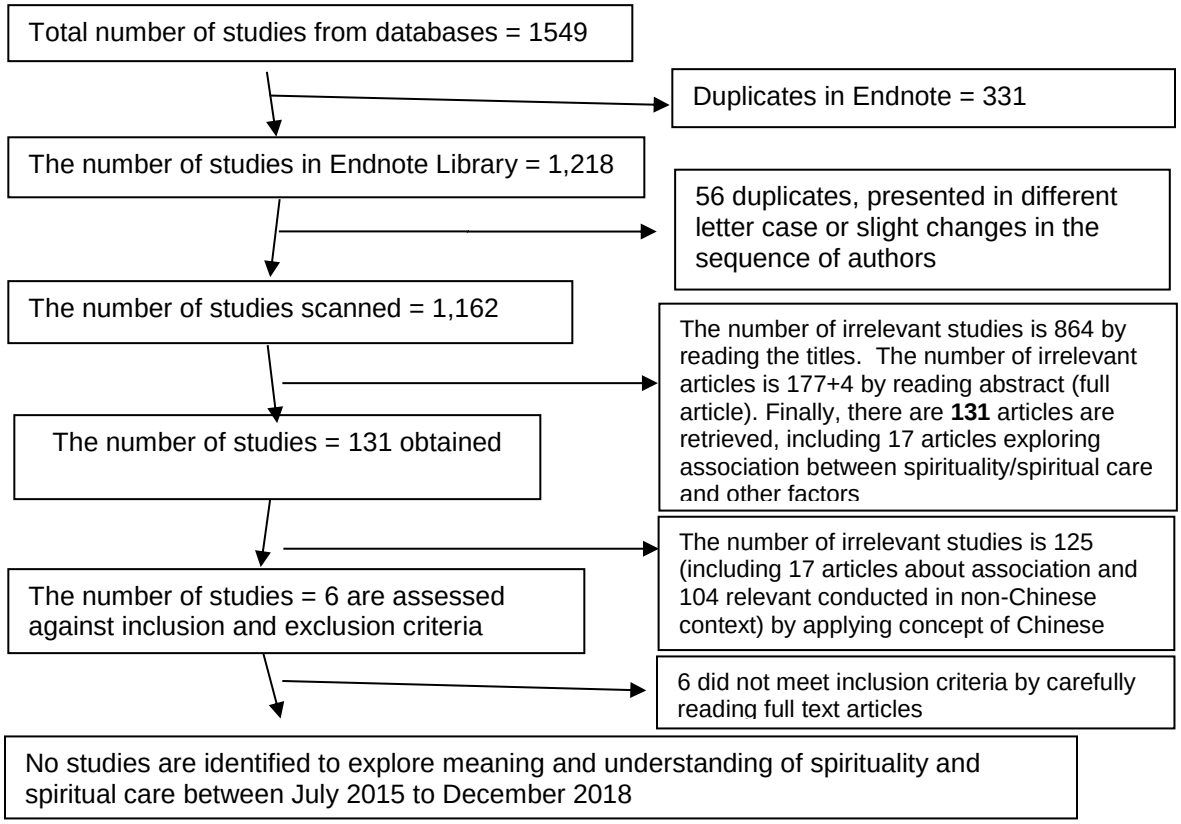


Figure Summary of the search results in Dec 2018

Search history and result in CINAHL (497 findings on 1 December 2018)

Search ID#	Search Terms	Search Options	Actions
S18	S3 AND S6 AND S15	Limiters - Published Date: 20150701-20181231 Search modes - Boolean/Phrase	**497**
S17	S3 AND S6 AND S15	Limiters - Published Date: 20150101-20181231 Search modes - Boolean/Phrase	562
S16	S3 AND S6 AND S15	Search modes - Boolean/Phrase	2,636
S15	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	Search modes - Boolean/Phrase	887,753
S14	meaning*	Search modes - Boolean/Phrase	47,202
S13	attitude*	Search modes - Boolean/Phrase	270,931
S12	opinion*	Search modes - Boolean/Phrase	33,592
S11	view*	Search modes - Boolean/Phrase	102,559
S10	concept*	Search modes - Boolean/Phrase	159,748
S9	perspective*	Search modes - Boolean/Phrase	107,319
S8	experience*	Search modes - Boolean/Phrase	338,785
S7	perception*	Search modes - Boolean/Phrase	126,985
S6	S4 OR S5	Search modes - Boolean/Phrase	808,666
S5	nurse*	Search modes - Boolean/Phrase	439,939
S4	nursing	Search modes - Boolean/Phrase	640,131
S3	S1 OR S2	Search modes - Boolean/Phrase	17,649)
S2	spirituality	Search modes - Boolean/Phrase	14,743
S1	spiritual care	Search modes - Boolean/Phrase	4,806

Search history and result in MEDLINE (466 findings on 1 December 2018)

Search ID	Search Terms	Search Options	Actions
S17	S5 AND S6 AND S15	Limiters - Date of Publication: 20150701-20181231 Search modes - Boolean/Phrase	**466**

S16	S5 AND S6 AND S15	Search modes - Boolean/Phrase	2,177
S15	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	Search modes - Boolean/Phrase	2,459,368
S14	meaning*	Search modes - Boolean/Phrase	118,297
S13	attitude*	Search modes - Boolean/Phrase	389,352
S12	opinion*	Search modes - Boolean/Phrase	(99,163)
S11	view*	Search modes - Boolean/Phrase	(436,793)
S10	concept*	Search modes - Boolean/Phrase	(492,703)
S9	perceptive*	Search modes - Boolean/Phrase	(1,982)
S8	experience*	Search modes - Boolean/Phrase	(958,036)
S7	perception*	Search modes - Boolean/Phrase	(395,154)
S6	S3 OR S4	Search modes - Boolean/Phrase	(788,415)
S5	S1 OR S2	Search modes - Boolean/Phrase	(11,056)
S4	nursing	Search modes - Boolean/Phrase	(672,083)
S3	nurse*	Search modes - Boolean/Phrase	(344,761)
S2	spiritual care	Search modes - Boolean/Phrase	(2,456)
S1	spirituality	Search modes - Boolean/Phrase	(9,865)

Search history and result in “PsycINFO” (274 findings on 1 December 2018)

	Search Terms	**Search Options**	**Actions**
S18	S5 AND S6 AND S15	Limiters - Published Date: 20150701-20181231 Search modes - Boolean/Phrase	(274)
S17	S5 AND S6 AND S15	Search modes - Boolean/Phrase	(1,446)
S16	S5 AND S6 AND S15	Limiters - Full Text Search modes - Boolean/Phrase	(152)
S15	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	Search modes - Boolean/Phrase	(1,925,374)
S14	meaning*	Search modes - Boolean/Phrase	(158,341)
S13	attitude*	Search modes - Boolean/Phrase	(531,118)
S12	opinion*	Search modes - Boolean/Phrase	(61,608)
S11	view*	Search modes - Boolean/Phrase	(294,767)
S10	concept*	Search modes - Boolean/Phrase	(462,186)
S9	perceptive*	Search modes - Boolean/Phrase	(2,697)
S8	experience*	Search modes - Boolean/Phrase	(621,601)
S7	perception*	Search modes - Boolean/Phrase	(532,198)
S6	S3 OR S4	Search modes - Boolean/Phrase	(155,602)
S5	S1 OR S2	Search modes - Boolean/Phrase	(24,304)
S4	nursing	Search modes - Boolean/Phrase	(130,699)
S3	nurse*	Search modes - Boolean/Phrase	(70,945)
S2	spiritual care	Search modes - Boolean/Phrase	(1,515)
S1	spirituality	Search modes - Boolean/Phrase	(23,766)

Search history and result in PsycARTICLES (6 findings on 1 December 2018)

	Search Terms	**Search Options**	**Actions**
S17	S3 AND S6 AND S15	Limiters - Year of Publication: 2016-2018; Published Date: 20150701-20181231 Search modes - Boolean/Phrase	**6**
S16	S3 AND S6 AND S15	Search modes - Boolean/Phrase	(13)
S15	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14	Search modes - Boolean/Phrase	(100,621)
S14	meaning*	Search modes - Boolean/Phrase	(7,598)
S13	attitude*	Search modes - Boolean/Phrase	(23,287)
S12	opinion*	Search modes - Boolean/Phrase	(2,952)
S11	view*	Search modes - Boolean/Phrase	(15,136)
S10	concept*	Search modes - Boolean/Phrase	(23,442)
S9	perceptive*	Search modes - Boolean/Phrase	(114)
S8	experience*	Search modes - Boolean/Phrase	(25,755)
S7	perception*	Search modes - Boolean/Phrase	(37,317)
S6	S4 OR S5	Search modes - Boolean/Phrase	(2,320)
S5	nurse*	Search modes - Boolean/Phrase	(1,086)
S4	nursing	Search modes - Boolean/Phrase	(1,505)
S3	S1 OR S2	Search modes - Boolean/Phrase	(1,831)
S2	spiritual care	Search modes - Boolean/Phrase	(20)
S1	spirituality	Search modes - Boolean/Phrase	(1,830)

Search history and result in ProQuest (279 findings on December 2018)

Search Terms	Applying limiters	Actions
(spirituality OR "spiritual care") AND (nurse* OR nursing) AND (meaning* OR experience* OR perception* OR attitude* OR opinion* OR view* OR concept* OR perspective*)	Limiters - Published Date: 20150701-20181231 Document Type: Article, Case study, Dissertation/Thesis, Evidence based Healthcare	279

Search history and result in ScienceDirect (27 findings on 1 December 2018)

The application of search strategy in ScienceDirect yielded 697 results, and I exported 26 citations individually into Endnote which contributes the totally citations exported to Endnote. This is due that the service of ScienceDirect provided in 2018 is different from 2015, and the currently search results cannot be together exported to Endnote library by selecting multiple citations in 'checkbox'.

Search Terms	Applying limiters	Actions
	Scanning article tiles regarding perception of spirituality and spiritual care, 27 individually exported to Endnote	**27**
(spirituality OR "spiritual care") AND (nurse OR nursing) AND (meaning OR experience OR perception OR attitude OR opinion OR view OR concept OR perspective)	Limiters - Published Date: 20150701-20181231 Document Type: Research article, Case report	697

Appendix 3.3 Characteristics of excluded studies and reasons for exclusion

From the search result in 2015

No	Author/ Study	Method	Reason for exclusion
1	(Yang and Yeh, 2012) An experience applying a spiritual care model to a first-time stroke patient [Chinese]	Qualitative case study	The focus is on the application of a spiritual care model (Chao et al., 2002), rather than the patients' perception of spirituality and spiritual care. The aspects of spirituality utilised in this study is not patients' perception but the developed concepts in Chao et al.'s (2002) study.
2	(Tiew and Drury, 2012) Singapore nursing students' perceptions and attitudes about spirituality and spiritual care in practice: a qualitative study	Qualitative, interpretative approach	Multicultural context, participants' pure Chinese backgrounds is unclear
3	(Lang et al., 2006) Patient's experiences of spiritual care: a phenomenological approach.	Qualitative, descriptive Phenomenological	Multicultural context, participants' pure Chinese backgrounds is unclear
4	(Liu, Fang and Gau, 2011) Nursing care experiences of a borderline personality patient with spiritual distress [Chinese]	Qualitative case study	Focus on application of an assessment tool rather than perception of spirituality and spiritual care
5	(Ku, Kuo and Yao, 2010) Establishing the validity of a spiritual distress scale for cancer patients hospitalized in southern Taiwan.	Quantitative design	Establish the validity of the spiritual distress scale (SDS) rather than perception of spiritual care
6	(Wong, Rew and Slaikeu, 2006) A systematic review of recent research on adolescent religiosity/spirituality and mental health	Systematic review	Report the relationships between adolescent Religiosity/Spirituality and mental health, rather than perception of spirituality
7	(Yang, Yen and Chen, 2010) Spiritual well-being: a concept analysis	A concept analysis frame work	Not an empirical study
8	(Chiu, 1996) Spirituality of women living with breast cancer in Taiwan: a phenomenological study	A phenomenological study	PhD thesis. Result was presented in 2000 journal article
9	(Lang, Hoon and Emily, 2004) An exploratory study on nurses' perception of spirituality and spiritual care from a multicultural context	Quantitative design	Multicultural context, participants' pure Chinese backgrounds is unclear
10	(Chien, 2010) Spiritual care of a terminal liver cancer patient: a nursing experience [Chinese]	Qualitative case study	The focus on application of spiritual care model in literature review rather than perception of spirituality and spiritual care
11	(Li, Lo, Liu et al., 2012)	Unclear (discussion?)	Report of caring process rather than a research

	A Nursing Experience of a Young Female Terminal Cancer Patient Suffering from Spiritual Distress [Chinese]		
12	(Wu and Lin, 2011) Exploration of clinical nurses' perceptions of spirituality and spiritual care	Quantitative design a cross-sectional	Not accessible through inter-library loan and contacting authors
13	(Wu, Liao and Yeh, 2012) Nursing student perceptions of spirituality and spiritual care	Quantitative a cross-sectional descriptive design	Not accessible through inter-library loan and contacting authors
14	(Tiew, Kwee, Creedy et al., 2013a) Hospice nurses' perspectives of spirituality	A descriptive, cross-sectional design	Participants' pure Chinese backgrounds not assured
15	(Tiew, Creedy and Chan, 2013) Student nurses' perspectives of spirituality and spiritual care	A cross-sectional survey	Participants' pure Chinese backgrounds not assured

From the search in 2018

Author/Study/Context	Method	Reason for exclusion
(Wu et al., 2015) Nursing student perceptions of spirituality and spiritual care Taiwan	Quantitative questionnaire survey	The focus is on the association between patients' spiritual care needs and nurses perceived knowledge to meet these needs. It is not about the meaning and understanding of spirituality or spiritual needs.
(Chew et al., 2016b) Acute care nurses' perceptions of spirituality and spiritual care: an exploratory study in Singapore Singapore	Quantitative questionnaire survey	Multicultural context, participants' pure Chinese backgrounds is not assured
(Kao and Lin, 2018) Spiritual care of patients with depression (Chinese) Taiwan	A discussion and reflective article	A discussion and reflective article using the existing spiritual care concepts to explain spiritual need and spiritual care. It is not a primary study.
(Xie et al., 2018) Nurse Spiritual Therapeutics Scale: Psychometric evaluation among cancer patients China	Quantitative questionnaire design	To evaluate *Nurse Spiritual Therapeutics Scale (NSTS)* rather than perception and understanding of spirituality and spiritual care
(Yang et al., 2018) Mutual support beyond suffering and mortality-spiritual care for families of terminal cancer patients (Chinese) Taiwan	A discussion and reflective article	The description of the approaches meeting patients' spiritual need. It is not a primary investigation to explore the meaning of spirituality/spiritual care/spiritual need.
(Zhang et al., 2018) Spiritual perspectives of emergency medicine doctors and nurses in caring for end-of-life patients: A mixed-method study Singapore	A mixed-method design by using questionnaire and interview	Multicultural context, participants' pure Chinese backgrounds is not assured

Appendix 3.4 Appraisal of the studies

CASP appraisal tool for identified qualitative studies

No.	Author and year	1. Was there a clear statement of the aims?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	Remark
1	(Mok et al., 2010)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Very good
2	(Hsiao et al., 2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes.	Yes	Yes	Yes	Good
3	(Yang et al., 2012)	Yes	Yes	Yes	Can't tell	Yes	Yes observer	Yes	Yes	Yes.	Yes	Good
4	(Chio et al., 2008)	Yes	Yes	Yes	*Yes*	Yes	Can't tell	Yes	Yes	Yes	Yes	Good
5	(Shih et al., 2009)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Good
6	(Wong and Yau, 2010)	Yes	Yes	Can't tell	Yes	Yes.	No	Yes	Can't tell	Yes	Yes	Low quality
7	(Chiu, 2001)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Excellent
8	(Chao et al., 2002)	Yes	Yes	Yes	Yes	Yes	Yes.	No	Yes	Yes	Yes	Good
9	(Chiu, 2000)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Very good
10	(Sum and Leung, 2013)	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Can't Tell	Weak
11	(Lin et al., 2012)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Good

NICE appraisal tool for identified quantitative studies

++: clear in minimise the risk +: answer to the checklist is not clear or there is potential bias -: bias may persist
NR: not report NA: not applicable

No.	Author	1: Population			2. Method of selection of exposure (or comparison) group NA					3. Outcomes++					4. Analyses				5. Summary		Remark
		1.1 Is the source population or source area well described?	**1.2 Is the eligible population or area representative of the source population**	**1.3 Do the selected participants or areas represent the eligible population or area?**	**2.1 Selection of exposure (and comparison) group. How was selection bias minimised?**	**2.2 Was the selection of explanatory variables based on a sound theoretical basis?**	**2.3 Was the contamination acceptably low?**	**2.4 How well were likely confounding factors identified and controlled?**	**2.5 Is the setting applicable to the UK?**	**3.1 Were the outcome measures and procedures reliable?**	**3.2 Were the outcome measurements complete?**	**3.3 Were all the important outcomes assessed?**	**3.4 Was there a similar follow-up time in exposure and comparison groups?**	**3.5 Was follow-up time meaningful?**	**4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?**	**4.2 Were multiple explanatory variables considered in the analyses?**	**4.3 Were the analytical methods appropriate?**	**4.4 Was the precision of association given or calculable? Is association meaningful?**	**5.1 Are the study results internally valid (i.e. unbiased)?**	**5.2 Are the findings generalisable to the source population (i.e. externally valid)?**	
12		NR			NA					NA					++				NR		Weak
12	(Chan et al., 2006)	+	NR	++	NA	NA	NA	NA		++	++	++	NA	NA	NR	++	++	++	++	NR		
13		+			NA					NA					++				NR		Weak
13	(Chan, 2010)	+	NR	++	NA	NA	NA	NA	NR	++	++	NR	NA	NA	++	++	++	++	++	NR	
14		++			NA					NA					++				++		Weak
14	(Wong et al., 2008)	++	++	++	NA	NA	NA	NA	NR	++	++	NR	NA	NA	NR	++	++	++	++	++	
15		NR			NA					NA					++				++		Weak

15	(Chung et al., 2007)	NR	NR	NR	NA	NA	NA	NA	NR	++	++	++	NA	NA	++ Reported. sample size insufficient	++	++	++	++	++ Not generalisable	
16		+			NA					NA					++				NR		Weak
16	(Yang, 2006)	+	NR	NR	NA	NA	NA	NA	NR	++	++	++	NA	NA	NR	++	++	++	++	NR	
17		+			NA					NA					++				NR		Weak
17	(Yang and Mao, 2007)	+	NR	NR	NA	NA	NA	NA	NR.	++	++	++	NA	NA	NR	++	++	++	++	NR	
18		+			NA					NA					++				NR		Weak
18	(Yang and Wu, 2009)	+	NR	NR	NA	NA	NA	NA	NR	++	++		NA	NA	NR	++	++	++	++	NR	

Appendix 3.5 JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer _____ Date _____
Author _____ Year _____
Journal _____ Record Number _____

Methodology	
Method	
Phenomenon of interest	
Setting	
Geographical	
Cultural	
Participants	
Data Analysis	
Author's conclusion	
Reviewer's comments	

JBI Extraction of Findings

Finding	Illustration from the Study (Page Number)	Level of Credibility

UE – unequivocal, C – credible, US - unsupported

Note: Each finding was allocated a level of 'credibility' based on the researcher's perception of the degree of support each illustration offers for the specific finding it is associated with (The Joanna Briggs Institute (JBI), 2014a)

Unequivocal (findings accompanied by an illustration that is beyond reasonable doubt and therefore not open to challenge)

Credible (findings accompanied by an illustration lacking clear association with it and therefore open to challenge)

Unsupported (findings not supported by data).

Appendix 3.6 Findings of the literature review

F = findings, number = sequence of an extracted finding, bold findings are referred to in the discussion

Theme (Level 3)	Category (Level 2)	Sub-category	Findings (themes, sub-themes and main points extracted from the included studies) (Level 1)
Meaning of spirituality	1. Characteristics of spirituality	Abstract complicated personal	**F110 Spirituality is an abstract state which is difficult to articulate** **F093 They pointed out that spirituality is complicated** **F094 It is a part of integrity and related to faith** F002 A unique personal belief and experience
	2. Internal force	1. Expression of internal forces	F053 Spirituality and healing are intimately related and continue through life F074 Inspiration from nature: spirituality is the resonance of the marvellous beauty of nature F075 Creativity: spirituality is conceiving imaginatively F100 Happy manifestation: healthy spirituality is happy manifestation F104 Resilience: healthy spirit **F109 Spirituality is a true and existing spiritual power** F111 An expanding transformation like a ripple
		2. Thought	F001 Integration of mind and spirit F075 Creativity: spirituality is conceiving imaginatively F076 Faithfulness: spirituality is keeping the trust dependably F078 Gratitude: spirituality is giving thanks and embracing grace F092 Frequently used words related to the mind such as thoughts and feelings to describe spirituality, and equated the mind with spirituality F094 It is a part of integrity and related to faith **F097 It is the source of wisdom** F099 Positive and optimistic attitude: healthy spirituality is a positive and optimistic attitude F116 Mixture of feelings and rationality
		3. Inner being	**F091 Nursing students described spirituality as a person's inner spiritual world** F095 The function of spirituality is that people can get support from it F097 It is the source of wisdom F111 An expanding transformation like ripples
		4. Functioning of inner force	**F026 Sources of support** **F090 Healing experience** F095 The function of spirituality is that people can get support from it F096 Spirituality influences people's behaviour F097 It is the source of wisdom F111 An expanding transformation like ripples F112 A comforting and healing power
	3.Connection	1. Expression that spirituality is a connection	**F101 Harmony: healthy spirituality is harmony** F073 Reconciliation: spirituality is to forgive and to be forgiven. F070 Wholeness: a human being is full of contradictions but still in wholeness

			F056 Spiritual care enhances communication F050 Spirituality as connectedness F005 Receiving and giving love in relationships and connectedness
		2. Connection with other	F036 Being empowered through encouragement from family members, friends and/or cancer patients **F063 Family closeness – spiritual resource family closeness**
			F005 Receiving and giving love in relationships and connectedness F014 Seeking others love and caring for others F023 The struggling relationship and attitude between psychiatric patients and society F036 Being empowered through encouragement from family members, friends and/or cancer patients F039 Being self-transcendent through helping other cancer patients F085 Relationship with self, others, God or deity or *T'ien* (heaven 天) F098 Spirituality is interpersonal connection F114 Helping others and enhancing self
			F006 Having faith in God or a higher power F016 Follow God's or Heaven's will F042 Sense of being protected through practising religion F085 Relationship with self, others, God or deity or *T'ien* (heaven 天) F086 Power: empowered by a higher being
			F003 Harmony with self and nature **F074 Inspiration from nature: spirituality is the resonance of the marvellous beauty of nature**
			F051 Spirituality enables people to be in touch with the mystery and meaning they encounter along their life's journey
		3. Connection with self	F003 Harmony with self and nature F027 The self as a resource F085 Relationship with self, others, God or deity or *T'ien* (heaven 天) F114 Helping others and enhancing self
			F005 Receiving and giving love in relationships and connectedness **F007 Being a good person** F028 Changing thoughts and thanksgiving F039 Being self-transcendent through helping other cancer patients F071 Inner peace: spirituality is negotiating conflicts for self-reconciliation. F072 Love: spirituality is a caring relationship but not an over-attachment to others F081 Appreciation of life, people, and beloved things F102 Being kind: healthy spirituality is being kind F114 Helping others and enhancing self **F115 Besides being responsible, being kind**
			F009 Knowing the truth and fostering hope for survival **F010 Encouraging oneself** F013 Maintaining one's dignity F025 Revealing the self or proving self-efficacy F028 Changing thoughts and thanksgiving F038 Gaining positive view of life's meaning through searching for religious and other explanations

			F042 Sense of being protected through practising religion F046 Passing without regret F080 Taking full responsibility F088 Liberation F089 Opening life and death: opening attitudes to life and death F113 Being competent and responsible F117 Withdraw feelings, transforming the mood and facing reality
			F004 Letting go F015 **Offering forgiveness** F037 Feeling released through patients practising beliefs of letting go and living in the moment F073 Reconciliation: spirituality is to forgive and to be forgiven.
			F008 Having a sense of peace: effect F009 Knowing the truth and fostering hope for survival **F012 Learning the meaning of life and fulfilling it** F017 Making one's living will F018 Reaching a destination in the afterlife F019 Dying without physical pain F042 Sense of being protected through practising religion F043 The need to maintain physical and spiritual integrity F045 The need for a final resting place for the body F046 Passing without regret F047 Ascertaining a sustained being in the world F048 Searching for belonging in the future world by attainment F052 Spirituality is meaning and purpose in life F069 Self-identity: spirituality is the discovery of the authentic self F077 Hope: spirituality is claiming possibilities **F082 Purpose and meaning in life** F103 Having purpose and hope, healthy spirituality is having purpose and hope
			F009 Knowing the truth and fostering hope for survival F039 **Being self-transcendent through helping other cancer patients** F045 The need for a final resting place for the body F088 Liberation F089 Opening life and death: opening attitudes to life and death
	4. Suffering	--	F020 Taiwanese or Chinese ideology: using Taiwanese or Chinese ideology to explain significant events in life **F021 Limited autonomy, self-actualisation and dignity: limited autonomy, self-actualisation and dignity leads to a sense of powerlessness** F022 Disconnection or estrangement from the family F023 The struggling relationship and attitudes between psychiatric patients and society F024 The end of the road, end of life or hope and my future F029 Feeling a fear of death F030 Feeling sad and hopeless because of disability problems **F031 Feeling distressed because of physical pain** F032 Sense of guilt for being the family burden F033 Pessimistic thoughts about wanting to die

			F034 Self-blame for doing things wrong F035 Feeling sad and hopeless because of lack of support from some family member(s) or friends **F036 Being empowered through encouragement from family members, friends, and/or cancer patients** F037 Feeling released through patients practising beliefs of letting go and living in the moment **F038 Gaining positive view of life's meaning through searching for religious and other explanations)** F039 Being self-transcendent through helping other cancer patients F040 Passive attitudes towards life's meanings F041 Lack of support **F044 Need for companionship linked to a struggle with embarrassment and vulnerability** F079 Living with encounter **F087 Suffering**
	5. Traditional Chinese cultural values	---	**F011 Seeking complementary alternative therapy and religious help** **F020 Taiwanese or Chinese ideology: using Taiwanese or Chinese ideology to explain significant events in life** F034 Self-blame for doing things wrong F064Traditional Chinese cultural values: spiritual resource **-** traditional Chinese cultural values **F066 Spiritual resource: alternative therapies - ba guo lian jun** F068 Spiritual resource: Chinese support group
	6. Religion	---	**F006: Having faith in God/higher power** F011 Seeking complementary alternative therapy and religious help **F016 Follow God's or Heaven's will** F042 Sense of being protected through practising religion F049 Spirituality is related to religiosity **F084 Religion** F094 It is a part of integrity and related to faith

Implementation of spiritual care	1. Ways of spiritual care		**F011 Seeking complementary alternative therapy and religious help** F065 Spiritual resource: religion **F066 Spiritual resource: alternative therapies - ba guo lian jun** **F067 Spiritual resource: art, prose and literature** **F083 Finding alternative way of life: restructuring life perspective** **F105 Physical method: achieve healthy spirituality through physical method** **F106 Psychological method: achieve healthy spirituality through psychological method** **F107 Social method: achieve healthy spirituality through social method** **F108 Spiritual method: achieve healthy spirituality through spiritual method**
	2. Barriers and benefits of spiritual care	Barriers	**F058 Difficulties in applying spiritual care: spiritual care increases workload** **F059 Worries about insufficient knowledge and skills** **F062 Cultural factors inhibit spiritual care** **F061 Insufficient workforce and resources** **F060 Lack of managerial support**
		Benefits	**F054 Benefits of applying spiritual care: spiritual care improves physical comfort** **F055 Spiritual care improves psychosocial comfort** **F056 Spiritual care enhances communication** **F057 Spiritual care enhances nurses' autonomy**
	3. Factors influencing spirituality and spiritual care *(quantitative synthesis)*	Demographic factors	**F118 Demographic information and cluster characteristics** **F121 Demographic characteristics** **F122 Factors associated with nurses' level of practising spiritual care** **F122a Demographic information** F123 Participant characteristics F124 Relationship of nurses' spirituality to their understanding and practice of spiritual care **F125 Relationship of demographic variables to spirituality, understanding and practice of spiritual care** F126 Factors contributing to understanding and practice of spiritual care **F128 The effect of demographic characteristics on spiritual intelligence in nurses** F129 The mode of nurses' spiritual intelligence and related factors **F130 The profile of nurses' spiritual intelligence** F131 Relationships between individual characteristics and spiritual intelligence **F132 Effect of religions on spiritual intelligence** F133 Demographics **F135 Nurses' spiritual intelligence in relation to demographics**
		Other factors	F119 There was a significant difference in the nurses' perceptions between the three clusters for all statements **F120 Nurses' perceptions were significantly positively correlated with practices** **F122** Factors associated with nurses' levels of practising spiritual care **F126 Factors contributing to understanding and practice of spiritual care** F127 Nurses' spiritual intelligence profile F129 The mode of nurses' spiritual intelligence and related factors **F130 The profile of nurses' spiritual intelligence** F134 Profile of nurses' spiritual intelligence **F135a Factors associated with nurses' spiritual intelligence**

Appendix 4.1 Ethical approval

Version 1

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher Name:	**Yanping Niu**
Title of Study:	The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in four regions in England: a grounded theory study
Status of approval:	**Approved subject to amendments**

Thank you for submitting your application which the panel has now considered. The panel's recommendation is that your application is approved subject to amendments. See below for details.

Detail required:

- An (approximate) anticipated duration of the interviews should be stated. This detail should also be included on the participant information sheets.
- Terminology associated with grounded theory is listed, but in places it would be reassuring if the practical implications of the approach were acknowledged briefly. For example, what does theoretical sampling mean in practice and how will it be conducted? In addition, how will theoretical saturation be ascertained?
- The English versions of the supporting materials (cover letters, information sheets) require proofing throughout.
- The declaration of confidentiality for translators and interpreters requires consideration. The phraseology should be adjusted. In addition, reference is made to disciplinary rules and summary dismissal: is this not outside the realm of university control? The ethical review form could state that appropriate confidentiality agreements will be sought from translation services. If an additional university form is required, then the present draft requires reworking.
- The age-ranges on the demographic form could be adjusted to be more balanced. 'Educational qualification', on the same form, does not include school-based qualifications. The section on employment is also quite difficult to follow.
- Although sample over 18, is there potential of contributions of/from non-Chinese speakers, to be misinterpreted or misrepresented How vulnerable are the participants as a group?

Action now needed:

Please revise your proposal to take account of the feedback provided by the ethics committee which is listed above.

You should arrange to meet with your supervisor as soon as possible to discuss the revision of your proposal. When you have addressed all the comments, please **email the**

revised form, and a **covering letter** indicating how you have addressed the points raised to [redacted]

Please make sure that **all appropriate signatures** (Researcher Signature and Supervisor Signature) are included on the amended Ethics Form.

You are reminded that you cannot commence the implementation phase of your study until you have received a written response from the Faculty Panel confirming approval.

[redacted]

Date: 9th April 2015

Deputy Chair of the Faculty of Health Sciences Ethics Panel

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Yanping Niu
Title of Study:	Spirituality and Spiritual care among people from Chinese backgrounds in England
Award Pathway:	PhD/ MPhil
Status of approval:	Approved

Thank you for addressing the committee comments. The following are things for you to think about, but are not further requirements of the ethical approval process:

1) With respect to the confidentiality clause: would it be worth adding in the requirements that they return all recordings to you, and that they undertake to destroy any copies they have in audio or written format once you have confirmed safe receipt of the original recordings and the translated interviews. (you want to ensure they are not keeping any of your data).
2) You changed the question about employment to 'What do you do?' – this is now so open, it is not clear that it relates to employment. You could simply ask:
    a. Do you have a paid job? Please describe
    b. Do you do voluntary work? Please describe

Action now needed:

Your project proposal has been approved by the Faculty's Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

[redacted]

Chair of the Faculty of Health Sciences Ethics Panel

Date: 8th October 2015

Ethical approval for recruiting participants through friend's recommendation

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	**Yanping Niu**
Title of Study:	*The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in three regions in England: a grounded theory investigation.*
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of a minor amendment to your study to enable the inclusion of a snowball sampling process:

1) The participant who already took part in the study identifies a new contact who they think would be willing to take part in the study.
2) The principal investigator gives the participant a pack containing the cover letter and information sheet. The participant then gives this to the new contact.
3) the new contact then contacts the investigator by phone or email. The investigator explains the study in detail to ask their permission to participate in an interview. The consent form will be signed prior to the interview.

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Faculty's Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

[redacted]

Date: 16/8/16

Chair of the Faculty of Health Sciences Ethics Panel

Appendix 4.2 Letter for Chinese community centres

Date

(Chinese centre address)

……....

Yanping Niu
Room B155
School of Nursing and Midwifery
Faculty of Health Sciences
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD
Mobile: +44 (0)7438859806
E-mail: yanping.niu@research.staffs.ac.uk

Dear…… (name of administrator in the centres)

My name is Yanping NIU; I am a Chinese PhD student from the Faculty of Health Sciences, Staffordshire University. Currently, I am conducting a research study that explores perceptions of spirituality and spiritual care among people from Chinese backgrounds in England.

I am hoping to collect data among people from Chinese backgrounds between May 2015 and January 2016. Therefore, I am writing this letter asking for your help with identifying potential participants for this research. I plan to collect data by using face to face interviews with each participant.

Prior to data collection, I would be willing to present my study to you and/or your clients at your centre where I could introduce myself, talk about my research and distribute covering letters, information sheets as a way to potentially recruit participants. Alternatively, I could leave the information sheets with you, so that people from Chinese backgrounds can read and make a decision about whether to participate.

If you have any questions concerning the research study, I am prepared to visit you to discuss the study further. If you have any questions then I can be contacted on +44(0)743885 9806 or email me at yanping.niu@research.staffs.ac.uk

Alternatively, you are invited to contact my supervisors:

[redacted]

I would greatly appreciate your help, and look forward to receiving your response.

Yours sincerely,

Yanping NIU

PhD student in Staffordshire University
Mobile: 07438859806
Email: yanping.niu@research.staffs.ac.uk

Appendix 4.3 Supporting letter from Chinese community centers

[redacted]

Yanping Niu
PHD Student
Room B155
School of Nursing and Midwifery
Faculty of Health Science
Staffordshire University
Stafford
ST18 0AD

24th April 2015

Dear Yanping

I write to inform you that we will be happy to assist with your PHD research on perception and spirituality and spiritual care for the people from Chinese backgrounds in UK. Our residents in [redacted]

We agree to assist you with recruitment, participants and interviews in regards to the PHD research and provide Chinese dialects interpretation when necessary.

I look forward to hear from you soon.

Yours sincerely

[redacted]

Yanping NIU

PhD student
Room B155
School of Nursing and Midwifery
Faculty of Health Sciences
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD
Mobile: +44 (0)7438859806
E-mail: yanping.niu@research.staffs.ac.uk

May 13th, 2015

TO WHOM IT MAY CONCERN

Dear Yanping,

[redacted] agreed to assist you in your interviews with regard to the researches on your PhD thesis at the Staffordshire University. Please do let us know the further arrangements in due course.

With best regards,

[redacted]

Yanping NIU
B128, PhD student room
Brindley Building
School of Nursing and Midwifery
Faculty of Health Sciences
Staffordshire University
Leek Road
Stafford ST18 0AD

2/9/2015

TO WHOM IT MAY CONCERN

Re: Yanping NIU PhD research project at the Staffordshire University.

Having discussed with Yanping NIU this morning about her research project, I would be pleased to support her proposal research 'Exploring perception of spirituality and spiritual care among people from Chinese backgrounds in England'. [redacted] will assist her to recruit participants and interviews with regard to the researches on her PhD thesis.

Please don't hesitate to contact me if you require any further information about [redacted] Projects and let us know the further arrangements in due course.

Yours faithfully

[redacted]

[redacted]

Yanping NIU

PhD student
Room B155
School of Nursing and Midwifery
Faculty of Health Sciences
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD
Mobile: +44 (0)7438859806
E-mail: yanping.niu@research.staffs.ac.uk

20 April 2015

TO WOM IT MAY CONCERN

Dear Yanping,

[redacted] has agreed to assist you in your interviews with regard to the researches on your PhD thesis at the Staffordshire University. Please do let us know the further arrangements in due course.

With best regards,

[redacted]

[redacted]

Appendix 4.4 Cover letter for potential participants

Yanping Niu
Room B155
School of Nursing and Midwifery
Faculty of Health Sciences
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD
Mobile: +44 (0)7438859806
E-mail: yanping.niu@research.staffs.ac.uk

Date:

Dear Sir or Madam,

Meaning of Spirituality and Spiritual Care – Participant Interview

My name is Yanping NIU; I am a Chinese PhD student enrolled at the Faculty of Health Sciences, Staffordshire University. Currently, I am conducting a research study exploring perceptions of spirituality and spiritual care among people from Chinese backgrounds in England. I am writing to invite you to take part in my research study.

Spiritual care is considered by the International Council of Nursing as one of the four domains in providing holistic care. But there has been no research conducted about these areas involving people form Chinese backgrounds. The main reason for undertaking this study is to explore how the concept of spirituality and spiritual care are perceived among people from Chinese backgrounds living in the UK. The result of this study will provide some insight to improve spiritual care for this group of people.

If you choose to participant, you will be agreeing to take part in a one to one interview with the researcher which we hope you will find both interesting and enjoyable. Full details of the research can be found in the accompanying information sheet.

Participation in this research is entirely voluntary and participants are free to refuse to take part or withdraw at any time. All information provided by participants will be kept confidential and participants will not be mentioned by name in any reports or publications arising from this investigation.

I hope you will consider participating in this study. If you have any question concerning the research. I can be contacted on +44 (0) 743 885 9806 or email me at yanping.niu@research.staffs.ac.uk

Alternatively, you are invited to contact my supervisors:

[redacted]

Yours Sincerely,

Yanping NIU

PhD Student in Staffordshire University
Mobile: (+44 (0)7438859806
Email: yanping.niu@research.staffs.ac.uk

Enc. Information sheet

Cover Letter to participants for interview in traditional Chinese Script

Yanping Niu
Room B155
School of Nursing and Midwifery
Faculty of Health Sciences
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD
Mobile（手機）: +44 (0)7438859806
E-mail （郵箱）: yanping.niu@research.staffs.ac.uk

親愛的女士或先生，

我叫牛艷平， 是 Staffordshire 大學健康學院的一名中國籍的PhD學生。目前，我正在進行我的博士研究項目，題目為 —探讨居住在英格蘭地區有中国背景的群众對精神/靈性和精神/靈性護理的看法。

精神/靈性護理是提供全人護理的四大範疇之一，這是國際護士理事會提出的。但是目前對於居住在英格蘭地區的有中国背景的民众的精神/靈性和精神/靈性護理的研究卻沒有。這項研究的主要原因是了解對於居住在英格蘭地區的有中国背景的民众，什麼是精神和精神護理。研究結果將會為提高他們的護理質量提供深刻的看法。

如果您選擇參加，這意味您將同意被研究人员面對面採訪。我希望您會對此很感興趣。研究的全部細節可以在信息單中找到。

您參加這項研究是完全自願的，您任何時候都可以拒絕或者退出研究。您提供的信息將會被嚴密保存。 在任何與此相關的報導和出版物中，您的姓名都不會被提及。

我真誠的希望您能參加這項研究。 如果您對此有疑問，我可以拜訪您並對此做進一步討論。 我的手機號碼是 +44 (0) 743 885 9806 ， 郵箱是 yanping.niu@research.staffs.ac.uk

另外，您也可以聯繫我的導師。 他們的聯繫方式是：

[redacted]

祝您一切順利！

此致，

敬禮

牛艷平

Staffordshire University博士研究生

手機: (+44 (0)7438859806

郵箱: yanping.niu@research.staffs.ac.uk

2015年　月　日

附：信息單

Cover Letter to participants for interview in simplified Chinese Script

Yanping Niu
Room B155
School of Nursing and Midwifery
Faculty of Health Sciences
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD
Mobile（手机）: +44 (0)7438859806
E-mail（邮箱）: yanping.niu@research.staffs.ac.uk

亲爱的女士或先生，

我叫牛艳平，是斯塔福德郡大学健康学院的一名中国籍的博士学生。目前，我正在进行我的博士研究项目，题目为 - 探讨居住在英格兰地区有中国背景的群众对精神和精神护理的看法。

精神护理是提供全人护理的四大范畴之一，这是国际护士理事会提出的。但是目前对于居住在英格兰地区的有中国背景群众的精神和精神护理的研究却没有。进行这项研究的主要原因是了解对于居住在格兰地区的有中国背景的群众，什么是精神和精神护理。研究结果将会为提高他们的护理质量提供深刻的看法。

如果您选择参加，这意味您将同意被研究人员面对面采访。我希望您会此很感兴趣。研究的全部细节可以在信息单中找到。

您参加这项研究完全是自愿的，您任何时候都可以拒绝或者退出研究。您提供的信息将会被严密保存。在任何与此相关的报导和出版物中，您的姓名都不会被提及。

我真诚的希望您能参加这项研究。如果您对此有疑问，我可以拜访您并对此做进一步解释。我的手机号码是+44 (0) 743 885 9806， 邮箱是 yanping.niu@research.staffs.ac.uk 。 另外，您也可以联系我的导师。他们的联系方式是：

[redacted]

祝您一切顺利！

此致，

敬礼

牛艳平

Staffordshire University博士研究生

手机: (+44 (0)7438859806

邮箱: yanping.niu@research.staffs.ac.uk

2015年 月 日

附：信息单

Appendix 4.5 Information sheet

INFORMATION SHEET

Dear Sir/ Madam,

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being conducted and what would be involved of you. Please take time to read the following information carefully.

Study Title
The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in four regions in England: a grounded theory investigation

1. What is the purpose of the study?
The purpose of this study is to gain some knowledge about how people from Chinese backgrounds in four regions in England understand spirituality. This knowledge may be necessary to improve quality of life for people from Chinese backgrounds in England.

2. Do I have to take part?
No, it is up to you to decide. Participation in this research is entirely voluntary and if you take part, you can withdraw at any stage, or ask for the interview to be stopped. If you chose to withdraw consent you may request that all your data you have provided relating to this research to be destroyed.

3. What are the risks and benefit to take part in the study?
If you choose to take part, we expect that you will find the experience both interesting and enjoyable. It is possible that you may find some of the questions somewhat sensitive. However we have ensured that involvement in this study is safe and your wishes are respected throughout. The data and time to conduct the interview will be arranged to suit your own needs and to cause a minimum of inconvenience.

4. How long the interview will last?
It is expected that the interview will last approximately one hour.

5. What will happen to me if I take part?
You have been provided with this information sheet to help you decide whether or not you wish to take part in this study. If you would like to be involved, please email or telephone the researcher (details can be found in the accompanying letter). You will then be contacted to ensure you have understood what is involved, and arrange a time and location you prefer for the interview to be conducted.

The interview will begin with a reminder that you may withdraw consent or chose not to answer particular questions. The researcher will check that you have understood the contents of this information sheet and will gain your consent to record the interview.

During the interview, the researcher will ask questions concerning your perceptions and experience of spirituality and spiritual care. Please tell us if you find any of the questions invasive or unhelpful. You may ask for the recording to be stopped or paused at any time. At the end of the interview we will check whether you have any concerns or would like any additional support.

After the interview, you may be contacted to see if you would like a copy of the interview transcript to be sent to you, so that you can confirm and amend the transcript if required. Any anomalies can be revised until your agreement is reached.

6. Will my taking part in this study be kept confidential, and how do you deal with data collected from me?
Yes, your name and your address will not be mentioned during interview, meaning these will not be recorded. No one but researcher will know your identity. All the details that you supply will be securely held by Staffordshire University and will be treated confidentially in accordance with the Data Protection Act 1998 for the purposes outlined in the study 'The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in four regions in England: a grounded theory investigation'. Data will not be disclosed to external organisations. The University will only keep your data until 10 ten years following the conferment of the award by the award board in line with the University Code of Practice. It will be disposed of securely after this time.

7. Will my information be disclosed in your publication?
No information will be published that could lead to the identification of any individual. We will not publish any quotes that might reveal the identity of the participant. If we quote something that you have said, the quote would be followed by your participant number used for the research. Neither name nor initials will be used.

8. Could I get a copy of your finding?

Yes. If you would like to receive a summary of the findings when the research is complete, you will be asked to provide a forwarding address so that we can send it to you. Your address will not be used for any other purposes. Any address you provided for this purpose will be destroyed immediately after the summary has been sent.

9. Do I get paid for the participation?
You will not receive any payment for taking part in this research nor will the researcher make any direct profit from it.

10. What if there is a problem?
If you have concerns about any aspect of the way you have been approached or treated during the course of this study you may wish to contact the Chair of the

[redacted]r contact is:

Professor Dr. [redacted]

11. Does your research require ethics approval?

This research has been reviewed and approved by the Faculty of Health Sciences Research Ethics Committee Staffordshire University.

Yanping NIU
PhD student in Staffordshire University

INFORMATION SHEET (INTERVIEW) IN TRADITIONAL CHINESE SCRIPT

参加者信息单

親愛的女士或先生，

我真誠地邀請您參加這項研究。在您決定之前，您需要了解我們為什麼要進行這項研究以及您參與的注意事項。 請您花些時間仔細閱讀一下信息，然後決定是否參加這項研究。

題目：探讨居住在英格蘭四個地區有中国背景的群众對精神/靈性和精神/靈性護理的看法。

1.這項研究目的是什麼？

這項研究的主要目的是了解對居住在英格蘭四個地區的有中国背景的民众，什麼是精神/靈性和精神/靈性護理。這些知識對於提高他們的護理質量會很有必要。

2.我必須參加嗎？

不是，由您決定。您參加這項研究是完全自願的。如果參加這項研究，您在任何時候，任何階段都可以拒絕或者退出。您也可以隨時要求停止採訪。如果您決定退出，您可以要求您所提供的所有資料被銷毀。

3.參加這項研究的利弊是什麼？

如果參加這項研究，我們期盼您會發現這是一件有趣、值得享受的事。您有可能發現有些問題會很敏感。但無論怎樣，我們保證您參加這項研究是安全的，您的期望在整個研究過程中都受到尊重。為了最大限度地減少給您帶來的不便，採訪日期和時間將會被安排在最合適您的時候進行。

4. 訪談會持續多久？

據預測， 訪談會持續大約一小時。

5.如果我參加的話會發生什麼？

給您的這個信息單是幫助您決定您是否希望參加這項研究。如果您決定介入，請您給研究人員發郵發件或者打電話（詳情可見介紹信）告知。之後，研究人員會聯繫您以保證您明白參加這項研究的事項，並和您約定您認可的時間、地點進行採訪。

採訪開始時，研究人員會提醒您隨時可以退出採訪，也會提醒您可以對研究人員提出的問題不作回答。研究人員會核查您對信息單的內容的了解情況，並且徵求您的同意，對採訪錄音。

採訪期間，研究人員會提出一些問題，這些問題是關於精神和精神護理的看法和經歷的。如果您感覺有冒犯或者沒與幫助的問題，請您一定告訴我們。您可以要求暫停或者停止錄音。在錄音結束時，我們會核實您是否有什麼擔心的問題，或者您有沒有其他的需要。

訪談結束後，我們可能會聯繫看您是否需要一份有關您的採訪記錄以便您澄清和修改一些有必要修改的內容。我們會盡量修改不恰當處，直到您滿意。

6.我參加這項研究會被保密嗎？

是的， 採訪過程中，你的名字和地址經不會被提及以防被錄音。研究者由此會知道您的身份， 但是不會洩露給任何人。您提供的所有的數據將會被Staffordshire大學按照1988年數據保存法案嚴密保存，目的是保密研究項目-探讨居住在英格蘭地

區有中国背景的群众對精神和精神護理的看法。這些數據將不會透漏給外部機構。依據大學實踐法案，在研究項目由頒獎理事會授獎後10年之內，大學會保存這些數據，此後被安全銷毀。

7.我的信息會在你的出版物裡被揭漏嗎？

可能導致任何個人的身份暴露的信息不會在發表文章中出現。如果我們引用了您所說的話，引用後邊跟着的是參加者的編號。您的姓和名的首寫字母不會被用。

8.我可以得到你的研究結果的複印件嗎？

是的。 當研究結束後，如果您想要一份研究結果的複印件，我們會索要您的更新地址以便結果能送到您手中。您提供的地址不會被用於任何目的。 複印件送出之後，地址信息會被馬上銷毀。

9.我參加這項研究會被付錢嗎？

您參加這項研究不會被付酬金，研究者也不會從中牟取直接利益。

10.如果有問題怎麼辦？

在這項研究中，如果您擔心您被接近和對待的方式有問題的話，你可以聯繫[redacted]教授。 她的聯繫方式是：

Professor Dr. [redacted]

11.你的研究徵求倫理同意了嗎？

這項研究已經通過Staffordshire 大學倫理委員會的審批和批准。

牛艷平
Staffordshire大學PhD學生

STAFFORDSHIRE UNIVERSITY

INFORMATION SHEET (INTERVIEW) IN SIMPLIFIED CHINESE SCRIPT

参加者信息单

亲爱的女士或先生，

我真诚地邀请您参加这项研究。在您决定之前，您需要了解我们为什么要进行这项研究以及您参与的注意事项。请您花时间仔细阅读一下信息，然后决定是否参加这项研究。

题目：探讨居住在英格兰四个地区有中国背景的群众对精神/灵性和精神/灵性护理的看法

1.这项研究的目的是什么？

这项研究的主要目的是了解对于居住在英格兰四个地区有中国背景的群众，什么是精神和精神护理。这些知识对于提高他们的护理质量会很有必要。

2.我必须参加吗？

不是，由您决定。您参加这项研究是完全自愿的。如果参加这项研究，您在任何时候，任何阶段都可以拒绝或者退出。您也可以随时要求停止采访。如果您决定退出，您可以要求您所提供的所有资料被销毁。

3.参加这项研究的利弊是什么？

如果参加这项研究，我们期盼您会发现这是一件有趣、值得享受的事。您有可能发现有些问题会很敏感。但无论怎样，我们保证您参加这项研究是安全的。您的期望在整个研究过程中都会受會到尊重。为了最大限度地减少给您带来的不便，采访日期和時間将会被安排在最合适您的时候进行。

4. 访谈会持续多久？

据预测， 访谈会持续大约一小时。

5.如果我参加的话会发生什么？

给您的这个信息单是帮助您决定您是否希望参加这项研究。如果您决定介入，请您给研究人员发邮件或者打电话（详情可见介绍信）告知。之后，研究人员会联系您以保证您明白参加这项研究的事项，并和您约定您认可的时间地点进行采访。

采访开始时，研究人员会提醒您随时可以退出采访，也会提醒您可以对研究人员提出的问题不作任何回答。研究人员汇核查您信息单内容的了解情况，并且征求您的同意，对采访录音。

采访期间，研究人员会提出一些问题，这些问题是关于精神和精神护理的看法和经历的。如果您感觉有冒犯或者没有帮助的问题，请您一定告诉我们。 您可以要求暂停或者停止录音。在录音结束时，我们会核实您是否有什么担心的问题，或者您有没有其他的需求。

访谈结束后，我们可能会联系看您是否需要一份有关您的采访记录以便您澄清和修改一些有必要修改的内容。我们会尽量修改不恰当处，直到您满意。

6. 这项研究会被保密吗？你怎样处理从我收集的信息？

是的，采访过程中，你的名字和地址都不会提及以防被录音。研究者由此会知道您的身份，但是不会泄露给任何人。为了保持您参加这项研究是匿名的，您的个

人信息将会被编号。所有的资料（包括数字和书面的）会被研究人员或主要导师保管10年，此后被销毁。

7. 我的信息会在你的出版物里被揭漏吗？

可能导致任何个人的身份暴露的信息不会站在发表文章中出现。如果我们引用了您所说的话，引用后边跟着的是参加者的编号。您的姓和名的首写字母不会被用。

8.我可以得到你的研究结果的复印件吗？

是的。 当研究结束后，如果您想要一份研究結果的复印件，我们会索要您的更新地址以便结果能送到您手中。你提供的地址不会被用于任何目的。复印件送出之后，地址信息会被马上销毁。

9.我参加这项研究会被付钱吗？

您参加这项研究不会被付酬金，研究者也不会从中牟取直接利益。

10.如果有问题怎们办？

在这项研究中，如果您担心您被接近和对待的方式有问题的话，您可以联系[redacted]教授。 她的联系方式是：

Professor Dr. [redacted]

11.你的研究征求伦理同意了吗？

这项研究已经通过Staffordshire大学伦理委员会的审批和批准。

牛艳平

Staffordshire大学PhD学生

Appendix 4.6 Consent form

INFORMED CONSENT FORM

Study Title

The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in four regions in England: a grounded theory investigation

	Please Tick
1. I have been given a complete explanation of the research study in which I have been invited to take part, including details of how I will be involved, and what this will entail.	☐
2. I have had opportunity to ask questions	☐
3. I have received an information sheet about this study, which I have read and will keep safe	☐
4. I know there is no obligation to take part in the study, and that I need not give any reason if I do not wish to take part.	☐
5. I am aware that I may withdraw from the study at any time without the need to give a reason.	☐
6. I agree to the interview being digitally recorded, and I understand the digital record will be erased after the study has been completed	☐
7. I am happy for anonymous information arising from this interview to be used in reports and publication	☐

Consent

I ……..agree to take part in this research project, the nature, purpose, and possible consequences of which have been described to me.

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Top copy to be retained by researcher. Second copy to be retained

INFORMED CONSENT FORM (traditional Chinese script)
知情同意書

題目

探讨居住在英格蘭四個地區有中国背景的群众對精神/靈性和精神/靈性護理的看法 - 紮根理論

Please Tick

1. 我已經得到被邀請參加這項研究細節的充分解釋。這些細節包擴，我是怎樣被包括在研究中的、研究的具體事項。	☐
2. 我知道我有提問問題的機會	☐
3. 我已經收到這項研究的信息單，對此我已閱讀並且會安全保存。	☐
4. 我知道我沒有被強迫參加這項研究，我也知道如果不想參加的話，我沒有必要給出任何理由。	☐
5. 我明白我在參加這項研究時，任何時候都可以退出，不需要給出任何理由。	☐
6. 我同意面試被錄音。 我明白當研究完成的時候，錄音會被銷毀。	☐
7. 我樂意以不記名方式在報導和出版物中使用訪談信息	☐

同意

我.....同意參加這項研究。 研究的性質，目的和可能的後果都已經介紹給我。

參加者姓名	日期	簽名
研究者姓名	日期	簽名

研究者持首聯，參加者持複印件

INFORMED CONSENT FORM (simple Chinese script)
知情同意书

题目

探讨居住在英格兰四个地区有中国背景的群众对精神/灵性和精神/灵性护理看法 – 扎根理论

	Please tick (initial)
1. 我已经得到被邀请参加这项研究细节的充分解释。这些细节包括，我是怎样被包括在研究中的、研究的具体事项。	
2. 我知道我有提问问题的机会	☐
3. 我已经收到这项研究的信息单，对此我已阅读并且会安全保存。	☐
4. 我知道我没有被强迫参加这项研究，我也知道如果不想参加的话，我没有必要给出任何理由。	☐
5. 我明白我在参加这项研究时，任何时候都可以退出，不需要给出任何理由。	☐
6. 我同意面试被录音。 我明白当研究完成的时候，录音会被销毁。	☐
7. 我乐意以不记名方式在报导和出版物中使用访谈信息	☐

同意

我…….. 同意参加这项研究。 研究的性质，目的和可能的后果都已经介绍给我。

参加者姓名	日期	签名
研究者姓名	日期	签名

研究者持首联，参加者持复印件

Appendix 4.7 Interview agenda

Interview Agenda

Please note that this interview schedule consists of a checklist. As the research is qualitative (The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in four regions in England: a grounded theory investigation), the questions provided are prompts. These questions may change as interviews are conducted and analysed, if additional exploration is required.

The interview schedule is a checklist to ensure a standardised format to all interviews.

Preliminaries

Item	Purpose	Example/prompts
1. Welcome	To introduce self (where necessary) and establish (confirm) relationship with participant(s) so that they feel at ease. Remind individual(s) that the interview will last no more than one hour.	
2. Gain consent and outline right to withdraw	Ensure informed consent has taken place and to put participant(s) at ease	you may withdraw consent or chose not to answer particular questions
3. Consent to tape, outline right to pause or stop the recording,	Reminder that the interview will be digitally recorded and that this can be paused, stopped, destroyed **RECORDER ON**	You may pause or stop recording
4. Reference to Information Sheet	To further check that the participant(s) is giving informed consent to address any issues that they may have about the nature of the study	
5. Confidentiality	Check that terms of confidentiality are clearly understood	

6. Check understanding of information sheet	To ensure that participant understand the risk and benefit of the study.	Experience of being interviewed may be interesting to you. Some questions may be sensitive. We ensure you are safe, and will not ask you questions that you do not want to answer (same as info. sheet)

Introduction

7. Setting and Context	Research title: The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in four regions in England: a grounded theory investigation	
8. Verification	Check that the participants are aware of the purpose of the interview	Could you tell me why this interview has to be carried out?
9. Opportunity	Because of the nature of qualitative research, it is vital that individuals have an opportunity to shape the structure of the investigation rather than just answering predetermined questions	Prompts in section 13 are open-ended to capture participant experiences
10. Validation	It is vital to draw on participants understanding to ensure the data about the concept of spirituality and spiritual care are collected	

Detail

11. Check out experience of spiritual care	Build rapport with participant(s)	Have you ever been provided spiritual care?
12. Check out level of implementation of spiritual care	Check with participants that they understand the area about to be explored -- meaning and experiences of spirituality and spiritual care	Do you think the spiritual care helped you a lot or just little?

13. Prompts	**Prompts for participants' interview– One-one interviews** 1) How do you describe spirituality? 2) How do you describe spiritual care? 3) Do you have any experiences of spirituality, can you describe this? 4) Do you have any experiences of spiritual care, can you describe this? 5) Have you been hospitalised in recent 12 month? 6) In your opinion, there is any spiritual element in traditional Chinese medicine (TCM)? If there is, could you give some details?

Conclusion

14. Gaining demographic information	To gain detail for later comparison	Could you fill in this simple form by providing the following details (p.411)?
15. Opportunity for supplementary questions	Participants will be asked if they have any questions or further comments that they would like to make. This provides with an opportunity to contribute any additional information that may not already have been addressed.	Are there any other questions or comments you would like to make?
16. Debriefing	To maximise the likelihood that the participant feels that they have been listened to and respected.	As we move towards the end of this interview do you have any comments or observations to make?
17. Opportunity for support	To let the participant(s) know where they might seek additional support if required.	If you find that anything discussed in the interview has caused you concern, you may want to discuss this with your GP.
18. Confidentiality	Redefinition of confidentiality	I will not be passing on to anyone anything that you have discussed or told me during this interview.
19. Consent and Data protection	To confirm that informed consent has been obtained.	Double check that participants have signed and received a copy of the consent form, that they are happy for me to use the data from the project, that if they

		change their mind they can withdraw at any stage?
20. Conclusion of recording	To mark the formal end of the interview. **RECORDER OFF**	I'm now going to switch the recorder off which marks the end of the interview.
21. Thank you	To communicate to the participant(s) that they have made a valuable contribution to this research and to thank them for their time.	Thank you. I have really enjoyed exploring the meaning and experiences of spirituality and spiritual care with you. I believe that this research could make a real contribution to the quality of life for people from Chinese backgrounds in the UK.
22. Dismissal	Ensure that the participant(s) is able to return to what they were doing and to leave the interview room.	Unless there's anything else that you would like to discuss outside the interview, I am going to leave you now. For participants: would you like me to escort you/ arrange a taxi for you back home/community centres?

Appendix 4.8 Declaration of confidentiality form

DECLARATION OF CONFIDENTIALITY FOR SIGNATURE BY TANSLATOR AND INTERPRETER

I, …… hereby declare that I will hold in strict confidence any personal information, concerning participants recruited from Chinese community centres which may become known to me verbally during the period of interviews. I will return all recordings to the researcher (Yanping NIU), and will destroy any copies I have in audio or written format once I have confirmed safe receipt of the original recordings or the interviews have been translated. I will not keep any data with regard to this research.

Please sign below to confirm the above.

Print
Name: ……
…….

Address……..
……
……
……

Signature: ……
Date: ……..

Witnessed by

Name: ……
……..

Address: ……..
……
……
……

Signature: ……
Date: ……..

DECLARATION OF CONFIDENTIALITY
(IN TRADITIONAL CHINESE SCRIPT)
翻譯人員簽署的保密聲明

我, …… 在此宣布，我嚴格保密從華人社區招募來的任何個人在採訪中可能被口頭透漏的信息。

請在以上空格簽字

姓名：……

地址：……

……

……

……

簽名：…… 日期:……..

證人

姓名:……

地址: ……..

……

……

……

簽名: ……日期:……..

DECLARATION OF CONFIDENTIALITY
(IN SIMPLE CHINESE SCRIPT)
翻译人员签署的保密声明

我, ……在此宣布，我严格保密从华人社区招募来的任何人在采访中可能被口头透漏的的信息。

请在以上空格签字

姓名：……

地址：……

……

……

……

签名：…… 日期:……..

证人

姓名:……..

地址: ……..

……

……

……

签名: ……日期:……..

Appendix 4.9 Demographic information form

DEMOGRAPHIC FORM FOR INTERVIEW

Please answer the questions， and place a tick in the appropriate box

1. Which part of China do you come from?

Mainland China☐ Hong Kong ☐ Taiwan ☐

Guangzhou Province ☐ Fujian province ☐ others, please specify_____

2. Ethnic group

Han ☐ please specify _____

3. Could you tell me your age? Please specify _____

4. Religious group

Christian ☐ Buddhist ☐ Muslim ☐ Atheist ☐

Communist ☐ Common people following mixed Chinese philosophy ☐

Others, please specify_____

5. Have you been hospitalised during the last 12 month?

Yes ☐ No ☐

6. What is the reason for this? Please specify_____

7. How long have you been hospitalised? Please specify_____

8. Marital status

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Others, Please specify_____

9. Do you have any qualifications? Please specify _____

10. Do you have a paid job? Please describe _____

11. Do you do voluntary work? Please describe _____

Demographic form for interview (traditional Chinese)

人口信息

回答以下問題，並在適當的方框後打勾

1. 您是來自中國哪個地方的？

中國☐ 香港☐ 台灣☐ 廣州省 ☐ 福建省 ☐ 其他，請指明_____

2. 民族 漢 ☐ 其他，請指明_____

3. 年齡 請指明_____

4.宗教信仰

基督教☐ 佛教☐ 穆斯林 ☐ 無神論者☐ 共產主義者☐ 一般群眾☐ 其他，請指明 _____

5.您最近12 個月住過醫院嗎？

有☐ 沒有☐

6. 您住院的原因

請指明_____

7. 您住院有多長

請指明_____

8. 婚姻狀況

已婚☐ 單身 ☐ 離異☐ 喪偶☐ 其他，請指明_____

9. 教育程度 請指明_____

10. 您做付錢的工作嗎？ 請指明_____

11. 您做義工嗎？ 請指明_____

Demographic form for interview (simple Chinese)

人口信息

回答以下问题，并在适当的方框后打勾

1. 您是哪个地方的？

中国☐ 香港☐ 台湾☐ 广州省☐

福建省☐ 其他，请指明 _____

2. 民族 汉 ☐ 其他，请指明_____

3. 龄段 请指明 _____

4. 宗教信仰

基督教☐ 佛教☐ 穆斯林☐ 无神论☐

共产主义者☐ 一般群众☐ 其他，请指明

_____

5. 您最近12 个月内住过医院吗？

有☐ 没有☐

6. 您住院的原因

请指明 _____

7. 您住院有多长

请指明 _____

8. 婚姻状况

已婚☐ 单身☐ 离异☐ 丧偶☐

其他， 即 _____

9. 教育程度 请指明 _____

10. 您是做付钱的工作吗？ 请指明 _____

11. 您做义工吗？ 请指明 _____

Appendix 4.10 Interview prompts and sampling after the first five interviews

General guidance of theoretical sampling: the recruitment of participants is guided by the variety of participants available. For example, only older aged participants have been interviewed, and so younger participants need to be recruited in the future.

Topic	Question	Purpose	Sampling
	How long have you been in the UK? What is your perception to life? What is important to you?	Warm up	
General understanding of the term spirituality	Can you say something about spirituality?	To elicit meaning of spirituality	General guidance
Chinese culture	Speaking about Chinese culture, How do you practice Chinese culture? When do you think you need maintain it? What can you gain from it? Do you believe in Karma? Could you explain it? Why do you believe in Karma? What is the result of believing in Karma? How to forgive? Why to forgive? When to forgive? Result of forgiving? What does self-cultivation mean to you? What requirement do you have for yourself in terms of self-cultivating?		Participant familiar with Chinese tradition, for example, with hobby of practicing art
Religion	Could you talk about religion?		Participant with religious belief
	How do you practice religion? When do you practice religion? What is the consequence of this practice? How do you believe in higher being? Why do you believe in higher being? What is the benefit of it? Do you have experience of telepathy? Could you give me an example? What makes you believe this? What is the result it can bring?		
Good life	How to make life meaningful? In what circumstances is making life meaningful? What is the benefit of making life meaningful? What is inner peace - Meaning of inner peace? How to gain it? When do you need inner peace? Where to gain inner peace Why need it?/What can inner peace can bring?		

Relationship	Describe relationship, Its connection to spirituality? What is the result of a good or bad relationship?		General guidance
Life event (Suffering)	Do you have a major life event? Could you describe it? What you do in suffering? What is the relationship between spirituality and suffering? What is the result it can bring?		Participant with suffering experience
Hope	Is hope important to you? What is your hope? What is the benefit of being hopeful?		General guidance
Spiritual care	Do you have spiritual care experience? Could you describe it? What do you expect the nurse do in spiritual care?		General guidance

Appendix 4.11 A sample of field note

Name	**You Hao (YH) 友好**
Sequence	1
Place	[redacted]
Date	14 July 2015
Time	11am – 12n (34mins), 14 July 2015
Field note	**Field note (Reflection during or right after interview)** YH does not know how to respond to the word spirituality when asked initially. Prompts for concepts, such as, God or supreme being, worship place, the need to forgive or being forgiven, meaning of good or bad deeds, hope, peace, art (listening to music, drawing), personal relationship, and ancient Chinese Sage education, are asked. Although the participant talked something about these concepts, she did not express that this is part of spirituality. This may be due that I did not emphasise that "do you think this is part of spirituality?"
Reflection 1	**Reflection during transcript** YH keeps talking in Cantonese, which impedes the interpreter to interpret sentence by sentence. I cannot understand what YH says, but I can observe her expression and gesture, from which I know she is friendly and wants people to know her story. I have to show my interest to her talking by keeping eye contact and nodding. As a result of this, I lose the opportunity to give right prompt. On the halfway of the interview, I require the interpreter to interpret sentence by sentence. But the conversation remains the same because YH does not stop until she finishes the whole story telling. To improve this, I need to communicate with the administrator and interpreter about pausing sentence by sentence. This means that they have to explain to the participant that pausing is important. From this reflection, I realise that the management skill of interview is not the responsibility of the administrator, but the interviewer. I should have emphasised interpreting by sentences to both participant and interpreter before the interview. This may somehow interrupt the interviewee's story telling line. I also need to remind them of keeping the conversation in a catchable pace, namely the interviewee in a slower pace and make a short pause between sentences, while the interpreter in a quicker pace. In this way, the interruption to storytelling line may be improved.

	Family support came to notice YH states that family support in spiritual care is not important. This may due that her faith in Jesus Christ is very strong, she is independent all her life, and health care in the UK can meet patients' needs. General feeling After the interview, I feel the questions asked did not illicit the proper meaning of spirituality. Two questions need to be added: 1. Any other forms of spirituality can you describe/add? 2. Any other forms of spiritual care do you expecting?

Appendix 4.12 A sample of verifying interpreting or translating transcript

The parts highlighted in yellow were corrected by the academic;
Highlighted parts with strike-through are meaning added by interpreter;
Normal writings are transcript from participant or interpretation from interpreter;
The words in red is the part I feel necessary to clarify with the academic regarding the accuracy of the transcription.

AZ 17：11-17：25

我通常会呆在家里，看书看报，听音乐，这样就能让自己平静下来。就算上街，我也是一个人，多数都是自己一个人，这样才会比较平静，才能跟神对话，祈祷，从而更平静。

YN

这都是很好的概念。

AZ 18：05-18：22

我向往豁达的人生，如果上天受了我的命可以解救更多的人，我愿意奉献。基督徒是不害怕死亡，不认为人生会死亡的 ~~没有（一般）中国人认为的生死，死了以后什么都不存在了（没有这个）。~~

I think this is interpreter's own opinion.

YN

真的很好

AZ

不是我好，是神好。（laughed）

Wife

这个概念真的很好，因为好多人认为死了就死了，这个不好呀，是吧？

AZ 19：07-19：33

我能看通生死。（如果发生在我的孩子身上，我也看得开。）人要乐观一点，不要想为什么所有的不幸都降临到我头上。

YN

那您觉得人死后生命还是存在的，是吗？

AZ 20：10

肉体不在了，但神识还存在。

每个人都这样吗？

AZ 20：33

我 66 年到英国，我妈妈 67 年就走了。我们的理解，信神的人的灵是存在的，不是随着肉体死亡而消失的。信神灵才会存在。

（I realized that she was talking about holly spirit）

YN

不信的人死后他就没了吗？

AZ 21：36-22：15

我不能够评论别人，我也不能代他说这个事情。

（I feel interpreter's own opinion causes some misunderstanding. When I ask the above question, she explained to the participant "due to some religion thinks that spirit still exists afterlife"

我只是说，我信基督教，我相信是有这样的灵，死后这灵是上天堂的。我母亲已经去世了，但我相信她一直在我身边。当我去世以后，我们是可以在天堂见面的。其他人如果愿意信其他的神的话，他们也是可以得到解救的。在他们肉体去世以后，他们的精神还是在。我不能妄加评论，因为我不能替别人说他们会怎么样。

AZ 23：06-23：20

我只属于这样的，人更重要的是以身作则，你是这样去做的，你这这样去说的，那自然人家觉得你是对的，他自然会跟从你，不需要你真正的费力气去劝说人家，去感染人家，说"你要跟我怎么样"。 而是说你看到我这个样子，你觉得好，你自然而然会跟随我去做。

AZ 23：54-24：25

我讲个个人例子。我的父母亲在病重的时候，我觉得是，求上天不要让他们再痛苦了，让他们安静的走吧。在旁人看来好像这样非常残忍，~~因为作为女儿这样想是很残忍的（没说~~）。我觉得是与其让他们这样受罪，不如让他们舒舒服服的走。这就是我对于死亡的理解。我也很支持安乐死。这个是政府目前正在讨论的，要不要实行安乐死的问题。

（the recorder stopped and I did not notice）

Q09.Spirituality is about interpersonal relationship

AZ

（According to my note,） interpersonal relationship is also led by God.

QJ14：50

教会找一个崇拜基督，看圣经，有好多东西都很奇妙，对人生好多东西都有帮助，家庭，思想的观念，做人要很正道。不要走偏路，不要做坏事，什么什么东西，都要帮助人家。Going to church is about worship the Christ, reading the bible. Many things there are wonderful and helpful to life, such as thought about family and ideas

Going to church is about worshipping the Christ and reading the bible. Many things there are wonderful and helpful to life, such as thought about family and ideas. They require people be honest and helpful, rather than going wrong way and doing evil things.

INT 比如说家庭，说做人观念。不要争斗，不要做坏事，做什么什么什么的，都有帮助的?/ go to church…we worship Christ, read the bible, a lot of thing are ok and helpful to life. As for family, it talks about how to be a good person, not fighting and doing bad things, whatsoever. It is helpful.

Q04.Spirituality is about to forgive and be forgiven

YN

在生活中在们都需要原谅别人或者被别人原谅，您觉得这是不是精神的一部分呢？

It is better to ask "what does it mean to you? /原谅别人和被别人原谅对您意味着什么？"

In our daily life, we need to forgive and be forgiven. Do you think forgiving or being forgiven is a part of spirituality?

QJ 16:10 -20：24

这个是很重要. 在这个社会慢慢越来越来就不同了。人的做法，想法，好多东西 出现在这个社会,不过在社会之间呢，人与人,什么东西有些不同，有个思想观念有不同。不过我进来教堂走正路，走正路，对一个人我很尊重人家，有什么帮到我就帮，我帮不到就没有办法啦。不过这个我一个人我都会尊重。不过有的人不尊重我，就看不起我，讲坏话，这我就不听。这在这个耶稣基督圣经说你走正路，如果另外的人不走正路，他不听，这同一邦人是很坏的，他欺侮我这个，不好人不好要离开他。就是这样。

This (forgiving) is very important. The moral standard of our society is slowly getting worse. People's thought and action, relationship amongst human beings, individual principles and ideas are all different. But as a Christian, I walk a righteous way. I treat everyone with respect, whenever I can, I help others.

But I tried to forgive those, who disrespected me, looked down on me and said bad words to me. Jesus Christ said in the Holy Bible that you are to walk a righteous way and distant yourself from those who don't.

QJ 41：31-42：26

我有个朋友朋友身体很不好，去医院，我都有去几次。那几次那病人，我认为它需要要护士，叫什么照顾好，或者周到的，对病人 的精神有个不同在这里。如果一个人孤独在那里，叫茶，水也没有人拿，或者也没有什么人怎么理，精神就会影响心情。有的人会发脾气，不出奇。

I had been to the hospital several times visiting a friend who had been sick. I thought he needed considerate care from nurses at that time, as this could make difference for the patent's spirituality. If he was left lonely without being helped with water and tea, and nobody talking to him, his spirituality will be affected. It is not surprised that some people get bad temper.

int ~~我觉得如果护士能够友善一点，~~如果护士对病人的要求能够及时回应，不如病人按了灯护士能及时来，对病人精神上会有很大的支持和安慰的。

I feel interpreter has interrupted the participant talking

YN

那您觉得护士在这方面还是做得不够，是吗？

You think that nurses are not good in this aspect, isn't?

QJ 43：07-43：41

这，当然啦，这样个个人做法不一样，有的护士很好，相当好，甚至会跟你聊天，讲一下笑都可以。有的不一样，很快就走了，不同啦。有的对病人很好，同他聊天两句。或者问他怎么样怎么样呀，就这样不同的心情。所以有点不同。

Of course each nurse had a different approach toward the patient. Some nurses were good. They chatted and joked with you. They are kind to patient, ask how patient feels and chat with them. On the other hand, some nurses spent as little time with you as possible. It depends on individual nurse. There is difference.

YN

您遇到过护士就是说当您有精神方面的需要的时候，护士会不会安排让牧师来祈祷？比如说信耶稣的，需要牧师来祈祷的时候。

Spiritual care is about nurse arranging a visit by the hospital chaplain or the patient's own religious leader ? for example, a Christian is in need of praying from pastor.

Appendix 4.13 A sample of transcription and translation

The transcripts and translations for the recording of my speech (interviewer) is in bold, and those for participants is in normal font.

对于精神这个词，您自己是怎么理解的？ Ok. What is your understanding of the term spirituality?

2：40 我怎么理解呀？就是很简单，假如精神好的话，精神状态好的话，给人家看上去很阳光，很那个…精神不好的话看上去就病泱泱的嘛， 对不对？ 我都不想让人家看我病怏怏的，我想最好的状态跑出来，对吧。

my understanding? It is simple. If your spirituality is good and your mental state is good, you appear sunny and… If your spirituality is not good and you look sick, isn't? I do not want to appear to sick and I appear with my best outlook.

明白，明白。那咱们做一些…最近您 12 个月住院吧？ I see. Have you been hospitalised in the recent 12 months?

3：07 有啊。 Yes.

住了大概多长？ How long is it probably?

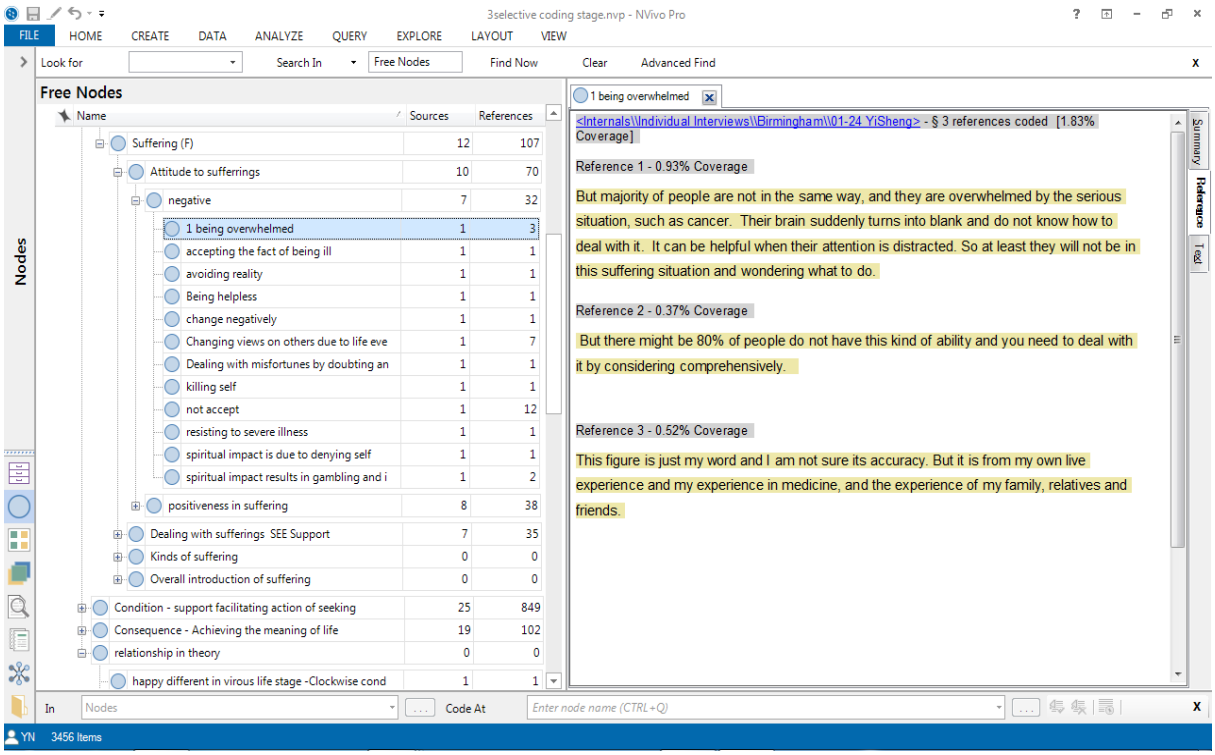
二月份那个乳腺癌开刀嘛，乳腺癌开刀，开完刀以后做化疗，然后化疗好以后一直发烧，一直发烧，住了一个多月，那是在上海。然后又回来英国，三月份回来，回来我又连续做化疗，但是每次化疗都把我倒下，都把我倒下， 然后又发高烧，然后又住医院，哎呀，连着最后三次，等于说三次五次化疗，第一次化疗在上海，然后住院啦，然后这里第二次，第三次没有…第二次没有，第三次，第四次，第五次，三次完以后到星期天又到医院去住，第一次又住了两个星期，上次有住了两天，每次都发烧的，所以说没精神，根本就没精神讲话呀，走路呀，没有这个力气，很难的。

I had operation in February. Afterwards I had chemotherapy. I then had fever and got hospitalised for a month in Shanghai. I came back to the UK in March to continuing the chemotherapy. I had in fever and got hospitalised after each of this therapy which let me down. By estimate, the last three therapies… the first therapy was done in Shanghai and I was hospitalised there. The second took place here. I was not hospitalised in the third time. No, I was not hospitalised in the second time. For the third, fourth and fifth therapy I was hospitalised. I was there for two weeks for the first time and two days last time due to fever. I have no spirituality at all, and I do have no strength to walk. It is very

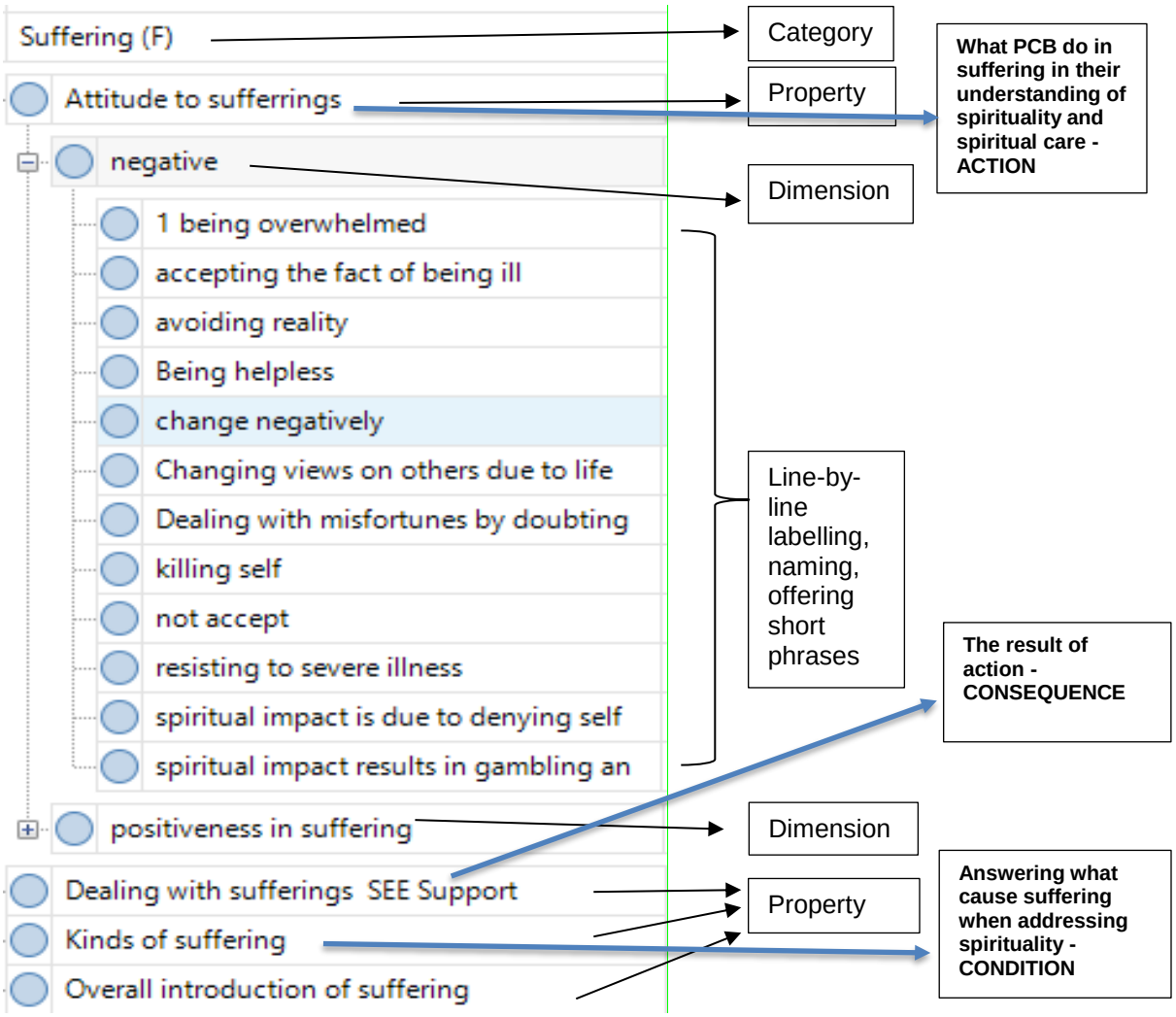
difficult.

Appendix 4.14 Examples for data analysis in NVivo11

The first figure below demonstrates a result of line-by-line coding/labelling. For example, there are three references in Yisheng's transcript labelled as 'being overwhelmed', which is one of the negative attitude to concept 'Suffering'.



The second figure below shows how concept 'suffering' is established under *action, condition and consequences,* forming different properties and dimension of this concept (category).


Suffering (F)
Attitude to sufferrings
negative
1 being overwhelmed
accepting the fact of being ill
avoiding reality
Being helpless
change negatively
Changing views on others due to life
Dealing with misfortunes by doubting
killing self
not accept
resisting to severe illness
spiritual impact is due to denying self
spiritual impact results in gambling an
positiveness in suffering
Dealing with sufferings SEE Support
Kinds of suffering
Overall introduction of suffering
Category
Property
Dimension
Line-by-line labelling, naming, offering short phrases
Dimension
Property
What PCB do in suffering in their understanding of spirituality and spiritual care - ACTION
The result of action - CONSEQUENCE
Answering what cause suffering when addressing spirituality - CONDITION

Appendix 10.1 The poster presentation of the research design in July 2015

The meaning and experiences of spirituality and spiritual care among people from Chinese backgrounds in four regions in England: a grounded theory investigation

Yanping NIU, Professor. Wilf McSherry, Dr. Martin Partridge *Faculty of health sciences*

STAFFORDSHIRE UNIVERSITY

Aim: This study will develop a theory of spiritual care by investigating people from Chinese backgrounds, living in four regions in England. This will be achieved by capturing and exploring the meaning and experience of spirituality and spiritual care among this group of people.

Rationale for the research

- There is a lack of research involving people from Chinese backgrounds, investigating their perception of spirituality and understanding of spiritual care in the UK.
- Research on spiritual care has been carried out in some Chinese speaking regions may not be generalized to people from Chinese backgrounds living in the United Kingdom.
- Spirituality is subjective. There is a need to give close consideration to the beliefs, values and philosophies people hold, and how these shape and influence peoples worldviews.
- Research studies into spirituality and spiritual care conducted within mainland China are very few. This may be due to the fact that the Chinese nursing model consists of three domains, physical, social and mental care , rather than international nursing model consisting of four domains, physical, social, psychological, and spiritual.

Research method

This study will use a qualitative, grounded theory design based on Strauss and Corbin's (1990) method, to investigate the meaning and experience of spirituality and spiritual care among people with Chinese backgrounds living in four regions of England.

Sampling: The participants will be recruited from four Chinese community centres in four regions across England. Participants will be selected by using theoretical sampling, and a sample of 20 to 30 is estimated.

Data collection: The interviews will be conducted in the participants' preferred dialect and Chinese, and an interpreter who is fluent in that language will be hired to facilitate the communication. The interview will be translated by a professional translator into English and transcribed by the researcher. Data collection and data analysis will be conducted simultaneously.

Data analysis: Data analysis involves several techniques, constant comparison, open coding, axil coding, categorising, finding patterns, discovering a core category, and development of an emergent theory.

Data management: Data will be entered into qualitative instrument NVivo10 to assist with data management, data analysis, and the identification of concepts, categories, and themes.

Research method justification

- **A qualitative design**
  The rationale for a qualitative design over a quantitative one is to gain in-depth understanding of the subjective and abstract nature of spirituality and spiritual care .
- **A grounded theory**
  The reason to employ a grounded theory methodology over other qualitative designs is because grounded theory methodology is highly systematic for qualitative data collection and analysis. This will assist in the testing and generation of new and existing theories .
- **Strauss and Corbin's grounded theory**
  Choosing the Strauss and Corbin's (1990) adapted version of grounded theory over others is this approach is compatible with contemporary thinking and describes clearly the stages in data analysis for new researchers to follow.

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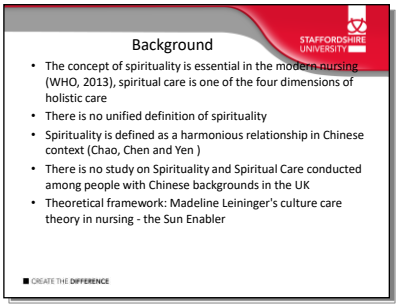
[redacted]

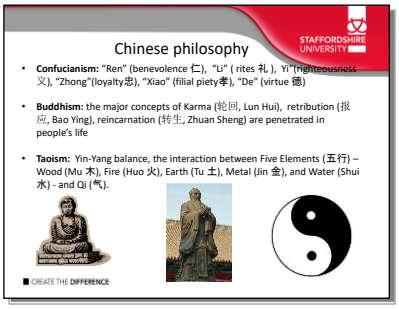
Appendix 10.2 The PowerPoint presentation of uncompleted research findings in the 2016 conference

Slide 1

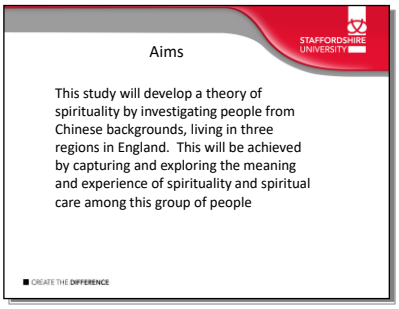
Slide 2



Slide 3

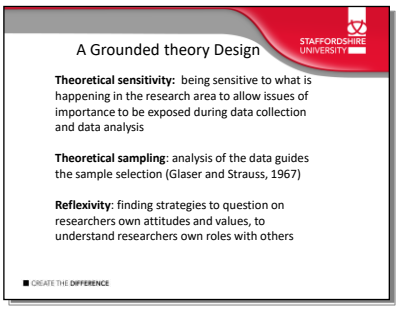


Slide 4



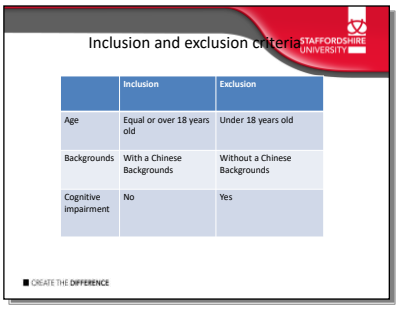
Slide 5

Slide 6

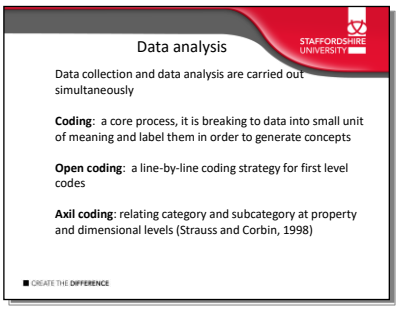


Slide 7

Slide 8

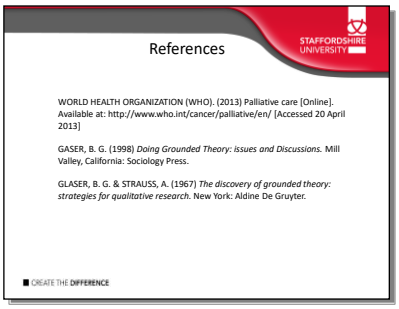


Slide 9



Slide 10

Slide 11



Slide 12