Caring in the Nurse-Patient Relationship through the Caritas Lens: An Integrative Review

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Abstract

This integrative review of the literature is an exploration of current research on the phenomenon of caring in the nurse-patient relationship. A literature search was conducted using CINAHL, Google Scholar, EBSCO, MEDLINE, Ovid Nursing, ProQuest Nursing, SAGE journals online, and ScienceDirect. Data analysis was performed using Watson's 10 Caritas Processes as a descriptive, categorical framework. Narrative summary was used to report findings. Results show emergence of complex concepts. Incongruence was found between nurses' and patients' perceptions. Further research is needed to generate more knowledge regarding the phenomenon of caring in the nurse-patient relationship.

Keywords: *caring, nurse, patient, relationship*

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Nursing is considered an art and a science, and is anchored in service to humanity (Jenner, 1997; Rogers, 1970). The American Nurses' Association (n.d.) defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (para. 1). Nursing in the nurse-patient relationship is committed to developing knowledge of human life patterns and processes and their interactions with the environment for health promotion and full-life potential; caring is a key aspect of this commitment (Roy, 2008).

Caring has been identified as a foundational value for nursing (The American Association of Colleges of Nursing [AACN], 2008; National League for Nursing [NLN], 2007). It is a professional and personal aim for nurses engaged in patient relationships, and an expectation of patients receiving healthcare. Nursing has attempted to understand the essence of caring in the nurse-patient relationship since Nightingale (Nightingale, 1860; Watson, 2012). Caring, within the paradigm of nursing, goes beyond providing 'care' or performing duties to improve health (Leininger, 2002). Caring is also viewed as multi-faceted, nurturing and skillful processes in the nursepatient relationship that manifest as compassion, empathy, education, protection, and others, depending on patient needs (Leininger, 2002; Watson, 2012). Other nursing scholars assert that caring is a conscious way of being with another; it is a holistic, mutual encounter that is compassionate (Stone, 2011; Todaro-Franceschi, 2013; Watson, 2012). The humanistic nature of the open, nurse-patient relationship involves body, mind, soul, and spirit with a conscious determination to relieve human suffering (Norman, Rossillo, & Skelton, 2016; Stone, 2011; Todaro-Franceschi, 2013; Watson, 2012). Each intrapersonal caring relationship is unique, and it is within the relationship that the meaning of illness is appreciated, and healing and health are maximized (Butts & Rich, 2011. Watson, 2012).

Based on the work of early nursing theorists, current research efforts include using nursing models to meet the needs of nursing as a profession in the present and future (Norman, et al., 2016; Watson & Brewer, 2015). The use of theoretical underpinnings provides an organized conceptual framework which serves as the foundation for nursing research, education, and practice (Brewer & Watson, 2015). The essential component of nursing is nurturance, a caring relationship that cultivates mutual giving and receiving (Roy, 2008). Nursing's concern is caring holistically, with the whole person, not just the pathology (Roy, 2008).

Professional acknowledgement of caring as being unique to nursing was noted when Leininger (1978) first introduced the Culture Care Theory in the 1950's. One of the oldest theories in nursing, the Culture Care Theory is recognized for its holistic, multi-dimensional and culture-specific focus on caring (Leininger, 2002). The Culture Care Theory expanded

the traditional mind-body medical view of caring to culturallyentrenched care, including broad, humanistic life experiences and values (Bailey, 2009; Leininger, 2002; McCance, McKenna, & Boore, 1999). Since Leininger, the richness of the phenomenon of caring has prompted numerous nursing theorists to use caring as the core concept for their theoretical frameworks (Boykin & Schoenhofer, 1990,2003; Leininger, 1978, 2002; Roach, 1984; Swanson, 1991; Watson, 2008, 2012).

Roach's (1984, 2002) conceptualization of caring as the human mode of being, refers to caring as a path for living that promotes the freedom of humankind in every relationship. Roach delineated six main attributes of caring in human relationships: compassion, competence, confidence, conscience, commitment, and comportment (Bailey, 2009; Roach, 1984, 2002).

Swanson's Middle-Range Theory of Caring (1991) incorporates the interactive/ interpersonal nurse-patient relationship, and suggests knowing (understanding events in another's life), being with (emotionally present), doing for (doing for another that they would do for themselves), enabling (facilitating another's self-care), and maintaining belief (faith in another's capacity) as processes that define the caring relationship (Bailey, 2009; Swanson, 1991, 1993).

Watson's Human Caring Science (2008; 2012), first developed in 1979, centers around transpersonal human caring-healing; authentic, caring relationships that strengthen and facilitate healing processes (DiNapoli & Nelson, 2010; McCance, et al., 1999; Norman et al., 2016; Watson, 2012). The impact of this theory is most evident in the development of the 10 Caritas Processes that are contained within: practicing love and kindness, authentic presence and instilling faith and hope, being sensitive to self and others, developing helping and trusting relationships, promoting expressions of feelings, using creative, scientific decision-making methods, sharing teaching and learning, creating a healing environment, assisting with spiritual, emotional and physical human needs, and allowing miracles to enter the relationship (Watson, 2008, 2012). Derived from the Latin to cherish, Watson defines caritas as "appreciating and giving special, if not loving attention to patients. It represents charity and compassion, generosity of spirit" (Watson, 2008, p.39). Latterly, the development of the Watson Caritas Patient Score (WCPS), "designed to measure critical characteristics associated with deep, personal, human-to-human connection" (Watson & Brewer, 2015, p. 235) provides a theoretical foundation for the advancement of professional nursing practice (Watson & Brewer, 2015). The WCPS measures Watson's Caritas Processes as clinical indicators of caring in relation to patient outcomes, thus providing theoreticallybased empirical data for evaluation of human caring, and advancement of caring research (Watson & Brewer, 2015).

Boykin & Schoenhofer's (1990, 2003) Nursing as Caring Theory was developed as a practice theory on the premise that all persons are caring by virtue of their humanness (Boykin, et al., 2005; Boykin, et al., 2003; Butts & Rich, 2011). Four major concepts comprise the Nursing as Caring

Theory: personhood (living grounded in caring), the nursing situation (lived experience between patient and nurse), calls for nursing (caring requests heard by the nurse) and nursing as caring (the other's personal growth and experience is enhanced). In this theory, nursing is caring (Boykin, et al., 2005; Boykin, et al., 2003; Butts & Rich, 2011).

In addition to the various theoretical frameworks that have been developed around the caring phenomenon, many studies and humanistic interpretations of the nurse-patient caring relationship have been performed by nurse researchers and scholars, attempting to pinpoint qualifying attributes of caring (Beckett, 2013; Chokwe & Wright, 2012; Fabri, et al., 2013; Gustin and Wagner, 2013; Holopainen, Nystrom, and Kasen, 2014; Liu, Mok, & Wong, 2006; Meng, Xiuwei, and Anli, 2011; Pearcey, 2010; Ranheim, Karner, & Bertero, 2012; Stone, 2011; Todaro-Franceschi, 2013; TaylorHaslip, 2013).

Within and outside of nursing, there are many interpretations of caring in the nurse-patient relationship (Fingfeld-Connett, 2008; McCance et al, 2008; Swanson, 1991). However, the 10 Caritas Processes of Watson's Theory of Human Caring Science are most prevalent in caring research and practice, they provide language and structure for the processes of caring in the nurse-patient relationship, and they have been instrumental in the empirical measurement of caring (Watson, 2012). In light of Watson's work, the purpose of this review is to examine the current research, and provide the state of the science for caring in the nurse-patient relationship through the Caritas lens.

Literature Review Method

Using the methodology proposed by Whittemore and Knafl (2005), an integrative literature review was performed. This broad type of review allows inclusion of both experimental and non-experimental studies, as well as doctoral dissertations, to gain a fuller understanding of the phenomena of concern (Whittemore & Knafl, 2005). Theoretical and empirical data from the literature may be combined for several purposes: concept definition, and theory and evidence review (Whittemore & Knafl, 2005).

Multiple electronic databases were used for this comprehensive data search, including CINAHL, Digital Dissertations, EBSCO, Google scholar, MEDLINE, Ovid Nursing, ProQuest Nursing, SAGE journals online, and ScienceDirect. Nursing, social sciences, and philosophy were the specific realms visited. References from articles, books and journals were used for finding benchmark studies. Four initial search keywords/phrases were used: caring, nurse, patient, relationship. These keywords were selected with intent to identify studies examining caring in the nurse-patient relationship. The Boolean search method was implemented, separating the search categories with 'OR' and 'AND' in various combinations for category expansion (Appendix A).

Criteria for Inclusion/Exclusion

Inclusion criteria were: English language, human subjects, qualitative and quantitative research, theoretical frameworks, and meta-analysis and integrative review studies. Criteria also included caring relationships within nursing. To ensure incorporation of recent literature, the

limitation of 'past ten years' or the parameters 2008-2017 were imposed upon all searches. Studies referring to caring as a psychomotor action or implementation of tasks were eliminated. Other excluded works were reflective writings, editorials, informational pieces, inaccessible papers, and incomplete studies (findings only). All selected studies were anchored in the phenomena of caring.

Results

The data base search yielded 2,309 records, and an additional 37 records (three doctoral dissertations) were found from other sources such references from other studies and publications, and books. Duplicate removal resulted in 1,354 records for consideration. Studies that were impertinent by title, or inaccessible, were discarded, leaving a total of 403 records for abstract screening. Upon further scrutiny of the 403 potentially relevant papers, 334 were eliminated because the context of caring was action-oriented only. The eligibility for inclusion of the remaining 69 studies was determined after reading all of them in full-text.

Of the 69 studies read, 22 met the inclusion criteria as stated; 13 were qualitative (two nursing doctoral dissertations) and nine were quantitative (see Appendix B). No mixed-method studies were included. Five books were found and used to provide insight into the phenomenon. One of the books provided theoretical guidance. Quality of Included Studies

All selected studies for this integrated review were appraised for quality. Nine quantitative studies were evaluated using Bowling's (2009) critical appraisal checklist (Appendix C). Thirteen qualitative studies were evaluated using Pearson's (2004) Quality Assessment and Review Instrument (QARI) critical appraisal scale (Appendix D).

Bowling's appraisal checklist consists of 20 evaluation criteria. Four studies reviewed (Brewer and Watson, 2015; Merrill, Hayes, Clukey, and Curtis, 2012; Persky, Nelson, Watson, and Bent, 2008; Schmock, Breckenridge, and Benedict, 2009) were rated medium-high quality, meeting between 13 and 15 of the criteria. The remaining five studies (Arslan-Ozkan, Okumus, and Bukdukoglu, 2013; Berry et al., 2013; DiNapoli and Nelson, 2010; Papastavrou, Efstathiou, & Charalambous, 2011; Sossong and Poirer, 2013) met between 16 and 19 criteria, rating them high-quality for inclusion in the review.

Pearson's QARI qualitative critical appraisal scale consists of 10 criteria for quality assessment. Three studies (Beckett, 2013; Fabri et al., 2013; Norman et al., 2016) met six of the criteria, and were considered medium quality for inclusion in the review. The remaining 10 studies (Bridges et al, 2012; Gustin & Wagner, 2013; Holopainen, Kasen, and Nystrom, 2014; Holopainen, Nystrom, & Kasen, 2014; Meng, Xiuwei, & Anli, 2011; Pearcey, 2010; Ranheim et al., 2012; Stedman, 2013; TaylorHaslip, 2013; Vouzavali et al., 2011) met between seven and 10 of Pearson's criteria, rating them high quality for inclusion.

The overall critical appraisal of the literature was examined by tallying the number of articles that met each criteria individually (see Appendix E). This process revealed limitations in both the quantitative and

qualitative works. Of the nine quantitative papers, just one (DiNapoli & Nelson, 2010) was piloted before execution. Of the qualitative group, the influence of the researcher on the research was not addressed in 8 of the 13 studies. Despite these limitations, overall quality of the literature was deemed suitable for the study.

In light of the initial quality appraisals, all 22 articles were read a second time for further analysis. Critical examination explored country of origin, research aims, sample type and size, research design, analytical methods, and study findings. This information was formatted into a general description summary (see Appendix F).

Countries of Origin

Upon examination of the 22 studies included, 45% (ten) were conducted in the United States (Berry et al, 2013; Brewer & Watson, 2015; DiNapoli & Nelson, 2010; Merrill et al., 2012; Norman et al., 2016; Persky et al., 2008; Stedman, 2013; Schmock et al., 2009; Sossong & Poirer, 2013; Taylor-Haslip, 2013), 14% (three) in United Kingdom (Beckett, 2013; Ranheim et al., 2012; Pearcey, 2010), 9% (two) in Sweden (Gustin & Wagner, 2013; Ranheim et al., 2012), and 9% (two) in Finland (Holopainen, Kasen, & Nystrom, 2014; Holopainen et al., 2014). The remaining 23% of the studies (five) were conducted in China (Meng et al., 2011), Cyprus (Papastavrou et al., 2011), Greece (Vouzavali et al., 2011), Portugal (Fabri et al., 2013), and Turkey (Arslan-Ozkan et al., 2013).

Theoretical Perspectives and Frameworks

All of the selected articles contained discussion regarding various theories and perspectives on the phenomena of caring. However, 45% (10) of the studies had no particular theoretical framework to guide them. Ten of the selected studies (45%) used Watson's Human Caring Science theory for their underpinnings (Arslan-Ozkan et al., 2013; Berry et al., 2013; Brewer & Watson, 2015; DiNapoli & Nelson, 2010; Gustin & Wagner, 2013; Norman et al., 2016; Persky et al., 2008; Ranheim et al., 2012; Schmock et al., 2009; Stedman, 2013). Of these ten studies, six were quantitative (Arslan-Ozkan et al., 2013; Berry et al., 2013; Brewer & Watson, 2015; DiNapoli & Nelson, 2010; Persky et al., 2008; Schmock et al., 2009), and four (Gustin & Wagner, 2013; Norman et al., 2016; Ranheim et al., 2012; Stedman, 2013) were qualitative. Two quantitative studies used Wolf's (1986) Caring Behaviors Inventory (CBI) as their foundation (Merrill et al., 2012; Sossong & Poirer, 2013).

Data Analysis

Universally definitive attributes of caring have yet to be defined (Beckett, 2013; Berry, et al., 2013; DiNapoli & Nelson, 2010; Fabri, et al., 2013; Holopainen et al., 2014; Papastavrou, et al., 2011; Pearcey, 2010; Ranheim et al., 2012; Sossong & Poirer, 2013 Vouzavali, et al., 2011). Watson's seminal work, Human Caring Science, and the 10 Caritas Processes contained within the framework, is the most prevalently used theory in this review (45%), and one of the most prominent theories used to guide nursing practice (Arslan-Ozkan et al., 2013; Berry, et al., 2013; DiNapoli & Nelson, 2010; Gustin & Wagner, 2013; Persky et al., 2008; Ranheim, Karner, & Bertero, 2012; Schmock et al., 2009; Stedman, 2013; Watson & Brewer, 2015;

Watson & Browning, 2012). Watson identifies the 10 Caritas Processes as the essential aspects of caring in nursing to potentiate healing: (1) practicing loving kindness, (2) authentic presence and instilling faith and hope (3) being sensitive to self and others, (4) developing helping and trusting relationships, (5) promoting expressions of feelings, (6) using creative, scientific decision-making methods, (7) sharing teaching and learning (8) creating a healing environment, (9) assisting with spiritual, emotional and physical human needs, and (10) allowing miracles to enter the relationship (Brewer & Watson, 2015; DiNapoli & Nelson, 2010; Watson, 2008,2012; Watson & Browning, 2012). These 10 Caritas Processes give fluidity and language to the phenomenon of caring in the nurse-patient relationship (Watson, 2008; Watson & Browning, 2012), and will provide the structure and organization for various attributes of caring revealed in this literature review.

Caritas Process 1: Humanistic- altruistic values through cultivating personal profession and practice of loving kindness compassion and equanimity with self / other.

According to Watson (2008), equanimity is a mindful ability to enter the nurse-patient relationship, and allow whatever the experience is to flow without judgment or interference. Emotions and feelings are experienced by self and other, moving continually, seeking balance (Watson, 2008). In their concept analysis study, Ranheim et al. (2012) examine nurses' caring intentions and define equanimity for self/other as an interconnectedness and balance between nurse and patient. Norman et al. (2016) define the caring relationship as a deep, transpersonal connection. Metaphorically, Vouzavali et al. (2011) explain this interconnectedness and balance as syncytium, denoting coexistence in harmony in a shared world. A review of philosophical texts (Holopainen et al, 2014) unearths the nurse-patient relationship as an interconnectedness with mutuality; it is an invitation to the other to share an existence. In their research study examining attributes of caring among nursing scholars, Meng et al. (2011) found that attitude (including humanitarianism, respect, and love) reflects the intention and commitment that the nurse has to the relationship. Other researchers (Beckett, 2013; Holopainen et al., 2014; Ranheim et al. (2012); Watson, 2008, 2012) add that contemplation upon entering the nurse-patient relationship reaches open awareness and insight to see the relationship as an interdependent, greater whole for a potentiated healing process.

According to Watson (2008), this interdependent, greater whole is the foundation for compassionate caring. A reflective study by Gustin & Wagner (2013) supports Watson's theory, and reveals altruistic attributes for compassionate caring as "being there with and for self/ other", "respect for human vulnerability", "being nonjudgmental", and "being able to accept the gift of compassion from others". This study (Gustin & Wagner, 2013), and research by Norman et al. (2016) both posit that this first Caritas Process guides the nurse to intentional and mutual reciprocity with the patient, and serves as the starting point for compassionate care. Watson (2008) describes loving kindness as the open compassionate heart that "bubbles over into one's life circumstance"

(p. 59). Ten studies reviewed cite human compassion with loving kindness as the core of caring (Bridges et al, 2012; DiNapoli & Nelson, 2010; Fabri et al., 2013; Holopainen et al., 2014; Gustin & Wagner (2013; Meng et al., 2011; Norman et al., 2016; Stedman, 2013; Taylor-Haslip, 2013; Vouzavali et al., 2011). Gustin & Wagner (2013) described this compassion as a "full immersion into being human" (p. 176). Love for humanity as an emotive aspect of compassion in the nurse-patient relationship was noted in quite a few studies as well (Gustin & Wagner (2013); Pearcey (2010); Taylor-Haslip, 2013; Vouzavali et al., 2011). Aspects of the first Caritas Process are evident throughout the literature.

Caritas Process 2: Being authentically present: allowing faith and hope/belief system that honors inner life world or self/ other.

In their compassionate care study, Gustin & Wagner (2013) conclude that the nurse has a conscious intention for being present in the moments of another's despair. Taylor-Haslip (2013) refers to this presencing of oneself with another in caring as a united engagement. Two studies of nurses' experiences in the nurse-patient relationship, Bridges et al. (2012) and Norman et al. (2016) both found that the connection between patients and nurses is perceived to be dependent on nurses' ability to be present. Holopainen et al. (2014) and Ranheim et al. (2012) define authentic presence as being true to self and other. Holopainen et al. (2014) cite that presence is "to be close to one's self and the presence of the other brings one closer to one's self" (p. 187). Ranheim et al. (2012) refer to authentic presence as "intergrade", an openness and reflection with the other, but make note that procedural nursing care opposes this concept. In a study of trauma patients (Merrill et al., 2012) who rate caring behavior of nurses, factors related to assurance of human presence and positive connectedness rank highest, and account for 51.85% of the total variance (no additional data is provided).

Watson (2008) explains that being present within the nurse-patient relationship instills faith and hope in both nurse and patient. The presence of the nurse is hope for the patient who may feel fear and pain, and the nurse feels hope for the patient and herself with caring, healing interactions (Bridges, et al., 2012; Fabri, et al., 2013; Watson 2008, 2012). In a quantitative study by Merrill et al. (2012), Caucasian and Latino trauma patients rate their nurses' caring behaviors using the Wolf's (1986) Caring Behaviors Inventory for the Elderly (CBI-E). Being hopeful for the patient is one of the lowest-rated items by Caucasian patients (no data was provided), indicating that these patients do not perceive their nurses as being hopeful (Merrill et al., 2012).

Faith and hope in the nurse-patient relationship at end-of-life transcendence is cited in two studies; the possibility of impending death makes the experience more profound and spiritual (Vouzavali, et al., 2011), and acknowledgement of bodymindspirit promotes an empathetic, honorable passing (Norman et al., 2016).

The qualitative research in this review expound on Watson's first two Caritas Processes. The quantitative studies strongly support the main caring concepts, especially when the Caritas Factor Survey (DiNapoli & Nelson, 2010) or the WCPS

(Brewer & Watson, 2015) is implemented. It is, however, difficult to determine from the brief terminology in the instruments whether or not patients respond with similar intentions, conceptualizations and understandings as nurses do. All studies reviewed support the importance of the nurse-patient relationship itself, and how it transpires for healing.

Caritas Process 3: Being sensitive to self and others by cultivating own growth and spiritual practices, beyond ego-control.

This Process makes explicit that, for caring to be authentic, one must be sensitive to one's inner self, which leads to spiritual growth and increased sensitivity towards the other (Watson 2008). Merrill et al. (2012) found that being sensitive to the patient is highly-rated by Latino patients, suggesting that this population is more sensitive and receptive to nurses' sensitivity in caring for them than Caucasian patients (no data was provided). This outcome not only indicates the subjective conceptualization and importance of sensitive, but also poses that perceptions of sensitivity towards others may have cultural influences; can compromise the authenticity of the nurse-patient relationship. One other study (Norman et al., 2016) recognizes the significance of the third Caritas Process, and incorporates sensitivity to self/others through experiential theoretical teaching and learning.

Caritas process 4: Developing and sustaining loving, trusting, helping, and caring relationships.

The caring relationship itself, one of love, trust, and compassion, is considered intrinsic to healing (Watson, 2008). Four studies (Holopainen et al., 2014; Norman et al., 2016; Ranheim, et al., 2012; Taylor-Haslip, 2013) reveal that trust in the nurse-patient relationship is essential for healing. Holopainen et al. (2014) found that patients valued the promise of future caring encounters with the nurse; a trust that bears from day-to-day. These patients trust that the nurse will be available to give time, receive time and have time with them to sustain the relationship. Stedman's (2013) study of new graduate nurses' voices the importance of making connections and keeping promises to patients and families to gain trust in the nurse-patient relationship, while Ranheim et al. (2012) reveal that an optimal patient goal is to achieve trust and confidence in the caring encounter. Development and sustenance of the nurse-patient relationship is noted in two studies (Norman et al., 2016; Persky et al., 2008). Norman et al. (2016) incorporate experiential exercises for trust-building amongst nursing staff, and Persky et al. (2008) report that nurses rated by patients as the most caring provide the most continuity of care from admission to discharge (no data was provided).

Caritas process 5: Promoting expressions of positive and negative feelings; authentically listening to another person's story.

This Caritas Process is basic for all relationships, and in the nurse-patient relationship, being present to allow constructive expression of all feelings is an act of caring and healing (Watson, 2008). Merrill et al. (2012) reveal that allowing the patient to express about his/her disease and treatment was rated of high importance by Latino patient participants (no data was provided). Another study by Bridges et al. (2012) reveals that strong feelings

are provoked for both nurse and patient within the nurse-patient relationship, such as personal enrichment, gratification and privilege. The same study also notes that if aspirations and healing are not fulfilled, feelings of frustration, guilt and regret may be expressed. Persky et al. (2008) reported that nurses who were perceived to be the most caring were the most affected by stress in the relationship (no data was provided).

In a caring relationship, Gustin & Wagner (2013) reveal the importance of promotion of feelings; the nurse and patient must be truthful, and "give voice to what is needed to be said and heard" (p. 178). Nurse participants in a study by Vouzavali et al. (2011) perceive that nurse and patient reveal themselves to one another through a mutual gaze that encompasses each other's world for a deeper understanding of what cannot be communicated.

In addition to provocation and evocation of emotion, authentic listening in the nurse-patient relationship is paramount throughout the literature (Arslan-Oskan et al., 2013; Gustin & Wagner, 2013; Holopainen et al., 2014; Holopainen et al., 2014; Merrill et al., 2012; Norman et al., 2016; Ranheim et al., 2012; Sossong & Poirer, 2013; Stedman, 2013), supporting Caritas Process Five.

Caritas process 6: Using creative, scientific decision-making methods: creatively problem-solving/solution seeking through caring process; full use of artistry of self, embracing all ways of knowing/being/doing/Becoming.

Watson (2008) explains that the ultimate goal of nursing is to deliver quality, humane care. This healing-caring requires the formal use of creative problem-solving with the systematic use of rational logic and all ways of knowing (Watson, 2008). Stedman's (2013) interviews with new nurses' identify a theme that supports this Caritas: nurses' desire in caring is "to make a difference, no matter what." Implementing Watson's Caring Science Theory, Arslan-Ozkan et al. (2013) encourage nurses and patients to be creative and engage in independent problem-solving. Bridges et al. (2012) reveal that nurses recognize the importance of honoring and advocating for the patient's choice in caring; a decision-making process in which patient's and family wishes are central. Ranheim et al. (2012) discusses the importance of individualization and creativity in nursing care, and notes that a major obstacle occurs when nurses get lost in a "common-sense attitude" and pre-set standards that guide the nurse towards noncreative caring. This same study referred to one's ability to see the totality of a person and respond to their needs with an openness to creative and individual solutions as "completeness", thus supporting Watson's sixth Caritas Process.

Caritas Process 7: Sharing teaching and learning: engaging in transpersonal teaching and learning within context of caring relationship; staying within the other's frame of reference.

In this Caritas Process, the patient becomes his/her best own problem-solver (Watson, 2008). Bridges et al. (2012) and Norman et al. (2016) discuss the importance for nurses to take into account the patient's perspective to link nursing interventions with patient outcomes. "Each is responseful to the other's story" (Gustin & Wagner, 2013, p. 179). Patients should be engaged in their

care, but Bridges et al. (2012) suggest that patients may be socialized by the media to place emphasis on technical skills, and not on the teaching-learning relationship. Findings from Beckett's (2013) qualitative study acknowledge that academic nursing emphasizes humanity, morality and openness, but warn that if care is depersonalized, it may just be the nurse-relationship's coping mechanism, not a loss of morality. Nurses claim they have limited control of care within the medical model (Beckett, 2013). Stedman (2013) calls this depersonalized, robotic, task-oriented care noncaring (p. 87).

One study in particular (Arslan-Ozkan et al., 2013) uses psychological interventions based on the mind-body-soul approach of Watson's framework. Women were instructed in relaxation methods and strategies to facilitate coping with infertility. These interventions statistically significantly increased adjustment to infertility ($t = 9.7$, $p < .001$), decreased infertility distress ($t = -8.1$, $p < .001$) and increased perceived selfefficacy ($t = 8.9$, $p < .001$). Between group comparisons in this same study show statistically significant mean differences between groups in adjustment ($t = -4.20$, $p = .001$), distress ($t = -6.42$, $p = .001$), and self-efficacy ($t = 7.33$, $p = .001$), all supporting caring theory-driven practice and Caritas Process seven.

Caritas Process 8: Creating a healing environment at all levels; subtle environment, attending to energetic caring healing field consciousness.

The nurse-patient environment can be supportive, protective, and corrective when comfortable, clean, safe, aesthetic and private (Watson, 2008). One experimental study (Schmock et al., 2009) revealed a statistically significant difference between comparison ($M = 78.89$) and experimental groups ($M = 103.85$) in operating room patients' perceptions of caring ($t = 9.61$, $p < .01$) when the perioperative environment was designed as a caring-healing space (soft lighting, warmth, selected music, artwork) and nurses were educated in Watson's theory. Another similar study (Norman et al., 2016) supports these findings. In contrast, a systematic review by Papastavrou et al., (2011) of nurses' and patients' perceptions of caring found that more information is needed on the relationship between caring behaviors, patient outcomes, and elements of the healthcare environment. Pearcey (2010) revealed caring to be the little things we're not supposed to do anymore, implying that nurses cannot achieve what they want in terms of caring due to constraints of modern health services. Eight studies cited the nature of the clinical setting as a key determinant in building and sustaining therapeutic relationships with patients; concerns were voiced regarding physical environment, resources, staffing, time pressures, management, medical staff, and administrative policies as barriers to patient care (Beckett, 2013; Berry et al., 2013; Bridges et al., 2012; Holopainen et al., 2014; Norman et al., 2016; Sossong & Poirer, 2013; Perksy et al., 2008; Stedman, 2013).

Two similar studies (Berry et al., 2013; Persky et al., 2008) measured caring and work environment conditions as reported by the patient and the nurse, respectively. Persky et al. (2008) found that nurses perceived to be the most caring by patients had more frustration with work environment, had the most work experience, enjoyed their co-workers the most, and were the most affected by

stress in the nurse-patient relationship (no data was provided). A replication study by Berry et al. (2013) found that the patients' perception of caring is statistically significantly related to nurses' satisfaction with environment [F(13, 186) = 2.29, p = .008], relationship with physicians [F(7, 192) = 2.85, p = .007], relationship with nurses [F(7, 192) = 2.30, p = .028], workload [F(10, 189) = 2.89, p = .002], professional patient care index [F(11, 188) = 1.89, p = .043] and feeling about executive team members [F(12, 187) = 2.77, p = .002]. Overall, as nurses' scores on work relationships increased, so did the patients' perceptions of nurses' caring. This direct correlation was incongruent with the results of Persky et al. (2008). Studies by Norman et al. (2016) and Stedman (2013) found that nurse collaboration and teamwork enhanced patient outcome and improved environmental satisfaction. The aforementioned studies provide insight into nurses' desires to provide quality care, actual care delivery, and environmental factors that affect caring.

Caritas Process 9: Assisting with spiritual, emotional and physical human needs: reverentially assisting with basic needs as sacred acts; touching mind body spirit of other while sustaining human dignity. This Caritas Process of caring brings the nurse face-to-face with the sacredness of humanity itself with all its life processes (Watson, 2008). Norman et al. (2016) refer to this as "Caritas Consciousness" (p.406). Vouzavali et al. (2011) refer to such closeness to the patient's body as bearing spiritual qualities: "The body becomes the starting point of the nurse's actions. It is the place where the patient suffers. The body is the sacrificial altar, and the spirit and a soul dwell within" (pp. 145-146.). Holopainen et al. (2014) and TaylorHaslip (2013), refer to the body as the patient's way of being in the world. According to Holopainen et al. (2014), the patient should be allowed to be a patient and a human being with dignity; the body represents both. Three studies reviewed focus on the perceptions of the basic physical needs of caring (Merrill et al., 2012; Papastavrou et al., 2011; Sossong & Poirer, 2013). Merrill et al. (2012) found that meeting physiological needs in a confident and timely manner was highly-rated by Caucasian patients as a significant aspect of caring (no data was provided). Papastavrou et al. (2011) reveals that patients' perceptions of caring places emphasis on physical needs and technical skills, suggesting that patients may not be open or receptive to expressive caring behaviors until physical needs are met. Sossong & Poirer (2013) suggest that healthcare institutions may need to orient inexperienced nurses to be more comfortable and competent in skills so they can be more focused on transpersonal connections with their patients. In this same study, both patients and nurses rate assisting you to meet your spiritual needs lower than the overall mean (no data provided). Due to the complexity of spiritual, emotional, and physical human needs, most studies do not provide enough information to support this ninth caritas process completely.

Caritas process 10: Allowing miracles to enter the relationship: opening to spiritual, existential, mystery, unknowns. Watson (2008) clarifies this last Caritas Process simply by stating that one must be open to unknowns, and things that cannot be controlled; not

everything can be explained. Just one study directly supports this premise, as such:

> *We cannot give meaning to our own lives. It is given to us by others from mystical moments. Another imagines themselves as us and we as them. That which is neither me nor you, but what lies between us from which we both can gain strength, which we carry with us in our hearts… (Holopainen et al, 2014, p. 190).*

Analyses of attributes, behaviors, and concepts of caring in the current literature using Watson's 10 Caritas Processes helps to define the unique caring that is the core of the discipline of nursing (DiNapoli & Nelson, 2010).

Limitations

Although all selected studies were in English, study populations were diversified, posing a limitation on generalizability of the findings. In addition, several studies had small sample sizes, which also limits generalizability. Most of the studies selected did not examine demographic variables that may affect caring. The number of quantitative studies selected was small compared to qualitative studies. Two quantitative studies selected did not provide statistical data. Lastly, due to the complexity of caring in the nurse-patient relationship, interpretations of the researchers may impart biases upon study results.

Discussion

Review of the literature found that the phenomenon of caring in the nurse-patient relationship remains elusive and complex (Beckett, 2013; Berry, et al., 2013; DiNapoli & Nelson, 2010; Fabri, 2013; Holopainen et al., 2014; Papastavrou et al., 2011; Pearcey, 2010; Ranheim, 2012; Sossong & Poirer, 2013; Vouzavali, 2011). Many of the studies consider caring to be essential to the identity of the nurse, and caring has been presented by various nursing scholars and theorists as the guiding, core concept of nursing practice (Brewer & Watson, 2015; DiNapoli & Nelson, 2010; Meng et al., 2011; Merrill et al., 2012; Sargent, 2012; Schmock et al., 2009; Sossong & Poirer, 2013; Watson, 2008, Watson, 2012). Watson's (2008;2012) theory of Human Caring Science is a prevalent underpinning and resource for current research studies on caring (ArslanOzkan, 2013; Berry et al., 2013; Brewer & Watson, 2015; DiNapoli & Nelson, 2010; Gustin & Wagner, 2013; Holopainen et al., 2014; Meng et al., 2011; Norman et al., 2016; Persky et al., 2008; Ranheim et al., 2012; Schmock et al., 2009; Sossong & Poirer, 2013; Vouzavali, 2011; Watson, 2008, 2012; Watson & Brewer, 2015; Watson & Browning, 2012). Human Caring Science Theory is a foundation for qualitative and quantitative research in nursing science, is a prominent theoretical framework for nursing practice in healthcare systems internationally, and the basis of a nursing doctoral program in caring science as sacred science (Watson 2008, 2012, 2014; Watson & Brewer, 2015; Watson & Browning, 2012). Watson's 10 caritas processes contained within the theoretical framework encompass many of the behaviors, attributes, and emotions cited in various other nursing caring theories (Boykin & Schoenhofer, 1993; Leininger, 1978; Roach 1984, 2002; Swanson, 1991) and current caring literature. Watson (2008) describes these processes as connections between caring and love, enabling human-to-human connection from an open, intelligent heart

center rather than the ego center. These processes provide direction for discussion of this state of the science.

Loving kindness and equanimity of self/other and authentic presence (Watson, 2008, 2012), are often described together in the literature as the interconnectedness and 'encounter' of the nurse-patient relationship (Bridges et al., 2012; Holopainen et al., 2014; Norman et al., 2016; Ranheim et al., 2012). Equanimity of self/other is the antecedent of the relationship, referring to the nurse's intention or consciousness of being with the patient, and the nurse's and patient's allowance of the relationship to happen or flow between the two, without judgment (Norman et al., 2016; Ranheim et al., 2012; Watson, 2008, 2012). It is a deep love for human value and vulnerability (loving kindness) that incentivizes the relationship (Fabri, et al., 2013; Gustin & Wagner, 2012; Meng, et al., 2011; Ranheim et al., 2012; Stone, 2011; Watson, 2008, 2012). The nurse experiences a sense of awareness, a contemplation of the other's suffering, with an intent to do whatever it takes to relieve that suffering selflessly (Gustin & Wagner, 2013; Meng, et al., 2011; Ranheim, et al., 2012; Stone, 2011; Todaro-Franceschi, 2013; Watson, 2008, 2012). This awareness manifests itself as compassion (Fabri, et al., 2013; Gustin & Wagner, 2013; Stone, 2011; Todaro-Franceschi, 2013; Vousavali et al., 2011; Watson 2008, 2012). Along with love and compassion, nurses may experience feelings of awe towards patients and their circumstances, often in admiration of human uniqueness (Vouzavali, 2011).

Authentic presence is a mutual "being" of self and other; it is a mindful interdependence of openness and sharing (Bridges et al., 2012; Holopainen et al., 2014; Merrill et al., 2012; Norman et al., 2016; Ranheim et al., 2012; Vouzavali et al., 2011; Watson 2008, 2012). Authentic presence instills hope and faith in both nurse and patient; each is hope, and gives hope to the other, while allowing their faiths to help with healing and contentment (Bridges et al., 2012; Fabri et al., 2013; Watson, 2008, 2012).

Sensitivity to self and others by cultivating one's own growth and spiritual practices, is often referred to by nurse scholars and eastern philosophers (Chodron, 2008; Stone, 2011; Todaro-Franceschi, 2013; Watson, 2008). This process, often intertwined with compassion and love, is referred to as 'bodhichitta', the ability to identify altruistically with another, using loving kindness and meditation to awaken and open one's mind and heart, and to expose our most sensitive, vulnerable self (Chodron, 2008; Stone, 2011; Todaro-Franceschi, 2013; Watson, 2008). It is, in part, the nurses' enhanced sensitivity and compassion to feel the pain with another (Chodron, 2008; Stone, 2011; Dalai Lama, 2001; Stone, 2011; Todaro-Franceschi, 2013). The word, "sensitivity", is often used plainly, sometimes as a synonym for awareness. However, the meaning of the word does not convey the intricate process of growing spiritually and intellectually with it. "Sensitivity" alone cannot reach the depth and breadth of what the third caritas process actually is.

Watson (2008), in the fourth caritas process of developing and sustaining the loving, trusting, helping, and caring nurse-patient relationship, incorporates the first three processes. Trust is introduced here as

the factor of sustenance (Holopainen et al., 2014; Norman et al., 2016; Ranheim, et al., 2012; Taylor-Haslip, 2013). Trust instills and perpetuates belief in self and other, and is earned with truth and openness (Bridges et al., 2012; Gustin & Wagner, 2013). Trust is necessary for teaching, for learning, for caring, for feeling (Norman et al., 2016). It is trust in one's self, in the other, and in the nurse-patient relationship that keeps the relationship moving, makes good on promises, and promotes healing (Holopainen et al., 2014; Perksy et al., 2008; Ranheim et al., 2012; Stedman, 2013; Taylor-Haslip, 2013). The concept of trust in the nurse-patient relationship is accompanied by the concept of vulnerability (Gustin & Wagner, 2013; Holopainen et al., 2014; Watson 2008, 2012). The two concepts seem to satiate each other: when one's guard is down, there seems to be more trust, and when one senses more trust, their guard can be let down. Trust is a requirement for sustaining a therapeutic nurse-patient relationship (Holopainen et al., 2014).

Promoting expression of feeling, both positive and negative, is a manifestation of trust. It is a human need to listen and be heard; to speak and be spoken to; to touch and be touched; to smell and be smelled; to see and be seen. Patients' perceptions of caring confirm this (Merrill et al., 2012). Combined with trust, the human desire to use the senses initiates the flow of emotions. Nurse and patient are open and present with each other to allow an array of feelings to propagate (Stone, 2011; Todero-Franceschi, 2013; Vouzavali et al., 2011; Watson, 2008). One's feelings and expressions, whether verbal or non-verbal, stimulates the senses of the other, evoking response (Meng et al., 2011; Vouzavali, 2011). The authenticity of this process is that it is infinite, continually occurring without interference. One responds to the other, and so on, with an inertia that potentiates the process towards healing. A natural human assessment between people involves every sense and expressive motion or movement possible to give and gather information about the relationship (Gustin & Wagner, 2013; Vouzavali, et al., 2011). The Human Caring Science Theory is constructed on authenticity of everything (Watson, 2008). It seems unfortunate that Watson (2008) limits this caritas process in words to just "listening".

The processes of creating scientific decision-making methods and sharingteaching-learning are initiated from expressions and feelings, nurse-patient interaction, and communication (Arslan-Oskan et al., 2013; Watson, 2008). The sixth and seventh caritas processes reflect the development of individualized and creative intervention strategies developed by nurse and patient, based on physical and psychosocial needs, emotions and beliefs shared within the relationship. Patient and family should be encouraged to be involved in caring, and their wishes made central to the decisionmaking process (Bridges et al., 2012; Papastavrou et al., 2011; Sossong & Poirer, 2013). The nurse-patient agreement is key to patient satisfaction, and consequently, comfort, health behaviors and healing (Papastavrou et al., 2011). Communication and perception of caring are integral to caring decisions, teaching and learning; both the nurse and patient should be "on the same page" as far as priorities and goals (Meng, et al., 2011). An incongruence exists between

the nurses' and patients' perceptions of caring (Beckett, 2013; Papastavrou et al., 2011; Persky et al., 2008). Nurses value holistic caring, and recognize the need for authenticity and compassion in the nursepatient relationship (Beckett, 2013; Berry et al., 2013; Papastavrou, 2013; Pearcey, 2010; Vouzavali, 2011). Nurses voice concern regarding their ability to provide compassionate care within the confines of health systems (Beckett, 2013; Papastavrou et al., 2011; Pearcey, 2010; Persky et al., 2008). Patients, on the other hand, place a greater emphasis on basic physical needs and technical skills (Papastavrou et al., 2011; Sossong & Poirer, 2013). Ethnic differences in patients' perceptions of caring indicate that culture can significantly influence the nurse-patient relationship (Merrill et al. 2012).

Authentic presence elicits a compassion to view the patient as another self, and to do whatever is necessary to lessen the other's hardship (Dalai Lama, 2001; Stedman, 2013; Stone, 2011). The art of nursing is the intentional, creative use of oneself, based upon knowledge and expertise, to transmit knowledge and meaning for the other's healing (Jenner, 1997). It is important to take the patient's perspective into account when practicing this art to minimize caring perception incongruence in planning care (Bridges et al., 2012). Staying within the patient's frame of reference evokes feelings of empowerment, encouragement, motivation, and positive thinking (ArslanOskan et al., 2013). It also promotes subjective creativity and imagination, customized teaching and learning, and individualized problem-solving for engagement and self-care (Arslan-Oskan et al., 2013; Jenner, 1997). Some creative caring interventions are deep breathing and relaxation exercises, aesthetic and comfortable environmental changes, and back massage (Arslan-Oskan et al., 2013; Schmock et al., 2009). The full use of artistry of self and other in the nurse-patient relationship adds richness and new possibilities for healing (Sossong and Poirer, 2013).

The importance of the healing environment, as first emphasized by Nightingale (1860), continues to evolve and maintain its significance in the nurse-patient relationship (Norman et al., 2016; Watson, 2008). To create a healing environment that is conducive to intimate interaction, the nurse must respect the patient's humanity, dignity, needs, and desires while meeting physical, emotional, and spiritual needs (Nightingale, 1860; Schmock, 2009; Watson, 2008, 2012). Nursing's artistry and compassion are impetuses to incorporate mind, body and spirit with environmental factors to sooth senses, control anxiety and pain, provide comfort, and create a sense of well-being so natural healing may occur (Jenner, 1997; Schmock, 2009; Nightingale, 1860; Watson, 2008). The nurse-patient relationship is present within the environment, mutually sharing, and together, are part of a greater whole (Rogers, 1970; Watson, 2008). Numerous research studies have supported the significance of environment for healing in nursing practice. Some focus on the patient's sacred space; the physical, mental, and spiritual environment where caring interaction occurs (Stone, 2011; Watson, 2008, 2012). The incorporation of things like music, lavender, candlelight, scent, color, fresh air and warmth have significant impact on patient healing and

patient satisfaction with caring (Arslan-Ozcan, 2013; Jenner, 1997; Norman et al., 2016; Schmock, 2009; Stone, 2011). Others focus on the greater environment, such as institutional layout, organizational factors, administration, time, workload, and interdisciplinary relationships (Beckett, 2013; Berry et al., 2013; Bridges et al., 2012; Holopainen et al., 2014; Pearcey, 2010; Sossong & Poirer, 2013; Stedman, 2013; Persky et al., 2008). The environmental nature surrounding nurse and patient significantly affects the sustenance of the relationship and the efficacy of caring and healing. (Bridges et al., 2012; Watson, 2008; 2012).

Caring is a privilege in which one is intimate with another in mind, body, and spirit. (Norman et al., 2016; Watson, 2008, 2012). Compassion in caring provokes virtuous action (Todero-Franceschi, 2013, p. 33). The act of touching another person transcends beyond the physical body where the spirit of another is deeply affected (Watson, 2008). Each caring act the nurse performs in a loving kind way provides feelings of security, safety and protection for the patient (Gustin & Wagner, 2013; Watson, 2008; 2012). The nurse touches the life force, the soul of another (Watson, 2008). It is the love for humanity that impels nurses to minister sacred acts while preserving human dignity and life.

The mystery of life evolves. We do not know where life will go, or where it came from. Life is, and then life is not. Life cannot be explained. Life is the miracle, and as nurses we have belief and commitment to allow life, as such.

Implications

Research has established that caring attributes are significant individually, but when taken together, represent a much greater whole: the human caring experience. Several theoretical frameworks on caring, including Watson's (2012), attempt to carefully define caring in the nurse-patient relationship. These frameworks are significant, but when taken together can be much more impactful on caring and nursing. One implication for future research would be a systematic integration of existing caring theories to substantiate the core caring attributes and processes, and minimize misinterpretation.

Instruments developed from nursing caring theory frameworks are structured for empirical measurement, and are designed to be brief and concise. The abbreviation of complex caring concepts for a simplified tool can distort the concepts, or convey meanings that are not representative of the concepts. Future research focused on caring instrument accuracy and representation of the phenomenon is warranted.

There is little qualitative caring research from the patient's perspective. Future phenomenological research on patients' perspectives of caring can provide truer insight into what patients' need and expect as human beings in the nurse-patient relationship.

Summary and Conclusion

Analysis of the literature has shown that the phenomenon of caring in the nursepatient relationship remains elusive and complex. As nursing continues to grow as a science, there is genuine effort to define, understand, and operationalize the phenomenon of

caring in the nurse-patient relationship. Quantitative research using theory-based tools helps to provide empirical data on human caring for the advancement of professional practice (Watson & Brewer, 2015). Nurse theorists are instrumental in the recognition of caring as integral to the profession, and it is evident that Jean Watson (2008, 2012) has had enormous impact on the phenomenon. The 10 Caritas Processes may be used as a structural framework to categorize attributes, behaviors, and concepts related to caring as found across the literature.

The research reveals that the nurse-patient relationship is a caring, transpersonal relationship that begins with a conscious intention of love of self, other, and being human. Caring is the willingness to be authentically present with another, instilling hope, with openness and mutuality. Caring emotes compassion, with respect for the other. Love and trust provide the sustenance for the caring nurse-patient relationship, and enable the evocation of true feelings. Caring requires both knowledge and creativity for teaching, learning and decision-making. An environment that is conducive to healing and incorporates the patient's "sacred space" preserves human dignity and enables sacred acts of caring to be performed. Caring is a privilege to be intimate with another in mind, body, and spirit, and allows the miracle of life.

Though nurses' perceptions throughout the literature support the Caritas Processes of caring, further research is needed to examine patients' lived experiences of the nurse-patient relationship and caring.

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Appendix A

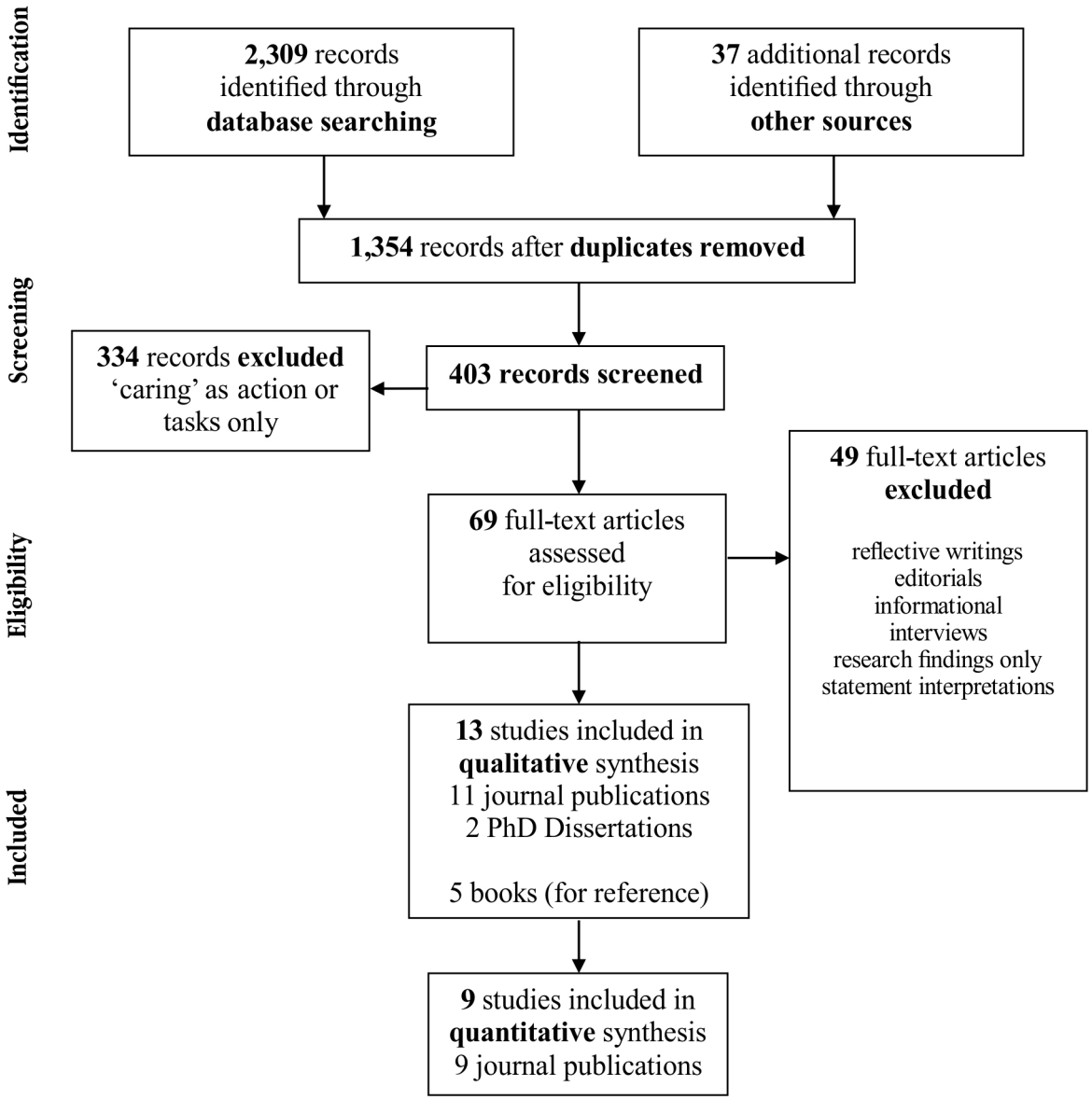
Table

Search terms

Caring	Nurse	Patient	Relationship
Care	Nurses	Patients'	
	Nurses'		
	Nursing		
	Nurse-Patient		
	Nurse Patient Relationship		

Appendix B

PRISMA flow process of information for current systematic review (Moher , 2009)



THE PHENOMENON OF CARING

Appendix C

Quantitative studies critical appraisal checklist (Bowling, 2009)

	1. Aim and objectives	2. Research question	3. Variables stated	4. Variables clear	5. Design	6. Method appropriate	7. Instruments tested	8. Sample described	9. Error	10. Ethics	11. Piloted	12. Analysis adequate	13. Results	14. R/t hypothesis	15. Limitations	16. Conclusions	17. Generalize	18. Implications	19. Conflict	20. Accessible data
1 Arslan-Ozkan et al. (2013)	×	×	×	×	×	×	×	×		×		×	×	×	×	×			×	×
2 Berry et al. (2013)	×	×	×	×	×	×	×	×		×		×	×	×	×	×	×	×	×	×
3 Brewer & Watson (2015)	×				×	×	×	×		×		×	×		×	×	×	×		×
4 DiNapoli & Nelson (2010)	×	×	×	×	×	×	×	×		×	×	×	×	×	×	×	×	×	×	×
5 Merrill et al. (2012)	×		×	×	×	×	×	×					×	×	×	×	×	×		
6 Papastavrou et al. (2011)	×	×	×	×	×	×	×	×				×	×	×	×	×	×	×	×	
7 Persky et al. (2008)	×		×	×	×	×	×	×		×		×	×	×	×	×	×	×		
8 Schmock et al. (2009)	×	×	×	×	×	×	×	×				×	×	×	×	×	×	×	×	×
9 Sossong & Poirer (2013)	×		×	×	×	×	×	×		×		×	×	×	×	×	×	×		

Appendix
Qualitative findings critical appraisal scale
(Pearson, 2004)

	Criteria	**1.** Beckett (2013)	**2.** Bridges et al. (2012)	**3.** Fabri et al. (2013)	**4.** Gustin & Wagner (2013)	**5.** Holopainen et al. (2014)	**6.** Holopainen et al. (2014)	**7.** Meng et al. (2011)	**8.** Norman et al. (2016)	**9.** Pearcey (2010)	**10.** Ranheim et al. (2012)	**11.** Stedman (2013)	**12.** Taylor-Haslip (2013)	**13.** Vouzavali et al. (2011)
1	Congruity between stated philosophical perspective and research methodology		X		X	X	X	X	X	X	X	X	X	X
2	Congruity between methodology and research question or objectives	X	X	X	X	X	X	X	X	X	X	X	X	X
3	Congruity between methodology and methods used to collect data	X	X	X	X	X	X	X	X	X	X	X	X	X
4	Congruity between methodology and representation and analysis of data	X	X	X	X	X	X	X	X	X	X	X	X	X
5	Congruity between methodology and interpretation of results	X	X			X	X	X	X	X	X	X	X	X
6	There is a statement locating the researcher culturally or theoretically			X		X	X	X					X	X
7	The influence of the researcher on the research, and vice-versa is addressed		X		X		X						X	X
8	Participants and their voices are adequately represented	X	X	X		X			X	X			X	X
9	Ethical according to current criteria, evidence of ethical approval		X		X		X	X		X		X	X	X
	Conclusions drawn flow from analysis or interpretation of data	X	X	X	X	X	X	X	X	X	X	X	X	X

Appendix E
Critical appraisal of literature (Pitt, 2012)

	Criteria	Yes	No
	Quantitative studies critical appraisal checklist (Bowling, 2009)		
1	Aims and objectives clearly stated	9	0
2	Hypothesis/research question clearly stated	5	4
3	Dependent and independent variables clearly stated	8	1
4	Variables adequately operationalized	8	1
5	Design adequately described	9	0
6	Method appropriate	9	0
7	Instruments used tested for reliability and validity	9	0
8	Source of sample, inclusion/exclusion, response rates described	9	0
9	Statistical errors discussed	0	9
10	Ethical considerations	6	3
11	Was the study piloted	1	8
12	Statistically analysis appropriate	8	1
13	Results reported and clear	9	0
14	Results reported related to hypothesis and literature	7	2
15	Limitations reported	9	0
16	Conclusions do not go beyond limit of data and results	9	0
17	Findings able to be generalized	9	0
18	Implications discussed	9	0
19	Existing conflict of interest with sponsor	4	5
20	Data available for scrutiny and re-analysis	7	2
	Qualitative studies critical appraisal checklist (Pearson, 2004)		
1	Congruity between stated philosophical perspective and research methodology	11	2
2	Congruity between methodology and research question or objectives	13	0
3	Congruity between methodology and methods used to collect data	13	0
4	Congruity between methodology and representation and analysis of data	13	0
5	Congruity between methodology and interpretation of results	11	2
6	There is a statement locating the researcher culturally or theoretically	9	4
7	The influence of the researcher on the research, and vice-versa is addressed	5	8
8	Participants and their voices are adequately represented	8	5
9	Ethical according to current criteria, evidence of ethical approval	8	5
10	Conclusions drawn flow from analysis or interpretation of data	13	0

Appendix F
General description summary of included studies

No.	Author(s) and year	Country	Research Aims	Sample	Research Design	Analytical Method	Findings
1	Arslan-Ozkan et al. (2013)	TR	To investigate the effects of Watson's Human Caring Science on women with infertility	Women with infertility at a university hospital infertility center Control group (n = 53) Intervention group (n=52)	Quantitative; Prospective, randomized controlled trial Control group received routine nursing care Intervention group was interviewed according to caritas processes and was trained in relaxation. Intervention group also kept a diary for experience evaluation	Descriptive statistics Chronbach's alpha was used to determine reliability of the scales t-tests for group comparisons	The intervention group showed a statistically significant decrease in infertility distress ($t = 8.1$, $p < .001$), increased infertility self-efficacy ($t = -8.9$, $p < .001$) and increased adjustment levels to infertility ($t = 9.7$, $p < .001$) from pre- to post- intervention. The control group showed no statistically significant difference in infertility distress, self-efficacy, or adjustment levels. Comparison t-tests revealed statistically significant differences between groups post-interventions ($t = -6.42$, $p < .001$), ($t = 7.33$, $p < .001$), ($t = -4.20$, $p < .001$).
2	Arslan-Ozkan et al. (2013)	UK	To obtain, compare and contrast perspectives on caring from nurses and physiotherapists	Physiotherapists (n=11) Nurses (n = 12) All participants were involved in trauma care	Qualitative; Independent nested Semi-structured interviews with specific questions asked regarding service provision	Thematic analysis	Both groups faced challenges, but nurses felt the context of their work was not conducive to caring, and had less job satisfaction than the physiotherapists
3	Berry et al. (2013)	US	To examine factors that influence the relationship between nurses' satisfaction with job environment and patients' perception of caring	Nurses (n = 20); for each nurse, data was collected from 10 patients for whom they cared for (200 nurse-patient dyads	Quantitative; Instrumental Each nurse completed the HES (healthcare environment survey); each patient completed the CFS (caring factors survey) based on Watson's framework	Descriptive statistics ANOVA was used to determine relationships between the nurse HES score and the patient CFS score, and also the relationship between the nurse HES and the variability within the CFS scores of the patients the nurse cared for	As nurses' positive perceptions of the work environment (work area, physicians, other nurses, workload) increased, patients' perceptions of caring increased ($p < 0.05$) to the nurses' perceptions of the work environme
4	Bridges et al (2012)	UK	To synthesize evidence and knowledge from research about nurses' experiences of nurse-patient relationships in acute hospital settings	Sixteen primary studies (18) papers	Synthesis via meta-ethnographic method	Repeated readings, first, second and third order interpretations followed by comparisons for similarities and differences	Constructs revealed: 1. Nurse-patient relationships (characterizations and strategies) A. Connecting with patients B. Knowing the individual C. Involving patients in their care 2. Emotional impact on nurses 3. Influence of clinical setting on capacity to care

Appendix F
General description summary of included studies

No.	Author(s) and year	Country	Research Aims	Sample	Research Design	Analytical Method	Findings
5	Brewer & Watson (2015)	US	To present an instrument and comparative database designed to evaluate patients' perceptions of caring behaviors of caregivers	Random sample of patient responses (n = 1010) from 48 units in 8 hospitals across the US. Patients were on unit >24 hours, >18 years old, and able to complete the WCPS in English.	Quantitative; The Watson Caritas Patient Score (WCPS), a 5-item, Likert-type scale, was distributed to hospitalized patients.	Data analysis used the Statistical Package for the Social Sciences (Armonk, NY). Individual-level data were aggregated to unit-level and then evaluated for group-level validity. Descriptive statistics evaluated differences across unit types and hospitals. Spearman p non-parametric correlations were performed to examine relationships among caring items & unit-level quality indicators. Each WCPS item and WCPS score were correlated with Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) scores for the participating units.	All individual items and the scale score proved acceptable (F > 1.4, p < .05) for aggregated individual care items to reflect a group (patient care unit) score. Two HCAHPS items (communication with nursing and responsiveness of hospital staff) correlated with 3 of the WCPS items: Communication with nursing correlated with 1. Meet my basic needs with dignity (Spearman p = 0.33, P < .05) 2. Helping and trusting relationships (Spearman p = 0.36, P < .05) 3. Create a caring environment that helps me to heal (Spearman p = 0.43, P < .01) Responsiveness of hospital staff correlated with Helping and trusting relationships with me (Spearman p = 0.33, P < .05) The WCPS is a valid and reliable tool to measure the effectiveness of human caring theory in a professional practice environment. The tool is successful in comparing caring behaviors across hospitals and unit types.
6	DiNapoli & Nelson (2010)	US	To develop a brief,10-item survey to measure the caritas process of caring from Watson's original, 20-item Caring Factor Survey (10 facets measured by 2 statements each)	Patients and families (n = 89) Secondary data from a collected database including nurses (n = 450)	Quantitative; Exploratory factor analysis and principle component factor analysis	Exploratory & Principle Component Factor Analysis	The revised, 10-item CFS is reliable (α = 0.95) for measuring caring

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General description summary of included studies

No.	Author(s) and year	Country	Research Aims	Sample	Research Design	Analytical Method	Findings
7	Fabri et al. (2013)	PT	To analyze nursing knowledge related to caring	Primary care nurses from 10 different units in Juiz de Fora, Portugal (n = 18)	Qualitative; Descriptive, exploratory Semi-structured interviews including a questionnaire about caring	Data analysis used three steps: 1. Pre-analysis (organization of material) 2. Categorization and data analysis 3. Data interpretation	Four categories emerged as being attributes in caring: 1. Compassion 2. Health prevention and promotion 3. Systemization of nursing actions (Nursing process) 4. Product of administration guidelines
8	Gustin & Wagner (2013)	SE	To explore the participants' understanding of self-compassion as a source to compassionate care.	Clinical nursing teachers with an interest in learning about themselves and Watson's Theory of Human Caring (n = 4)	Qualitative; Clinical application research Four clinical nursing teachers met for twelve hours of experiential and reflective work – written and oral reflections on human caring focusing on the first five of Watson's 10 caritas processes	Phenomenological-hermeneutical method. Three steps: 1. naïve reading, 2. structural analysis 3. interpretation of the whole	Compassionate care is not an intervention from the caregiver; it is an interpersonal phenomena Five themes: 1. Being there, with and for self and others 2. Respect for human vulnerability 3. Being non-judgmental 4. Giving voice to things that need to be said and heard 5. Ability to accept compassion from others "Butterfly effect" – small acts of compassionate caring make change that transcends the present
9	Holopainen et al. (2014)	FI	To gain a deeper understanding of the essence of the caring encounter	Philosophical reference works (n = 10)	Qualitative; Hermaneutic interpretation	Four steps: 1. reading 2. interpretation 3. theme categorization 4. interpretation of the whole	The essence of the caring encounter: 1. Being in presence 2. Encounter as recognition 3. Encounter as availability 4. Encounter as mutuality 5. Encounter as togetherness – the mutual glimpse of Mystery 6. The New Understanding
10	Holopainen et al. (2014)	FI	To understand the meaning of the caring encounter in women with breast cancer	Women diagnosed with breast cancer no more than 3 years previously (n = 49)	Qualitative;Secondary analysis of a primary research Questionnaire consisting of statements about caring encounters. Questionnaires were distributed to women attending follow-up control visits for breast cancer	Phenomenological-hermeneutical method. Meaning of text is interpreted with a process of three re-readings: 1. for how encounter takes shape 2, for finding prerequisites 3. for core message	The interpretation of text resulted in four themes: 1. Promises of a future encounter comforts 2. Trust is established in the caring experience 3. Giving/receiving time = mutual time 4. Permission is given to be both human and patient

Appendix F
General description summary of included studies

No.	Author(s) and year	Country	Research Aims	Sample	Research Design	Analytical Method	Findings
11	Meng et al. (2011)	CN	To describe the components of caring in nursing in the context of Chinese culture	Scholars of nursing, medicine and the humanities with knowledge of and experience in caring from a variety of agencies and demographic locations in China (n = 16)	Grounded theory; Individual, tape-recorded non-structured interviews Two-round Delphi technique via correspondence	Qualitative content comparative analysis for categorization	Caring is a synthesis (integrated concept) of four concepts: 1. attitude 2. knowledge 3. ability 4. perceptions Four concepts can be used as teaching objectives for caring, and for applying and evaluating nursing in the Chinese culture
12	Merrill et al. (2012)	US	To examine how trauma patients with multiple injuries requiring hospitalization perceive nurses' caring behaviors	Convenience sample; Adult, level II trauma inpatients (n = 103); both men (n = 69) and women (n = 34)	Interview format-verbal questioning/answering with the 42-item CBI (Caring Behaviors Inventory) with a 6-point Likert scale	Descriptive statistics	The patients rated the caring behavior of their nurses very highly (M = 5.45). They valued nurse behaviors that demonstrated patience and attention to their needs (explained 51.85% of the total variance) Chi-square showed that gender [$\chi 2(4)11.893$, $p < .001$] and ethnicity [$\chi 2(4) = 328.257$, $p < .001$] did not make a significant difference in the ratings The modified CBI is reliable and valid for trauma patients' perceived caring behaviors in their nurses
13	Norman, Rossillo, & Skelton (2016)	US	To create a healing environment for patients and staff through the implementation of Watson's 10 Caritas Processes	All nursing staff in in-patient areas in a Catholic hospital in California	Qualitative; Narrative summary Experiential teaching and learning approach to explore Watson's theory with staff members.	Two staff nurses from the unit attended the six-month Watson Caring Science Institute Caritas Coach Education Program (CCEP) to become committed to Caritas principals and to model heart-centered approaches to health care. These two nurse Caritas Coaches educated the nurse leaders, nursing education staff, and unit staff using experiential teaching and learning (caring language, simulation, and patient empathy). The Caritas Coaches and nurse leaders conducted weekly Caritas sessions with the staff to introduce the theory.	Staff nurses incorporated Caritas Processes in electronic patient care plans, clearly documenting caring interventions. Nursing leadership and staff expressed greater ease and understanding of Watson's theory. Patient feedback was positive regarding their caring experience. Patients were receptive to the positive energy of the Caritas nurse.

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General description summary of included studies

No.	Author(s) and year	Country	Research Aims	Sample	Research Design	Analytical Method	Findings
14	Papastavrou CY et al. (2011)		To examine the congruence between patients' and nurses' perceptions of caring behaviors, and identify areas of agreement and disagreement between these perceptions	Quantitative research studies published in scientific journals with focus on nurse-patient interaction and patient outcomes in varied settings (n = 24)	Quantitative; systematic review; narrative summary approach	Data was extracted and categorized by two members of the research team and a narrative synthesis of data was performed	There is considerable evidence of no congruence between patients' and nurses' perceptions regarding which behaviors are considered caring; intended caring is not always perceived as such by the patient.
15	Pearcey UK (2010)		To examine the meaning of caring in nursing in the current clinical environment	Nurses from five different hospitals (n = 25)	Qualitative; Interview, with semi-structured format	Coding and categorization A framework of values was used for categorization: the personal value of caring is the one discussed	Nurses feel caring in nursing is difficult to define and achieve in the current cost-dominated culture of healthcare (not enough time to care, administration has little value for caring)
16	Persky et al. (2008)	US	To create a profile of nurses who are effective in caring within Watson's caritas framework	Primary care nurses (n = 87) paired with patients from med-surg/psych to form dyads (n = 85)	Quantitative: Descriptive; Correlational Participative Action Research (PAR) process HES (Healthcare environment Survey) completed by nurses CFS (Caring Factor Survey) completed by patients Qualitative: Factor comparison between both groups	Correlation tables were used to link data from the two instruments (HES and CFS) for each dyad Analysis of variance t-tests Qualitative: Data from HES was themed and categorized	The HES (α =.95) and CFS (α =.97) provided good reliability Nurses said to be caring by their patients: 1. reported most frustration with environment and workload 2. were the most experienced 3. work their scheduled hours only 4. are the most affected by stress in the patient relationship 5. enjoy coworker relationships 6. most often provide continuity of care

Appendix F
General description summary of included studies

No.	Author(s) and year	Country	Research Aims	Sample	Research Design	Analytical Method	Findings
17	Ranheim et al. (2012)	SE	To consolidate Watson's transpersonal caring theory with the findings of three studies to reveal nurses' caring intentions and their lived experience of reflecting caring theory into practice	Watson's theory of caritas processes and empirical results from three studies conducted by author	Qualitative; Simultaneous concept analysis (SCA) by four nurse researchers with varied backgrounds and perspectives	Simultaneous concept analysis (SCA) 9 steps: 1. development of consensus group 2. selection of concepts for analysis (nine) 3. Refinement of concept clarification approach 4. clarification/refinement of individual concepts 5. Development of validity matrices 6. Revision of individual concepts 7. Re-examination of validity matrices 8. Development of process model 9. Results from SCA/submission	A process model was developed to reveal the dynamics of caring theory and caring practice Nine key concepts were found to be interrelated with their outcomes being "larger than the whole" (mediating care): 1. Interconnectedness 2. Contemplation 3. Insight 4. Intergrade (approaching) 5. Completeness 6. Contentedness 7. Reflexivity 8. Intentionality 9. Interdependence
18	Schmock et al. (2009)	US	To create an alternative to the traditional environment for surgical patients in the operating room designed according to Watson's Theory of Human Caring Science	Comparison Group (n=50) Experimental Group (n=50)	Quantitative; Post-test only design with comparison group	Descriptive statistics t-tests	There was a statistically significant mean difference (t = 9.61, p < .01) in perceived sacred space evaluation between the experimental group (M = 103.85) and the comparison group (M = 78.89). There was a statistically significant mean difference (t = 2.80, p = .006) in perceived nursing care behaviors between the experimental group (M = 29.87) and the comparison group (M = 29.05). There was no statistically significant mean difference in patient satisfaction by group.
19	Sossong & Poirer (2013)	US	To compare nurses' and patients' perceptions of caring using Wolf's CBI-E	RNs (n = 216) Elderly patients (n = 228); both groups from a large, rural US medical center	Quantitative; Comparative, cross-sectional design	Descriptive statistics t-tests	Overall, nurses rated their caring behavior higher than patients did. Statistically significant differences were found between patients' and nurses' perceptions of caring on specialty units Findings indicated some areas of congruency (humanistic aspects of caring) and some areas of incongruence (interpersonal skills and technical skills – no stats given)

Appendix F
General description summary of included studies

No.	Author(s) and year	Country	Research Aims	Sample	Research Design	Analytical Method	Findings
20	Stedman (2013)	US	To examine caring and non-caring patient encounters of graduate nurses	Graduate RNs from four public colleges in NYC AAS program (n = 23)	Qualitative; Phenomenological Semi-structured interviews	Modified van Kaam method 1. horizontalization 2. reduction 3. validation 4. individual description 5. textural description 6. structural description 7. textural-structural description	Six themes for caring: 1. Making a difference no matter what 2. Making connections with patients, families, and co-workers 3. Collaboration and teamwork 4. Noncaring: Becoming robotic 5. Time and resources: Not enough of either 6. Administration: The great divide
21	Taylor-Haslip (2013)	US	To understand the lived experience of caring presence among nursing students and faculty and reveal the meaning of the phenomena for each group	Non-probability snowball sampling; Faculty, full-time (n = 9) Nursing Students (n = 6)	Qualitative; Phenomenological hermeneutic approach Unstructured, digital audiotaped interviews	Interviews were transcribed, reflected upon, and categorized into essential themes. Themes were interpreted and analyzed to formulate a description of the experience of caring presence.	"Caring presence among nursing faculty and nursing students is intimate metaphysical caring as being available through a caring connection of unity through presencing, with openness in a trusted relationship of heart-centered caring and concern while lifting another to a pathway of transitions and transformative change (Taylor-Haslip, 2013)"
22	Vouzavali et al. (2011)	US	To explore ICU nurses' perceptions of nurse-patient relationships	Intensive care RNs in Athens (n = 12)	Qualitative; Phenomenological interviews	Interpretive analysis Categorization by theme	Emerging Themes in Nurse-Patient Relationship: Core theme: Syncytium 1. Emotive aspects A. love B. awe C. compassion 2. Perception of ownership in the relationship 3. Spatiality and temporality of the nurse-patient relationship 4. A relationship of care via the patient's body and gaze 5. Patient's Gaze 6. Empathy 7. Nurse's role perception 8. Perception of death

Note. CN = China, CY = Cyprus, FI = Finland, GR = Greece, PT = Portugal, SE = Sweden, TR = Turkey, UK = United Kingdom, US = United States