

Nursing Standard

spirituality

Why you should read this article:

- To understand how to incorporate spiritual care into your day-to-day nursing practice
- To be aware of the competencies and personal qualities required to provide effective spiritual care
- To familiarise yourself with the concepts of availability and vulnerability in relation to spiritual care

Understanding the role of spirituality in providing person-centred care

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Abstract

An awareness of the concept of spirituality is integral to the provision of person-centred holistic care. However, the nurse's ability to provide spiritual care is often impeded by time pressures and the prioritisation of clinical tasks. Confusion about the meaning of spirituality and its relationship to religion may also compound the challenges involved in providing spiritual care, and nurses often feel ill-equipped to address this area of care. This article discusses the challenges associated with the concept of spirituality, and describes the competencies and personal qualities that nurses require to achieve spiritually competent practice. It also explains the concepts of availability and vulnerability, which can support the personal development required for nurses to become spiritually competent.

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Keywords

care, compassion, patient experience, patients, professional issues, spiritual care, spirituality, therapeutic relationships

Key points

- *Wattis et al (2017) defined spiritually competent practice as ‘compassionate engagement with the whole person as a unique human being, in ways which will provide them with a sense of meaning and purpose’*
- *The nurse’s capacity for implementing spiritually competent care is related to their individual personality traits and their ability to empathise with others*
- *Nurses are well placed to connect with patients who are experiencing illness and personal crisis, and it is this connection that forms the basis of spiritually competent nursing*

During periods of illness, nurses are often required to undertake personal and intimate nursing interventions for patients, while patients must trust nurses to provide optimal care. Throughout these periods of illness and distress, some patients may ask questions such as: ‘Why is this happening to me?’, ‘How will I cope?’ and ‘What does this mean for my life?’ (Rogers and Wattis 2015). For patients, these questions relate to hope, meaning and purpose, which are all important elements of spirituality. However, some nurses may be uncertain about the role of spirituality in nursing and how it can be integrated into their practice (Lewinson et al 2018).

Clarke (2013) recognised spirituality as an intrinsic component of holistic care, a concept that has been detailed in several healthcare directives and guidelines (NHS Education for Scotland 2010, International Council of Nurses 2012). Similarly, Lewinson et al (2018) identified that spirituality has traditionally been considered a fundamental dimension of nursing practice, and one which contributes to patients’ well-being. Nurses are expected to provide holistic care, which incorporates spirituality, and nurse education should prepare them for this role. However, Lewinson et al (2018) also noted that some nurse education programmes do not adopt a consistent approach to the teaching of spirituality.

Various authors have provided definitions of spirituality (Koenig et al 2012, Clarke 2013, Rogers and Wattis 2015). However, a simple definition is one that regards spirituality as providing a method for finding hope, meaning and purpose, and simply ‘being human’ (Clarke 2013). Because there are a range of understandings and definitions of spirituality, in this article the authors refer to the concept of ‘spiritually competent practice’ when discussing spirituality in nurse education and practice.

Spiritually competent practice

The provision of spiritually competent practice depends on the quality of the relationship between the nurse and the patient. Wattis et al (2017) defined spiritually competent practice as ‘compassionate engagement with the whole person as a unique human being, in ways which will provide them with a sense of meaning and purpose’. The concept of ‘compassionate engagement’ relates to Ballat and Campling’s (2011) notion of ‘intelligent kindness’, which states that compassion displayed by healthcare professionals is essential to patients’ perceptions of care.

Spiritually competent practice requires the nurse to acquire spiritual care competencies and personal qualities that will enable them to engage compassionately with patients. Spiritually competent practice also requires a work environment that supports the development of therapeutic relationships between nurses and patients, and does not focus solely on the completion of clinical tasks.

To effectively implement spiritually competent practice, the nurse requires (Wattis et al 2017):

- » Spiritual care competencies such as spiritual self-awareness and sensitivity to patients' spiritual beliefs, which can be taught.
- » Personal qualities such as empathy and compassion, which need to be developed and sustained.
- » Opportunities such as time to develop therapeutic relationships, which depend on how the professional environment is organised.

Spiritual care competencies

A major European study – Enhancing Nurses' Competence in Providing Spiritual Care Through Innovative Education and Compassionate Care (EPICC) – has developed a spiritual care education standard that describes the spiritual care competencies expected from undergraduate nursing and midwifery students (EPICC 2019). EPICC states that these competencies should be 'practised within a compassionate relationship and founded in a person-centred and reflective attitude of openness, presence and trust, that is fundamental for nursing and midwifery as a whole' (EPICC 2019). Table 1 shows the spiritual care competencies, alongside the knowledge, skills and attitudes required to implement these in practice.

Table 1. Spiritual care competencies and the knowledge, skills and attitudes required for implementation in practice				
Competence	Definition	Knowledge required	Skills required	Attitude required
Intrapersonal spirituality	» Awareness of the importance of spirituality in health and wellbeing	<ul style="list-style-type: none"> » Understanding of the concept of spirituality » Ability to explain the effect of spirituality on a person's health and well-being » Understanding of the effect of their values and beliefs in providing spiritual care 	<ul style="list-style-type: none"> » Ability to reflect meaningfully upon their values and beliefs and recognise that these may be different from those of other people » Ability to 'take care' of themselves 	<ul style="list-style-type: none"> » Willingness to explore their personal, religious and spiritual beliefs » Ability to be open to, and respectful of, other people's diverse expressions of spirituality
Interpersonal spirituality	» Ability to engage with an individual's spirituality, acknowledging their unique spiritual and cultural worldviews, beliefs and practices	<ul style="list-style-type: none"> » Understanding of how an individual may express their spirituality » Awareness of various world/religious views and how these may affect an individual's response to life events 	<ul style="list-style-type: none"> » Recognition of the unique nature of an individual's spirituality » Ability to interact with, and respond sensitively to, an individual's spirituality 	<ul style="list-style-type: none"> » Ability to develop a trustworthy, approachable and respectful attitude to an individual's expressions of spirituality and their religious and worldviews
Spiritual care: assessment and planning	» Ability to assess an individual's spiritual needs and resources using appropriate formal or informal approaches; plan spiritual care; maintain confidentiality; and obtain informed consent	<ul style="list-style-type: none"> » Understanding of the concept of spiritual care » Awareness of various approaches to spiritual assessment » Understanding of other professional roles in providing spiritual care 	<ul style="list-style-type: none"> » Ability to undertake and document a spiritual assessment to identify an individual's spiritual needs » Ability to collaborate with other healthcare professionals » Ability to appropriately contain and manage their emotions 	<ul style="list-style-type: none"> » Ability to display openness and approachability and to remain non-judgemental » Willingness to contain their emotions
Spiritual care: intervention and evaluation	» Ability to respond to spiritual needs and resources within a caring, compassionate relationship	<ul style="list-style-type: none"> » Understanding of the concepts of compassion and presence and their importance in spiritual care » Knowledge of how to respond appropriately to identified spiritual needs 	<ul style="list-style-type: none"> » Recognition of their limitations when providing spiritual care and the confidence to refer to other healthcare professionals where appropriate » Ability to evaluate and document personal, 	<ul style="list-style-type: none"> » Ability to demonstrate compassion and presence » Willingness to collaborate with, and refer to, other healthcare professionals where appropriate

		» Awareness of how to evaluate whether an individual's spiritual needs have been met	professional and organisational aspects of spiritual care and reassess appropriately	» Ability to display a welcoming, accepting and empathetic attitude » Willingness to display openness, professional humility and trustworthiness when seeking additional spiritual support
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(Adapted from Enhancing Nurses' Competence in Providing Spiritual Care Through Innovative Education and Compassionate Care 2019)

Personal qualities

The nurse's capacity for implementing spiritually competent care is related to their individual personality traits and their ability to empathise with others. Thorup et al (2012) stated that caring stems from emotional involvement as opposed to professional distance; therefore, to provide care a nurse must have a sense of their own personal qualities so that they are able to relate to others. Therefore, developing these personal qualities is an important focus for undergraduate nurse education and continuing professional development. Rogers and Wattis (2015) detailed several recommendations for providing spiritually competent practice, outlined in Box 1, which emphasise the personal qualities required.

Box 1. Recommendations for providing spiritually competent practice

- » Be aware of your own spirituality, including where your own sense of meaning, purpose and values come from
- » Listen for cues and be attentive to patients' perceptions of what their illness means for them
- » Be fully 'present', for example by paying attention to patients when undertaking practical tasks so that they understand that you respect and value them
- » Promote person-centred care rather than task-centred nursing. For example, a nurse may regard washing a patient as a purely clinical task, or they might treat the patient with kindness, compassion and care during what could be a potentially embarrassing experience for the patient (Clarke 2013)
- » Reflect daily on how compassionate and mindful you have been when communicating with patients and colleagues

(Adapted from Rogers and Wattis 2015)

The use of effective compassionate engagement as part of spiritually competent practice depends largely on the personal qualities of the nurse and their well-being. Ali et al's (2018) review of spirituality in nurse education emphasised that nurses seeking to provide spiritual care should develop traits based on humanistic philosophy, such as self-awareness, compassionate caring, and cultural and religious sensitivity.

Many people who choose nursing as a career do so to provide compassionate care; however, maintaining their compassion in the 'real world' of nursing requires attention to personal development (Seager and Bush 2017). The concepts of 'availability' and 'vulnerability' provide a framework for nurses to develop and sustain spiritually competent practice, particularly in relation to personal development (Rogers 2016, 2017, Wattis et al 2017).

Availability and vulnerability

Several nursing theorists have explored the concepts of availability and vulnerability (Martinsen 2006, Thorup et al 2012, Alvsvåg 2014, Lindström et al 2014). Rogers (2017) investigated the concepts of availability and vulnerability in a study of advanced nurse practitioners in primary care. This led to the development of a practical framework that nurses can use to integrate spirituality into their practice, which involves connecting with patients on a human level (Rogers 2017, Rogers and Béres 2017). Nurses are well placed to connect with patients who are experiencing illness and personal crisis, and it is this connection that forms the basis of spiritually competent nursing.

Availability

The concept of availability can be viewed in several ways, for example in terms of physical availability, emotional availability or vocational availability.

Young and Koopsen (2011) suggested that a desire to assist others is often cited as a reason for people deciding to become a nurse. The nurse's relationship with a patient can improve the patient's experience of healthcare. However, simply attending work and completing the required clinical tasks is not enough to enable nurses to develop meaningful therapeutic relationships with patients. Stevens Barnum (2011) stated that being available to the patient, and seeking to understand how the healthcare experience is affecting them, are crucial to developing a therapeutic relationship and providing spiritually competent care. This approach should be incorporated into the nurse's day-to-day practice and throughout all aspects of nursing care (Clarke 2013).

An authentic and compassionate approach to care enables the nurse to be 'present' and is important when developing trust and assisting healing and recovery (Rankin and DeLashmutt 2006). Emotional availability is demonstrated when the nurse chooses to exceed their clinical responsibilities and focus on the holistic needs of the patient. The principles of availability and its implementation in practice are outlined in Table 2.

Table 2. Principles of availability and its implementation in practice	
Principle	Implementation in practice
Availability to self	» Reflect on yourself and accept yourself; this will allow you to embrace spirituality by understanding your meaning, purpose and direction in life
Availability to others	» Welcome people into your care by offering your time, acceptance and understanding. This involves being truly 'present' and listening attentively » Provide care and demonstrate concern through active participation in therapeutic relationships with patients
Availability to community	» Develop your practice in response to the needs of the community and those in your care

(Adapted from Rogers 2016, 2017)

The emotional effects of being available and providing holistic care for the patient has the potential to result in burnout, which is not uncommon among nurses, particularly because they are often committed to the caring role (Wright 2005, Rogers 2016). This is particularly relevant when healthcare organisations prioritise outcomes and clinical competencies over holistic care, which is often the nurse's priority (Wright 2005, Rogers 2016). Undertaking supervision and reflection is essential to maintain nurses' emotional well-being, by enabling them to reflect on their values and practice (Wright 2005).

Nurses are in an optimal position to develop therapeutic relationships with patients through their caring role, and their ability to self-reflect and develop self-awareness will assist nurses to recognise the positive emotional effects of care. In this way, spiritually competent practice is mediated through the nurse's availability to the patient (Rogers and Béres 2017).

Vulnerability

The concept of vulnerability in practice can be contentious because it may be perceived by some nurses as a weakness (Rogers 2016). Vulnerability can be classified as physical, emotional or professional. If nurses are to incorporate vulnerability into their practice, exercising self-awareness and reflection can provide the insights required to maintain emotional well-being and appropriate boundaries with patients (Sherwood 2000, Tacey 2004). The principles of vulnerability and its implementation in practice are outlined in Table 3.

Table 3. Principles of vulnerability and its implementation in practice	
Principle	Implementation in practice
Vulnerability to self	» Embrace the vulnerability of your role and the reality that you can never 'know it all'
Vulnerability to others	» Embrace accountability and engage in supervision and reflection, and accept constructive criticism

	<ul style="list-style-type: none"> » Allow yourself to be vulnerable in your approach to practice » Acknowledge your mistakes and limitations » Share your uncertainty with patients to reveal your openness, honesty and transparency
Vulnerability to the community	<ul style="list-style-type: none"> » Advocate for those in your care » Question authority where necessary, keeping the interests of your patients at the centre of care
(Adapted from Rogers 2016, 2017)	

From a sociological perspective, the importance of vulnerability was identified by Brown (2010), who found that those willing to demonstrate vulnerability experienced a higher quality of life than those who regarded vulnerability as a weakness. Some nurses may be concerned that there is an element of uncertainty or risk involved in admitting vulnerability; however, evidence suggests that demonstrating vulnerability has a significant positive effect on relationships and trust (Brown 2010, Thorup et al 2012).

Vulnerability is an essential aspect of caring, and involves the nurse developing a therapeutic relationship with the patient based on trust, honest communication and compassion (Martinsen 2006, Alvsvåg 2014). Caring involves a sense of vocation rather than the straightforward provision of task-orientated care and is regarded by several theorists as the essence of nursing (Kirk 2007, Watson 2012). Thorup et al (2012) recognised the courage required by a nurse when entering a therapeutic relationship with a patient. Although vulnerability involves an element of risk for the nurse, since there will be the possibility of psychologically challenging experiences such as rejection, the reward can be an increase in nurses' job satisfaction and patients' quality of life (Sherwood 2000, O'Brien 2014).

Case studies

The following two anonymised case studies provide examples of how the framework of availability and vulnerability enabled two advanced nurse practitioners to provide spiritually competent practice.

Case study 1 – Stephen

Stephen was a 52-year-old mechanic. He was married with one son and had an active interest in cycling and dancing. Stephen presented to an advanced nurse practitioner in primary care with symptoms of depression. He had been experiencing low mood, anhedonia (inability to enjoy activities that are usually pleasurable) and low concentration, as well as a loss of hope, meaning and purpose in his life. Stephen felt worthless, and although he was still working when he attended the GP surgery, he had stopped cycling and dancing and spent much of his time worrying about the future. He had also stopped spending time with his family.

When the advanced nurse practitioner met Stephen, she spent time listening to his story, and asking questions to assess his mood and whether he was experiencing any suicidal feelings. Creating a 'safe' environment where patients can share their concerns, and feel listened to and accepted is a vital element in providing spiritually competent practice. Stephen was able to talk about his depression, but was tearful and felt ashamed of his feelings. The advanced nurse practitioner reassured Stephen that depression is a common condition and that there were several treatment options available to him. She also undertook a comprehensive mental health assessment, which led to a provisional diagnosis of moderate depression.

The advanced nurse practitioner saw Stephen each week in a GP surgery, which contributed to the development of a trusting relationship and enabled her to provide Stephen with support and care until his mood began to improve. Stephen was offered various treatment options and decided to begin a course of antidepressants and undergo a referral for cognitive behavioural therapy (CBT). The advanced nurse practitioner continued to visit Stephen regularly over the course of the following year, during which time he was supported to gradually begin taking up activities he had previously enjoyed, such as dancing.

During their consultations, the advanced nurse practitioner and Stephen also discussed changes proposed during Stephen's CBT sessions, which had the potential to help him gain more enjoyment from life. With the ongoing support of the advanced

nurse practitioner, Stephen began to increase the time he spent with his family, and was increasingly open with his wife about his feelings and concerns.

As well as being available to Stephen through regular consultations, the advanced nurse practitioner demonstrated vulnerability by reflecting on her own competence and skills in mental health assessment. On one occasion, the advanced nurse practitioner had referred Stephen to local specialist mental health services; however, they informed him that his mental health issues were not 'severe enough'. Stephen reported that he felt 'messed around' by this and that he had been 'treated poorly'. The advanced nurse practitioner apologised to Stephen and acknowledged that the service he had received had not been sufficiently supportive.

After the conclusion of their therapeutic relationship, Stephen told the advanced nurse practitioner that he appreciated how she had provided a consistent presence during his period of depression. Stephen felt that her care, kindness and compassion had enabled him to regain hope for the future.

Case study 2 – Jane

Jane was a 48-year-old teacher. On presentation to the advanced nurse practitioner, Jane explained that she was concerned about a deformity on her toe, which was causing her pain on mobilisation. The advanced nurse practitioner took a full medical history and examined Jane's toe. While the advanced nurse practitioner was taking her medical history, Jane mentioned that her husband had died of motor neurone disease ten years previously, and that she had cared for him throughout his illness. Jane also explained that she had stopped socialising because her mother, who had moved into Jane's house five years previously because of ill health, was experiencing deterioration in her health and could not be left alone.

During the initial consultation, rather than simply focusing on Jane's presenting condition – the pain in her toe – the advanced nurse practitioner took some time to further explore Jane's social circumstances. The loss of her husband had had a significant negative effect on Jane's life, but she had subsequently made new friends and had begun walking regularly, attending a book club and taking short breaks. When Jane's mother had originally asked to move in with her, it was with the agreement that, when her mother required additional support, she would move to a residential care home. However, three years previously, her mother had broken her hip and had since deteriorated physically. She now refused to move into residential care as she 'felt at home' in Jane's house. As a consequence, by the time she visited the advanced nurse practitioner, Jane had stopped socialising with her friends and felt 'stuck and trapped'.

The advanced nurse practitioner arranged weekly appointments with Jane over the following four weeks and together they discussed treatment options. Jane's toe deformity was addressed through a podiatry assessment, which resulted in the provision of orthotics. In addition, Jane's mother agreed to move into a residential home near to Jane's house. The advanced nurse practitioner also supported Jane to begin seeing her friends again, as well as investigating self-help strategies that would improve her self-esteem, such as exercise and mindfulness. On her final appointment with the advanced nurse practitioner, Jane said that she had begun to socialise again, returning to a book group and beginning a pottery class.

As well as demonstrating availability by arranging weekly appointments with Jane, the advanced nurse practitioner also demonstrated vulnerability by referring Jane for treatment in areas outside of her competence, such as podiatry. Additionally, when Jane told the advanced nurse practitioner that she felt 'selfish and cruel' for wishing her mother would move out, the advanced nurse practitioner was able to empathise and told Jane that she would experience similar feelings if expected to become a carer for her own mother.

Following her final appointment with the advanced nurse practitioner, Jane told the clinic receptionist that her sessions had made her 'feel that it was okay to talk about her worries'.

Discussion

In each of the case studies, the patients felt they had lost meaning and purpose from their lives, Stephen because of his depression and Jane because she felt trapped in her role as carer for her mother. Both patients had stopped taking part in

activities that had given them pleasure, with Stephen feeling no sense of self-worth and Jane feeling that her role as a carer had negatively affected her social life.

In both cases, the advanced nurse practitioner listened to the patients' stories and practised compassionate engagement, committing to their care over time. In each case, the advanced nurse practitioner provided a safe environment where Stephen and Jane could discuss their concerns openly and honestly, and consistently supported them as they re-engaged with aspects of life that they had previously enjoyed. This process assisted Stephen and Jane in regaining a sense of hope for the future and meaning in their lives.

The nurse-patient relationships demonstrated in these case studies are fundamental to the provision of spiritually competent practice and the development of a 'human connection' (NHS Education for Scotland 2010, Stevens Barnum 2011). Therapeutic relationships require a willingness on the part of the nurse to connect with the patient, while working within professional boundaries – a process that demonstrates vulnerability. Developing a therapeutic relationship also requires the nurse to develop an environment where the patient feels safe and listened to, which demonstrates availability (O'Brien 2014).

Conclusion

There is a tendency among some healthcare professionals and services to prioritise clinical tasks and competencies over person-centred holistic care that involves the development of a therapeutic relationship between the nurse and the patient. Spiritually competent practice is an approach that can be integrated into all aspects of nursing care and emphasises that, alongside technical competencies, a level of personal development is required to achieve a person-centred approach. The availability and vulnerability framework can be used to integrate spiritually competent practice into nurses' day-to-day care. This requires a willingness on behalf of nurses to develop therapeutic relationships based on acceptance, respect and compassion.

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