Stone, Elizabeth (2010) Spirituality in Nursing. [Dissertation (University of Nottingham only)] (Unpublished)

Introduction

Throughout this dissertation spirituality in nursing has been examined in many ways. Firstly there is a literature search, which puts forward some of the most prolific authors within the field and their personal ideas and theories and spirituality, and this is followed by a discussion of these theories. In order to provide a field of reference to look at all of these pieces of research and theories around different attitudes towards spirituality, it explores the humanistic approach to spirituality as put forward by Narayanasamy (2006) and the traditional approach to spirituality as put forward by Bragen (1996). All of definitions used within this dissertation have been 'deconstructed' to help provide an understanding of what each definition means and the language that surrounds spirituality as a topic. The reason this has been done is because not everyone has studied spirituality or religion and as such may not understand the specific language used when discussing either religion or spirituality, particularly philosophical or theological terminology. The definitions provided by those discussing spirituality have therefore been explained in more simplified terms in order to be accessible to almost everybody regardless of profession or previous learning. Many of these definitions are not specifically tailored to nursing. Therefore, by using the activities of daily living model as put forward by Roper, Tierney and Logan (2000) this has been used to highlight areas from each definition that can be applied to nursing and nursing care. Further explanation of why the activities of daily living model has been used are included within the deconstruction of spirituality section of this dissertation.

Following this deconstruction and clarification of the varying definitions found within the literature surrounding spirituality in nursing, there is a discussion of the comparative strengths and weaknesses of various definitions. This section of the dissertation contains the main part of the analysis of the literature found within the field of spirituality in nursing and also identifies some of the contentious aspects currently found in the literature.

The main aim of this dissertation is to examine the literature currently available from the United Kingdom on spirituality in nursing; whose theory of spirituality (found within the pool of literature used this dissertation) is being applied to current nursing practice; and to discuss the merits of the various theories of spirituality found within the nursing literature in the application nursing care within the National Health Service.

Method

Using a range of databases available via the University of Nottingham library, a number of literature searches were completed on 'spirituality in nursing'. CINAHL and Wiley were the databases used in the initial searches. These databases were selected due to their containing more theoretical based articles as opposed to clinical skill based articles found in databases such as Ovid or the National Institute of Clinical Excellence (NICE). Although the research is looking into topics that affect practice, the appropriate articles are concerned with underpinning theories and ideas. Therefore they would not be found in skill based materials and consequently would not be found in the Ovid or NICE databases.

The keywords used in the database searches were 'spirituality' and 'spirituality in nursing'. From the results generated by the databases in relation to these keywords, articles were filtered again by relevance. For the purpose of this dissertation the relevance of articles and other literature was decided by an additional set of exclusion criteria. The exclusion criteria used were country of origin, language, and articles written from specific religious perspective.

The reason country of origin was selected as an exclusion criteria was primarily due to the differences in practice between the United Kingdom and other countries. For example, according to 'Prayer in Nursing' (O'Brien, 2003), a book from America written and published with an evangelical standpoint, prayer with nurses is an integral part of healing and as such

should be encouraged in medical settings. This attitude towards prayer and religion in hospitals and other care areas is diametrically opposite to that within the UK. This point is illustrated by the recent case in the media (Nursing Times, 2009) where a nurse was suspended because she offered to pray for a patient. Hence literature from alternative health stances from outside the UK that encourage prayer and religious/faith-based attitudes towards nursing would not be applicable to the current structure of the National Health Service, and so would not be particularly helpful to those working within it.

Language is an exclusion criterion for this piece due to the lack of available accurate and reliable translations. If translations are not accurate, the content of the piece of research could also be perceived inaccurately. Religious based literature has been excluded for a range of reasons; one relates to the reason for the exclusion of literature from outside the United Kingdom. Literature from a religious standpoint can also suggest behaviours that are currently discouraged by the Nursing and Midwifery Council (NMC, 2008). Additionally, texts from a religious background have been excluded from this work as this particular dissertation is examining spirituality, and not religion. Although spirituality is a part of religion, religion is not necessarily a part of spirituality (Narayanasamy, 2006). In order to look at spirituality in nursing and have the work apply to the current working environment found within the National Health Service this work cannot focus on one or more religions' view of spirituality. Service users are beginning to identify themselves as spiritual without identifying themselves as belonging to a specific religion (McSherry, 2007). Consequently,

although religion is important to some service users, in order to represent the secular side of spirituality, religious articles in relation to nursing have therefore not been used.

Deconstructing definitions of spirituality found in nursing literature

Spirituality is a difficult concept to define. There have been many attempts to define spirituality made by a variety of writers such as Speck (2005), Tanyi (2002), Narayanasamy (2001) and McSherry (2007) to name a few. These will be discussed later in this section, deconstructing these differing definitions, and examining how these can be applied to nursing practice.

In order to compare the many definitions of spirituality that appear within the literature, the Roper, Tierney, and Logan model will be explored as this is comprehensive, and widely used across the National Health Service to assess patients' conditions, capabilities and social circumstances – which could include how spirituality affects them. The Roper, Tierney and Logan model incorporates activities of daily living, and is a model used by nurses when creating care plans for patients. By using the activities of daily living, as well as explaining the definitions of spirituality, an effective comparison between the definitions and their applicability to nursing can be achieved.

The Roper, Tierney and Logan model is currently used in the original form and in a modified form by the National Health Service . The model is a holistic model and activities of daily living cover the way in which each aspect of a patient's life is catered for whilst being treated. This is a useful tool for nursing staff because it enables nurses to treat each patient as an individual with individual strengths, weaknesses and abilities. The aspects found in the original version of the activities are:

- Maintaining a safe environment
- Communicating
- Breathing
- Eating and drinking
- Eliminating
- Personal cleansing and dressing
- Controlling body temperature
- Mobilising
- Working/ playing
- Expressing sexuality
- Sleeping
- Dying

Roper, Tierney and Logan (2000)

Holistic care is one of the 'buzz words' used in the NHS. As opposed to previous models of patient care, holistic models ensure that a patient is looked after as a whole person and not just as a problem, condition, disease (or a collection of these problems) to be fixed and discharged from medical care. By looking at the patient as a whole as per the aspects identified in models such as Roper, Tierney and Logan (2000), nursing staff are able to ensure that: a patient is safe; is as healthy as they can be before they return home; and is able to return home and cope with their surroundings and lifestyle. By using the aspects outlined above, nurses are able to tailor the care to each individual's needs and abilities. Patients are assessed during their stay on the ward to ensure that their needs are met: if the patient's condition changes, their care plan is also altered so that the

patient receives the best level of care possible while maintaining their autonomy.

The aspects listed above are incorporated into the patients care plans in several ways. Not all specialist areas use the same layout and, as previously stated, not all aspects on the bullet point list included above are necessarily used. As an example of this, maintaining a safe environment is often omitted from care plans, and dying has its own care plan paperwork. This is due to the nature of the current nursing environment and the nature of the individual points.

Maintaining a safe environment is often included in other aspects such as mobilising, breathing and communicating. Patients are assessed on their mobility; what they can safely do alone and what aids they may need. This assessment is often done in two parts, with nurses filling in the day-to-day mobility aspect of the care plan documentation, and the moving and handling risk assessment for the patient, which is filled out by nurses and, on occasion, physiotherapists. This documentation is necessary in maintaining both patient and staff safety. All the aspects listed above are examined and assessed by the health care staff on the wards in a similar manner.

Nursing care plans are an integral part of nursing and multidisciplinary team communication- everything that is done for a patient should be documented in the plans. This means that any treatment a patient receives from occupational therapists, dieticians, or other health care professionals is

accessible by any other professions and in turn their notes are also accessible.

Despite covering a wide range of activities and experiences, there do not appear to be any holistic models that include an aspect that is specifically labelled spirituality. There are no assessment pages in a care plan for this aspect of the human condition. Often the only mention of anything remotely spiritual is where the patient's religious beliefs are noted down on the admissions and patient information sheets. This is usually a very small box on the form where it is difficult to write anything more complex than a simple term such as 'Christian' or, if being slightly more specific, Church of England (C of E). As peoples' beliefs are often more varied and complex than can be summed up in a little box on a sheet of paper, this presents challenges.

It can be said that a patient's beliefs are not important to their care in hospital. However, this attitude does not easily fit in with the ideology behind holistic care: how can you take care of all parts of a person - their safety, dignity and individuality - if you do not acknowledge that people believe many things and their actions are affected accordingly?

Using religion as an example, not an all encompassing one but an easily comprehended one none the less, a follower of any religion is likely to have tailored their behaviour to follow what they believe. To clarify this example; Jehovah's witnesses will usually not accept a blood transfusion because they believe that the passages in the Bible (Genesis 9:4, Leviticus 17:12-14,

Acts 15:29, Acts 21:25) apply to all forms of blood, including blood transfusions. However, depending on each individual's personal understanding of what they believe, these behaviours may vary from person to person. Again, using the example above, some Jehovah's witnesses will allow a transfusion of their own blood or will allow blood reclamation during surgery, whilst others will decline any sort of blood product (such as platelets) being used on their person. Applying appropriate ethical considerations to managing such patients' refusals presents medical staff with a variety of challenges to manage the potential for negative health indications if such measures are not applied (BMJ, 2001; Jabbour et al, 2004).

In order to assess the core theories of spirituality as put forward by humanitarian theorists and traditional religion, the activities of daily living will be applied a framework to do this analysis. Applying this framework will be essential to understand how spirituality is accounted for in the current nursing environment. The activities of daily living will therefore be used as a framework, with each definition of spirituality being examined in order to see how it could fit into this framework. As a further assessment other important documents will be used. These will include the Nursing and Midwifery Council code which suggests how staff should practice and behave. The NMC Code (2008) is a list of guidelines complied by the Council. These guidelines can be used to assess the various definitions of spirituality found in nursing literature by highlighting conflicting points between the definitions and the prescribed guidelines.

Consequently, the structure of this deconstruction of the definitions below, using the activities of daily living, draws out the differences between these. The definitions start from very different viewpoints in order to systematically highlight the distinctions between them. It therefore moves from one that is more humanistic to another that is quite heavily based on philosophy. As the definitions progress the manner in which they define spirituality identifies greater similarities between each definition. Therefore, the first two definitions are the most extreme in differences regarding spirituality and by the last definitions, deconstructed below, the definitions are quite similar to one another. These similar definitions may well indicate a shared belief or method of working between the authors of the articles.

The first definition comes from Narayanasamy and has a more humanistic approach to spirituality than selected examples of the other definitions also discussed later in the chapter.

Narayanasamy (2001) defines spirituality as a need for meaning and purpose, a need for love and harmonious relationships, a need for forgiveness, hope and strength, a need for trust and a need for personal beliefs and values. This particular definition is relatively user-friendly when looking at how a nurse could address these points. All of the words used in the definition are quite straightforward and require little to no in-depth knowledge of the theoretical background of spirituality. This means that this definition can be applied directly to nursing practice. While aspects of this definition are not necessarily seen as acting upon a patient's spiritual needs,

they can be seen as part of working effectively with patients and part of patients activities of daily living.

A nurse can provide certain aspects of Narayanasamy's definition for a patient. For example a nurse can give a patient a sense of meaning and purpose by explaining to them what they will be doing e.g. helping somebody understand why they are in hospital or why they need the input from health services and helping the patient feel that services are there to help them and support them. The way this can give a sense of meaning and purpose to the patient is to make them feel that they are more in control of what is happening and to aid the patient in becoming proactive in their interactions with health services.

Other aspects of this definition are more difficult to accommodate for health service providers, such as nurses and other professions within the health service. An example of this is the part of Narayanasamy's definition from 2001 that states that part of spirituality is a need for loving and harmonious relationships. The Nursing and Midwifery Council have strict guidelines on how much nurses can interact with service users. Nurses are supposed to engage in but then must end therapeutic relationships; this means it is inappropriate within the Nursing and Midwifery Council guidelines to provide a loving relationship although it is possible to provide a harmonious one. Following this guideline, nurses are not really able to provide that this aspect of Narayanasamy's definition. While nurses can facilitate a patient accessing such relationships with their family and or friends, nurses themselves are not permitted to engage in such relationships with patient

due to the Nursing and Midwifery Council's edict (2008). Other aspects of the definition are included in the nursing role of advocate. However all aspects of Narayanasamy's definition cannot be filled completely by nurses looking after patients due to the nature of those aspects. For example nurses are not able provide forgiveness for a patient. The patient may be seeking forgiveness from a family member, from friend or from a different source entirely; while a nurse may facilitate some of this, a nurse cannot grant forgiveness and so is unable to fulfil that aspect of the above definition.

A very different response and definition to spirituality is explored by Cobb and Robshaw (1998). Cobb and Robshaw base their definition of spirituality on one given by Bragen (1996) which speaks of spirituality as transcendency, that is the feeling of rising above and experiencing something beyond everyday experience. This includes an awareness of what is around us but also an awareness of the "abstract and timeless" (Bragen, 1996 citied in Cobb and Robshaw, 1998, p.2), and an understanding that the awareness of certain experiences can have an uplifting quality.

Before comparing any further definitions of spirituality, it is worth further exploring and comparing these two viewpoints. Bragen's definition of spirituality as it is paraphrased above is similar to definitions of spirituality found within philosophical areas. It uses a lot of language commonly found in philosophical writings and academic studies that are not commonly known or used in everyday life, or at least not with the same meaning.

Cobb and Robshaw's definition, based as it is on Bragen, is also not tailored specifically to the healthcare environment and is actually quite difficult to explain to somebody who has not had prior experience of these terms. For example, transcendence is a term that refers to rising above something i.e. transcending social boundaries. The Oxford dictionary defines transcending and transcendence as either transcending normal or physical human experience or (of God) existing apart from and not subject to the limitations of the material universe. This is a difficult definition to use as the definition of transcendence actually uses the word itself to describe itself. This creates a problem if one does not understand the word initially and is also a flawed method of defining something. Additionally, looking from a healthcare perspective, transcendency is not something easily addressed while caring for service users. Transcendency in relation to spirituality is also not something easily accessible or addressable in everyday life.

While trying to explain transcendency Bragen has used the words abstract and timeless. These words together with transcendency create a whole new set of meanings. Abstract is a word we may be more familiar with in relation to art rather than in relation with spirituality. The definition of abstract is itself potentially unclear and is often used to define something as theoretical rather than physical and concrete. Such a division between abstract and concrete is commonly explored in sociology and psychology (e.g. Emmons, 1992). Consequently, Bragen's definition of spirituality suggests that spirituality has a feeling of being rising above something as well as being apart from the physical and scientifically tested world. In addition to these two words, Bragen also uses timeless. Timeless will usually mean something

is unaffected by the passage of time or changes in fashion. From examining the individual words used within Bragen's definition of spirituality we gain the idea that spirituality is something that rises above normal human experience, is not concrete or fixed and yet is unaffected by time.

Relating Bragen's definition to healthcare is actually complex, as healthcare service providers such as nurses are required to care for their patients. In current nursing practice, patient care is split into smaller tasks: one example of this is the Roper, Tierney and Logan activities of daily living method (2000). This is deemed to be a holistic method of patient care and while the activities of daily living method does take into account the patients personal beliefs under the heading of spirituality it does not lend itself to working with a definition as diffuse and circuitous as Bragen's definition.

This raises the question of narrowing down from the extreme ends of the various definitions of spirituality to finding one nearer the centre that may be suitable for nursing. A further definition of spirituality from the humanistic perspective, though with a greater reference to complex philosophical ideas and concepts such as God, can be taken from McSherry (2000). McSherry acknowledges that spirituality is a difficult topic to define and also sets out to explain why it is difficult to define. Initially McSherry (2000) does not address spirituality itself but attempts to define the human spirit first in order to subsequently try and define spirituality. McSherry suggests that the word spirit from the Latin spiritus relates to an individual's

life force or essence and the energy of their being. From here McSherry states that:

'After exploring the word spirit the next step is to try and define what is meant by the word spirituality.'

McSherry (2000) uses keywords like descriptive, anecdotal, rhetorical and subjective. If we take subjective first and explain the meaning of that then other aspects of this definition will fall into place. Subjective refers to something that is based upon personal experience, feelings, tastes or opinions. This means that spirituality is highly personal and what each individual person believes or feels is for them spiritual and yet others may not sure such beliefs and feelings.

Anecdotal also has a similar meaning, usually referring to something that relates to a person specifically or even something that is hearsay. Again this word leads to the feeling that from McSherry's definition spirituality is something incredibly personal and individual. From the definition above, rhetorical means something that is expressed in such a way that is meant to impress or persuade somebody. This definition is not one found in common usage of the term 'rhetorical' but makes more sense than the definition used in common usage, rhetorical questions are used as a means of attempting to get others to agree with what you have said by stating a question e.g. ' I said the flowers had to be red, you agree don't you?'. From this example the person asking the question is expecting the answer to be what they want; often a rhetorical question does not require an answer.

The final word in McSherry's (2000) exploration in defining spirituality is 'descriptive' and this word is quite self-explanatory. After separating out each of the words found within the definition given by McSherry of spirituality we come to the conclusion that spirituality is something that is specific to a person; extremely personal, similar to a personal opinion; often described in such a way as to attempt to persuade somebody else to the person expressing this view's idea; and something that is presented using a fair amount of description.

When we apply this definition of spirituality to the activities of daily living it is quite hard to see where in particular this idea of spirituality lies. Again, aspects of this definition are possibly interwoven with and throughout many of the 'activities of daily living' rather than they are able to be applied to any one specific activity. McSherry's definition of spirituality is followed up and further developed in his writings by additional attempts to define or express what spirituality is and specifically addresses how nurses and medical staff react to it (McSherry, 2007). In his doctorate, McSherry interviews with various number of both health service users and healthcare staff. In this later book McSherry again defines spirituality, but uses less emphasis on the necessity of belief in a supreme being or God. Although McSherry does mention a supreme being or God he no longer includes it as a necessary aspects of spirituality. McSherry does however identify that a theistic argument -- one that suggests that God or a supreme being is necessary to spirituality -- is not essentially a satisfactory argument for various schools of thought such as the humanistic (as illustrated above by

Narayanasamy, 2001 and 2006) or an atheistic stance. Within the 2007 literature from McSherry there is a greater emphasis on a definition of spirituality from individuals within the National Health Service and from the uses of the same service. This leads to much different idea of spirituality and was presented in the 2000 literature. This later definition by McSherry will be explored later in the definitions.

McSherry (2000) specifically states that spirituality does not only equal religion but also goes beyond religion. In order to further describe and develop this idea McSherry uses the system very similar to Narayanasamy's, through which McSherry splits various aspects of human nature in order to express spirituality in relation to individuals. Like Narayanasamy, McSherry identifies the need for meaning and purpose, a need for forgiveness, trust and for harmonious relationships. These individual needs can be dealt with in the very similar way if not exactly the same way as identified above for Narayanasamy's key aspects of spirituality, for example both Narayanasamy and McSherry look at the need for meaning and purpose in relation to spirituality. However in addition to these McSherry also identifies self-awareness, creativity and the belief in God or a supreme being as being equally integral part of human spirituality. McSherry therefore slips back into a Theistic stance for his definition of spirituality.

This particular addition to the definition by McSherry creates a possible issue with using this definition in nursing practice. This issue is that if spirituality requires a belief in God or a Supreme Being can patient's

spirituality still be cared for if the patient does not believe in either of the above? Further argument on this point could suggest that McSherry is in fact suggesting that spirituality must include a belief in God or a supreme being, meaning that anyone who does not subscribe to the belief system that promotes the existence of God or of a supreme being cannot have their personal beliefs catered for all their own personal spiritual belief recognised and cared for. This appears self-contradictory regarding McSherry's earlier position as moving towards existential spirituality therefore seeing spirituality as something that is generated within the self. However, the authors that McSherry uses to back up this point suggested that it is not necessarily a person's faith or belief in God or the supreme being that is necessary. The author used by McSherry, Victor Frankl (2004), suggests that if somebody loses their 'faith in the future' they will lose their spiritual hold themselves.

However Frankl (2004) is referring to a particular group as he recounts about prisoners in the concentration camps of the Nazi regime. This is not suggesting that McSherry is comparing the experience of the prisoners in the camps to that of people in hospital or with serious illness but feels that the point raised by Frankl is still valid in these instances. McSherry is instead using the idea that when someone loses their faith in having a future, of believing that things will get better, they will lose their determination or their will to carry on. It is not clear between Frankl and McSherry what this faith is in. McSherry, from his own definition, suggests that this is faith in God or a Supreme Being. Frankl does have a sense of this to his writing but the emphasis seems to be instead on the person's

faith in their own spirituality. Frankl is looking at the type of attitude found in the survivors of one of the most horrific torture and labour regimes in the last century. There is also an idea that people of faith, while not necessarily still believing in God after such an experience, still had faith in something.

Moving from the humanistic perspective which has religious overtones as demonstrated by McSherry and by extension Frankl, we move to look at the spirituality presented by Orchard (ed. 2001). This particular definition or set of definitions draws on various authors as this is a compiled work of collected essays and the definitions come from a more theologically and philosophy based background. Many of the writers in this book are philosophy or theology professors who are looking at spirituality in healthcare from their own individual viewpoints. The definitions found within this book are therefore all theological and ontological definitions, as ontology is concerned with the nature of being and existence.

Ontology fits alongside spirituality within philosophy. Ontology is a study of existence and how, as well as why, things are what they are and this means that there is an overlap in certain places between ontology and spirituality. The areas where ontology fits with spirituality are presented quite well by Narayanasamy (2001) in both his earlier and later works. Narayanasamy states that part of spirituality is the need for meaning and purpose and this is similar to the ontological studies of existence, in such a way that ontological studies look at why things are the way they are and often look for the meaning and purpose or at least the purpose of existence.

Spirituality also fits with ontology when looking at the nature of being. Throughout this dissertation spirituality is discussed as an essential part of being human. Although as previously stated authors like Dawkins (2006) refute the idea of spirituality, and the spiritual dimension of humanity, even Dawkins has stated that there is something different about humans. Many of the authors discussed within this dissertation had made attempts at defining what it is that makes humans different, both from one another and from the other creatures found on this planet. This search for the meaning of existence and study into the nature of being can be said to come from the 'traditional' religious background but can clearly also be applied to the more humanistic approaches to defining spirituality.

Whilst some of the definitions from Orchard (2001) containing ontological arguments include humanistic aspects all of them have a distinct focus on a belief in God. As a point of interest within this work almost every contributing author is approaching spirituality from the Judaeo-Christian background or framework.

While not discounting the validity of these arguments there is very little within them that is applicable when attempting to define spirituality for those individuals who are not working within or coming from the Judaeo-Christian background. Those ideals that are applicable to secular society come from the humanistic background and again reflect Narayanasamy's work. For example, within Orchard's book, definitions repeatedly articulate a need for meaning and purpose which they see as being essential to human existence. This is directly akin to Narayanasamy's definition which

also suggests that meaning and purpose in one's life is a necessary part of spirituality, although Narayanasamy limits the extent to which such spirituality requires a concept of God. Therefore, one large issue when using the definitions found within Orchard's book is that meaning and purpose, as well as other humanistic qualities as outlined by Narayanasamy, appear to be needing to be derived from religion.

This dissertation in no way is seeking to deny that for some people religion provides meaning and purpose as well as other aspects found within the humanistic definitions of spirituality, such as a source of hope and strength as well as providing, for some people at least, a set of personal beliefs and values.

However, personally, for the purpose of this dissertation this analysis is trying to look at the secular definition of spirituality that will be applicable to all health care service users regardless of where they come from and what they believe. Orchard's book examines mainly theologically based definitions and heavily relies on the use of God as the defining agent with whom each person needs to have their spiritual relationship within their definitions. Due to this issue, this dissertation will not go into too much detail of each of the individual definitions included in the Orchard collection.

Another humanistic approach to spirituality is put forward by Greenstreet (2006). In order to define spirituality Greenstreet uses a simplification of the humanistic definitions found above, Greenstreet simplifies Narayanasamy's (2001) aspects of spirituality; such as the need for

meaning and purpose as well as loving relationships as psychological and social article aspects.

Greenstreet looks spirituality as being an overlapping section between social, physical and psychological aspects of a person as illustrated in the image provided.

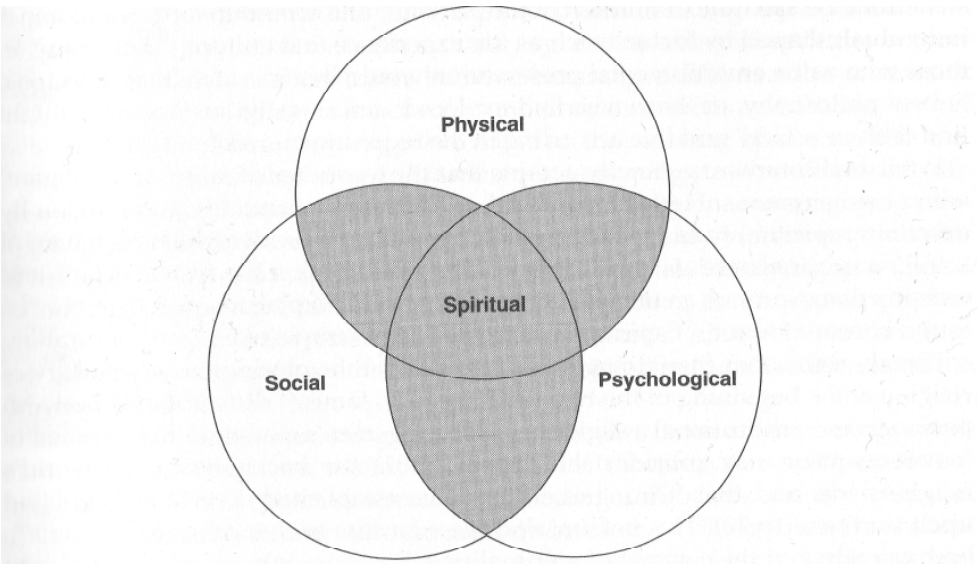

Figure 1.2 Spiritual, physical-spiritual, socio-spiritual and psycho-spiritual components of being a person.

(Greenstreet, 2006, page 9)

With this spirituality being a mix of the aspects described above, Greenstreet goes on to further expand what makes up spirituality within each of the categories of social, physical and psychological aspects. While using the works of previous authors, Greenstreet acknowledges the theological and high philosophical definitions of spirituality then attempts tie those definitions closer to the humanistic definitions she is interested in exploring. In order to do this Greenstreet looks at the spirituality of individual and the spirituality of humanity as a whole. Within this ideology the individual is the more humanistic version of spirituality as presented by Narayanasamy and the spirituality of humanity as a whole is more in line

with the philosophical view of spirituality as presented by Bragen. Quite a number of the articles contained within Greenstreet (2006) are interested in religion as well as spirituality and not seem to have separated religion and spirituality but rather confront them as the same thing. The focus of Greenstreet's work is on how to integrate spirituality into the care provided by health service workers. As such some of the literature does not go into an in-depth definition of spirituality prefers to work off previous definitions found in literature.

When looking at Greenstreet's work alongside the activities of daily living as put forward by Roper, Tierney and Logan (2000), it is quite clear to see where the activities of daily living and easily applied. The social and physical aspects of Greenstreet's definition, as illustrated above, are quite easily dealt with when using the activities of daily living. Activities of daily living are mainly focused on the physical and social aspects of the patient's life, with a patient's physical well-being being the points of interest in eliminating waste products, maintaining a safe environment and breathing. A patient's social well-being is focused on communication, mobilising, working and expressing sexuality. The psychological aspect of Greenstreet's definition is not at first obvious as to where it fits in to these activities that every action taken by a nurse or by healthcare staff on the behalf of the patient has an effect on the patient not just physically but also mentally. This effect on the mental aspects of the patient is the psychological effect of healthcare interventions on the patient. As such, it is now demonstrated that nurses and healthcare staff who look after the psychological aspect of every patient in their care by caring for the patient are therefore using the

activities of daily living and also work under the Nursing and Midwifery Code (2008). Hence, nurses and healthcare staff are able to provide all three aspects of Greenstreet's definition.

From all of the definitions discussed so far, even those attempting to combine philosophical and humanistic aspects or philosophies, there is a clear split between the two ideologies of humanistic and philosophical approaches to defining spirituality. Within these, the philosophical tends to lean towards religion and 'traditional' views on spirituality. The humanistic definitions tend to appear more 'new age', a phrase used to describe what is seen as the modern or more recent interest in things that are either not mainstream such as being Wiccan or philosophies and religions from the East.

Many of the philosophies and ideologies thought of as new age by current culture are actually either old religions from other parts of the world such as Buddhism or Taoism, or sects that have split off from current world religions. The Kabalah is considered new-age in its approach and is also considered to be a very recent religion or sect. The Kabalah roots itself in Judaism claiming it has roots over 4000 years old but also considers itself quite modern as well as quite ancient in its approach (Kabalah Centre International, 2009). Another part of spirituality that falls under 'new-age' is mysticism. Mysticism is a rather complex topic that looks at experiences outside of the 'normal'. Mystics are often people who view the world in a very different way than others in society; one prime example of this is Teresa of Avila. This particular lady was a nun in sixteenth century Spain

(Medwick, 1999). Starting with her time in the nunnery, Teresa of Avila went on to have several mystical experiences. When trying to read these experiences the language used, even though it is translated, is quite hard to come to grips with and to understand. The language used by Teresa of Avila can be interpreted as being metaphorical as opposed to being literal physical experiences. Nevertheless the experiences described, even with the descriptions being interpreted as metaphors, are quite outlandish for a sixteenth century nun. As is the case with many mystical experiences, the mystics themselves are subject to a vast amount of criticism from their original order or religion. Although at times their literature may be buried and forgotten it does tend to reappear periodically throughout history. However many of the people access to this information other scholars from the original religion or order that the mystics came from. As such the knowledge was not widely spread after the mystics lifetime, and with modern press able to spread literature across the world, when these articles are now printed they are considered 'new-age' due to the information they contain and the manner in which it is presented. Since mysticism often adopts the same language about transcendence regarding spirituality it consequently shares a lot of its concerns with philosophy.

After explaining some of my own perspective in the next section, this dissertation will continue to attempt to define spirituality in such a way that it is demonstrated as understandable and applicable to the current National Health Service.

My Personal Beliefs

I find myself frustrated by the idea that what I believe can be summed up in two words. We are who we are because of what we believe; belief can form a support system, whatever we chose to believe. If a person belongs to a specific religion they have a support network in the form of others from that belief system as well as by their own faith.

Some people have no religion that they claim allegiance to; they act in ways that they believe are right and do not attribute their actions or the actions of others to anything other than human nature. These are just two statements but by no means are they the only standpoints when looking at spirituality: they are simply the first that come to mind. Someone who believes actions are attributed to human nature is Dr Richard Dawkins. Dawkins positively refutes the existence of a spiritual aspect of humanity (Dawkins, 2006); in itself his attitude towards science is one of blind faith. Science is an ever evolving thing, which means its proofs are often based on assumptions based on what is known at the time. Consequently it could be said that whatever people choose to believe, at some point, it is based on faith. This faith can shape how a person behaves towards others in their choice of actions and is therefore relevant to nursing practice.

Personally I fall somewhere between the two ideas of religious allegiance and my actions being based in human nature. My background is technically lapsed Orthodox Judaism; as my family have all grown up within this

tradition for many generations. Were I to say I was Jewish that label would never come close to what I believe. It is possible to be Jewish and not practice- my family is a prime example. While I know this is not true for all religions, Judaism is a culture and a race. While I may be frowned at for my less than strict interpretation of my culture and religion- no one from my synagogue will ever say that I am not Jewish. Some of my colleagues on the nursing course asked me how I could be Jewish if I did not practice, and aside from being highly affronted, I could not comprehend how they did not understand. It is not uncommon for people to consider themselves Christian even if they do not regularly attend church.

My personal beliefs have their grounding in Judaism but after studying religious studies my own beliefs have been tempered by the parts of other belief systems that I admired and disliked. I find that the parts we dismiss are as important as the parts we accept; there is a reason that these parts do not sit well with us be they too restrictive, too exclusive or even appear superfluous. One reason I chose to move further away from Orthodox Judaism was the sheer number of rules that exist. There are six hundred and thirteen laws in Judaism, including the ten commandments: of those there are a large number of purification rituals that, as far as I can see are no longer geographically or historically relevant to modern life. In ancient times they would have been essential but in the modern world they have lost their efficacy.

I think that there is a spiritual aspect to all people, one that is not necessarily attached to a religious belief system. Because of this I have

chosen to look into spirituality in nursing. Not the way that people's religious needs are catered for but the spiritual needs of all people, religious or secular and anywhere in between. By reviewing nursing literature I hoped to find the spiritual aspect I believe exists is supported by the literature, as well as what debates around this topic exist and if there are provisions in place within the nursing infrastructure to deal with spirituality.

Reconstructing spirituality and finding a working definition

Using previous definitions found in the literature as well as my own personal background and ideas, this dissertation intends to come up with a definition of spirituality that I feel is closer to what spirituality actually is and hopefully is easier to apply to the principles of providing quality nursing care. In order to test whether the definition presented here is adaptable to nursing care, this dissertation will use the Roper, Tierney and Logan (2000) activities of daily living as described previously.

By exploring this adapted definition that draws on previously discussed definitions and my own beliefs, this dissertation ensures that while my own personal views are expressed the dissertation itself not being biased. When looking at spirituality and seeing the different ideological backgrounds found within definitions one of the only ways to compare and contrast all the definitions in relation to nursing care is to use models of nursing care that are actually in use at the current time.

To my understanding spirituality is both the study of the spiritual aspects of life and an umbrella term used by many people to cover topics that they do not wish to or feel unable to discuss. Clarke (2008) illustrated this point quite eloquently but the words 'universal Polyfilla' also quite pithily sum up the current attitude towards spirituality. Clarke, in her article, expresses the view that there is a lack of critical analysis within the field of spirituality.

Consequently, while spirituality is essentially based in the subjective views held by individuals, critical analysis is still an essential part of developing theories and so should also be applied to the theories put forward about spirituality. In exploring my own personal attempt to define spirituality and the spiritual aspect of life, whilst reconciling this with the existing definitions, this dissertation hopes to manage to be somewhat critical.

This dissertation argues that there is a spiritual side to all people regardless of whether they believe in traditional religion or not, and while I personally believe in God I recognise that many people are either atheistic or agnostic meaning they either do not believe in God or are unsure as to whether God exists. As such in order to include everybody, the definition presented here would have to include the possibility of believing in something other than the self. Additionally, I think that the part of ourselves which examines our morals and our attitudes to various things which make the rules by which we live our lives is also, if not necessarily part of our spiritual being, is nevertheless deeply affected by it. Many people from religious backgrounds rely upon the teachings of those particular religions for their moral building blocks but even without this background humans have a set of rules which they themselves as individuals have created. To use a nursing example for this argument, there are always issues surrounding the sanctity of life and abortion. Each individual has their own views on when life begins and in the case of abortion when that life becomes applicable to a foetus. While there is the scientific side which states when the foetus is viable, when it is not and when it begins to look like a human being, there are many different viewpoints on when the baby is considered a human being with the same

sanctity of life as an adult, including legal viewpoints (Sample, 2005; Evening Standard, 2007). Within the healthcare professions there are people who will not work on abortions and there are doctors who will refuse to put a patient forward for this procedure based on their own morals (DOH, 2005; Hope, 2008).

While this specific issue tends to fall more into an ethics debate or category there is still the individual's point of view that they bring into this debate. This dissertation argues that part of the forming of these views is based in the spiritual aspect of a person's life, and hence that the spiritual part of somebody is the part that continues to grow and change throughout our lives. The spiritual aspect of each individual person is responsible for the person's views and attitudes and responses to certain issues.

In summary of the points above, the definition of spirituality presented here must include a belief in something other or greater than their self, and an intellectual aspect that allows for reason and moral decision. The intellectual aspect of the definition presented is akin to Greenstreet's (2006) psychological aspect. However it could also be similar to the social aspect as well, in so far as morals may come from the environment we were raised in as much as from our own intellect. Together with the aspects described directly above, this dissertation wishes to use some points from the humanistic definitions such as Narayanasamy's (2001) aspect of meaning and purpose. The reason for including Narayanasamy’s aspect of meaning and purpose is that this dissertation would argue that it fits in quite well with the idea of morals and reasoning. Quite often people rely on their

morals and reasoning to provide a guide to their life but also to provide a reason why they do things they do as they do them. It is the search for a reason that is part of the task of applying meaning and purpose not only to ourselves but to the world around us. People are often interested in the 'why' of actions, choices, Additionally, nurses are often confronted with the patient's need to know why something has happened to them, and it is part of the nurses role as advocate to help the patient obtain the knowledge that they need. However, it is also important that this dissertation should acknowledge the role of hope which I feel is important to any definition of spirituality. From the interpretation of Frankl (2004) presented here, it is not just belief that sustains people, but hope as well. Consequently hope is an incredibly important part of nursing. While people still have hope they will fight, not just against a disease or illness, but also for treatments that they may believe will help them when they are very ill.

It can be argued that hope is sometimes as much a type of blind faith as it is an emotion and as such ought to be included in the definition of spirituality presented here. This is because hope is a key response that distinguishes human beings from animals as well being a psychological reaction and emotion.

Narayanasamy (2006) identifies that in some of his earlier work he commented on a need for hope and strength as well as trust and creativity as part of a spiritual identity. While the above paragraph argues the need for hope, it is questionable whether trust and creativity need to be included as spiritual aspects alongside hope.

On the other hand, it is possible to support the identification of strength as an important factor whilst still disagreeing with it being defined as a spiritual need. Instead of being a spiritual need, instead this dissertation argues that strength comes from the spiritual side of the person rather than being a necessary part of that spirituality. As stated in a previous paragraph, people who have hope have a type of internal strength that carries them forward. I would instead argue that spirituality allows a person to draw strength from spirituality, rather than strength being one of the direct aspects of spirituality.

As nurses it is both quite easy and quite difficult to nurture hope. It is easy because we can provide the simplest level of human contact and support, giving a patient or their family information that will mean that somebody knows what to expect and what help is available. At a slightly higher level or perhaps just more complex because of the intricacies of human nature, nurses are also able to provide what is not necessarily identified as hope. An example of this is when there are patients in the hospital who are on the Liverpool care pathway (NHS, 2009). The Liverpool care pathway is a care plan for the last days of life. Active treatments such as antibiotic treatments are withdrawn and patients are kept comfortable. There are also certain drugs such as morphine sulphate that are made available in order to alleviate the pain the patient may be in. While at this point there may be hope on the behalf of the relatives that the patient will get better (and this does sometimes happen, as confirmed by direct observation from a current placement). There is not often a real hope that the patient will get better,

and while family and patients would prefer this, there is a secondary level of hope, that the patient will not suffer. In this way, we are able to provide more for the secondary level of hope, namely that the patient's suffering will be reduced and limited, rather than meeting the primary hope.

The impact of the definitions of spirituality and the literature surrounding it on nursing practice

While there is a wealth of information from the various authors within the field of spirituality and nursing when the two meet, there seems to be a distinct lack of cross-examination. What is meant by this is that most of the authors found within nursing who examined spirituality, almost without opposition concluded that spirituality had a place within nursing. Authors who agreed with this stance are Narayanasamy (2006), Praill (1995), Greenstreet (2006) and Baumhover (2009) to name just a few. Most of these authors set forward to define spirituality in such a way that they can apply it to nursing care. One particular word that repeatedly crops up in these discussions in relation to these authors is the term 'holistic'.

Baumhover (2009), while not providing individual definition of spirituality, examines some of the quantitative research that has gone into the field of spirituality and draws conclusions from this research. Baumhover is examining the effect of including family members during resuscitation treatment. That is not to say getting the family to do the resuscitation but to include them in the decisions made and ensuring that they understand what is going on. The reason Baumhover may find it difficult to separate spirituality and holistic care is that while holistic care includes spirituality, spirituality does not necessarily include holistic care. The use of the word spirituality is therefore possibly inaccurate in this article. Baumhover at least does specifically state that she is examining spirituality by use of

certain tools such as the SAS scale (spirituality assessment scale) developed by Howden.

The SAS scale consists of 28 questions and these rely on a scale from 1 to 6 to state how much somebody agrees or disagrees with the statements given. While this type of scale would be useful on the ward or in hospitals, it is only due to the general nature of the scale itself that it is able to present itself as a quick and relatively easy method of assessment. However, due to the nature of such a scale and the nature of a topic such as spirituality the scale becomes grossly inaccurate before it begins to be used. Even with the scale examining spirituality in relatively open-ended statements such as "I feel a connection to all life" and "my innerness or an inner resource helps me to deal with uncertainty in my life" (Baumhover, 2009, p.360) these open-ended statements are incredibly ambiguous and are not really themselves applicable to any researched idea or theory about spirituality. As such when Baumhover speaks about spiritual care for not just the patient but also for the patient's family it could be believes that this is holistic care not spiritual care that is being spoken of.

The mistake Baumhover makes in regards to spirituality is by no means an uncommon one and is typically found in many American studies. Many people found within the nursing literature find it difficult to separate spirituality from both holistic care and from religion. This may be due to the manner in which spirituality is covered in training within the medical professions. Neely and Minford (2008) undertook a study of how spirituality was taught in medical schools. While this does not specifically state that

nurses were included in this, education information provided to both medics and nurses will be similar. Neely and Minford undertook a quantitative study using a questionnaire in order to assess the instruction of medics in spirituality. Neely and Minford (2008) found that whilst the majority of schools that replied to the questionnaire, taught or covered under the curriculum some aspect of spirituality, it would be beneficial for all medical schools to teach about spirituality.

However, in taking a more in-depth look at the study, the curriculum is far more focused on religion-specific spirituality rather than secular spirituality or those spiritual identities that will be covered by the new-age label. While some of the medical schools went over and above this basic level to include the philosophy of spirituality and spiritual counselling the focus of most of these extra topics will have a firm base in traditional religion such as "ethical aspects of dilemmas derive from specific religious beliefs" (Neely and Minford, 2008). Furthermore within the discussion part of this article Neely and Minford estimate the actual number of medical schools that will teach their students of spirituality. Neely and Minford indicate that only between thirty-one and fifty-nine percent of medical schools were actually teaching their students anything regarding spirituality.

As previously stated, the study is researching medical schools and not nursing schools. This lack of spiritual educational on behalf of the medical profession as a whole means that it can be an uphill battle for nurses to provide any holistic or spiritual care that may be in opposition to the medics training. Doctors swear to do no harm to their patients and nurses are

trained to be patient advocates, and as such nurses represent not just a patient but the patient's point of view as well as the patient's right to choose. At times this role of nursing advocate can come in direct opposition to doctors. From personal experience that happened many times during placement practice, several nurses have felt that a certain patient would benefit more from being put on the Liverpool Pathway than from continued advance treatments such as placing nephrostomy (this is an opening between the skin and a kidney which allows drainage of urine from the kidney directly into a bag on the skin, which is attached in a similar manner to a colostomy bag.)

One particular patient reflected on above was dying of cancer and in quite a lot of pain. It was quite clear that this lady was very ill and had not got much longer left to live. Nevertheless, while she was on the ward she was not producing a lot of urine, and so the doctors decided that she ought to have a nephrostomy to see if she was retaining urine which could make her worse. Although this could have been a beneficial idea if this lady had been more healthy at the stage of life she was at, this was not a beneficial treatment. Additionally, even though she did give consent for the procedure I personally feel and felt that she should have been better informed with regards to her options. By this it is meant that the lady ought to have been informed that the procedure would leave her in pain whilst the nephrostomy healed over and it may not have improved her condition, which in the end it did not. As nurses and patient advocates, we should have told her that the procedure would not necessarily increase the length of her life and could prove to be an ineffectual treatment.

Reflecting on situations long after the event it is not always possible to remember the details so in this instance it is unclear whether the lady was transferred to our ward following the nephrostomy or if she had it while she was there. Additionally, I was not on shift for the few days around this treatment. Nevertheless, recollection and reflection on the emotions of the situation included anger that as a third-year student, and a nursing student at that, I felt that I was more able to recognise that this lady was not going to survive to the end of the week and ought to be made comfortable than doctors who had completed their training. I do remember asking what the point of this lady's treatment had been as she was in more pain than she had been before and seem to have lost some of her will to fight.

It is acknowledged that nursing and medicine have a similar training but it can be quite hard to understand where the differences come in between the nursing attitude towards patient advocacy and the doctors' attitude that ought to be doing no harm. The point raised from both the study and this reflective critical incident is that while there is training for both nurses and doctors into spirituality, it is sometimes outside the scope of this training at our care exists.

When looking at both Neely and Minford's article and my own example from above it becomes very hard to see where this spiritual training comes in and how what has been said here can possibly be applied to spirituality. Using both Greenstreet's (2006) and my own definition of spirituality, the care this lady received would have had an effect on her psychological well-being as

well as on her physical well-being. While this lady was very swiftly moved on to the Liverpool care pathway we had affected her physically as well as mentally to some extent. Being in pain and continual discomfort has an effect on individual's ability to cope with the everyday aspects of life (Marie Curie Palliative Care Institute: Liverpool, 2007). By undergoing such a procedure this lady was in more pain than she would have been in due to her own illness. This will have impacted on her psychological well-being which is part of both Greenstreet's, and my own definition, of spirituality. In this manner any and all care given to a patient can be said to have an effect on spirituality. So despite Neely and Minford's (2008) findings in regards to spiritual education for medics the gap between nursing and medical attitudes towards care and spiritual care especially can be incredibly varied.

So as well as having to contend with misunderstanding of what spirituality is we, as nurses, also have to contend with medical attitudes toward spirituality which can often seem in direct opposition to the ones we are taught as nurses. The two examples used here of both Baumhover (2009) and Neely and Minford (2008), whilst not necessarily the most encouraging evidence in support of spirituality, both acknowledge spirituality is part of nursing or medical care. In the case of Neely and Minford, they suggest that training student doctors to acknowledge and work with spirituality as one of their tools will be beneficial not just to the patients but also to the level of care we are able to provide as a service.

Other authors have attempted to include spirituality as part of care by attempting to form a framework or guide for how spirituality can be applied to health care. Coyle (2002) is one of these authors.

Coyle takes a very similar journey to the one undertaken during this dissertation. Coyle examines what spirituality is and the authors that have put forward theories pertinent to what she is writing about. Throughout this article, Coyle refers to various schools of thought such as Marxism and how research into health has provided insight into spirituality. For example, Coyle specifically makes note of the rise in chronic illnesses and research correlation between the chronic illnesses and the increasing tendency to being actively faithful or believing rather than having passive faith. While the article does suggest ways in which health and spirituality can interact it is not precisely what is indicated by the word framework. When the word framework was used in the introduction of this article, the image brought to mind was similar to the Department of Health frameworks for care. These frameworks are quite precise guidelines on best practice. What is meant by this is that these frameworks provide the 'best' level of care, but quite often hospitals interpret this as the lowest level of care they should be providing for each area. The frameworks provided by the Department of Health are area- specific: for example, there are frameworks for care of the elderly, palliative care and strokes. Hospitals may choose to go above and beyond the level of care suggested by the framework for each specific area but must provide the level of care put forward by the framework.

Coyle (2002) provides a sense of the background work that goes into creating a framework and acknowledges this in her title: "towards a framework for exploring the relationship between spirituality and health". Whilst Coyle has done exactly as she set out to do she also seems to fall into the same pattern as many of the authors within the field of spirituality and health. As opposed to putting forward a theory of her own, Coyle has attempted interpretation of the varying articles found within the body of literature and drawn her own conclusions from these. While this is by no means a bad thing it does not provide any new information that would help with the formation of an actual framework of spirituality and health care. As such while this literature is not groundbreaking it does support the argument that spirituality has a place in nursing care, as well as attempting to illustrate where spirituality can be applied.

Kendrick (2001) identifies the idea that nurses are supposed to be able to provide spiritual care or care that includes a spiritual dimension but also identifies that many nurses and patients do not actually understand or are unable to articulate what is meant by spirituality. Kendrick points out that if we are unable to understand or articulate what is meant by spirituality, when coming from the nursing perspective, then the validity of spirituality as a nursing focus becomes questionable. In order to provide a solution to this issue, Kendrick suggests that simply clarifying what is meant by spirituality will provide a solution.

Kendrick (2001) pinpoints certain aspects as key to spirituality such as the need for meaning and purpose and awareness of something that is 'other'

to the self. In this way Kendrick's evaluation of what spirituality is, is similar to both Narayanasamy's (2006) definition of spirituality found in the first chapter of this dissertation and to McSherry's (2007) definition of spirituality which includes a sense of something different or other than the self. However, later within his work Kendrick goes on to discuss how spirituality is actually interwoven with every aspect of being human and of day-to-day life, and indicates through his writing that splitting spirituality into key aspects is not necessarily the best way to go about understanding spirituality. While on one level Kendrick is right, spirituality is interwoven between all aspects of human life, it is incredibly hard to view a topic as large and diffuse as spirituality as a whole topic without attempting to break it down into more manageable sections. Examining the entirety of human experience in relation to spirituality is a huge task. Therefore, in order to aid understanding of the nature of what we are looking at it is often easier to break down large topics into smaller sections to make it easier to assimilate.

Kendrick does raise some intriguing points in favour of spirituality being interlaced throughout human experience. When looking at studies by other authors Kendrick selects and brings forward a study by Kay and Robinson in 1995 which states a number of "spiritual behaviours" (Kay and Robinson 1995 cited by Kendrick 2001) are displayed by women whose partners have dementia. In support of what Kendrick has said about spirituality being interwoven throughout human experience and daily life, Kay and Robinson indicate that the women in their study often spoke to friends and family about things that concern them as well as sharing the joys of living. While

the latter of these could be included in most definitions of spirituality it is actually quite hard to see how speaking to friends and family about personal issues is spiritual. The definition of spirituality that could be used in order to fit personal issues into spirituality would be Greenstreet's (2006) definition of spirituality. As previously stated Greenstreet is interested in social, psychological and physical aspects of human life that come together, within her definition, as underpinning aspects of spirituality.

However, Kendrick's (2001) representation of Kay and Robinson's (1995) study does not give a clear background on where this idea is rooted within spirituality. Kendrick's definition or working supposition that spirituality is interwoven to all human experience and day-to-day life means that while on one hand all actions and experience have spiritual value, on the other it is difficult to separate what is a spiritual experience and what, if anything, is not.

When bringing the focus of his work back to nursing spirituality, Kendrick uses an example from one author in particular and cites the work of Lyall (1997) as their example. The particular excerpt Kendrick has chosen to illustrate his points focuses on Lyall's experience in hospital when in critical care. The excerpt talks about Lyall's need for human contact and comfort when she was very ill and speaks on the nurse’s actions which in no way provided the sought-for comfort. Through this excerpt, Kendrick illustrates his point that simple actions found in every day-to-day experiences can have spiritual value. In accordance with Greenstreet's definition of spirituality, the excerpt used by Kendrick illustrates how a simple thing like

physical contact can provide a psychological interaction and will affect a person's spirituality. The nurse in this excerpt from Lyall (1997) could have provided reassurance and comfort through the simple act of taking the patient's hand. This shows that at least under Greenstreet's (2006) definition of spirituality, and quite often under Narayanasamy's (2006) as well, it is easy to take care of somebody's spiritual needs. While this is true for the humanistic definitions of spirituality it is a lot harder to provide nursing care for spirituality following the more traditional definitions that include transcendence and abstract ideas.

Kendrick (2001) however does manage this whilst using the excerpt from Lyall. In order to show how Kendrick has included transcendence within his interpretation of Lyall's experience Kendrick has used symbolism. Symbolism itself is the application of meaning to an item or creature beyond the nature of what the item or creature is. A key example of this can be found in the Christian cross. The cross is a symbol of the Church: it represents that from a Christian perspective Jesus died in order to grant redemption to his followers. The cross is recognised globally as the symbol of Christianity; however, an actual cross can be something as simple as two pieces of wood bound together. In this case the meaning of the symbol has very little to do with the item; the materials used can be of very little importance or worth but what they represent suddenly gains meaning and value.

Symbolism is used everywhere and can be found in many aspects of life, looking around you on the street can provide you with many examples of

symbolism, and adverts are prime example of this. There is very little spiritual about adverts; however, everything in an advert from the colour of the background to the size of the product has meaning. For example, it is widely held that certain colours are linked to certain feelings, such as blue is considered a relatively calm colour whereas bright red is associated with danger and anger (Gombrich, 2002). When advertising a relaxing holiday break at a bus stop an advert is more likely to use a blue background than a red one purely for the associations with each colour.

Whilst symbolism is one of the tools Kendrick uses it is also a complex topic that has been widely discussed in a number of academic disciplines, as illustrated by Kendrick and Gombrich themselves. Consequently, it is difficult to fully explain the ideas and reasoning behind Kendrick's interpretation of Lyall's experience using a teddy bear as a symbol of transcendence. Further, within the excerpt used by Kendrick, Lyall indicates that she gained comfort from a teddy bear given to her by someone close to her when the nurse failed to take her hand and so the teddy bear gave Lyall the comfort she was looking for. Kendrick describes this teddy bear as a symbol for transcendence. Due to the nature of symbolism, this makes it impossible to argue with Kendrick's interpretation of what this teddy bear was to this person. This is because from Kendrick's point of view the teddy bear is a symbol for transcendence and experience that Lyall had. Therefore, ultimately it is only to those who embrace a symbol that it has meaning.

Kendrick uses the more humanistic aspects of spirituality in order to ensure that spirituality can be included in nursing care. Kendrick does recognise that spiritual care, when it can be provided, affects not just the patient or the recipient of care but also the nurse giving it. Kendrick does raise the issue that while a nurse may be willing to provide such care, not all patients wish to receive it. Abuse of staff by patients is used as an example of this, and Kendrick says that whilst a nurse may be willing to provide spiritual care to patients, abusive patients are often not receptive to such care.

One of the few authors that has been found who is in opposition to including spirituality in nursing is Paley (2007, 2009). Paley argues in favour of a secular health service, one which does not include spirituality, on the grounds that spirituality is a term that is linked with religion in most people's thoughts. This interpretation is supported by McSherry's doctoral research published in 2007, which contains several examples of both nurses and patients who believe that spirituality was an area of religion. Paley goes on to argue that the literature generated within the field of health care and spirituality is often covering areas that are already well-documented and debated on such as dignity and the value of life. Given that these topics are already debated elsewhere within nursing literature, Paley argues that they do not need to be discussed from the perspective of current 'spirituality'. One word that continually arises throughout Paley's 2009 Nursing Standard article (2009b) is the word is supernatural. In this case supernatural is used to describe something that is beyond the normal scope of everyday life and the scope of what is normal within human nature. One key point in Paley's 2009 articles is that the National Health Service should be providing

evidence-based practice as is suggested by the Department of Health and proven through trials and pilot schemes. Consequently, care should not be based on “ancient wisdom” as he cites as being suggested by NHS Scotland (Paley 2009b). Another key point found within Paley's argument is that the National Health Service should be based on principles very central to everybody and not just those who are open to this "ancient wisdom". This is quite an interesting argument. Paley did not deny the people have the rights to believe in whatever they choose, he simply states that in order for everyone to understand the principles of the National Health Service they need to be grounded in evidence and not in subjective ideas. The very subjective nature of spirituality and the manner in which it can be catered for is therefore as diverse as the people requiring the care.

Paley (2007) picks up on a point made by Narayanasamy (2006) in that holistic care is different from spiritual care, and Paley (2007) has no problem with holistic care being provided as part of patient care. This is quite possibly due to the amount of research done into holistic care that has provided a fairly standardised framework that this care can based within.

Paley also protests the education of nurses in spirituality. The main focus of this argument seems to be the lack of a standardised definition for spirituality. As demonstrated by the diversity of authors discussed within this dissertation, definitions of spirituality are highly subjective. Due to this it is a very hard subject to teach. There are a number of specific courses that focus on spirituality or at least some parts of spirituality, such as philosophy and religious studies. It is possible to spend several years of

your life studying spirituality and still only know that part of it. Paley illustrates this by examining the sociology of religion, a part of the nursing literature surrounding spirituality that Paley feels has been neglected. In this way Paley is partly correct; in order to understand the definitions of spirituality that are being produced within the literature at present we need to understand where these definitions have come from, the environments that have shaped the authors and the history that backs up the ideologies that are presented with the literature.

Further to this point Paley goes on to discuss the differences in literature between the United Kingdom and the United States of America. Paley highlights the differences between these two social backgrounds by the literature surrounding spirituality in nursing. The United States of America have a lot more of a traditional basis to their spirituality than that found in the United Kingdom which seems to tend towards a more secular definition of spirituality. As indicated in the method part of this dissertation, literature from abroad has been disregarded for these reasons. Paley indicates throughout his 2006 article, 'spirituality and secularisation' that excluding literature from outside the UK is one of the few approaches that makes sense when examining spirituality in relation to nursing. Paley states this merely because although he does not agree with the practice of spirituality in nursing, he does suggest that the literature at least be appropriate to the social background in which it would be applied.

In continuation to his objections against the literature produced to support spirituality in nursing care, Paley (2007) indicates that a number of the

arguments made to apply spirituality to everybody seemed to work backwards from the conclusion to construct an argument. Paley states that a number of the arguments work from the conclusion that spirituality must apply to everybody and then build up their arguments and evidence to support that conclusion rather than concluding something that is proven by the evidence.

However, Paley is contradicted by Nolan (2009) and Swinton (2006). Both of these authors provide an alternative or counterargument to that put forward by Paley -- in favour of a secular National Health Service. Nolan (2009) in his abstract primarily discusses Paley's own stance on spirituality in nursing and declares it biased against including spirituality in nursing care. Whilst this is true of Paley's work the manner in which Paley's points are put forward are more of an attack on Paley's personal point of view than on his actual work. Nolan calls Paley exclusivist, illogical and reductionist. Nolan initially seems to dismiss Paley's work on the basis that Paley is an atheist. By doing so Nolan is falling into the same trap that he is accusing Paley of falling into and judging Paley on the basis of his opinions and background rather than his evidence and the construction of his argument. Nolan (2009) writes from within his own frame of reference, that Christian chaplain, and while he states that he does not agree with what he sees as Paley's reductionist attitude Nolan does agree with Paley in that spirituality should be defined separately from religion. Nolan goes on to defend religion when speaking about spirituality, in order to do this Nolan quote statistics from the 2001 UK census. While this approach does support what will and saying it is not actually provide an argument against Paley's viewpoint.

Nolan has actually supported what Paley has said by his inclusion of this argument in his article, Paley is indicated throughout his work that religion is almost always included when speaking on spirituality (McSherry, 2000). Nolan does not contradict this point Paley was instead provides an example of exactly what Paley was speaking of. Throughout Nolan's article there are many points he raises in an attempt to counter Paley's discussion on spirituality and secular health service, however almost every counter Nolan raises can be applied to his own arguments as found in the 2009 article. There is very little evidence offered to offset Paley's arguments but there is quite a lot of signposting as to where Paley has 'made mistakes' or has flaws within his arguments. Unfortunately, whilst reading through this article it becomes apparent that with a little evidence offered to backup Nolan statements in a way that actively counter is what Paley is already discussed, Nolan comes across as constructing a largely 'straw man' argument. A straw man argument being one that attacks the author of the piece rather than offering a firmly grounded, in evidence, argument to counter that put forward by the original author, in this case Paley.
Many of the arguments Nolan uses throughout his 2009 article "In Defence of the Indefensible" are in themselves valid points however the manner of presentation renders them slightly or more than slightly ineffective.

Swinton (2006) looks not necessarily as a direct counter-attack as Nolan does but at the way in which critiques of papers found within nursing literature, on the topic of spirituality, can actually aid the development of the field of spirituality in nursing. Swinton argues that critiques of nursing literature make authors more cautious about what they are producing. in

this way Swinton provides a much better counterargument to Paley's argument that nursing literature in the field of spirituality and health care is poorly researched. Swinton acknowledges that nursing and health care in general within the Western world has a history of incorporating spiritual care into its practice. Swinton also recognises it is only recently that spirituality has been broadened to include a non-religious understanding. The main focus of Swinton's article is that criticism of any article or theory requires authors to think on what they are writing in how to counter the criticisms that their work is given. It is only through these criticisms that any work progresses.

Throughout his article Swinton covers a broad spectrum of issues relating to spirituality most of which focus on the point highlighted above. Swinton examines the education of nurses in the field of spirituality and how they define religious and non-religious spirituality. In his conclusion Swinton states that there is a need for greater reflection and critical thinking in both nurses training and within the defining and use of spirituality as a term.

Throughout much of the literature used within this dissertation there has been a common theme with regards to the effects of spiritual care on the provider of the care, in this case the nurse. Many authors have indicated that providing spiritual care has an effect not just on the patient but also on the carer themselves. Throughout all of the literature available on this, the authors view this as a good thing. Within nursing, nurses are patient advocates, as they represent the patient and the patient's best interests and wishes. If the patient does not want something done, it is within the

nurse's role as advocate to ensure it is not done. Narayanasamy (2006) and Kendrick (2001) have both suggested that such interaction with and provision for a patient spirituality has an effect on nurses and in accordance with the ideas put forward by other authors this is a good thing. However, this raises questions about what happens to the nurses choice? While it is part of human nature to change and grow, surely the nurses are also allowed to choose if they wish to grow spiritually. Throughout my reading of the literature I have not found many authors, possibly with the exception of Paley (2007, 2009a and 2009b), who argue that a change in the nurse's spirituality as well as the patient is not necessarily a good thing. Most of the literature found in the field of spirituality in nursing acknowledges that providing spiritual care will have an effect on the spirituality of the nurse but does not go into what happens if the carer or nurse is not ready to have their own beliefs challenged and altered during their provision of care.

Conclusion

Throughout the themes discussed within this dissertation many of the main issues surrounding spiritual caring nursing have been examined, these include: the level of spiritual education in nurses, what spirituality means, how spiritual care can be best provided and who spiritual care has an effect on.

From the literature we can draw many conclusions, firstly that spirituality is so highly subjective and while the study of spirituality in nursing is still quite a new field, there is no fixed definition that the health service is working from. If spirituality is to be included in patient care there needs to be a single definition that the National Health Service is working from, in order to provide standardised care across the entirety of the health service there needs to be a single definition that everyone everywhere can work to. Due to the nature of spirituality that definition is unlikely to be found any time soon. And as such spirituality, while being an important part of an individual's identity, is very hard if not close to impossible for a nurse to care for. The reason health care must be standardised across the National Health Service is to ensure that there is no vast inequality between the level of care being provided at hospitals around the United Kingdom.

A further conclusion that can be drawn from the literature of spirituality in nursing and within healthcare is that while there is an abundance of evidence in favour of spirituality in nursing the quality of the evidence varies and as such there are many arguments found within the field that are

either poorly critiqued or poorly constructed. Poorly structured arguments do not lead to a greater understanding of spirituality in nursing and do not further exploration of this field. As such this means that the body of literature can be viewed as quite limited and further research and better critiquing of literature found within this field should be used in order to further support or disparage evidence previously treated as hard fact.

Hence after viewing the literature available, and outlined within this dissertation, it could be concluded that until such time as there is adequate critiquing of the literature available and further research has been done into what to service users believe spirituality is and how it should be included in nursing care, as well as the effects this type of care provision will have on nursing staff, spirituality should be taken from national health service literature as a benchmark and instead used by individual trusts as an extension to care provided. As previously stated this is due to the subjective and therefore hard to quantify, nature of spirituality. National Health Service care is based on evidence and until such time as further evidence is provided and/or developed by the nursing community in order to support spirituality as a global association for all patients in all circumstances, spiritual care should be provided within a National Health Service trust as an extra alongside holistic care as opposed to as an individual, preferred aspect within a framework.

Reference List

Barnum B.S, (2006) **Spirituality in Nursing: From Traditional to New Age** New York: Springer Publishing Company

Baumhover N (2009) Spirituality and Support for Family Presence during Invasive Procedures and Resuscitations in Adults **American Journal of critical care.** volume 18, no. four, pages 357 – 366

British Medical Journal (2001). Letters: Changes in policy of refusal of blood by Jehovah's Witnesses. **BMJ**. *Issue* 322, page 1123 [online] Available at: http://www.bmj.com/cgi/content/full/322/7294/1123 accessed on:

Clarke J (2008) A Critical View of How Nursing Has Defined Spirituality **Journal of Clinical Nursing:** volume 18 pages 1666-1673

Cobb M and Robshaw V. (Eds.) (1998) **The Spiritual Challenge of Health Care** London: Churchill Livingstone

Coyle J (2002) Spirituality and health: towards a framework for exploring the relationship between spirituality and health **Journal of advanced nursing.** Volume 37 issue six pages 589 – 597

Dawkins R (2006) **The God Delusion** Orlando: Houghton Mifflin Harcourt

Department of Health (2005) **The Prohibition of Abortion [England and Wales] Bill** [online] available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_093676 accessed on: 15.02.2010

Emmons, Robert A. (1992) Abstract Versus Concrete Goals: Personal Striving Level, Physical Illness, and Psychological Well-Being. **Journal of Personality and Social Psychology.** Vol. 62, No. 2, 292-300

Evening Standard (2007) **More young doctors oppose abortions on ethical grounds** [online] Available at: http://www.thisislondon.co.uk/news/article-23392808-more-young-doctors-oppose-abortions-on-ethical-grounds.do accessed on: 15.02.2010.

Frankl, V. (2004) **Man's search for meaning: the classic tribute to hope from the Holocaust.** London: Rider.

Gombrich, E.H. (2002) **Art and Illusion: A Study in the Psychology of Pictorial Representation.** London: Phaidon

Greenstreet W (Ed.) (2006) **Integrating spirituality in health and social care: perspectives and approaches.** Oxford: Radcliffe Publishing

Holy Bible: King James Version (2008). London: Collins

Hope, J (2008) **Now NHS Doctors refuse to carry out late abortions on moral grounds.** [online] Available at:

http://www.dailymail.co.uk/news/article-566938/Now-NHS-doctors-refuse-carry-late-abortions-moral-grounds.html
accessed on: 15.02.2010

Jabbour, Nicolas MD; Gagandeep, Singh MD; Mateo, Rodrigo MD; Sher, Linda MD; Strum, Earl MD; Donovan, John MD; Kahn, Jeffrey MD; Peyre, Christian G. MD; Henderson, Randy; Fong, Tse-Ling MD; Selby, Rick MD; Genyk, Yuri MD (2004). Live Donor Liver Transplantation Without Blood Products: Strategies Developed for Jehovah's Witnesses Offer Broad Application. **Annals of Surgery**. Volume 240, Issue 2, pages 350-357

Kabbalah Centre International (2009) **What is Kabbalah?** [online] available at: http://www.kabbalah.com/about/what-is-kabbalah accessed: 11.02.10

Kendrick K (2001) Spirituality: Its Relevance and Purpose for Clinical Nursing in a New Millennium. **Journal of clinical nursing:** volume 9, issue five, pages 701 -705

McSherry W. (2000) **Making sense of Spirituality In Nursing Practice- An Interactive Approach.** London: Churchill Livingstone

McSherry W. (2007) **The Meaning of Spirituality and Spiritual Care within Nursing and Health Care Practice** London: Quay Books

Marie Curie Palliative Care Institute: Liverpool (2007) **Liverpool Care Pathway for the Dying Patient (LCP).** Available at: http://www.mcpcil.org.uk/liverpool-care-pathway/index.htm accessed on: 15.02.2010.

Medwick, C. (1999) **Teresa of Avila: The Progress of a Soul.** New York: Alfred A. Knopf Incorporated

Narayanasamy A (2001) **Spiritual Care: A Practical Guide for nurses and health care practitioners**. Second Edition. Dinton: Quay Books.

Narayanasamy A (2006) **Spiritual Care in Transcultural Care Research**. London: Quay books

National Health Service [NHS] (2009) **National End of Life Care Programme. Liverpool Care Pathway Fact Sheet 11.** London: NHS.

Neely D. and Minford E.J (2008) Current Status of teaching spirituality in UK medical schools. **Medical Education** Vol: 42 issue 2, Pages 176-182

Nolan S. (2009) In defence of the indefensible: an alternative to John Paley's reductionist, atheistic, psychological alternative to spirituality **Nursing Philosophy** 10: pages 203-213

Nursing and Midwifery Council (2008) **The Code in Full** [online] available at: http://www.nmc-uk.org/aArticle.aspx?ArticleID=3056 accessed on: 11.12.2009

Nursing Times (2009) PCT suspends Christian Nurse for offering to pray for patient. [Online] Available at: http://www.nursingtimes.net/whats-new-in-nursing/pct-suspends-christian-nurse-for-offering-to-pray-for-patient/1980310 article checked 7 October 2009.

O'Brien M.E. (2003) **Prayer in Nursing- the spirituality of compassionate caregiving.** Boston: Jones and Bartlett Publishers

Orchard H (Ed.) (2001) **Spirituality and Health Care Contexts**. London: Jessica Kingsley publishers

Paley J. (2007) Spirituality and secularization: nursing and the sociology of religion **Journal of Clinical Nursing** Volume 17 issue 2 pages 175-186

Paley J. (2009a) Religion and the secularisation of health care **Journal of Clinical Nursing** Volume 18: 1963-1974

Paley J. (2009b) Keep the NHS secular **Nursing standard** volume 23 no. 43 pages 26-27

Partridge C. (Ed) (2004) **Encyclopaedia of New Religions New Religious Movements, Sects and Alternative Spiritualities**. Oxford: Lion Publishing plc

Pearson J. (Ed.) (2002) **Belief Beyond Boundaries: Wicca, Celtic Spirituality and the New Age**. Milton Keynes: The Open University/ Ashgate Publishing Ltd

Praill D (1995) Approaches to spiritual care **Nursing Times:** volume 21 no. 34

Roper N., Tierney A.J and Logan W.W (2000) **The Roper, Tierney and Logan Model of Nursing: Based on the Activities of Daily Living**. London: Churchill Livingstone publishing

Sample. I (2005) **When does life begin?** [Online] Available at: http://www.guardian.co.uk/science/2005/feb/10/thisweeksscience questions Accessed on: 15.02.2010

Speck B.W (2005) What Is Spirituality? **New directions for teaching and learning** no. 104, pages 3 to 11

Swinton J (2006) The way forward- Identity and resistance: why spiritual care needs 'enemies' **Journal of Clinical Nursing** Volume 15 issue 7 pages 918-928

Tanyi R.A (2002) Towards Clarification of the Meaning of Spirituality **Journal of Advanced Nursing.** Volume 39, issue five, pages 500-509

UCL Institute of Child Health. **Protocol for Families Refusing Blood and Blood Components, including Jehovah's Witnesses**. [online] Available at: http://www.ich.ucl.ac.uk/clinical_information/clinical_guidelines/cpg_guideline_00151 accessed on: DATE

White G. (2006) **Talking about spirituality in health care practice.** London: Jessica Kingsley Publishers