University of Strathclyde

Department of Educational Studies

Teaching and learning about spirituality and spiritual care: A case study investigating nursing students' experiences of spiritual education

Beth Seymour

In part fulfilment of degree of Doctor of Education

2006

Acknowledgements

I wish to sincerely thank my supervisor, Dr. Peter Martin, for his interest, encouragement and guidance during this study. I would also like to thank Dr. June Mitchell for her support.

I am indebted to my students for their willingness to share their experiences with me and who made this study possible. I would like to thank my colleagues at Glasgow Caledonian University who helped with group facilitation. My thanks also to Jane Wilkins for her excellent library skills.

I am grateful to my family and friends for their support and forbearance especially my mother, Andrew, Esme, Beryl and Victor

Finally I would like to thank my friend Morag Campbell whose generous assistance in these last months was surpassed only by her kindness.

Abstract

There is a professional requirement that nurses should be competent in assessing and providing spiritual care. Yet there is little spiritual education in nursing curricula and even less evaluative research examining the efficacy of students learning about spirituality, particularly in the classroom. This study aimed to explore what understandings, if any, students had of spirituality and evaluate students' learning about spirituality in the classroom setting.

This is a small-scale qualitative case study bounded by participants' experiences of a short course in spirituality within a particular context. The students (54) engaged in learning methods throughout the course, some of which were used to provide research data. These research methods were the nominal group technique (NGT), reflective journals, reflective group interviews, and end of course student evaluation questionnaires (SEQ). The nominal group was conducted and analysed according to the technique outlined in Moore (1987); the rich qualitative data from the journals and interviews underwent constant comparative analysis; and the data from the evaluation questionnaires were collated.

The major findings from the study were that students did learn about spirituality and spiritual care in the classroom. Students valued learning methods which encouraged reflection and the sharing of ideas. The results from the NGT indicated that students were able to identify a variety of spiritual needs and that some ideas were held in common. Four key themes were derived from constant comparative analysis and interpretation of the qualitative data: (i) Beliefs and values about spirituality and attitudes towards spiritual care, (ii) The language of spirituality and spiritual care, (iii) Telling

spiritual stories: Biographical and autobiographical accounts, and (iv) Learning about spirituality and spiritual care. Theme (iv) was also informed by data from the SEQ.

Table of Contents

List of Tables

1. Introduction and Literature Review

1:1 Introduction

There can be few nurse educators unfamiliar with the view that nursing is both an art and a science. Since Carper's (1978) seminal work on the fundamental types or patterns of nursing knowledge, the debate concerning how best to constitute a balanced curriculum that gives credence to the art as well as the science of nursing has been evident in the literature (Beckingham 1982; Bevis and Murray, 1990; Scammell and Miller, 1999)

One way of achieving a balanced curriculum is to explicate all four forms of knowledge identified in Carper's schemata. In this way the nursing curriculum can articulate a theory of nursing which values not only empirical knowledge but also promotes three other forms of knowledge which are, aesthetics, personal and ethical (Van Maanen, 1990: Rutty, 1998).

However, despite metaphysical and practice justifications for nursing curricula to include the arts as well as the sciences, there continues to be an imbalance in the types of knowledge within nursing programmes. Those forms of knowledge which articulate most closely with the art of nursing - the personal, ethical and aesthetic - remain overshadowed by the scientific and the technical. Therefore it is important to highlight those subject areas which are intrinsic to nursing and yet are in danger of being ignored and unexplored because they do not belong to the kind of knowledge that is most valued by present day health care professionals. The study detailed in this dissertation is a response to the shadowy existence of one such subject area, namely spirituality, in nursing curricula.

The spiritual dimension is described in a multiplicity of ways but it is possible to summarise in broad terms as follows: that which strives for meaning and purpose, transcendence beyond the here and now, that which inspires, motivates and hopes by directing the individual toward the values of love, truth, beauty, trust and creativity (Ross, 1997).

Such descriptions of spirituality reveal its aesthetic quality but they also point to its fundamental personal and idiosyncratic nature. Thus teaching and learning about spirituality includes encouraging students to develop their personal knowledge through self-awareness and reflection.

Despite the professional requirement that nurse educators teach spirituality to pre-registration students (UKCC, 1986; NMC, 2004), research studies reveal that many nurses feel ill-prepared to provide spiritual care and this has been attributed, at least in part, to the neglect of teaching spirituality in nurse education (Waugh, 1992; Harrison and Burnard, 1993; Narayanasamy, 1993; McSherry, 2000a). As a consequence, there is a dearth of research literature concerning teaching spirituality to nursing students. Greenstreet (1999) makes the point that although studies have demonstrated the need for educational input to better prepare nurses for spiritual care, none identify how this might be effectively achieved. This study contributes to the developing interest among nurse educators about how to teach spirituality and spiritual care to students.

There is a more pressing incentive to find ways of teaching this subject to students of nursing and that relates to recent and worrying global events such as the terrorist attacks on the twin towers in New York in 2001 and more recently on the London transport system in 2005. Such attacks violate beliefs about the intrinsic dignity of human life and raise serious questions about why it is that perpetrators of terrorist acts believe in the rightness of their actions. Wars too arise when beliefs and values conflict such as in Bosnia-Herzegovina

whose citizens endured 3 years of inter-ethnic strife from 1992-1995. Nearer home, the decades of bloodshed between Protestant and Roman Catholic Christian denominations in Northern Ireland point to the need to find ways of defusing conflict which arises when different beliefs, religions, values and perhaps cultures supersede the intrinsic worth of being human. In putting spirituality on the curriculum agenda I hope to raise consciousness of the various manifestations of the human spirit in the belief that if it is an aspect of humanity that applies to anyone of us, it applies to us all.

It is difficult to investigate a concept like spirituality as it has many different meanings and the significance of any one interpretation of the concept can vary according to individual beliefs, values and circumstance but it invariably has something to do with personal truth - as Cicero states, 'For that man whom your outward form reveals is not yourself; the spirit is the true self' (De re publica bk. 6, ch 26). However I began this investigation with my own belief that nurses (and others) cannot understand the world they live in, with its joys, conflicts and suffering unless, to borrow a phrase from Glen (1995), they have enough critical spirit, the force which motivates nurses to be willing and sufficiently discerning to arrive at well-thought-through, albeit tentative, views of their own. So, difficult though the area of study may be, it is essential to examine the personal thoughts and values which direct educated nurses as they endeavour to provide spirited, critical and compassionate care to patients irrespective of race, lifestyle, culture and religious or political beliefs (NMC, 2004a)

> 'To educate one needs to attend to what students think and value – not because one approves but because otherwise the most powerful thoughts and values they possess, affecting all others, can be left untouched.' (Glen, 1995: 175)

1.1.1 The professional context

As a lecturer with responsibility for 4th year undergraduate nursing students at a University, I noted that spiritual education was absent from the curriculum. With the clear expectation from the NMC (2004) that nurses ought to be able to assess patients' spiritual needs and the rising interest in spiritual matters in the nursing literature as well as among the general UK population (Hay and Hunt, 2000), I decided to conduct a small-scale study into spiritual education with 4 groups of nursing students. My first degree was in theology and although acquired some time ago, I felt reasonably comfortable with the subject in academic terms. Professionally, I had taught optional modules in nursing humanities over many years and therefore was familiar with different ways of teaching the art of nursing to students.

1.1.2 The context of the study and the participants

There were 4 groups of students participating in the study amounting to 54 students in total. For 3 of the groups, teaching took place in classrooms within the university setting while a 4th group was taught in a seminar room in a local NHS trust hospital. Authorisation for the conduct of the study was sought and acquired from the university's departmental research ethics committee. All data were collected during the course by way of teaching methods that were also used as a means for data collection. These included the nominal group technique (NGT), reflective group interviews (RGI), reflective journals (RJ) and student evaluation questionnaires.

1.1.3 The purpose of the study

The purpose of this study was to describe and explore nursing students' understanding of spirituality and spiritual care and to

evaluate the impact of an educational intervention on their understanding of spirituality and spiritual care. To that end the aims of the study were to:

1. Design a short course in spirituality sensitive to the learning needs of nursing students at different stages of their educational and professional development.

2. Explore the ways that students considered their understanding of spirituality and spiritual care had developed, if at all, as a result of participating in the short course.

3. Examine nursing students' understanding of spirituality through their personal and professional accounts.

4. Explore the personal abilities that students thought they required in order to provide spiritual care.

1.1.4 Intended outcomes

I hoped that this study would shed light on the effectiveness of learning about spirituality and spiritual care in the classroom. This was achieved through an examination of the ways in which students considered that they had developed their understanding of the subject by undertaking the course. In other words, as aims 1 and 2 indicate, what did students think they had learned about spirituality and spiritual care and how did the teaching methods help them to learn? Other intended outcomes of this study are embodied in aims 3 and 4. These were to develop an understanding of students' views on spirituality and spiritual care including which personal abilities students considered enabled the provision of spiritual care.

The intended outcomes of the study, the nature of the subject matter itself and the context of the study all influenced my decision to use a

qualitative investigative methodology and case study was selected as the most suitable approach.

1.1.5 Constraints

The period of data collection took place over 7 months within the time-table for the academic year 2001-2002. To a large extent the choice of groups and the time and place for teaching my course was determined by each groups' overall curriculum, their time-table and the module leaders' willingness to accommodate the short course. The educational material was piloted with a medium sized group of 20 honours year students who were taking a module that I led and the teaching and learning experience ran smoothly for that group. The groups who participated in the study included 1 large (38) group and 3 small (5, 5, 6) students per group.

I would have preferred to conduct the study with groups which were of medium size. One reason for my preference for medium sized groups was that I was the only lecturer with an academic background in a related field and this restricted the involvement of my colleagues to that of facilitators. This meant that I was actively teaching and researching at the same time and although this held few difficulties with the small groups it proved more difficult to organise with the large group (38) of students. Indeed it would have been impossible to conduct the reflective group interviews with the large group had 4 colleagues not volunteered to act as facilitators. Similarly, the nominal group technique would not have been possible with the large group without the assistance of a colleague.

Within the small groups there were 2 occasions when poor attendance affected data collection. The nominal group technique was not used for one university based group as only 3 students arrived on time for the first day of teaching. The other occasion occurred on the final day

of teaching the in-service group who were taught off-site at a local hospital. Due to clinical demands on their time, 3 (out of a possible 5) were able to take part in the reflective group interviews and complete student evaluation questionnaires.

The above constraints notwithstanding, certain professional developments have taken place as a result of the study. These have been useful to students, the university and my personal academic work. They include developing and running modules in spiritual care during the last 2 academic sessions, acting as a consultant for chaplains seeking educational accreditation for modules in pastoral care, conference speaking, and during this academic year, I have been working on an inter-professional project for a centre for spiritual and pastoral care studies at the university. The professional usefulness of this dissertation is discussed further in the final chapter.

1.1.6 The dissertation structure

In the following literature review the place for spirituality and spiritual care will be explicated in relation to the nursing curriculum, different kinds of nursing knowledge and its relevance for nursing practice.

Chapter 2 will inform about the educational strategy adopted for the teaching and learning of the course and provide a rationale for the choice of teaching and learning methods.

Chapter 3 provides a justification for the research methodology and research methods with a detailed appraisal of the appropriateness of case study for this investigation.

Chapter 4 highlights matters of process, ethics and trustworthiness that were employed during data collection and analysis procedures.

In chapters 5-9 an exposition of the findings from the study is undertaken and reviewed in the light of relevant literature.

Finally chapter 10 provides a concluding commentary on the study as a whole including a synthesis of the findings, recommendations arising from the study for future research and the professional, institutional and academic outcomes generated in response to this investigation.

1:2 Literature Review

A review of the health care literature was conducted in order to identify how spirituality and spiritual education were being addressed in the nursing curriculum and in clinical practice. For the purposes of this literature review, the CINAHL and MEDLINE bibliographic data bases were accessed. These databases were searched between the years 1992 and 2004. I decided to search from 1992 as that was the year of completion for the first substantive research study into nursing and spiritual care in the UK (Waugh, 1992). There followed a flourish of interest in papers on health and spiritual care. The key terms used were 'spirituality', 'spiritual education', 'spirit', and 'spiritual care'. Relevant historical literature was also searched as were policy and professional documents. In addition the search brought to light several studies which investigated spirituality within a nursing context and which also used a qualitative investigative design.

1.2.1 Why is spirituality an important part of the nursing curriculum?

Professional nursing practice is guided by tenets that include holism and respect for the individual and students must learn how to practise in ways that reflect these values. Spirituality, it is argued, is intrinsic to the practice of holistic care and, therefore, is essential to the art of nursing practice (Greenstreet, 1999; McSherry and Draper, 1998). Perhaps more than any other health care professional, nurses purport to be concerned not only with the physical care of individuals but also with their psychological, social and spiritual nature thereby acknowledging that people live in communities (Valiga and Bruderle, 1997). Nursing care extends beyond the performance of a technical skill to a concern for the holistic nature and needs of individuals (Kelly, 1992).

The literature reviewed provided some explanations for the low status of the art of nursing generally in the nursing curriculum and as a consequence, nurse educators' poor record in preparing nurses adequately to provide spiritual care. But the most recent literature showed a rising interest in spiritual education in nursing as well as indicating a marked change of public opinion about the significance of spirituality in peoples' lives. The provision of spiritual care too has received attention of some consequence notably from, The NMC (2004), formerly, the United Kingdom Central Council for Nurses Midwives and Health Visitors (UKCC) and The Scottish Executive Health Department (SEHD) (2002).

It may be that this rising interest in spirituality as a curricular subject is the acceptable means, in this present milieu, of including the art of nursing in the curriculum. In other words the increased attention towards the spiritual in health care is a reaction to the dominance of the scientific model. 'Art' may be too remote or general a notion for many to relate it to nursing practice. However nurses value qualities such as love for others, compassion, creativity, sensitivity and the ability to find meaning in sometimes very difficult situations. Such concepts are rarely found in a curriculum dominated by clinical skills and scientific knowledge but they are fundamental to spiritual discourse. Including spirituality and spiritual care in the curriculum ensures that these qualities remain taught and valued in nursing and helps towards a balanced curriculum.

A review of the literature provided 3 major areas of discourse which informed the study. These discourses articulate with issues pertinent to (i) nursing education, (ii) nursing as a practice discipline and (iii) the nature of spirituality itself.

In terms of nurse education, spirituality and spiritual care are explored as to their legitimacy as part of the curriculum. Thus their value is addressed within the context of the different kinds of knowledge that

inform nursing. It is important to explore the tension between educating nursing students to be safe practitioners and educating nursing students to be educated people. Similarly, in relation to nursing being a practice discipline it is argued that a narrow interpretation of the competency requirements for pre-registration nursing students will result in spiritual care being squeezed from the curriculum and likewise from patient care. Finally it is important to explicate the issues and arguments arising from the nature and expression of spirituality within the literature itself. The importance of such discussion is made all the more relevant at this time due to an increased interest in matters pertaining to spirituality and spiritual care from professional and public sources.

1.2.2 Different kinds of nursing knowledge and their value

Bell (1976) states succinctly that while society is founded on knowledge, some kinds of knowledge receive higher marks than others. The same could be said of nursing knowledge. The emphasis on evidence based practice in current nursing and health care (Sackett et al., 1996; Mulhall, 1997) has given rise to concern that nursing education may regress to a narrow interpretation of what constitutes legitimate knowledge. It is argued that restricting knowledge to that of the 'gold standard' of evidence, the randomised controlled trial, will reduce the value of the artistic aspects of nursing which cannot be explained by scientific method (Marks-Maran, 1999; Kitson, 2001). Limiting nurse education to scientific knowledge would seriously impair student opportunities to gain a rich personal education. As a consequence, nursing care would also be limited as the patient experience could be reduced to care solely informed by science and technology.

Nursing is an applied discipline and so the quality of learning is ultimately uncovered by patients who are the recipients of nursing

care. As far back as 1974, Wilson (1974: 412) suggested that a curriculum which focused solely upon the physical and social sciences and neglected the humanities was guilty of ignoring the 'constitution of human nature'. Grindle and Dallat (2001) point out that it is not only patients who are disadvantaged by this deficiency but nursing students who are exposed only to knowledge derived from a positivist approach cannot be prepared for the uncertainty, ambiguity, conflict and personal involvement which are part and parcel of practice.

However nurse education also has a history, if a fairly recent one, of moving towards a wide conception of what counts as evidence, one which includes a post-positivist, interpretative stance. During the 1980's and 1990's a 'new nursing' movement developed which, influenced by critical social theory, sought to emphasise the social construction of knowledge as truth and therefore the relevance of the lived experience of persons (Duchscher, 2000). In curricular terms, students were expected to develop a critical consciousness through active reflection and human caring became a central nursing orientation. 'Caring' was variously expressed as a guiding principle, an ethic, or a condition of being human (Salsberry, 1992; Benner and Wrubel, 1989; Darbyshire, 1994; van Hooft, 1995; LeVasseur, 1999).

Thus it is possible to perceive of contemporary nursing philosophy shifting gradually away from the rationalist, scientific approaches to knowledge. As Glen (1995) points out, the search for an unquestionable foundation to validate our claims to knowledge has been challenged by many including philosophy of science, sociology of knowledge, epistemology, critical theory, post structuralism and post modernism. The significance of other ways of verifying knowledge may be seen in nurse education, through for example, the growing interest in using the arts and humanities as a teaching approach, an emphasis on the personal and the subjective experience of being human (particularly in times of suffering), the place of emotional learning, and, a belief that caring is fundamentally a

creative act (Beckenham 1982; Robb and Murray 1992; Darbyshire 1994; Lafferty, 1997).

Yet, convincing though the arguments may be that the art of nursing is integral to the practice of nursing, in my experience, pedagogy in nursing education remains centred on teaching technical skills and the sciences. The art of nursing is often relegated to a small component or theme of a nursing theory module or is presented as an optional module which, by nature, is viewed as less important than knowledge that is 'core' and compulsory to learning. The claim that the art of nursing is integrated throughout a programme (through, for example, nursing science or theory modules) leaves learning the artistic dimension susceptible to being squeezed out by other subjects. An explicit and coherent expression of the constituencies of the art of nursing – and specifically in this context, spirituality and spiritual care - is required across the curriculum not only to ensure its inclusion but also to encourage lecturers to develop their expertise in a legitimate area of teaching.

There is no doubt, though, that nurses need to acquire a lot of knowledge because they are often faced with complex situations that require them to draw on knowledge from a breadth of perspectives. Carper (1978: 22) makes this point well:

'Nursing thus depends on the scientific knowledge of human behaviour in health and in illness, the aesthetic perception of significant human experiences, a personal understanding of the unique individuality of the self and the capacity to make choices within concrete situations involving particular moral judgements'

Since Carper's (1978) typology remains highly influential in curriculum design, it is useful to explicate further how her analysis of nursing knowledge might accommodate teaching and learning about spirituality in nursing curricula.

In terms of aesthetics, Carper (1978: 17) considers aesthetic knowledge to be embedded in the art of nursing and essential if nurses are to provide holistic care:

'One gains knowledge of another person's singular, particular, felt experience through empathic acquaintance'

Carper (1978) maintains that as perception and empathy develop so does the capacity to creatively select and deliver satisfying holistic care. Thus, empathy is an important mode of aesthetic knowing and necessary for individualised care. Aesthetic knowledge also contains notions of synthesis (Jacobs-Kramer and Chinn, 1988) as it is essential in the provision of holistic care. Empathy, understanding of the lived experience of individuals and the ability to perceive and provide holistic care are also considered necessary human characteristics for spiritual care provision (Swinton, 2001) and so, in terms of curriculum design, spirituality and spiritual care might find a place within the aesthetic domain of knowledge.

It should be noted that aesthetics is not the only kind of knowledge required in order to provide spiritual care. Personal knowledge helps nurses develop meaningful therapeutic relationships with others and understanding of themselves. Carper (1978: 18) describes personal knowing as:

'perhaps the pattern most essential to understanding the meaning of health in terms of individual well-being. Nursing considered as an interpersonal process involves interactions, relationships and transactions between the nurse and the patient-client. ... Such personal knowing extends not only to other selves but also to relations with one's own self.'

Those who engage in deep analysis of the concept of spirituality (Kellehear 2000; Coyle, 2002: Tanyi, 2002) all highlight the

intrapersonal and the interpersonal essence of spirituality in terms of connectedness with oneself and others. So, it is not surprising then that nurse educators suggest that learning about spirituality ought to include the development of self awareness and a sense of presence and relationship with others (Narayanasamy, 1991; McSherry, 1996).

Although Carper (1978) found it necessary to explore knowledge in a categorical way, she stressed that all four types of knowing are crucial, interrelated and interdependent elements of nursing. If the above descriptions of personal and aesthetic knowledge are considered in relation to notions of spirituality, it is clear that spiritual education is largely concerned with students developing and interrelating their personal and aesthetic knowledge. However it has been highlighted that spirituality embraces strongly felt beliefs and values and these can result in both cohesion and conflict among individuals and indeed, nations. Therefore it is my opinion that spirituality is best taught within a context which also acknowledges the ethical dimension and is informed by ethical principles.

If this discussion is placed within a wider educational context, the view that education has a personal as well as a social dimension is also an explicit value of both school and higher education (Kirk, 1982). This shared educational aim should make it easier for nursing students to develop their personal knowledge as personal knowledge has been a feature of school curricula for almost three decades. The Munn report (1977), so influential for the present day school curriculum, recognised that personal and social education is essential for individual achievement. School students already have a developing understanding of self, of the world of subjective experience and the human condition, interpersonal skills and a concern for others. Thus the ground work is in place prior to their entry into tertiary education.

Higher education has a vital role in further developing personal education. A major government inquiry into higher education of almost forty years ago, known as the Robbins Committee (1963) produced an enlightened report which continues to have relevance today. Robbins identified four aims of higher education: preparation for the world of work, the advancement of learning, promotion of cultivated men and women, and the transmission of culture and citizenship. The last two aims require that students of higher education are given the opportunity to develop personal, ethical and aesthetic knowledge - at least to some degree.

1.2.3 Nursing as a practice discipline: educating for a competent workforce

The origins of the common usage of competence in nursing in the UK can be traced back to its inclusion in Rule 18 of the 1983 Nurses, Midwives and Health Visitors Act (HMSO). The up-dated professional requirements for pre-registration nursing programmes (NMC 2004) - which followed on from the publication of the report of the Council's Education Commission, *Fitness for practice* (UKCC, 1999) - resulted in a UK wide exercise among nurse educators to ensure that their programmes incorporated the up-dated requirements. The requirements are expressed in terms of outcomes to be achieved for entry to the branch programme (which students enter after a year of foundational studies) and competencies for entry to the register (usually on completion of 3 years of study).

There is concern among some nurse educators that a competency-based education is unsuitable for nursing students (Ashworth and Morrison, 1991). It is argued that such a preparation tends to be reductionist because it limits learning to that which is easily phrased in measurable terms or identifiable in behaviours and therefore fails to acknowledge the humanistic and psychosocial aspects of nursing care

(Milligan, 1998, Chapman, 1999). It follows then that the subjective and abstract nature of subjects such as spirituality and spiritual care can result in their neglect within a competency-based course.

A narrow interpretation of what constitutes competency in students reduces the educational ideal that nurses should be 'educated' to the less worthy aspiration that they be 'competent'. Although being competent and being educated are, in the best of worlds, complementary, in an educational environment where the priority is to produce a competent workforce, those aspects of education which are not perceived to be essential to the production of a competency, are often neglected. Furthermore, as it is difficult to describe those dimensions of nursing which fall most readily within the art of nursing in terms of competency statements, it is those less easily describable aspects of care such as the spiritual, the ethical and the emotional which are most at risk of being overlooked.

There is another reason for 'glossing over' the significance of aesthetic knowledge in nursing curricula. Unfortunately, far from being perceived as an essential aspect of learning to nurse, teaching the art of nursing may be viewed politically and professionally as a subversive activity which undermines the uniformity required of the 'competent' practitioner. Creativity, so essential for the art of nursing, does not ensure uniformity of care but encourages diversity in students' thinking and practice (Harrison, 1992; Lafferty 1997). Creative, questioning nurses who have a holistic perception of themselves and their patients may not fit a narrow interpretation of an 'outcomes and competence' pre-registration nursing programme.

However it would be unfair to accuse the recent NMC (2004) requirements for pre-registration programmes as reductionist and constricting in either their expression or intent. The competencies are described in broad terms that clearly reflect a philosophy of holistic care along with the expectation that nurses will learn how to provide

such care. Sensitivity, empathy and ethical awareness are considered important aspects of learning to nurse. Furthermore the competencies do not stand alone. The intention is that they are read alongside accompanying guidelines which reinforce the need to provide students with a broad knowledge base to meet the demands of practice:

'Safe and effective practice requires a sound underpinning of the theoretical knowledge which informs practice and is in turn informed by that practice. Such knowledge must therefore be directly related to, and integrated with, practice in all programmes leading to registration as a nurse. The competencies, and preparation for such competencies, must therefore reflect a breadth of practice and of learning' (NMC, 2004: 5).

Critics of the competency orientation of nurse education do not necessarily deny the usefulness of competencies as benchmarks designed to safeguard the public against 'incompetence'. However a preoccupation with competence could result in closure of learning once the student is deemed competent. This could result in content such as values, personal and interpersonal skills and creative work being omitted from the curriculum because they are too difficult to assess (Milligan, 1998). And this is a serious omission:

'To educate one needs to attend to what students think and value – not because one approves but because otherwise the most powerful thoughts and values they possess, affecting all others, can be left untouched' (Glen, 1995: 175)

It is clearly possible to have an educational framework which *includes* competencies yet which does not reduce education *to* competencies. It is my view that the difficulty arises when nurse educators apply a narrow interpretation of competency statements and lack symmetry in their judgement of the relevance of both the art and science in the curriculum.

I would suggest that competencies are necessary guides to nurse education, a means of trying to protect the public against incompetent practitioners. However, nurse education must include a breadth of learning, which, although sometimes difficult to describe in terms of competency statements, is nonetheless essential to learning for practice. Competencies should not be allowed to control the curriculum to the extent that they exclude the artistic aspects of practice. Rather nurse educators should ensure that their interpretation of competencies takes notice of the accompanying guiding principles, specified by the NMC (2004), which identify broad concepts such as holistic and spiritual care, reflective capacities and ethical awareness as integral to competent practice.

The above discussion draws attention to two major reasons for spiritual matters being under represented in nursing curricula. Spirituality and spiritual care are subject to being squeezed out of a curriculum because of the value placed on other kinds of knowledge such as the scientific, the technical and the kind of knowledge which may be easily described in terms of competencies. But, secondly, and more problematic, is the inhibitory effects on the curriculum of a narrow interpretation of the constituencies of a holistic philosophy of nursing. Fortunately, the map of influences on the curriculum is more complex than that described so far and I now turn to those which have made it possible to include spirituality and spiritual care in nursing programmes. There follows a discussion of some of the influences which have resulted in the rise in interest in spirituality and spiritual care.

1.2.4 The nature of spirituality: towards an understanding of the noumenal.

Caldwell (1997) stresses that the development of curricula cannot be viewed in isolation from the socio-political context within which it exists. My interest in spiritual issues and health care appears to be part of a general increasing interest in these matters as evidenced by reference to professional, political and public sources.

For example, there is a professional recognition that spiritual care is part of the work of nursing. Since the UKCC (1986) published *'Project 2000 - A New Preparation for Practice'*, newly qualified nurses have been expected to be able to identify physical, psychological, social and spiritual needs of the patient or client.

The latest NMC (2004) competency requirements for pre-registration nursing programmes re-iterate that the ability to carry out a full, systematic and accurate assessment of spiritual needs of patients and communities is a competency necessary for entry to the register:

'Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities' (NMC 2004: 13).

Furthermore, newly qualified nurses must be able to:

Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences' (NMC 2004: 17).

Therefore, nurses must not only be able to carry out an assessment of spiritual needs but also be able to provide a justification for that care. This suggests that nursing students ought to have time in their programme to gain an understanding of what constitutes spiritual care, the theoretical perspectives that inform such care and the opportunity

to develop the capacity to become skilled in the practice of assessing the spiritual needs, not only of patients and clients but also those of communities. Incorporating the spiritual needs of communities as part of nursing assessment undoubtedly makes the task of spiritual assessment even more challenging for nurse educators as it requires of them that they teach about wider cultural and religious contexts.

McSherry and Ross (2002) make the point that while the above competencies seem to locate responsibility for spiritual assessment at the door of nurses there is a failure to give any consideration to the practical implications of so doing. In Scotland, in recent years, there have been political attempts to put in place a preliminary infrastructure for a spiritual care service in the NHS. For example, the Scottish Executive Health Department (SEHD) have funded a Healthcare Chaplaincy Training and Development Unit whose responsibilities include, amongst others, the development of staff training in assessing spiritual need. The publication by the SEHD in 2002 of 'Guidelines on Chaplaincy and Spiritual Care in the NHS in Scotland' require NHS organisations to develop and implement spiritual care services that are tailored to the needs of the local population. This document makes the point that spiritual care provision is not solely the province of the chaplain but is also the responsibility of all staff who are involved in the direct care of patients and carers:

'Patients and carers often express their own spiritual needs and their direct care staff must be able to advise them of the spiritual and religious care available to them. ... The assessment of spiritual need is a skilled task best undertaken by those who directly care for patients and their families. Staff who are aware of spiritual needs will be able, if properly trained, to offer better spiritual care themselves and will be proactive in accessing spiritual care services....' (SEHD, 2002: 48)

Again it would appear that nurses, who provide most of the direct care to patients and their families are expected to be able to assess spiritual needs and, if properly trained, offer spiritual care themselves. In answer to McSherry and Ross' (2002) criticism that thus far there has been a failure to consider the practical implications of such a role, this document at least acknowledges not only that staff require training to enable them to meet those expectations but that resources in terms of personnel and in-service training are necessary. But even the promise of such resources and, hopefully the fulfilment thereof, may not be enough for spiritual care to be come a reality in the NHS. For this to happen, it must be valued.

In a sense both the NMC (2004) in its publication 'Requirements for pre-registration Nursing Programmes' and the SEHD (2002) in its publication, 'Guidelines on Chaplaincy and Spiritual Care in the NHS in Scotland' have laid out that they expect those who organise nursing education and those who organise NHS health care to create the opportunities for students and staff to learn how to assess and, in some cases, provide spiritual care. What they may not be able to do is ensure that spiritual care is a priority by either education or service providers. But they do open the door for interested parties to pick up the baton for change and there is some evidence that enthusiasm for this change extends beyond professional and political will to that of the general population - who are also users of health care facilities.

One reason why spiritual care is receiving so much attention at the moment in health care is that there appears to be an increasing interest in personal spiritual experiences among the general public. It is notable that when describing what spirituality might be, it is often stressed that spirituality is not considered synonymous with religious belief and practices. This recognises that many agnostics and atheists do not express their spirituality in terms of religion (Burnard, 1993). Indeed, I would add that the spirituality of religious people is not solely revealed through their religion, though some may consider it

the most important expression of their spirituality. However, the separation of the spiritual from the religious may be viewed as a major factor, even a catalyst, in sparking the present emphasis on spiritual care. It is well known that mainstream church attendance in the UK is dropping at a significant rate with regular church attendance down more than 20% between 1989 and 1998 (Brierley, 2000). Yet surprisingly, Hay and Hunt (2000) report that national population surveys undertaken over approximately the same period of time reveal that those who admitted having had a spiritual or religious experience increased by almost 60%. Whereas 48% of the national sample felt that they were personally aware of this kind of religious or spiritual experience in 1987, 13 years later, slightly more than 76% of the national sample felt that they had had such an experience (Hay and Heald, 1987; Hay and Hunt 2000). So while church attendance decreased, religious and spiritual experiences among the population increased. This suggests that people have become more aware of such experiences and also perhaps are more likely to report them. In turn this willingness to acknowledge and discuss such experiences may have contributed to the renewed interest in (and need for) spiritual care.

It would appear that freeing the spiritual nature from the religious seems to have highlighted a widespread belief in the spiritual as part of the human condition although this belief is not new. For example correspondence may be found in Rudolf Otto's 1917 theory of 'The Idea of the Holy' in which he contends that the human predisposition for numinous experience is not just a characteristic of some individuals but of all people (Baldacchino and Draper, 2001). With Hay and Hunt (2000) reporting that 76% of the national sample claimed a personal awareness of a spiritual or religious experience it would seem that many believe that spirituality is part of being human and indeed that spirituality is a universal attribute.

Nurse educators who advocate that spirituality should be part of learning to nurse often justify their position by using similar notions about spirituality. For example, McSherry and Draper (1998: 688) emphasise spirituality as central to holism 'a unifying force at the foundation of holistic philosophy' and believe that unless nurses can provide spiritual care, they will be unable to engage in holistic care. So in providing spiritual care to patients, it is not enough for nurses to feel that they have met the spiritual needs of patients by referring them to a minister of religion. If nurses are to provide holistic care that is sensitive to the spiritual dimension of patients then they must learn to do it themselves (Harrison and Burnard 1993). Bradshaw (1996) and Wright (1997) share the view that spirituality is an integral part of being human and also that all aspects of life are inter-related. To neglect a patient's spiritual needs then could have a detrimental effect on other aspects of their lives such as their physical or emotional or social well-being.

The view that unless nurses can provide spiritual care, they will be unable to engage in holistic care is both logical and persuasive though its power rests on whether the concept of holism is valued philosophically and practically in education and practice. Few would disagree with the premise that health is more than the absence of illness. Modern health care incorporates the belief that health is more than pathophysiology and as far back as 1948 The World Health Organisation (WHO) defined heath as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948).

It must be stressed though, that not everyone agrees that spirituality is or can be a universally defined concept in the same way as there are common understandings of what it means to have a physical, mental or social dimension. It is generally agreed that since spirituality is a highly subjective, personal and individualistic concept it is a

particularly difficult human dimension to define (Bradshaw, 1996; McSherry, 2000) and some, for example Chuengsatiansup (2002:10) caution against attempting a definition:

'Defining spirituality is a complex undertaking because there seems to be neither one specific spiritual experience nor single spiritual quality. Also, spiritual health seems to resist defining because it is not only subjective but a relational state of inner experience. Spiritual growth is also non-linear. All these qualities of spiritual life make it a dogmatically impossible task to come up with an all encompassing definition of spiritual health. Perhaps, to define it is to rob it of the mystical quality essential for being what it has been.'
Chuengsatiansup (2002:10)

Cawley (1997) and Bash (2004) take this argument further and conclude that the nature of spirituality defies development of a standard definition. Bash (2004:13-14) considers that in asking the question, 'What is spiritual experience?' we are in danger of turning what is a philosophical question into a scientific question:

'*Any* working definition of spiritual experience comprises value judgements – saying, in effect, spiritual experience is this or that, but not something else. The selection of criteria is necessarily subjective, arbitrary and personal.'

Bash (2004) asserts that spiritual experience is what each person says it is and that there may be as many spiritualities as there are people. Thus it is a categorical error to develop an analytical taxonomy that presupposes that the spiritual experiences of people can be identified by universal norms or generic categories. This suggests that developing or using assessment tools based on a received view or definition of spiritual experiences rather than the individual patient's own subjective description of spirituality is profoundly flawed. If

spirituality is indeed idiosyncratic, there is no place for universal categories.

On the other hand there is also support for believing that, however difficult the task, it is essential to seek a standard definition because until then any comparison of the findings of studies on spirituality and the relationship between spirituality and health will remain poorly understood (Ross, 1995; Coyle, 2002). Through a conceptual analysis of how spirituality is used in the literature on spirituality and health between the years 1990-2000, Coyle (2002) encapsulates three main approaches to spirituality:

1. The Transcendent Approach in which some form of transcendence is seen as an essential feature of spirituality.

   Fry (1998) distinguishes between transpersonal transcendence which is a sense of connectedness that one has to God, a higher power or consciousness and intrapersonal transcendence which describes the potentiality of the self and its concern with inner knowing and inner strength. It is a person's spirituality which is responsible for enhancing this inner resourcefulness. It is during times of ill health and suffering that demand is greatest on a person's inner strength and I would suggest that this feature of spirituality provides a valid argument for nurses being in the front line of providing spiritual care.

2. The Value Guidance Approach where spirituality is held to reside in any firmly held value that gives life meaning and purpose.

   Meaning may be found in both the divine and the secular through, for example, adherence to political ideals and relationships with others or perhaps by way of aesthetic appreciation of music, poetry and art. One difficulty with this approach is that if spirituality is whatever is of most value to an individual, is the person who values money, personal gain, power above all else or even, harming others, still a spiritual person?

3. The Structural-behaviourist approach focuses on reproduced actions and behaviours associated with organised religion.
McGilloway and Myco (1985) argue that spiritual care would be relatively straightforward if it were confined to religious practice. Religions have recognised tenets of faith and practices and learning what these are is far more accessible than uncovering what spiritual needs might be. But I would argue that however tentative and abstract spiritual knowledge might be this should not distract us from its significance.

'One of the aims of educators must be to explain how knowledge can be reviewed as tentative, as uncertain, as changing and evolving while at the same time not necessarily being seen as relative, subjective, personal and incapable of being expressed in any generally agreed form' (Glen 1995: 172).'

And so although Kellehear (2000) agrees that it is extremely difficult to find any precise definition of spirituality, he argues that a certain level of definition is possible and desirable – not in terms of capturing the spiritual essence of self but in describing the pattern of its desire and direction.

Indeed, Coyle (2002) also points out that although these approaches outlined above constitute differing ways of viewing spirituality, they may not be mutually exclusive. In effect, most definitions that are used in nursing and health care literature tend to be inclusive of different and diverse interpretations of spirituality and reflect a broad understanding of the concept. As such they tend to uphold the subjective and encompassing interpretations of spirituality and shy away from prescribing a standard definition. For example Murray and Zentner's (1989: 259) definition of spirituality is used widely in health care texts:

'A quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in any god. The spiritual dimension tries to be in harmony with the universe and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death'.

The appeal of this definition for nurses and other health care professionals includes the view that spirituality is universal but unique to each individual; that people may become more spiritually aware when ill; it involves the search for meaning in an individual's life (and illness), and, that spirituality is essential for harmonious living and transcending what may be a punishing existence.

Also, within this definition it is clear that spirituality is not considered synonymous with religious belief and practices thereby acknowledging that many do not express their spirituality in terms of religion.

The argument that 'spirituality comes into focus when the person faces emotional stress, physical illness or death' is important if spiritual care is to be recognised as a legitimate dimension of nursing work. Perhaps it is stating the obvious to say that had I taken the counter position - that spirituality does not exist in some way or does not feature in illness, I would not have conceived of this study but it is also the case that some might disagree with my premise. Although it is not the business of this study to prove the argument, it is important to acknowledge that without the premise that it makes sense to say that people are spiritual beings and that it is at least possible to suggest that spiritual concerns might feature during illness, this study would have been somewhat brief.

Encouragingly there is literature which suggests that my premise is based on more than assumptions as there is empirical evidence which

suggests that when ill, people find that employing spiritual strategies, both religious and existential, helps them cope with their illnesses (Koenig et al 2001). For example, Koenig et al (2001) conducted a critical and comprehensive review of empirical studies which examined the relationship between religion and a variety of mental and physical health conditions during the twentieth century. Their extensive analysis provided evidence that the relationship between religion and health is overwhelmingly positive. Support for the positive relationship between spirituality and health is also argued for in Baldacchino and Draper's (2001) literature review which was aimed at identifying which spiritual coping strategies both believers and non-believers use when ill. Baldacchino and Draper (2001) concluded that spiritual coping strategies involving relationship with self, others, ultimate being/God or nature were found to help individuals cope with their illness. They suggested that the onset of illness makes people realize the lack of control over their lives and that the employment of spiritual coping strategies may enhance self-empowerment, leading to finding meaning and purpose in illness. Thus illness may bring about a heightening of spiritual awareness (Ross, 1995) and spiritual coping strategies may help restore a sense of integrity and wholeness. If a person's spirituality has an influence on their physical or mental health then it seems appropriate for nurses to view spiritual care as part of their practice.

Studies investigating spirituality in nursing practice have explored areas such as nurses' concepts of spirituality; nurses' awareness of spiritual aspects of care; assessment of patients' spiritual needs, and caring and coping strategies for nurses and patients (Greenstreet, 1999; Baldacchino and Draper 2001; Kuuppelomaki, 2001; Narayanasamy and Owens 2001).

Unfortunately, to date no in-depth empirical research has been conducted that is specifically concerned with nursing education and spirituality although several studies have found that nurses felt poorly

equipped to provide spiritual care and many nurses were reluctant to provide spiritual care in the first place (Kuuppelomaki, 2001). For example, McSherry's (1997) large descriptive survey of nurses and spirituality in a NHS trust in the north of England provides evidence that there is a significant lack of teaching about spirituality in nurse education. One of the aims of his study was to establish whether qualified nurses feel that they received sufficient education and training to enable them to meet patients' spiritual needs effectively. McSherry (1997) found that only 39.9% of qualified nurses felt able to meet their patients' spiritual needs and 71.6% felt that they did not receive sufficient training into this aspect of care. Disconcertingly, 52.8% of qualified nurses stated that they had not received any formal education in the spiritual dimension of care and this finding raises questions about the quality and type of spiritual care that patients are receiving. Caution needs to be exercised when interpreting the significance of these findings because a newly designed rating tool was the sole means of collecting data and it requires refinement and validation by further research. However the study does indicate that only some nurses received educational instruction and there was no consistency about the nature or quantity of any education. These findings raise questions about the mismatch between the statutory and professional expectations of nurses in that they should be able to provide spiritual care and nurse educators' preparedness to provide spiritual education.

1.3 Concluding Comments

Spirituality is a difficult dimension to define with precision and learning about spirituality is a deeply personal, sensitive and highly subjective area (Bradshaw, 1996; McSherry, 2000). This makes teaching and researching spirituality particularly challenging as students and lecturers will hold a variety of views on the nature of spirituality. On the one hand, materialists would see little value in teaching, learning or conducting research about spirituality as by its very nature it is non-physical and open to interpretation. On the other hand, if Bash's (2004) relativist position (that there are as many definitions of spirituality as there are individuals) was found to be representative among the nursing students who were the participants for this study – it would be impossible for me to capture their interpretations and meanings in any coherent or authoritative account. It was important when choosing both the educational and research designs that I acknowledged that participants may not have any sense at all of the noumenal or that they held such diverse interpretations of meaning that I would be unable to capture their understandings.

2. The Educational Strategy

In this chapter I will discuss the educational strategy within the context of the aims of the study. A detailed rationale for the research strategy follows in Chapters 3 and 4.

2:1 Aims of the Study

The purpose of this study was to describe and explore nursing students' understanding of spirituality and spiritual care and to evaluate the impact of an educational intervention on their understanding of spirituality and spiritual care. Case Study was the methodology of choice for this investigation and all data was generated from participants' educational activities during a short course on spiritual education. The aims of the study were to:

1. Design a short course in spirituality sensitive to the learning needs of nursing students at different stages of their educational and professional development.

2. Explore the ways that students considered their understanding of spirituality and spiritual care had developed, if at all, as a result of participating in the short course.

3. Examine nursing students' understanding of spirituality through their personal and professional accounts.

4. Explore the personal abilities that students thought they required in order to provide spiritual care.

The methods used to address the aims of the study included student evaluation questionnaires, reflective group interviews (RGIs),

reflective journals (RJs) and the nominal group technique (NGT). The rationale for their selection as educational methods is discussed further on in this chapter while Chapter 4 explores their usefulness as research methods.

2:2 How should Spirituality be Taught?

The literature search brought to light some theoretical expositions and models about the nature of spirituality (Stoll, 1979; Kellehear, 2000) and theoretical models for teaching spirituality (McSherry, 2000a; Narayanasamy, 1999). These were useful for informing the educational strategy. More recently, Callister et al (2004) and Cavendish et al (2004) have produced detailed accounts of teaching spirituality to nurses but although these accounts are strong in course content, evaluation information is limited. Only Bush (1999) provides a full evaluative account of teaching spirituality to nurses. This pointed to a significant 'hole' in understanding how best to teach spirituality and, more fundamentally, raised the question as to whether spirituality can be taught or learned in the classroom. Bradshaw (1997) asserts that understanding spirituality cannot be taught in the classroom, rather it is 'caught' in practice through role-modelling. Without wishing to undermine the significance of students learning in practice, it is apparent that, as so many qualified nurses feel ill-prepared and unable to provide spiritual care (McSherry, 1998; Kuuppelomaki, 2001), the opportunities for students to learn in practice from qualified nurses is somewhat arbitrary.

My task then was focused on the value of classroom teaching in an attempt to find out if students considered that learning in the classroom developed their understanding of spirituality and spiritual care. Therefore I was aware that little was known about how best to teach spirituality and spiritual care and that it was not at all certain that students would find it possible to learn of these matters in the classroom. So with this rather daunting knowledge, I turned to designing a teaching and learning strategy that would hopefully inform about the efficacy of a particular course of study.

2:3 The Educational Methods and Procedures

2.3.1 Student groups and their background

The study participants were all nursing students at very different stages of their academic and professional lives. Most of the participants were undergraduate students in their 3rd or 4th year of nurse training and therefore had very limited clinical experience but there were also 2 small groups of students who were very experienced practitioners. Students in one of these small groups were undertaking a Master's degree in nursing and therefore had a strong background in practice and academia while the other small group of students consisted of experienced ward staff with no prior higher education and who practised either as sisters or staff nurses. My task was to design a short course that facilitated learning for all these students whatever their academic or clinical experience. These were convenient groups selected for their ease of access and ability to inform about the phenomenon under investigation. Convenient sampling, typified by Patton (2002) as a kind of purposive sampling, is an appropriate strategy for case study (Cohen et al., 2000; Robson, 1993) - this will be revisited in chapter 3.

Participant groups

The 4 student groups participating in this study were:

roup 1 Participants were in their third year of an undergraduate nursing programme. The short course was taught over one day when students were on clinical practice and attending the university for study days. There were 38 students in this group.

roup 2 Participants were in their final year of an undergraduate nursing programme. The short course was taught over two weeks as a learning

theme within an optional module in the arts and humanities. There were 6 students in this group.

Group 3 Participants were registered nurses undertaking a master's degree in health studies. The short course was taught over two weeks as a learning theme within an optional module in health care ethics. There were 5 students in this group.

Group 4 Participants were registered nurses working in the acute sector of a Glasgow Trust Hospital. As they had requested in-service spiritual education, this course formed part of their professional development. The group were experienced nurses with no post-registration academic qualifications. There were 5 students in this group.

A short introductory course in spirituality and spiritual care was designed and delivered to these 4 classes of nursing students. The two groups of undergraduate students and the small class of masters' students accessed the course as part of a module. The fourth group were practitioners in a Glasgow Trust Hospital who had requested in-service education in spirituality. Student experience of the course lasted approximately 6 hours and although the teaching methods were the same for each class, the time-table varied according to the requirements of each group. Thus for group 1 teaching took place at the university as an all-day workshop; for groups 2 and 3 teaching took place at the university one afternoon a week over 2 weeks, and for group 4, teaching took place in a seminar room at a hospital for 1 hour and 15 minutes every Wednesday over a period of 5 weeks.

While the educational strategy was designed primarily to encourage learning about spirituality and spiritual care my selection of teaching and learning methods was also motivated by the need to choose methods which lent themselves to being responsive to the generation of research data.

2.3.2 Selecting the teaching and learning methods

As I considered how I could teach concepts as abstract, subjective, and diverse as those of spirituality and spiritual care, two primary areas of concern sprang to mind. The first concerned students' prior knowledge. Would students have any understanding at all of spirituality? If so, would such understandings be so diverse and idiosyncratic that it would prove impossible for students to understand what spirituality meant to people other than themselves? If that were found to be the case, the task of providing spiritual care for others would be a tricky business. I decided to address this concern by starting the course with a fairly well known class participation activity, the nominal group technique (NGT), a method that I had used before. According to Moore (1987) this technique is an effective way of generating ideas and is particularly useful in areas of uncertainty or disagreement, and therefore, I considered this to be an appropriate way of finding out what understandings, if any, students already had about the spiritual. Invented in 1968 by Andre Delbecq and Andrew Van de Ven, the NGT allows individual judgements to be effectively pooled and so the technique was an ideal vehicle whereby each student could articulate their own ideas while acknowledging the contribution of other students' views. The question for this activity was 'What are spiritual needs?'

My second area of concern was an ethical matter. If students had no personal belief in the spiritual, or very limited understanding of a spiritual dimension either within themselves or others, was it ethically justifiable to try to teach it? After all, what was taught would be my decision, and in a field as intrinsically personal as spirituality, my choice as to what and how to teach would undoubtedly colour what students were exposed to. Beginning with what students believed were spiritual needs by way of the NGT counteracted, to some extent at least, the notion that the class would be solely exposed to my own agenda but I was mindful that I set the scene for what students might

be 'encouraged' to learn. This feature also raised the profile of one of the 'hot-potato' issues discussed in the literature review, namely the view that it is desirable to seek a standard definition of spirituality. As previously explained, a standard definition of spirituality in nursing is advocated by some (Ross, 1995; Coyle, 2002) on the grounds that until then any comparison of the findings of studies on spirituality and the relationship between spirituality and health will remain poorly understood. However this view is thrown into sharp focus when one considers the appropriateness of *teaching* a standard definition of spirituality. Surely the richness of the subject is found in its personal and idiosyncratic essence and if I succeeded in valuing students' own interpretations of the 'spiritual' in an educational context, they, in turn, were more likely to value the spirituality of individual patients. It is one thing to introduce students to different ideas and understandings about spirituality but it is quite another to suggest that there is a 'received view' which defines spirituality for the nursing population. Furthermore were nurses to adopt a particular definition of spirituality, rather than enhance their ability to provide spiritual care, it could lead to a gulf in understanding between them and the general public who use the health care service – a matter recently raised by McSherry et al (2004).

As the literature review also demonstrated, spirituality has received little attention in nurse education and it was thought likely that students would require new knowledge to develop their understanding. Bearing in mind the problem of teaching spirituality according to a narrow parameter, it was important to introduce students to a wide spectrum of theoretical considerations of spirituality and this was delivered in a lecture format. Appendix 1 provides an overview of the lecture content.

By its very nature education in relation to spirituality in nursing has to be evocative of the personal beliefs, values and experiences of the student; it includes the kind of knowledge Carper (1978) described as

'personal'. Thus, the teaching methods in most of the classes enabled a time for discussion so that students could talk about their own experiences of spirituality both in relation to themselves and patients. The emphasis on centring learning round the thinking and experiences of students led to the course culminating in a reflective learning session, a method of learning chosen because it offered students the opportunity to examine a prior spiritual experience thereby uncovering insights that could inform future spiritual care practice. In a sense, reflective inquiry helps students assert a degree of control over their own theorising or metacognition (Eraut, 1994) thereby developing their cognitive and affective skills in a way that opens up new perspectives. By applying the skills of self-awareness, description, critical analysis, synthesis and evaluation (Atkins and Murphy, 1993) students can tease out their learning from practice - in Schon's (1987) sense of reflection-on-practice. Also as reflective inquiry was the final session, it was hoped that students could usefully integrate any new learning gained from previous classes.

Journal and diary writing is widely advocated in professional education (Fonteyn and Cahill, 1998; Lyons, 1999) as it is thought to provide students with the opportunity to move from passive to active thinking and reflect on practice. In her critique of journal writing, Lyons (1999) showed that through reflective writing, most students were able to develop reflective skills and identify areas that required further development. Further, in a study about nurses' perceptions of the value of written reflection Jasper (1999) found that nurses thought that they developed their own personal as well as professional growth through reflective writing.

I felt that journal writing was an appropriate medium through which to encourage spiritual learning as such knowing would impact on both the personal and professional life of each student. Also Bush (1999) suggested that one of the limitations of his evaluation was an uncertainty surrounding the quality of students' critical reflection

which he determined to address by encouraging future students to keep individual journals which they would bring to the classroom. On the other hand, when making the decision about whether to use journal writing as a learning experience for students, I noted that it could be difficult to 'sell' as it is well reported that journal writing is difficult, time consuming and unpopular with students (Burton, 2000). Paterson (1995) states that, as reflective ability is necessary for practitioners to develop, alternative solutions to journal writing must be sought. As the course was short, it seemed unreasonable to require of students written reflective accounts. Therefore students were given the choice of either providing a written reflective account or, alternatively, discussing their accounts with one another in small groups.

All students were given a simple reflective schema to work from prior to writing their journal or participating in the reflective group session (Appendix 5). Also, those students who opted for the group session were informed that the key principles to guide discussions would be equality of opportunity to contribute, voluntarism, active listening and respect and sensitivity to others. These principles are in keeping with the concepts and practices of adult learning.

The purpose of these two techniques was to capture data that demonstrated students' thinking about what they perceived to be a spiritual experience. It was important not to colour participants' thinking by providing a religious framework so I deliberately did not include any religious education in the short course. This was particularly pertinent in view of the reported rise in spiritual experiences at a time of diminishing religious observance (Hay and Hunt, 2000). Bearing in mind our increasingly secular culture I was keen to discover the breadth and depth of experiences that students reported as spiritual, whether those transpired to be grounded in religious belief or not.

Students were informed that experiences that took place in their personal or professional lives were equally welcomed for discussion. This approach was chosen to try to uncover what individual students believed was a spiritual experience and was an attempt on my part as a teacher to avoid prescribing what students ought to believe constituted a spiritual experience. Reflecting on that experience was based on the premise that in so doing, students would gain deeper understanding of the meaning of the experience and be able to connect their experiences to practice (Glen, 1995). Thus, reflection facilitates the development of professional expertise by bringing to consciousness tacit knowledge inherent in practice (Schon, 1987).

Spiritual knowing also embraces the kind of knowledge that Carper (1978) described as 'aesthetic'. Aesthetic knowledge requires perception and empathy to form creatively elements of a situation into a cohesive whole. There is a sense of occasion, a coming together, even enlightenment in aesthetic knowledge as well as a sense in which this 'all at once' interpretation of the situation results in transformation (Carper, 1978, 1992; Smith 1992).

It is possible to consider the noumenal, the kind of knowing which cannot be gained through the senses – such as that of spiritual knowing - in a similar vein to aesthetic knowing, perhaps even as one and the same thing. For example, in an effort to emphasise spirituality as central to holism, McSherry and Draper (1998: 688) describe it as 'a unifying force at the foundation of holistic philosophy'. In terms of aesthetic teaching and learning, several authors (Sandelowski, 1991; Grindle and Dallat, 2001) recommend storytelling as a useful strategy to inform aesthetic knowing in nursing. Therefore, part of the course included students listening and interpreting an audio-tape by Lee Hall called Spoonface Steinberg. This tape was chosen for its illness narrative and spiritual content, which, in spite of its serious nature may be perceived as inspirational. Appendix 2 provides a synopsis of the audio-tape.

In outline, the short course was a 4 stage process:

Session 1: Whole class activity – the Nominal Group Technique

Session 2 Lecture: Theories and models of spirituality

Session 3 Audio-tape – Spoonface Steinberg

Session 4 Reflective Inquiry Groups

(Appendix 3 for Course Outline)

In summary, the educational strategy was designed to evoke subjective and particular knowing intrinsic to spirituality and spiritual experience and to that end teaching methods such as the nominal group technique, journal writing and reflective groups were incorporated in the course. In addition, in order to circumvent some notion of a received view of spirituality and spiritual care a lecture was included which incorporated various theories or concepts about spirituality in health care. Spiritual knowing is considered to be fundamental to holistic care which may be judged to be a kind of aesthetic knowing. This kind or pattern of knowledge is difficult to articulate and so the play, 'Spoonface Steinberg' was used as a means of assisting students (and lecturer) in seeing those important aspects of the human condition. Thus the educational strategy provided the methods for learning as well as the tools whereby the research could be undertaken.

3. Research Design: Methodology and Methods

This investigation is a case study. Reasons for selecting case study as the optimum methodology to guide the study over other strong contenders such as action research and grounded theory are explained in section 3.3.

In this chapter I will discuss the research methodology, research methods and the means of data analysis which informed the study. Cohen et al (2000) offer a useful demarcation of what is meant by research methodology and research methods and this provided a starting point for these considerations. Research methods are the techniques and procedures used in the process of data-gathering while research methodology helps towards an understanding of how the inquiry was conducted, concentrating on processes rather than its products (Cohen et al., 2000).

In addition it was necessary to bear in mind that any sound research design must feature consistency throughout the inquiry process (Proctor 1998) in that the analytical procedures must fit with the methods of data collection which, in turn, ought to stem from the research purposes and aims. Easterby-Smith et al (1997) suggest that in order to arrive at an integrated overall research strategy, the researcher requires knowledge of philosophy. Crossan (2003) makes the point that the philosophical underpinnings of a study can explain and direct the type of evidence gathered, the manner of its interpretation, and how it addresses the research aims.

3:1 Research Methodology

Porter (1996) states that research methodology concerns questions about the manner in which knowledge about what exists can be gained. Therefore methodology is informed by what the researcher considers exists as truth or reality (ontology) and how that truth or reality is knowable (epistemology). It is well documented that the researcher's experiences, understanding of philosophy and personal beliefs may also affect the way in which the research is undertaken (Denzin and Lincoln, 2000; Knight 2002) and so it seemed important to explain how my philosophical perspectives about the subject of the study impacted on methodological issues.

Thus I now turn to explaining beliefs about how knowledge about spirituality exists and how I might gain the knowledge required to address the aims of the study.

3.1.1 Ontological stance: in what sense does spirituality exist?

The increasing societal and professional interest in spiritual matters, particularly as they relate to health and well-being, suggests that many, though not all, people believe in the reality of the noumenal. Further, the beliefs that people hold provide a stimulus for health care professionals and educators to explore how these ideas affect individuals when sick or well. It is a material world but it may be also – for all we know – a super empirical world where the transcendent element of spirituality is real.

It is not the business of this study to judge whether spirituality exists in the metaphysical sense of a non-material entity or whether the reality of spirituality is confined to peoples' personal, biological and social worlds. It is possible, however, to highlight that spirituality may

be viewed quite differently and this difference can be illustrated by considering how two contrasting philosophical positions, realism and idealism, signify the nature of the spiritual. From a realist standpoint, unobservable phenomena have an existence which can be used to explain the functioning of observable phenomena and so, for the realist, spirituality might exist as an external reality independent of beliefs and understanding (as in the miraculous stories students told).

On the other hand, the idealist would contend that spirituality is only knowable through the human mind and socially constructed meanings. For the purposes of this study I wished to capture data that informed how students thought the spiritual dimension exists. As illustrated above, spirituality may be seen in a transcendent metaphysical sense akin to Platonic realism or it may be thought to reside solely in the socially constructed world. The view that I took at the outset of this study was to keep an open mind as to how spirituality may be thought to exist. In being open to either or both of these interpretations from participants I could remain more faithful when representing the views of the participants.

3.1.2 Epistemological position: how can knowledge about spirituality be gained?

Bassey (1999) differentiates in broad terms between research undertaken within the positivist paradigm and research informed by the interpretive research paradigm.

The positivist paradigm of medical science has dominated modern western health care and is particularly influential in the current emphasis on evidence-based health care. This epistemology is given the highest status in medical science where the scientific method is used to generate knowledge which is considered to be generalisable,

objective and context free (Rolfe, 1998). This type of knowledge is desirable if one is seeking to discover the best surgical technique for a particular condition or the best drug regime for a disease. However while the positivist paradigm is important when investigating the natural sciences it falls short of providing all there is to know about an individual's experience of, for example, having that disease or undergoing that treatment (Green, 1998; Swinton 2001). Thus when applied to the social world the positivist paradigm may provide useful but not comprehensive knowledge.

As discussed in the literature review, descriptions of spirituality included a holistic sense of the individual. If a holistic lens is applied to the nature of being human other sources of knowledge and truth become important such as personal beliefs, values and experience. Knowledge about spirituality fits mainly (though not exclusively) within the personal and aesthetic kinds of knowledge which cannot be captured within the parameters of wide generalisations evident in the positivist paradigm (Swinton 2001).

3.1.3 The personal and experiential nature of spiritual knowing

Clearly an inquiry which seeks to explore the complexity of peoples' beliefs about spirituality is unlikely to correspond with a positivist view of the world as access to those regions of peoples experience requires a research approach that seeks to view participants as subjects rather than objects of study. Also I began this study unsure if students held any ideas at all about the spiritual dimension never mind whether they might have any commonality of understanding of the issues and so my intent was to explore and describe rather than control. Therefore in order to gain insight into participants' understandings relating to the personal and experiential nature of learning about spirituality I turned to the interpretative research paradigm.

Researchers working within an interpretive paradigm reject the belief that human behaviour is governed by universal laws and underlying regularities, rather the social world can only be understood from the standpoint of the individuals who are part of the investigation (Cohen et al., 2000). Burns (2000:11) emphasises the significance of participants' experiences as the focus of qualitative research, an approach largely associated with interpretivism:

'Qualitative forms of investigation tend to be based on a recognition of the subjective, experiential 'lifeworld' of human beings. ... It is the lifeworld of the participants that constitutes the investigative field'

Thus far I have made the case for approaching my inquiry from within an interpretivist paradigm. In order to select an appropriate qualitative approach I re-visited the aims of the study and sketched out the kind of claims that I would wish to make. Knight (2002) recommends that a key question to ask at the design stage is about thinking through the sort of claims that the researcher might make and I found this process very helpful in clarifying a suitable qualitative approach as well as appropriate methods of data collection.

3:2 Selecting the Research Methods

What sort of claims would I wish to make? The first study aim had been addressed in part by designing a course with appropriate teaching and learning methods as discussed in the preceding chapter. However I also needed to generate some evaluative data from students to discover whether – and if so, in what ways - they thought that their understanding of spirituality and spiritual care had developed as a result of the course (see Aim 2). This data was collected by means of written end-of-course individual student evaluations (Appendix 4) which would also, it was hoped, indicate whether students considered the course 'sensitive' to their learning needs - an aspect of Aim 1.

1. Design a short course in spirituality sensitive to the learning needs of nursing students at different stages of their educational and professional development.

2. Explore the ways that students considered their understanding of spirituality and spiritual care had developed, if at all, as a result of participating in the short course.

Thus the sort of claims that I envisaged making about these 2 aims related to the appropriateness of the teaching methods employed and the ways, if any, in which students considered that they had developed their understanding of the subject by undertaking the course. In other words, what did they think they had learned about spirituality and spiritual care and how did the teaching methods help them to learn? In addition to data arising from the reflective groups these claims would be derived from the end-of-course student evaluations which were designed to encourage individual views of the course.

I also foresaw that in addressing Aims 3 and 4 I would wish to make some claims about how students understood spirituality and whether they considered themselves able to provide spiritual care.

3 Examine nursing students' understanding of spirituality through their personal and professional accounts.

4 Explore the personal abilities that students thought they required in order to provide spiritual care.

Such claims would be derived by means of data from the Nominal Group Technique (NGT) exercises, student individual journal accounts and also the Reflective Group Interviews (RGI). The journal accounts and RGIs would produce qualitative data of individual student perceptions about beliefs, values and experiences of spirituality and spiritual care.

The research methods needed to be coherent with the methods of teaching and learning. They also needed to minimise additional demands on the students. This was best achieved by ensuring that, where possible, the educational activities of students also provided research data.

3.2.1 Nominal group technique

The first learning activity, the nominal group technique, was used as a mechanism for gaining data about what ideas, if any, students held about spirituality. The NGT was considered a useful and speedy way of encouraging each student to focus on the complex concept of spirituality and generate beliefs and meanings from individual students in a group response (Cohen et al, 2000). As the process ends by sorting the participants' views into an order of priority the NGT produces numerical data (Knight, 2002). However, Moore (1987)

cautions against using the final product of a NGT in a representative way so this data was not used in any mathematically meaningful sense. Rather it provided data concerning which ideas about spirituality each group of students found important. These suggestions were of significance to the study as they revealed that students had an understanding of spirituality. It was a start - but I took on board the view that the NGT could be criticised for producing a rather shallow description of a phenomenon and that it 'needs to be used in conjunction with a technique for idea development' (Moore, 1987: 150)

3.2.2. Reflective journals and reflective group interviews

Two techniques were employed to gain a deeper understanding of students' ideas about the spiritual. As discussed in the chapter on educational strategy, students were asked to complete either a reflective journal (RJ) or participate in a reflective group interview (RGI). All students were given a handout containing a simple outline of a reflective model (Appendix 5) and asked to describe and review a situation that they believed constituted a spiritual experience. Students were advised that the experience could have occurred in either a personal or professional context. Either context was considered suitable because reflection is characterised by an individual's capacity to be self aware and so reflection evolves out of experiences – whether of a personal or professional nature (Scanlon et al, 2002).

The second method chosen for its capacity to examine phenomenon in some depth was the group interview. In contrast to one-to-one interviewing, one advantage of this method is the potential for discussions to develop, thus yielding a wide range of responses with the possibility of different opinions being raised (Cohen et al 2000). Also group interviews are deemed suitable when the research involves studying an established group (Robson, 1993), who have been set a particular task (Cohen et al 2000) - as in the case of the participants

who had been asked to engage in the reflective exercise. Knight (2002: 67) describes interviews which come after participants have engaged in some standard task as 'action interviews'. Significantly he suggests that one aim of such interviews is to reduce the distance between the sort of explanations we give when asked in general terms about something and what actually goes through our minds in action. In the context of the study, the reflective group interviews were designed to encourage and capture students thinking about the spiritual experiences they described thereby further developing the general responses arising from the NGT. Knight (2002: 68) points out that interviews have limited use for researchers who want to make a difference to peoples' practices:

'the fact that interviews tend to be saturated with espoused logic is a substantial problem, because it means that they are not finding out about the sort of thinking - the logic-in-use – that is really operating as people act.'

Spiritual experiences do not lend themselves to observational methods so it was not possible to examine students' spiritual experiences in action. However by asking students to recall an example of a spiritual experience in close proximity to the interview itself, it was thought possible to get closer to students logic-in-use as well as their espoused logic. Thus in a sense the reflective aspect to the group interviews was a means of evoking tacit knowledge.

Knight (2002) emphasises the point, though, that seeking espoused knowledge is a valuable activity because researchers need to understand both why people think they act as they do (espoused knowledge) and how they think when they are acting (logic-in-use). Both tacit and espoused knowledge were considered useful data for investigating nursing students' experiences of spirituality and spiritual care and the reflective group interviews provided a useful vehicle for attempting to acquire both types of knowledge.

The interviews were semi-structured and a schedule was compiled with open ended questions (Appendix 6). It was hoped that the open-ended nature of the questions would encourage participants to feel free to contribute their experiences and views as the interview progressed.

There were several reasons to focus the interview around some topic areas so an unstructured interview was not considered the best approach. Firstly the study had a clear purpose as illustrated by the aims and a focus was required to address these aims (Bassey, 1999). In a group situation a few members can dominate the conversation and possibly replace the topic of the inquiry with their own and so some structure was required to gently bring conversation back to the aims of the study. Further and importantly, I was not the only person facilitating the group interviews. Five colleagues were required to assist with the interviews for Group 1 as with a class of 38, it was necessary to form 5 small groups. All of my colleagues were experienced lecturers and well versed in facilitating groups. However none claimed prior knowledge of teaching spirituality or spiritual care and while they were willing to assist as facilitators, they valued the focus provided by the interview schedule.

There were other practical and organisational reasons too for using group interviews. Time was limited as the data had to be collected within the teaching experience and group interviews are often quicker than individual interviews (Cohen et al 2000). One limitation in using group interviews is that people can be reluctant to discuss personal matters in any depth within a group. Giving students the option of a more private way to respond by means of journal writing at least enabled choice in the matter of privacy. But it is interesting to note that while both the journal and the group interview worked well as techniques which facilitated the thoughts, feelings, reasons and actions of the students' experiences, the journals contained fuller and more complete self analysis of the experience. On the other hand the RGIs contained a greater breadth of experiences.

Two student groups chose to complete reflective journals and 2 groups chose to participate in the reflective group interviews. Only 7 out of a possible 11 students submitted their journals. One of the 2 groups which opted for RGIs, was the in-service participants and I chaired their interview on the final afternoon of their course. The other group was the much larger year 3 undergraduate students. This group required 5 facilitators and as their course took place as a study day their interviews were held at the end of the day. The interviews were recorded by audio tape which I subsequently transcribed.

3.2.2 Student evaluation questionnaires (SEQ)

Students also produced written individual course evaluations at the end of the final session in which they were asked to evaluate the teaching and learning according to each session. In these evaluations students were asked to comment on the areas of learning which were most significant to their personal and professional development and suggest ways of improving the teaching and learning experience. The questions were designed to generate qualitative data (Appendix 4).

In brief, I considered that the kind of claims that I would be making would be exploratory and descriptive in relation to what participants meant by the concept of spirituality and how they perceived spiritual care. I also wished to be able to make some evaluative claims about whether the course was worthwhile. Having scrutinised some qualitative methods to help guide my study I decided that case study provided the optimum method.

3:3 Case Study

Woods and Catanzaro (1988: 553) convey the key characteristics when they describe case studies as:

'intensive, systematic investigations of a single individual, group, community, or some other unit, typically conducted under naturalistic conditions, in which the investigator examines in-depth data related to background, current status, environmental characteristics and interactions among individuals, groups, and communities'.

There were good reasons for selecting case study as a strategy. Case study is an established comprehensive approach to research, particularly educational research, and I wished to evaluate an educational experience (MacDonald, 1974; Simons, 1987; Bassey, 1999). Although Yin (1994) argues against attempting to locate case study within a particular paradigm, it is mostly, though not exclusively, associated with qualitative research (Guba and Lincoln, 1989; Stake, 1995). Jones and Lyons (2004) point out that case study permits a flexible response to the area under examination so that the researcher is not limited by early preconceptions but can adapt to the research experience. At the outset, I was very uncertain as to the nature of students' experiences of spirituality as a personal phenomenon and spiritual care as a professional construct - the case study approach allowed me to continue to explore the area of study and remain with that uncertainty. As a heuristic endeavour, case study provided a lens to facilitate discovery of how students perceive and learn about the phenomenon of spirituality. Thus the case was an on-going concern and the boundary of the case was revealed as the study unfolded.

The rationale for adopting a case study strategy was also guided by the following:

1. Case studies are a useful way to explore phenomena about which little is known or understood (Robson, 1993; Jones and Lyons, 2004). Little was known about teaching and learning within the specific context of spirituality and spiritual care in nurse education and this study enabled both exploratory and evaluative investigation of this phenomenon.

2. Case studies are particularly useful when studying a unique, singular situation in depth, and where a great deal can be learned from a few exemplars of the phenomenon in question (Simons, 1987). Stake (1995) believes that case study is strongly associated with the uniqueness and wholeness of the individual. Spirituality is a personal dimension, unique to each individual, associated with holism and often hidden from examination. A deep investigative approach was required to tap into the hidden nature of spirituality and spiritual care.

3. Case study is a strategy which is characterised by the use of multiple sources of evidence to inform the phenomenon under investigation (Robson, 1993; Yin, 2003). One account from a class of students about their experiences of learning about spirituality and spiritual care would have been interesting but it would have fallen short of Stake's (1995) essential purpose for case study - that is to maximise what can be learned. In this study data were collected in several different ways and participant accounts were drawn from all 4 participant groups. Maximising what could be learned was best achieved by collecting data from several groups of students undertaking the same course and using a variety of methods of data collection.

Case study was chosen over other qualitative orientations such as ethnography, grounded theory and action research. Ethnography was considered less appropriate than case study because ethnography usually involves prolonged research on a single group and culture (Silverman, 2005). By contrast, the study under discussion involves 4

groups of unrelated people with the inquiry taking place over a relatively short time scale.

Grounded theory was more difficult to dismiss as the optimum design for this study as it fitted well on 2 counts. Firstly, my intent to firmly ground my analysis and any theoretical construction in the data correlates with the fundamental notion of grounded theory. Secondly, the method of analysis in grounded theory is based on comparative analysis between or among groups within a substantive area, using methods of field research for data collection (Polit and Hungler, 2006). This fitted well with my intended analytical approach for the reflective data, that is, the journals and group interviews. However there were also other data arising from the NGT exercises and the end-of-course evaluations that were not so conducive to a constant comparative form of analysis in accordance with grounded theory. Furthermore the singularity of the phenomenon under investigation, that is, students' learning experiences within a short course taught within a tight time-scale, did not lend itself to one of the required key grounded theory procedures, theoretical sampling. I felt that case study provided a more useful and achievable framework for a comprehensive research design that used a variety of methods and different analytical techniques and it did not preclude using the constant comparative method of analysis for the reflective data.

Action research was also considered a possible method within which to explore the phenomenon in question. Burns (2000) emphasises that in action research, the task is not simply to further understanding of a phenomenon but to bring about an improvement through change. The scope of action research is wide as it may be used in any setting where there is a problem involving people, tasks and procedures seeking a solution. In education it can be undertaken by an individual teacher or a group of teachers and can be used in a variety of areas such as teaching and learning strategies or evaluative procedures (Cohen et al 2000). If Kemmis and McTaggart's (1988:5) inclusive definition of

action research is applied to the study it can be seen that there is a match for some of the characteristics:

'Action research is a form of collective self-reflective inquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices, and the situations in which these practices are carried out...'

So for example, the self-reflective nature of the study, the purposeful examination of my own educational practices with a view to improvement and the desire to increase understanding of students' experiences of a phenomenon are all characteristics which fit well with action research.

However there are 2 characteristics of action research that did not fit the parameters of the study. Firstly action research is collaborative and participatory and is not research carried out on other people; rather it is research conducted by people on their own work (perhaps in collaboration with an external researcher) in an effort to improve their practice (Holloway and Wheeler 2002; Miles and Huberman 1994). While the aims of the study clearly valued the views and experiences of the participants, the participants themselves were not party to decisions about the educational and research design of the study. Secondly the aims of the study were to evaluate learning arising from a short course and to explore students' understanding and experiences of spirituality and spiritual care. Within the time-scale of the study it would not have been possible to undertake more than a single cycle and according to Holloway and Wheeler (2002) the existence of more than one cycle of research is a key characteristic of action research. Although it was appropriate to dismiss action research when making methodological decisions at the start of this study it is worth pointing out that changes have taken place as a result of the investigation.

These will be discussed in the concluding chapter and indicate that action research could be usefully employed in future research.

3.3.1 Analysing the type of case study undertaken

Various attempts have been made to distinguish between different types of case study (Bassey, 1999; Stake, 1995; Yin, 2003). Stake (1995) differentiates between 3 types: the intrinsic case which describes a particular case with no intention to generalise beyond the case or even to build theories, the instrumental case in which a case is examined to provide insight into an issue and in which the focus of the study is the issue rather than the case itself and, thirdly, the collective case study which is a type of instrumental study but includes a number of cases thereby making it possible to make generalisations. At this study's conception I would have classified it within Stake's (1995) intrinsic case study or Bassey's (1999) notion of story-telling case study as my intention was to describe students' understanding of spirituality and evaluate the short course. However as the study progressed and data revealed a richness in terms of theoretical concepts it seemed more accurate to describe the study in terms of Stake's (1995) instrumental case study or Bassey's (1999) theory seeking case study.

In truth I did not find classifying my study according to these typologies particularly helpful perhaps because there was no natural fit with any single classification but also because the study was fluid and contained exploratory, descriptive, theoretical and evaluative elements. That the emphasis of either one of these elements varied throughout was indicative of the study's fundamental heuristic and iterative nature.

3.3.2 Defining the boundaries of the case

A major benefit of case study is its flexibility and although there is a structure to its design, the emergent nature of the research encourages an adaptable approach to the design as unexpected factors arise as the study proceeds (Silverman, 2005).

This flexibility also presents a difficulty in case study research. Defining the case or 'unit of analysis' is problematic because the process of defining the boundaries of a case occurs as the study proceeds. Kemmis (1980) suggests that the researcher makes the case a case by carrying out the study, during which there is an attempt to transform the situation from an object of perplexity into an object of understanding. I found Miles and Huberman's (1994) suggestion that the case is the unit of analysis, or in other words, the 'heart of the study' a helpful comment in defining the boundaries of the case. At first I questioned whether the case was a single or multiple study - after all there were 4 student groups participating. However as the study progressed I realised that the case was in fact the course and how students learned during and from that experience. The multiple perspectives that students expressed about spirituality, spiritual care and their evaluation of their own learning all took place within the context of the course. Thus it was the experience of the course itself that constituted the specific context for, or singularity of, the case.

3.3.2 The trustworthiness of the study

While the quantitative paradigm attempts to address the rigour of a study by way of validity and reliability accounts, in qualitative research the criteria by which a study is judged is known as trustworthiness (Lincoln and Guba, 1985). There is debate as to the extent to which the criteria in qualitative studies parallels that of quantitative studies (Tuckett, 2005) but as this is a qualitative study

the criteria of trustworthiness will be used as a means of establishing the methodological soundness and adequacy of this study. Guba and Lincoln (1989) identify 4 criteria for trustworthiness in qualitative work – credibility, transferability, dependability and, confirmability. One way of enhancing the trustworthiness of a study is to include an audit trail which provides a description of the conduct of the research. The purpose of the audit trail is to provide sufficient description of the processes of the study at a level that others can follow in order to determine the trustworthiness of the study's conclusions (Polit and Hungler, (2006); White et al 2003 *in* Ritchie and Lewis 2003). While I have attempted to provide the reader with a clear description of the conduct of the study thus far the audit trail will be explored in greater detail in the next chapter.

Summary

As the aims of the study were exploratory and descriptive a qualitative approach was employed in order to shed light on the interpretations and experiences that nursing students held about spirituality and spiritual care. Qualitative methods were studied for their suitability and case study was selected as the optimum method for this investigation.

4. Research Design: Data Collection and Analysis

In this chapter I will discuss how the case study developed during the data collection and analysis phases. In so doing the audit trail will be expanded to support the trustworthiness of the study.

4:1 The Role of the Researcher

One of the strengths of case study is that it can be of use to the researcher practitioner because it offers a way of generating personal and experiential knowledge in the practice environment by the practitioner (Rolfe, 1998). I was both the researcher and the teacher for this study which was conducted within my work setting - with the exception of Group 4, the in-service group of students whom I taught at their place of work. The dual roles of teacher and researcher were both a strength and limitation. Robson (1993) points out that the insider researcher has the advantage of having intimate knowledge of the context of the study and is familiar with how best to gain access to participants. This was true in my case in that I certainly knew where the course might integrate with the curriculum and which teachers (for whatever reason) would be open to me using their classroom time. But as Hammersley (1993) highlights, while insider researchers may have privileged insights because of their close relationship with the research environment, it is also true that such insights may be limited, superficial or distorted and this, in turn, can influence the quality of the research. As teacher it is quite likely that students were keen to please because of my position and this could have affected both their willingness to consent to participate in the study and the data itself.

4.2 Ethical Considerations

The ethical issues surrounding this study were guided by principles of informed consent, anonymity and confidentiality and, non-maleficence.

4.2.1 Informed consent.

Prior to taking part in the course, all possible prospective participants from the 4 groups were given an information sheet explaining the purpose of the study, what would be required of them and how the data would be analysed. They were also advised that it was hoped to publish the results in an academic journal. Bearing in mind that the researcher and the study participants also had a professional relationship of teacher and students, it was particularly important to stress that participation was voluntary. In this context it is significant that students were not going to be assessed in any way either through course work or as part of the overall modular assessment strategies. Holloway and Wheeler (2002) suggest that when the teacher is also the researcher, the teacher-student relationship can lead to feelings of obligation on the part of students and gratitude from the teacher. In response to this, I thought it essential to stress the ongoing nature of consent to students and assured them that they had the freedom to withdraw from the study at any time. This was made clear verbally and in the written information sheet.

4.2.2 Anonymity and confidentiality.

Data was handled in accordance with the provisions of the Data Protection Act (1998) and participants were assured of anonymity. To help ensure anonymity, individual participants were identified within

the text by their student group and a number. The student groups were abbreviated as follows:

M refers to the group of masters' students (3) who compiled reflective journals. The numbers 1-3 denoted an individual, that is M1, M2 and M3.

AH refers to the group of undergraduate students who compiled reflective journals (4) and were taking the Arts and Humanities module. The numbers 1-4 denoted an individual, that is AH1, AH2, AH3, and AH4.

RG refers to the reflective group interviews. The numbers 1-5 denoted the group that is RG1, RG2, RG3, RG4, and RG5. The use of a letter following the group e.g., RG5(C) indicated the individual.

In order to maintain confidentiality the researcher must avoid the attribution of comments to identified participants. While direct attribution (when comments are linked to a name or a specific role), is relatively straightforward, indirect attribution is more difficult as it may be that the detail given by participants reveals their identity (Lewis, 2003). As journal writing can contain in-depth personal accounts participants were advised to be sure that they were comfortable with their revelations knowing that others would be privy to their content. Also I thought that it might be possible in some instances to identify individuals from the small group of in-service participants. In an effort to 'do no harm' every participant from this group was given a copy of the transcript of the interview and given the opportunity to amend or withdraw comments. Data was kept secure either by means of being stored locked in a cabinet or on computer which was password protected. An undertaking was made to destroy the tapes following completion of the study.

Ethical approval was sought and acquired from the university's Departmental Research Ethics Committee (Appendix 7). Informed consent was obtained in writing from all participants. (Appendix 8)

4.3 Selection of the Case Participants

Lewis (2003) considers the primary defining feature of a case study to be the multiplicity of perspectives which are rooted in a specific context. The consistent context of this study was the teaching and learning of the course although the delivery of the course was to different groups of students and therefore took place in different geographical settings. Lewis (2003) acknowledges that although those multiple perspectives may come from one or a variety of data collection methods the sample design of case study may be structured around contexts rather than individuals. As the context of this study was the teaching and learning of the course, the sample was the students who took the course. It is worth noting that the term 'sampling' is considered a misnomer in the context of case study. For instance Stake (1995) states that case study research is not sampling research as the conduct of good case study does not depend on being able to defend the typicality of the case. Rather it depends on selecting a case(s) which, given the purposes of the study, is likely to help in developing an understanding of these purposes.

4.3.1 Access

Access to the 4 groups was straightforward. Groups 1 and 3 were undertaking modules run by colleagues, who were pleased to include the short course and accompanying research inquiry as part of their module year. Group 2 were 4th year degree students taking a course that I run. Group 4 were self-selecting as they had requested some in-service teaching in spirituality and spiritual care.

4:4 Issues of Trustworthiness

Strategies undertaken to uphold the trustworthiness of the study will now be discussed according to Guba and Lincoln's (1989) 4 criteria for trustworthiness in qualitative work – credibility, transferability, dependability and, confirmability.

Credibility refers to confidence in the truth of the data and conclusions. Lincoln and Guba (1985) suggest a variety of techniques for improving the credibility of qualitative research including triangulation, member checking and peer debriefing.

Triangulation was a feature of this study in that evidence was acquired from different sources (both in terms of data received from many individuals and from four participating groups) and different methods of collecting data (that is, through the NGT, group interviews and journals and, end of course student evaluation questionnaire). How these different methods complemented one another in addressing the aims of the study were explored in the preceding chapter.

Peer debriefing involved two colleagues providing external checks on my analysis and conclusions. This consisted of colleagues separately coding segments of the transcripts to confirm the quality of my analysis. Both supported my analysis as sound by finding strong, valid connections with the excerpts under the various categories and the original 'raw' source. Where there were differences in interpretation these were discussed and decisions made accordingly. For example one of my colleagues pointed out the value of supervision (his field of academic expertise) in helping students further their understanding of spiritual experiences in practice and this issue is reflected in the recommendations discussed in chapter 10. Furthermore on three occasions the study was publicly 'aired' as I presented the process of data analysis and provisional findings at departmental academic

research forums and an international conference. This assisted transparency of the analytical and interpretive conduct of the study as peer discussion and challenge featured on these occasions.

Member checks were also carried out in the following manner. The findings of the NGT were presented for confirmation to the class following completion of the exercise. Also, following transcription of the reflective group interviews two members from each group volunteered to check for accuracy and, making changes as necessary, verified the accuracy of the transcriptions. Each participant from the in-service group of students was given a completed transcript of their RGI for verification and possible amendment due to ethical considerations (see above). It was inappropriate for participants to check the findings of the study because much of the data analysis was conducted through constant comparison and therefore the findings related to data provided from all participants rather than individual groups.

Transferability refers to the extent to which the findings from the data can be transferred to other settings or groups. Lincoln and Guba (1985) emphasise that while it is the responsibility of the investigator to provide sufficient descriptions of the conduct and findings of the study, it is for the reader to evaluate the transferability of the findings.

Lincoln and Guba (1985:110) reject the possibility of generalisation in their statement that 'The only generalisation is: there is no generalisation'. However by means of notions of transferability and fittingness concerning the degree of comparability of different contexts they also maintain that it is possible to judge the extent to which the findings in one context can be transferred to other similar situations or participants. Some, for example, Polit and Hungler, (2006) and Flick (2002) argue that in Lincoln and Guba's (1985; 1989) work transferability is simply about the generalisability of the

data. Similarly, when discussing Lincoln and Guba's concept of transferability, Holloway and Wheeler (2002: 255) argue:

'The knowledge acquired in one context will be relevant in another, and those that carry out the research in another context will be able to apply certain concepts originally developed. It seems to us that the concepts of transferability and generalisability are not too different.'

In case study the notion of generalisability is certainly debatable as a study of the particular does not have applicability to larger populations in the same sense as experimental research approaches. However, it is feasible to suggest that the findings of the study have a wider import by considering their transferability to theoretical positions rather than populations (Burns 2000). Although in qualitative research the term transferability is preferred to generalisability (Lincoln and Guba, 1985), it is interesting that Yin (1994) contends that it is perfectly proper to use the term generalisation for case study as the aim of case study as a method is to develop analytical generalisations not frequencies or statistical generalisations. This was a helpful idea particularly when discussing the findings of the study as links were sometimes readily observed between theoretical explanations found in the literature and specific findings from within the study.

Jones and Lyons (2004) indicate that the use of triangulation strategies may also enhance the transferability of the findings in addition to, as discussed above, supporting the credibility of a study.

Dependability relates to credibility as for a study to be credible the findings must also be dependable (Robson, 1993). Dependability is demonstrated by providing the reader with a clear systematic and well documented decision-making process so that it is possible to make an informed evaluation of the study. The value of an audit trail is that it enables the reader to follow the path of the researcher and demonstrate

how conclusions were achieved including how the researcher took safeguards against bias.

4.4.1 Researcher bias

Woods (2003) makes the point that the researcher exerts, either intentionally or unintentionally, a degree of influence on the research process and that this facet of trustworthiness is often overlooked in published qualitative research. This researcher influence is a feature of qualitative research:

> 'Qualitative approaches, however, acknowledge that the researcher and research cannot be meaningfully separated, and that neutrality is impossible. Researchers both influence and are influenced by, the process of engaging in research.' (Hand 2003: 18).

Taking on board the view that neutrality is impossible I considered how I influenced the study and how the study influenced me. Reinhertz (1992) highlights that unless researchers acknowledge how their own beliefs, values and role influence participants, they will not understand the phenomenon being studied. Such discussions are sometimes termed reflexivity, a construct used in qualitative research to enhance trustworthiness (Woods, 2003). In terms of how my personal experience might influence this study I was conscious that my upbringing, as part of a church-going family, and my early academic career as a theological graduate, might colour the beliefs underpinning the research design and interpretation of the data. My choice of colleagues for the peer debriefing process was a consequence of reflecting on how best to minimise researcher bias. Therefore neither of my colleagues had a theological or religious background and their academic constructs arose from psychology and mental health rather than, in my case, theology and adult nursing. Furthermore, those colleagues who volunteered to act as reflective

group facilitators did so on the basis of their expertise as teachers rather than their background understanding of spiritual matters.

Confirmability is concerned with ensuring that the data, interpretations, and outcomes of inquiries are rooted in contexts and persons rather than the researcher's imagination (Guba and Lincoln, 1989). Like dependability, this can be confirmed by means of an audit trail reflecting the decision making process.

4: 5 The Process of Data Collection

The period of data collection ran over 7 months from October 2001 until April 2002.

4:5:1 The nominal group technique.

Three of the groups took part in the NGT. The group of students undertaking the master's programme did not participate in a nominal group as it was thought too small to benefit from this learning approach as the group was reduced to 3 students during the first session. Instead the group discussed their ideas of spirituality and spiritual care in the first classroom session.

4:5.2 The reflective journals and reflective group interviews.

Two student groups chose to complete reflective journals and 2 groups chose to participate in the reflective group interviews. Seven out of a possible 11 students submitted a journal. Although all had signed the consent form, non-submission may be explained in terms of the extent to which participants actively consented to be part of the study but it may simply have been due to time constraints.

One of the 2 groups which opted for RGIs, was the in-service participants and I acted as facilitator for the interview on the final afternoon of their course. Attendance over the 5 week course had been varied for this group as they had to leave the clinical area to participate and the unpredictability of clinical responsibilities was not conducive to full attendance. On the day scheduled for the RGI, 3 out a possible 5 students attended.

The other group which opted for the RGI was the much larger year 3 undergraduate students. There were 38 students in this group and as their course took place over one study day, it was necessary to hold

the interviews concurrently at the end of the day. This required 5 facilitators all of whom volunteered for the task. I held a pre-study day information meeting for the facilitators during which I explained the purpose of the study and specifically the RGI. Facilitators were given a question guide for the RGI (Appendix 6) and the merits of encouraging the group to do as much of the talking as possible were highlighted.

It was hoped that the guide would encourage the reflective groups to address three main areas of research interest during their discussion.

- What situations, if any, do students describe as illustrations of spiritual need and spiritual care?

- What personal abilities do students think they have/don't have that enables them to provide/ not provide spiritual care?

- In what ways, if any, do students consider that the workshop might help them meet their own spiritual needs and provide spiritual care to others?

These three areas were chosen as they directly relate to the main foci of the study by exploring how students describe spirituality and spiritual care and evaluating how students experienced learning about spirituality and spiritual care.

As the interviews were to be recorded by audio tape, I checked that all the recorders and tapes were working and that the facilitators felt comfortable recording the group work. There was a problem with recording one of the interviews and as this was undetected during the interview, the tape was returned to me blank. Subsequently I transcribed all the group interviews.

4:6 Data Analysis Procedures

4.6.1 Data arising from the nominal group technique

In effect the seeds of analysis commenced at the end of the first teaching session as it culminated in the NGT data. This was encouraging because it meant that I knew early on that participants had some ideas about spirituality and spiritual needs. The results from the NGT will be discussed in the next chapter.

4.6.2 The reflective group interview and the reflective journals

All qualitative research thrives on comparison done well (Richards 2005) and when it came to analysing the rich journal and interview data I employed the constant comparative method of analysing data. Although this method of analysis forms part of the procedures associated with grounded theory it seemed a justifiable modus operandi. Holloway and Wheeler (2002: 152) point out that grounded theory procedures are not specific to a particular discipline or type of data collection and so:

'the way of analysing data (constant comparison) can be used for any type of material, such as interview transcripts, observations or documents'.

Using this method required that throughout the study each section of the data was compared with all other sections for similarities, differences and connections. Glaser and Strauss (1967) suggest that there are 4 stages. The first stage of the method starts with the researcher comparing incidents applicable to each category. The second stage requires integration of the categories and their properties.

PAGE NUMBERING AS ORIGINAL

The next stage consists of delimiting or bonding the theory and in the final stage, the researcher writes the theory.

As typical in qualitative research (Cohen 2000) analysis commenced as soon as the data was collected. Rather than arrange for someone else to transcribe the data, I transcribed the tapes from the reflective group interviews. The reflective journal entries were typed ready for analysis. This proved to be a valuable experience as it provided the opportunity for me to have an overview of the data and begin to get immersed in the data (Patton 2002).

In the constant comparative method the interpretation of data is characterised by three procedures, termed 'open coding', 'axial coding' and 'selective coding'. Flick (2002) emphasises that while open coding begins the interpretative process and selective coding comes towards the end of the analytical process, the coding of data is a cyclical rather than linear quest. During the initial analytical stage of open coding, codings are compared over and over again with codings and classifications that have already been made. It is in this way that the interpretive procedures become a method of constant comparison. The process of open coding required the identification of concepts (or codes) which were based directly on the data thereby grounding the analysis by attaching concepts to the empirical material (Flick, 2002). Open coding required that I undertook a line-by-line analysis of the data breaking it down into discrete parts by attributing concepts which were written in the margin of each transcript. The purpose of the initial analysis is to 'open-up' the data (Richards, 2005) in the sense that my inquiry was opened to wider considerations. This was pursued by formulating codes and concepts as close to the text as possible in the early stages and producing progressively more abstract concepts as analysis proceeded. The extent to which it was expedient to open up data was limited by the degree of fit between the concepts emerging from the data and the aims of the study. This helped to keep the aims of the study uppermost.

The next stage consists of delimiting or bonding the theory and in the final stage, the researcher writes the theory.

As typical in qualitative research (Cohen 2000) analysis commenced as soon as the data was collected. Rather than arrange for someone else to transcribe the data, I transcribed the tapes from the reflective group interviews. The reflective journal entries were typed ready for analysis. This proved to be a valuable experience as it provided the opportunity for me to have an overview of the data and begin to get immersed in the data (Patton 2002).

In the constant comparative method the interpretation of data is characterised by three procedures, termed 'open coding', 'axial coding' and 'selective coding'. Flick (2002) emphasises that while open coding begins the interpretative process and selective coding comes towards the end of the analytical process, the coding of data is a cyclical rather than linear quest. During the initial analytical stage of open coding, codings are compared over and over again with codings and classifications that have already been made. It is in this way that the interpretive procedures become a method of constant comparison. The process of open coding required the identification of concepts (or codes) which were based directly on the data thereby grounding the analysis by attaching concepts to the empirical material (Flick, 2002). Open coding required that I undertook a line-by-line analysis of the data breaking it down into discrete parts by attributing concepts which were written in the margin of each transcript. The purpose of the initial analysis is to 'open-up' the data (Richards, 2005) in the sense that my inquiry was opened to wider considerations. This was pursued by formulating codes and concepts as close to the text as possible in the early stages and producing progressively more abstract concepts as analysis proceeded. The extent to which it was expedient to open up data was limited by the degree of fit between the concepts emerging from the data and the aims of the study. This helped to keep the aims of the study uppermost.

After initial coding I condensed the codes into groups of concepts with similar traits. These groups are often called categories in qualitative research and they tended to be more abstract than the initial codes (Holloway and Wheeler, 2002). The data broken down by open coding was reassembled using the procedure of axial coding so that categories were grouped together to form major categories which I have referred to as themes. The themes identified were:

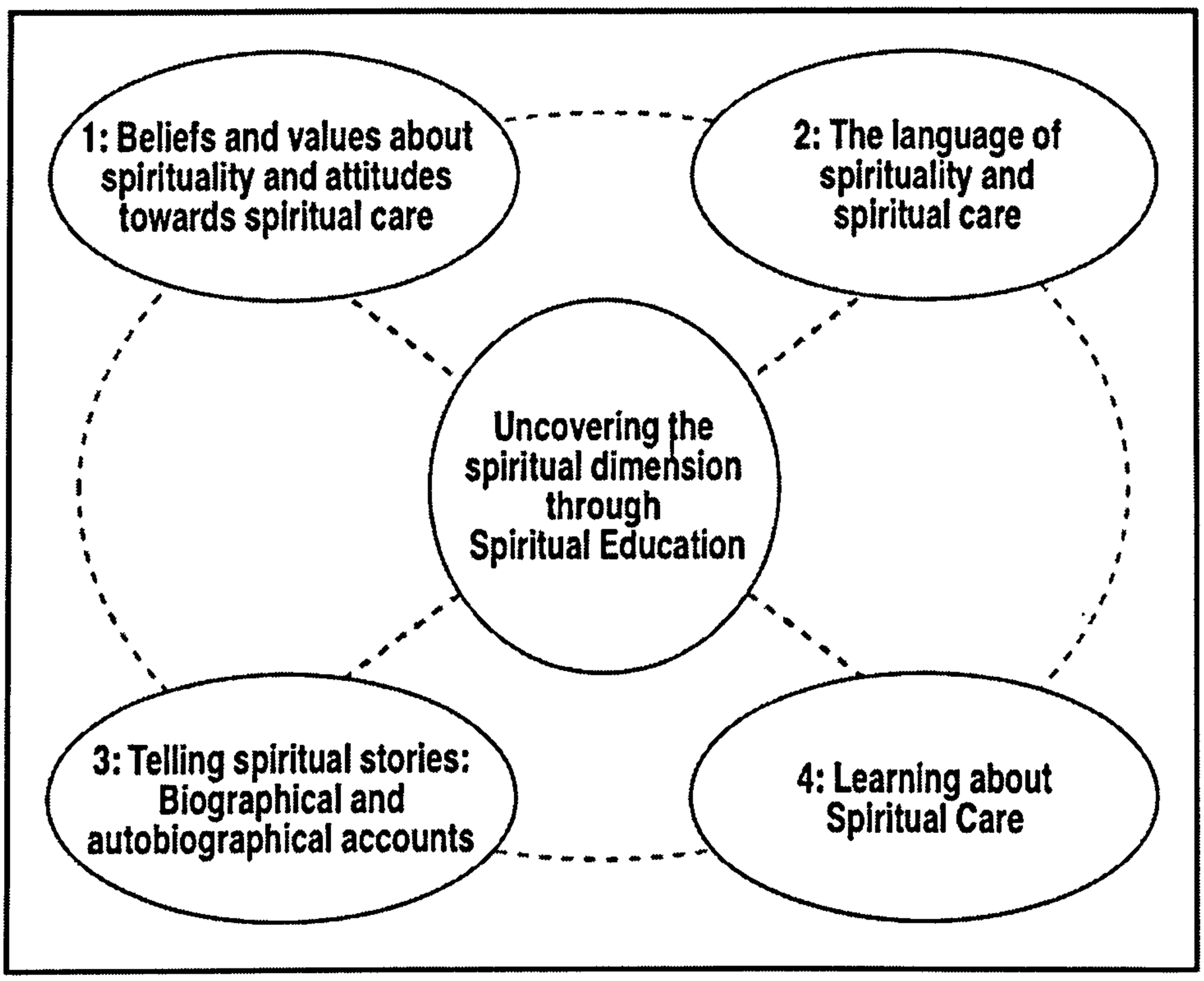
Theme 1: Beliefs and values about spirituality and attitudes towards spiritual care
Theme 2: The language of spirituality and spiritual care
Theme 3: Telling spiritual stories: Biographical and autobiographical accounts
Theme 4: Learning about Spiritual Care.

During this interpretive phase I was guided by the process outlined in Morse and Field (1996) for managing data manually. I made two copies of the transcripts and, using a different colour for each RGI and journal I placed a line down the left hand side of each page. Codes were written on the right hand side of the page. An example of this procedure is available in appendix 9. As analysis proceeded the significant passages from one of the copies were cut out and filed in the appropriate file for that category. This procedure is also illustrated in appendix 9. As new data were analysed, categories were adapted and coded data filed accordingly. This means of sorting made retrieval, comparison and review of data relatively straightforward.

The final coding procedure of selective coding, during which a central core concept is developed which captures all categories is a feature of constant comparative analysis when using grounded theory. As this study was guided by case study and not grounded theory it was inappropriate to feel compelled to discover a core category to represent the ideas most significant to the participants. Rather the aims of this study were key to decisions about its direction and boundaries.

Central to these aims is the exploration of students' understanding of, and learning about, spirituality and spiritual care. This was conceptualised as 'Uncovering the spiritual dimension through spiritual education'. Diagrammatic representation of the themes identified from the analytical and interpretive processes can be seen below.

Diagram 1: Thematic representation of students understanding of, and learning about spirituality and spiritual care:



4.7 Reviewing the Constant Comparative Analytical Process.

Using the constant comparative method of analysis certainly helped to identify common ideas and differences within the data. However I struggled with the notion that during the coding process, I was trying to 'reduce the irreducible' and my concern that I might be examining the concept of spirituality by a means that somehow missed the target was real enough particularly when engaging in the open coding of the initial analysis. This concern was significantly relieved when the picture of students' experiences of spirituality and spiritual care were synthesised in terms of categories as this stage helped to concentrate the findings and discussion on the stories, themes and issues that were related by students. Indeed one of the categories, perhaps the most relevant of the findings in terms of how to develop appropriate methodology for future research in this field, was that students talked about their understanding and experiences of spirituality and spiritual care in the form of stories. Since story form was found to be highly significant in both student discourse and journal writing within the study, it seems likely that the use of narrative as a method of data collection and unit of analysis may prove to be valuable in future research.

In this chapter decisions about how data were collected and analysed have been discussed. I have highlighted a number of strategies that were employed throughout the study to ensure that the data collection and interpretation accurately reflected the phenomenon. Appendix 9 provides extracts which demonstrate the processes of constant comparative analysis from the large database of qualitative text. Chapter 5 presents an overview of how data from each of the methods, the NGT, the reflective data and the SEQs were analysed and inter-related to present a coherent picture of the findings from this study.

5. Findings and Discussion: An Overview

5:1 An Overview

The findings from this case study reveal that many of the participants had an understanding of spirituality and spiritual care and were willing to engage in learning activities in the classroom. This was demonstrated throughout the course by students' interactions during the teaching sessions, the data from which were used to inform this study. As the course outline indicates these activities included the nominal group technique, reflective group interviews, the reflective journals and the end of course student evaluation questionnaires (Appendix 3).

5.1.1 Analysis of the Nominal Group Technique

The NGT took place in the first teaching session and provided data which helped to address one of the aims of the study, that is, to examine nursing students' understanding of spirituality and spiritual care. It was important to gather data which addressed this aim early on in the course as students' understandings of spirituality were key to the learning and research process. Three of the groups took part in the NGT. The group of students undertaking the master's programme did not participate in a nominal group as the group was reduced to 3 students during the first session and thought too small to benefit from this method of learning.

Two of the nominal groups were held in a university classroom with the third group being held at the trust hospital where the group of in-service students worked.

A total of 49 students completed the NGT which included 38 undergraduate third year nursing students; 6 undergraduate fourth year nursing students and the 5 in-service students.

The nominal group data were collected, analysed and guided by Moore's (1987) procedure for the nominal group technique as illustrated below:

1. Silent generation of ideas in writing

   The question 'What are spiritual needs?' was read aloud and class members were asked to list their responses.

2. Round-robin recording of ideas

   Each member of the class was asked for one idea and these were recorded on a flip-chart. Hitchhiking on other ideas was encouraged. Discussion, elaboration or justification were not encouraged.

3. Serial discussion of the list of ideas

   The class was invited to comment on each item on the flip-chart and discussion continued until all items were clarified.

4. Voting

   Each student selected 5 items that were most important to her or him. They were then listed on a card and rank ordered.

   The votes were recorded on the flip chart in front of the group.

   The results from the NGT are illustrated below in Tables 1-3

Table 1: Nominal group technique: Year 3 pre-registration students (38)
Question: *What are spiritual needs?*

Prioritisation of needs	*Score*
1. Respect for wishes and autonomy	84
2. Being understood	73
3. To love and be loved, feeling of belonging to someone	69
4. Feeling uplifted	58
5. Need for comfort and space	51
6. Communication	42
7. Expression of meaning and/or purpose	29
8. Holism	26
9. Spirituality common to all whether religious or not	24
10. Meditation and/or prayer	22
11. Understanding conscious/sub-conscious	14
12. Opportunity to see priest/minister	13
13. Dietary requirements or dietary observance	10
14. Expressing sexuality	8

Table 2: Nominal Group Technique: Year 4 undergraduates (6)
Question: *What are spiritual needs?*

Prioritisation of needs	*Score*
1. Love, family and friendship	23
2. Belief in god/ higher being	16
3.= Inner peace	11
3.= Self-awareness and worth	11
5. The touch of someone that you love, comfort	8
6.= Hope when there seems to be none	5
6.= Need to belong and to be accepted	5
8. Need to make sense of our lives	3
9.= Someone to share your thoughts with	1
9.= Respect	1
9.= Music/theatre, places of worship/history	1

Table 3: Nominal Group Technique: In-service students (5)
Question: *What are spiritual needs?*

Prioritisation of needs	*Score*
1. Friendship and love	27
2. Faith – in God and in self	21
3. Peace of mind	13
4. Supportive relationships (includes HCP)	8
5. Prayer (communication and asking for help in suffering)	6
6. Reflection	5
7. Guidance	4
8. Religious observances	0

The tables reveal that the NGT proved a useful means of finding out how students characterised spiritual needs early on in the study. As discussed in the literature review there are many definitions of spirituality and spiritual needs (McSherry and Draper, 1998) and some suggest that spirituality is so subjective in nature that it is indefinable (Martsolf and Mickley; 1998; Chuengsatiansup, 2002).

As evidenced in the results from the NGT this variety of meanings was true for the participants. However on collating and analysing the results it became apparent that there was a degree of consistency between the three groups both in terms of their identification of spiritual needs as well as the order of priority. For example, although the groups sometimes used different words to express a particular spiritual need, the idea of the importance of loving personal relationships with others was variously expressed. Group 1 used phrases such as, 'to love and be loved, feeling of belonging to someone' and 'being understood'; Group 2 highlighted 'love family and friendship' and the 'need to belong and to be accepted', while Group 3 concurred by signifying 'friendship and love' and 'supportive relationships' as key spiritual needs. Faith, hope or belief in oneself and/or God were priorities for Groups 2 and 3 while Group 1emphasised the importance of 'feeling uplifted'. Affective qualities such as the need for comfort and peace were also identified across the groups. The ethical principle respect for persons was considered significant by Groups 1 and 2 as depicted by terms such as 'self-awareness and worth', 'respect for wishes and autonomy' and 'the expression of meaning and/or purpose'. The value placed on religious practices too was common to all groups with meditation, prayer, dietary observances and places of worship mentioned although it is interesting to note that, on the whole, religious practices came near the bottom of the list of priorities.

The results from the NGT indicated that students were able to provide answers to the question 'what are spiritual needs?' Further the groups

demonstrated areas of similarity and common understandings of the value placed on certain aspects of the spiritual dimension. The literature on assessing spiritual needs also supports participants' understanding of spiritual needs (Emblen and Halstead, 1993; Govier, 2000; Kellehear, 2000). So for example, Emblen and Halstead (1993), Govier (2000), and Kellehear (2000) all purport categories of spiritual needs which include relationships, affective qualities and religion as significant spiritual needs.

As discussed above, one of the groups did not participate in the NGT and this unfortunately reduced the amount of data acquired from this research method. Nonetheless results from the NGT demonstrated that students were able to provide answers to the question, 'What are spiritual needs?' The NGT also revealed that there was both variety and consistency in these answers with some needs clearly more significant than others.

The NGT was a useful and quick way of encouraging each student to focus on the concept of spirituality and generated beliefs and meanings from individual students in a group response (Cohen et al, 2000). While it provided data of ideas about spirituality that each group of students found important these ideas required more in-depth exposition. This was undertaken through an analysis of the data arising from both the reflective group interviews and the reflective journals.

5:2 Reflective Group Interviews and Reflective Journals

The interviews and journals were the source of extremely rich data and formed the focus for the qualitative analysis and interpretation. Findings from this in-depth analysis are discussed in detail in chapters 6-9.

As discussed in chapter 3, students chose whether to reflect on an experience of spiritual significance by means of participating in a reflective group interview (RGI) or by writing of their experience in a reflective journal (RJ). Two student groups chose to complete reflective journals and 2 groups chose to participate in the reflective group interviews. The group of 4th year undergraduates and the group of master's students completed reflective journals although only 7 out of a possible 11 students submitted their journals. One of the 2 groups which opted for RGIs, was the in-service participants and I acted as the interview facilitator on the final afternoon of their course when 3 students attended. The other group was the much larger year 3 undergraduate students. This group required 5 facilitators and, as their course took place as a study day, their interviews were held at the end of the day. In total 41 students participated in the interviews. I subsequently transcribed and analysed the data using the constant comparative method.

5:3 End of Course Student Evaluation Questionnaire (SEQ)

This data will be discussed in the context of the findings relating to the theme 'Learning about Spiritual Care' in Chapter 9. Thirty three out of a possible 54 students completed the questionnaires giving a response rate of 61%. The SEQ provided data relevant to students' learning experiences and was additional to the RGI data analysed through the constant comparative method. The results of analysing data from both methods are discussed in Chapter 9: Findings and Discussion part 4: learning about Spiritual Care. Chapter 9 addresses aims 1 and 2 by exploring whether the course was sensitive to the students' learning needs and the ways that students considered that their understanding of spirituality and spiritual care had developed as a result of the course.

The findings from this study have been reported according to the conventions of presenting qualitative research. Thus the findings and discussion are integrated and discussed in chapters according to the themes arising from interpreting the data.

The findings of the study will be explored in the following chapters:

Chapter 6: Findings and Discussion Part 1: Beliefs and values about spirituality and attitudes towards spiritual care

Chapter 7: Findings and Discussion Part 2: The language of spirituality and spiritual care

Chapter 8: Findings and Discussion Part 3: Telling spiritual stories: Biographical and autobiographical accounts

Chapter 9: Findings and Discussion Part 4: Learning about Spiritual Care.

Each chapter begins with a brief introduction of the theme and a table linking data to categories. These categories act as a guide to the structure of the chapter for the reader in that they are numbered progressively down the left hand side of each table. They also provide further evidence of analysis and interpretation of data. In the conventions of reporting qualitative research, literature has been referred to when relevant to the point under discussion. All chapters end with a summary of the key points.

6. Findings and Discussion Part 1: Beliefs and Values about Spirituality and Attitudes towards Spiritual Care

In the previous chapter it was found that the results from the NGT indicated that students were able to provide answers to the question 'what are spiritual needs?' While each group identified a variety of spiritual needs there were also areas of similarity between the groups in terms of the value they placed on certain aspects of spirituality. The NGT provided ideas about spirituality that each group of students found important but, as a technique, it has been criticised for producing superficial understandings of a phenomenon (Moore, 1987). The findings discussed in this chapter are a result of an in-depth analysis of what meanings students held about spirituality. This analysis was undertaken through the process of constant comparison of the qualitative data generated from both the reflective group interviews (5) and the reflective journals (7).

Therefore in this chapter, I will continue to address Aim 3 by deepening my examination of the understandings that students held about spirituality and spiritual care. Haydon's (1987: 6) statement that 'Human beings live their lives in the light of beliefs and values' supports the importance of examining how students' beliefs, values and attitudes inform their understanding of spiritual matters.

What beliefs, values and attitudes did students express when discussing matters that they considered to be spiritual or to feature in spiritual care giving? What values did they have, if any, of spiritual experiences and spiritual care? Asking such questions of the data during the initial stage of coding resulted in the identification of codes or concepts from key texts. This process is illustrated in table 4. The right hand column signifies coded texts with the corresponding categories in the left hand column. In keeping with the procedures for constant comparison each section of the data was compared with all

other sections for similarities, differences and connections and sorted, or reassembled, in the form of groups of concepts or categories. As table 4 indicates the constant comparative analysis revealed 19 categories which were grouped together to form the major category or theme, 'Beliefs and values about spirituality and attitudes towards spiritual care'.

Table 4: Categories for Theme 1: Beliefs and values about spirituality and attitudes towards spiritual care

Sequence	Categories	Reflective Journal	Reflective Group	Coded Text
Beliefs 1	Spiritual care is difficult to identify because of its hidden nature		RG3 (K) RG3 (S) RG4 (J + L)	'you do it subconsciously rather than actively do it' RG3 (K)
Beliefs 2	Medical problems emphasised and spiritual problems ignored	M3	RG4 (A) RG2 (Mat)	'we just like to come in and look at the medical problems' RG4 (A) 'they don't look at the psychological or spiritual problems' RG4 (A)
Beliefs 3	Don't have all the answers to spiritual questions		RG4 (L) RG4 (A) RG5 (M) RG3 (K)	'they don't have all the answers and they know they can't fix everything' RG4 (L) 'if you don't have the answers for them it's hard and ...they just try to ignore it.' RG4 (A)
Beliefs 4	Spiritual care is not a nursing role		RG4 (J) RG3 (K)	'maybe it's not appropriate for nurses to get involved' RG4 (J)
Beliefs 5	A shared life experience	AH4	RG4 (F)	'if you've not experienced anything like it then you feel that you're not qualified to talk to them about it' RG4 (F)
Beliefs 6	Valuing family and friends as spiritual care givers	M1, 2, 3 AH2	RG2 (P) RG3 (R)	'knowing that I belong somewhere' RG2 (P) 'if they hadn't been there I don't think I would have coped with it' RG2 (P)
Beliefs 7	Beliefs are informed by own life experiences	AH3	RG2 (Mat) RG5 (M)	'different influences and things that make up what you believe' RG2 (Mat)
Beliefs 8	Patients and nurses don't always want to talk to each other		RG3 (R) RG3 (K) RG5 (T+M)	'some people like put up barriers immediately' RG3 (R) 'this idea that you care so much but you don't' RG3(K) 'some people find it hard to talk to someone who they're not familiar with' RG3 (R)
Beliefs 9	Painful when a strong relationship has to end	M2,3	RG2 (P)	'it's not easy to step away from it' RG2 (P)

Beliefs 10	Patients' suffering challenges personal beliefs		RG4 (J) RG4 (A)	'I don't make any effort to empathise because otherwise it would just challenge my own beliefs too much' RG4 (J) 'you don't understand why it happens to all these different people' RG4 (A)
Beliefs 11	Belief that life events have reason and purpose	AH2, 3	RG4 (A) RG4 (J) RG5 (C)	'I'd like to believe that there is a reason for everything that happens to people' RG4 (A) I want to believe that there is a reason behind life' RG4 (J)
Beliefs 12	Spirituality is expressed through religious and other belief systems and practices	M1 AH2	RG1 (K) RG 2 (K) RG3 (R) RG1 (F+L)	'my family members find a lot of strength in religion' RG1 (K) 'Many people do tend to look to God for help when they have suffered problems' AH2 'she would think that the reason that she had had a bad day was an act of God' RG3 (R)
Beliefs 13	Motivated by personal beliefs to provide spiritual care	*M1* *AH2, 3*	RG5 (C) RG4 (J)	'For me personally it's my faith' RG5 (C) 'to use an inner strength to keep a balance in all things (personal and professional) M1
Beliefs 14	Students identify with patients' life experience	M1 M2	RG4 (A) RG3 (R)	'I think about all the things that that I can do... and she doesn't have that anymore' RG4 (A) 'if I was diagnosed with that' RG3 (R)
Beliefs 15	A shared experience Connecting to and responding with another	M1,2 AH2	RG3 (Pat) RG2 (P) RG1 (K)	'She was squeezing my hand and that's just I thought it was what it was all about'RG3 (Pat) 'understanding the person. Treating her as an individual person' RG3 (Pat)
Beliefs 16	Spirituality is 'the thing we have in common'	AH3	RG4 (J)	'it's the thing we have in common' RG4 (J)
Beliefs 17	Enforced religious practice is counter to patient autonomy and meeting spiritual needs		RG3 (K)	'coerced into going to church every single morning' RG3 (K)
Beliefs 18	Spiritual care requires acceptance of others' beliefs	M1,3 AH4	RG3 (R) RG5 (C) RG1 (Nat)	'respect what they want... put your feelings and your thoughts completely out of the picture' RG3 (R) 'so that you're accepted, no matter' RG1 (Nat)
Beliefs 19	Conflicting beliefs cause professional and personal dissonance for staff	M2,3	RG1 (A) RG1 (L)	'you just can't accept why these people, why they won't take it' RG1 (A) 'dying just because of religious beliefs' RG1 (L) 'a distressing situation for all the staff because they can't do anything' RG1 (A)

These categories have been synthesised to highlight some key concepts students used concerning their beliefs and values about spirituality and attitudes towards spiritual care bearing in mind the aims of the study. Prominent ideas within this theme included these key ideas:

- The spiritual dimension is uncertain, hidden and lacking in answers
- The spiritual dimension has both individual and collective characteristics
- The emotions and the spiritual are often intrinsically linked
- Personal beliefs can be challenged by other peoples' suffering
- Personal beliefs help students find meaning and motivation to care for others
- Spiritual beliefs and care should be embedded in ethical principles
- Conflicting beliefs and values are difficult to resolve

6.1 The Spiritual Dimension is Uncertain, Hidden and Lacking in Answers.

Firstly, there was the belief that spirituality was to do with the uncertain aspects of life for which health care professionals have no definitive answers. This idea featured strongly in students' accounts:

RG4 (A).... *Like we just like to come in and look at the medical problems. And a lot of the time they don't look at the psychological or spiritual problems because I think like you said they're afraid because maybe they don't know how to deal with them. They don't have the answers for it because if you were a doctor in [tape inaudible], nine times out of ten you've got a good reason why and you can explain it and that's easy for you. But if you don't have the answers for them, it's hard and I think a lot of the time they just try to ignore it, forget it.*

RG4 (L) I think a lot of nurses...[say] I'll be back in a wee minute and they try to avoid it because they know that they don't have all the answers and they know they can't fix everything. And if they say, 'you know I'm going to die', the only thing you can say is 'Yeah, we know'. And I think that's hard for a lot of nurses and a lot of patients to deal with.

Thus there was a perception that medical problems were emphasised in health care by doctors and nurses and spiritual problems ignored. One reason given was the comparative ease with which it was possible to solve problems within the domain of medical science. In contrast, students characterised spirituality as metaphysical with qualities of uncertainty and compared these features with the philosophy of modern medicine which emphasises rational empirical knowledge. Participants recognised that some areas of peoples' experience cannot be explained by scientific knowledge and commented on how neither doctors nor nurses necessarily possessed the knowledge and skills to care for patients' spiritual needs.

The view that health is more than biological functioning is often voiced in terms of the philosophy of holistic care and yet in practice, the dominant medical model of health takes priority over other models of health. These other models are pictures of health which integrate the biological with the social, emotional and spiritual dimensions and are founded on the belief that the causes of ill-health are multi faceted and not simply due to biological malfunctioning. The practice of health according to these holistic approaches is more commonly seen in specialist health care systems such as hospices and complementary health services which are, at least in part, privately funded.

While the practice of holistic care is not part of standard national health care in the UK, it would seem that the present system of health care delivery contradicts the beliefs held by the majority of health care professionals who value holistic care. For example, in a Glasgow based study, Hasegawa et al (2005) investigated what GPs thought about using a holistic approach to health care. Nine out of 10 participants (87.3%) considered a holistic approach essential for the provision of good health care. In spite of the widespread belief that this approach was essential to enabling patient health, only 1 in 5 (21%) of participants were currently providing holistic care. Worryingly only 6.8% of GP's in this study considered that the current organisation of primary care made it possible. So it would seem that both clients and professionals desire holistic health care but in many parts of the UK only those who can afford to purchase it can get it and only those who work outside mainstream national health care will find it a valued mode of care.

Hasegawa et al's (2005) study also contradicts the view that nurses and doctors are somehow in opposition in terms of valuing a holistic view of health. Rather it would appear that both professional groups are subject to the constraints of the medical model and neither group is satisfied that the medical model enables holistic care. It must be

pointed out, though that the study only captures the views of general practitioners and medical practitioners working in other fields of health care may see less value in a holistic model of care.

Although a few participants questioned the view that doctors valued holistic care they were equally critical at times of their own inability to offer more than physical care. Thus responsibility for the lack of spiritual care was not necessarily directed at doctors but at the dominance of the medical model over nursing practice. Hasegawa et al's (2005) study indicates that many doctors also perceive this dominance as a restriction to their own practice. Therefore it could be that it is the value placed on the medical model of health care which is responsible for health care practitioners lacking a focus on spiritual care rather than individual shortcomings.

Not all of the participants were comfortable with the idea that nurses should provide spiritual care and one questioned whether spiritual care was a legitimate aspect at all for nurses:

RG4 (J) Maybe it's not appropriate for nurses to get involved

In support of this idea, Walter (2002) agues that not all nurses are able to discuss such difficult matters with patients and suggests that the task is left to the team responsible for the care of patients. As the notion of spiritual quest is different for each individual every patient situation should be addressed according to their particular needs in the hope that it may be possible to find someone within the team who can help the patient on their spiritual journey (Walter, 2002). Although Walter is discussing spiritual care specifically within palliative care which, unlike some other health care institutions, has a strong philosophy of team working, his argument challenges the view that spiritual care is the work of all nurses (NMC, 2004) or indeed all health care professionals (Scottish Executive, 2002). Certainly it

seems unlikely that all nurses would be able to offer spiritual care to any patient.

Spirituality and spiritual care are complex human experiences and the extent to which all nurses are able to discuss such matters with patients must be questioned. Answers to existential, spiritual, religious and moral questions are filled with uncertainty. The existential quest is normally seen to be part of spiritual well-being alongside the religious, humanistic and philosophical dimension (Paloutzian and Ellison 1982; Pesut, 2002) and is, for example, a significant inclusion in Paloutzian and Ellison's (1982) spiritual well-being scale.

Several participants expressed how unsure they felt about talking to patients when they had no personal experiences of a similar nature:

RG4 (F) *Like my life experience is whether I connect with somebody. If you've not experienced anything like it then you feel that you're not qualified to talk to them about it. But if you've experienced something like that you can share them from your own experiences*

The lack of confidence that students felt about trying to provide care when they had no personal experience similar to that of their patients needs to be addressed in educational terms. It raises questions about whether it is possible to prepare students so that they are qualified to provide spiritual care and what qualities and/or skills might they develop so that they are able to give such care.

Another student testified to the reality of living within a pluralist society and thought that it was her responsibility to make choices about the beliefs and values that would guide her life. She was doubtful that another person could help her in her quest:

RGI 2 (Mat): I don't know if it's the sort of thing you can get help on. In your personal life anyway it's more of a journey yourself you know

different influences and things that make up what you believe. And I don't know if it's something that somebody could help you with. Like, I've got a total range of influences my family and my friends. Like some of my friends are completely atheist at the moment and non-believing - like my Dad is. My mum's a Roman Catholic who was brought up Catholic and my flat mate's Free Church. Different influences (laughs). ...I think it's just a question of me doing it myself.

The above illustrates the particularity of spiritual beliefs, as well as how committed individuals might be to finding their own path. It also emphasises the private dimension of spirituality which may provide one explanation as to why nurses are reluctant to provide spiritual care and educators fight shy of the subject. Harrington (1995) suggests that one reason why spiritual issues are avoided is for fear of intruding on the patient's privacy and, in a similar vein, educators may avoid teaching the subject for fear of imposing (or being perceived as imposing) personal beliefs on students (McSherry 2000a).

6.2 The Spiritual Dimension has both Individual and Collective Characteristics.

While participants identified a source of spirituality within themselves, there was also the view of spirituality as an interpersonal activity, with family and friends as sources of help and support when they needed spiritual care. In a reflective account of a poem one participant commented on how although she sought spiritual strength from within herself, she also gained spiritual support from her partner:

M1 *The poem is something I feel is for me alone to use to maintain values and virtues, and not something that makes me look for support from my partner (which is another aspect of spiritual support that I use in life)*

Another illustrated the need for a sense of belonging to friends following an emotional break up of a relationship:

RG2 (P) *But very much for me, knowing that I belong somewhere and, like, my friends are there if I need them.... And I felt that I needed them there. If they hadn't been there I don't think I would have coped with it. Although a lot of people said, looking at me, that I was a strong person and all that. Inside I did not feel that way at all*

Thus participants located spirituality as being both a personal and a relational activity. As the above participant acknowledged, even a strong individual needs the support of others to strengthen her spirit when challenged by events. The quality of spiritual care-giving depended on the extent to which the people involved knew one another - thus friends and family were often seen as natural spiritual caregivers. There was recognition that some patients simply chose not to engage with a nurse and perceived nurses as inappropriate spiritual

caregivers because they didn't know them well enough – in fact, they were strangers.

RG3 (R) *Some people just don't want to talk. Some people like put up barriers immediately and they're, like, I don't want to talk about it with you. And I think they see you as a stranger, which you are, you are a stranger. And some people find it hard to talk to someone who they're not familiar with.*

It may be the case that normally patients would turn first to family and friends for spiritual care. However not all patients have family and friends at hand when they require such care and some may simply choose not to discuss spiritual matters with their friends and family. If the quality of the nurse-patient relationship is poor then spiritual care will not be provided. If a nurse and patient do not know one another well enough to experience a sense of connectedness, the depth of care could remain at a superficial level and spiritual care would not arise.

6.3 The Emotions and the Spiritual are often intrinsically Linked

One participant described this feeling of distance to patients whom she had known for only a short time and compared the relationship that she had with those patients with the relationship that she had with her own relatives. She noted that these different relationships involved quite divergent levels of care on her part. The following conversation arose when the group were discussing the shortcomings of a member of the medical staff whom they considered had spoken disrespectfully about a patient who was dying:

RG3 (S): ...that's shocking. How would she feel if she walked past somewhere and someone was saying that about, I mean, her mum or?

RG3 (Pat): It wasn't even that way 'she's going to die soon' she was saying... We're doing all we can medically so there's nothing else they can do for you.

RG3 (K): I feel like getting that way myself, saying, sometimes I just don't care. And it's terrible. And other times watching disheartens you sometimes, like

Facilitator: See the fact that you sometimes feel you don't care, this happens when?

RG3 (K): Sometimes I think well that's not my mother, brother, father, granny so I don't know them. I've only known them for about 2 days. They're going to go somewhere else so is it unrealistic to expect that you're going to care that much...

RG3 (R): Do you mean you kind of distance yourself? ...

RG3 (K): But I think this idea that you care so much - but you don't. And really at the end of the day it is a job.

RG3 (Pat): I don't know. I'm not in it for a job at all. It's why I always wanted to do it just to be there for people and to look after them.

RG3 (K): Originally that was the way I was but

In the above, participants explored how they felt health care professionals ought to care for patients by making comparisons with what they thought was the 'gold standard' of spiritual care. That is, whether the care they gave to patients measured up to the care they would give to a member of their own family. Their discussion suggests that participants developed different types of relationships according to their personal beliefs about what constitutes an appropriate nurse patient relationship. Thus knowing the patient and considering oneself to be in a relationship with the patient were important factors in determining the quality of nursing care and whether spiritual care was offered. One of the above participants felt disheartened in her caring role when it involved caring for someone for whom there is no cure. Another RG3 (Pat) challenged her attitude as one that she did not share. Nursing care was thought to differ from medical care in that the nurses caring role did not end when the patient could no longer benefit from medical intervention. This illustrated how students struggled to find an appropriate relationship with patients and how this relationship varies hugely from student to student.

If getting to know patients well is a pre-requisite for spiritual care, it may prove very difficult for student nurses to provide spiritual care. The opportunities for students to get to know patients well are limited as nursing students often have fairly short placements ranging from 2-8 weeks in length. So the length of the placement may preclude getting to know patients sufficiently well for spiritual care to be

possible but it can also mean that if a close relationship were established it would inevitably need to be broken. The following participant explained that breaking a close relationship was difficult for her:

RG2 (P) And I had spoken to... both ladies came in on my first shift as well which meant that we were both in there at the same time. And I felt it very difficult walking away from the ward. Very difficult for myself... And I suppose that's the benefit that the permanent staff have got but because I was only there for the 2 weeks and then walking away and not going back and thinking you know I wonder how they're doing.

It is possible that students' reluctance to get to know the patient in the first place could be because of their anticipation of the pain that could be caused by inevitably having to break a close relationship.

6.4 Personal Beliefs can be challenged by Patients' Suffering.

Participants explored whether their own personal spiritual beliefs and experiences influenced their practice. One participant admitted that he sometimes held back from empathising with patients who were suffering because to do so would challenge his own beliefs:

RG4 (J) *If you see someone suffering, or you see someone, I don't know, sometimes I feel I just harden to it, to be honest with you. I just philosophise it away. I don't really empathise. I don't make any effort to empathise because otherwise it would just challenge my own beliefs too much. And I want to believe that there is a reason behind life and to believe that, you know, people are going to be all right.*

This participant seemed to be suggesting that he held back from engaging emotionally when faced with patients' suffering because he found that the suffering of others challenged his own beliefs too much, particularly the belief that there is a purpose or reason to life and that people are going to be all right. The problem of pain and suffering has a long history within theological discourse but is seldom, if ever, given space in the nursing curriculum. This is a pity as, more than many professions, nurses are regularly faced with the suffering of others and struggle to understand why some people - and not others, including themselves - have to face this. Students who identify strongly with patients have particular difficulties when patients do not get better as the following conversation demonstrates:

RG4 (A): I've got a young girl just now who's 2 years younger than me and she's dying and on the one hand I was thinking I was very grateful for the fact that I was still alive and that I had all the things to look forward to and then I think about all the things that I can do or that I can potentially do and she doesn't have that anymore. And sometimes I feel as if I've failed to maybe help her and it can be quite depressing

because you feel as if you're supposed to be able to help people - not save them in a way - but you know what I mean?

Facilitator: yes, that's what you came into nursing for

RG4 (A): And there're just some people that you can't do it. You feel as if you're a failure sometimes and even when you've done something for them you still feel as if..

Facilitator: You would rather have done more for them

RG4 (A):... you'd like to do more. And it does centre on all your spirituality. It's what you believe. Because I'd like to believe that there is a reason for everything that happens to people and you try and think about it. Usually in your own life you can, if nothing really that bad has happened to you, you convince yourself yep there was a reason, you can apply reasons to your own life. But it happens to people all the time and.... you start to lose your ability to try and logic that reason out because you don't understand why it happens to all these different people. That can be quite unsettling.

Participants struggled to make sense of patients' suffering when they could find no satisfactory explanation for it within their belief system. There seemed to be a struggle to hold onto their belief that life has a pattern and that events are not arbitrary - rather they are imbued with meaning for the individual. The lack of an acceptable explanation within their belief system for those who find themselves in situations of serious ill-health could have an impact on the extent to which students empathised with patients and their feelings of failing patients.

In order to make sense of their own beliefs about suffering and perhaps help others find meaning through (or in spite of) their suffering, students may well benefit from exploring a variety of beliefs and explanations about pain and suffering. Such discussions

could help students find ways of exploring how they might properly engage with patients who are suffering without feeling that their own faith is necessarily under threat or that empathy is too burdensome.

Pesut's (2002) comparative study into nursing students' perceptions of their spirituality, spiritual health and spiritual care suggested that as nurses progressed through their nursing programme they moved away from their own personal agenda towards a more patient-centred approach to spiritual care. First year students entered the programme with a strong sense of their own personal spirituality and sought to care from that base-line whereas fourth year students placed less emphasis on their own agenda and more on supporting the patient's beliefs. However it is difficult to evaluate how helpful this study is in terms of its transferability to other undergraduate nursing students. Firstly, no information is given about the age of the students so there is uncertainty as to the influence of maturity on the students' perceptions. Secondly, the study was conducted in Canada within a very specific cultural context. One of the limitations with Pesut's (2002) study is that it took place within a private Christian university and many students chose that programme and institution because of their personal religious beliefs. But it does raise some interesting points which could help address the tension some students felt between their personal beliefs and reality of patients' lives. Conducting a study similar to that of Pesut's (2002) with students who did not have a particular religious focus would provide additional insight into the spiritual development that occurs during nursing students' educational experiences.

6.5 Personal Beliefs help Students find Meaning and Motivation to care for Others

While it would appear that patient care can be challenged when dissonance arises between personal beliefs and what is happening to the patient in reality, there were also examples from participants of how their personal beliefs helped them find meaning and motivation to care for others.

Participants suggested that their beliefs and values, whether arising from a religious framework or not, were highly significant to how they engaged in nursing care and what meaning they attributed to that care. For example, when discussing a poem that held personal spiritual significance, the following participant expressed what it meant to her through the framework of her religious beliefs:

AH2 '...I became a Christian at a young age that is, I believed that God's son Jesus, died on the cross to save me – and I asked him to forgive me for all the sins I had committed and that means I have a place in heaven – eternal life. ...Many people do tend to look to God for help when they have suffered problems; i.e. loss of loved ones, hurt. This poem looks at that and concludes that it is at times like that that God "carries you" and helps us through them.'

This participant considered that her spiritual beliefs, as expressed through her religious beliefs, gave meaning to her personal life and that she had come to an understanding of how these beliefs might provide purpose and meaning in her nursing care. In her reflective journal she describes a situation in which she used her personal faith as a means of providing spiritual care for another. This story is explored in depth in chapter 8 entitled 'Findings and Discussion part

3: Telling spiritual stories: Biographical and autobiographical accounts'.

Another recognised her religious beliefs and values as her overriding motivation for providing spiritual care:

Facilitator: What is it about you as a person and as a nurse that you feel makes you able to give spiritual care?

RG5 (C): For me personally it's my faith.

Facilitator: Right. Do you want to tell me a wee bit more about that?

RG5 (C): ... I'm not saying that only people who have some kind of faith are compassionate or caring.... But for my own self it definitely is my faith that makes me want to do my best for the patient, to care for them as best I can.

Participants also expressed the significance of non-religious beliefs and values on their perception and conduct of their nursing care:

M1 'The poem tells me to look within myself, to use an inner aspect/strength to get through life and take all events in my stride without complaining or expecting praise for my actions.
It does not hold any religious significance for me but tells me to use an inner strength to keep a balance in all things (personal and professional). ...

This is the spiritual aspect of the verse that I feel is most potent. It leaves it up to each individual to use the approach they find most suitable or relevant to achieve the balance.'

Whether authority for their beliefs and values was derived from a transcendent God or their own individual inner source of strength, students were clearly aware that it was their beliefs and values that motivated their desire to care for others through nursing. This idea that spiritual experiences motivated participants to care was a key finding from this study and is discussed in further chapters.

6.6 Spiritual Beliefs and Care should be embedded in Ethical Principles

A recurring theme in the interviews and journals was the belief that spiritual care was possible only if patients were respected as individuals and this involved trying to understand the person and a preparedness to be physically and emotionally with them. The following moving account illustrates a positive spiritual experience when the student demonstrates her compassion for the patient and her willingness to be present for the person:

RG3 (K) ...*a lady that I was looking after that was terminally ill and she was also MRSA so she was isolated for her nursing care. And she was just in so much pain and she was being moved about all the time changing her sheets and she had a colostomy that just continually just leaked and leaked and we couldn't get it under control. And just one night just when we were moving her about - she was so sore and she said, you know, thanks so much for being there. She was squeezing my hand and that's just I thought it was what it was all about.... You could say that was her spiritual needs, you know, how I responded. But certainly it made a difference to me I think.*

Facilitator: Did it feel like a kind of spiritual thing at the time?

RG3 (K): It felt like I was, she needed someone and I was there at the time.

Facilitator: So the company?

RG3 (K) : Yes absolutely. Understanding the person. Treating her as an individual person and not just...

Facilitator: So that was a positive experience for you.

RG3 (K): Yes

It seems that in order to attend to someone's spiritual needs it is necessary to be interested in the person as an individual to the extent that one can identify with that other. Scott (1995) describes moments like the above experience through the use of the term 'imaginative identification' when, through attending to another, the nurse acts on a realisation of the patient's real needs while dismissing any preconceived ideas of her own. Imaginative identification requires the ability to attend closely and creatively to another person in order to understand the lived experience of that other person. To do this an individual must see herself in relation to the other person, that is, their common humanity. As one participant put it when trying to explain spirituality and whether nurses ought to try to provide spiritual care:

RG4 (J): *...it doesn't make any difference whether they're, about their status in life really. It's the thing we have in common kind of thing...*

There must also be the willingness to act on that understanding of the other for the good of the other. This is a moral characteristic of spiritual care often valued in health care through ideas of beneficence, compassion or empathy. This ethical dimension of spiritual experience prevailed throughout participants' stories to the extent that it was difficult to find a story without some ethical exposition being intrinsic to it. This suggests that students thought that the spiritual and the ethical go hand-in-hand.

It is interesting to note the reciprocal nature of spiritual care as illustrated in the nurse-patient scenario described above. This concurs with several authorities (Price et al., 1995; Hoover, 2002; Pesut, 2002) who suggest that spiritual experiences are transformative in the sense that 'both the person caring and the person being cared for are influenced by the relationship' (Hoover, 2002: 80). Such transformative experiences illustrate how understanding and empathy

are in themselves effective forms, not only of therapy (Swinton, 2001) but of job satisfaction by way of promoting nurses' sense of self-worth and increasing their motivation to care.

Some students spoke of trying to identify with others and understand their experiences by asking questions of themselves about how they would respond were they in the patients' situation.

For example, compassion for others arose from a deep respect for how people conducted themselves in extremely difficult and often life threatening situations. The following participant discussed how she admired her aunt's positive way of living (and dying) when she was diagnosed with a terminal illness and felt that, were she in her aunt's shoes, she would have been more likely to mourn the loss of life than celebrate what was left to live:

RG3 (R): *...immediately the first thing I thought to myself was I don't think if I was diagnosed with - because she had lung cancer and it spread to so many places.... And I don't think personally I could say oh well I've got 2 years lets make the most of it...*

Admiration for the spirited way that people lived with their suffering and ill health enhanced the respect that participants held for them.

Participants considered that autonomy was a pre-requisite to spiritual expression – if patients were not free to make their own decisions about their spiritual practices, their spiritual needs would not be addressed. One student described how she had worked in an elderly care home that was run by staff belonging to a particular religious denomination. Residents were expected to participate in the daily services of the institution and this did not suit the wishes of all residents and resulted in a conflict of interests:

RG3 (K) ... And I had an old man who moved in and didn't want to go to church. 'I'll go on a Sunday but...'. And that was fair enough but he was sort of coerced into going to church every single morning. It was a fight every morning and he didn't want to go. But he shouldn't have been made to go. ...he was just wheeled down and plonked there.

...

Facilitator: Did you think it was meeting his spiritual needs? ...

RG3 (S): But then you're inflicting your spiritual needs on someone else, aren't you? Because that's your norm that you go to church every day, then it shouldn't be someone else's...

RG3 (S): That's not respecting their wishes or anything either is it so it isn't specially catering for their spiritual needs.

RG3 (R): And taking them – that's disrespecting their spiritual needs

Participants viewed attempts at religious proselytising or, as the above data illustrates, attempting to enforce religious practices on a patient, as not only contravening an individual's autonomy but, in so doing, contrary to respecting a patient's spirituality. Narayanasamy and Owens (2001) categorised nurses' responses to critical incidents according to four types: the personal, procedural (religious), culturalist and evangelical. Like the example above from the present study in which students oppose the coercion of patients, Narayanasamy and Owens (2001) cautioned that nurses using an evangelical approach may be subject to criticism were they to act in such a way as to compromise patient autonomy.

6.7 Conflicting Beliefs and Values are difficult to Resolve

Several participants indicated that respecting the patient's autonomy necessarily meant that there would be times when nurses had to set aside their own beliefs in order to treat patients as individuals. One participant explained that respect for others in a care situation required the nurse to put the patient's feelings first and the nurse's thoughts and feelings 'completely out of the picture'.

Facilitator: So do you think to meet spiritual needs of families and patients we need to kind of relinquish our control?

....

RG3 (R): I think you have to just respect what they want and be careful not to kind of push them. Put your feelings and your thoughts completely out of the picture.

This proved more difficult to do in practice as there were times when participants recounted dissonance when patients' beliefs conflicted with how they perceived their professional role or indeed their own personal beliefs. The following participant explored how she felt in her capacity as a professional and a non-professional when a critically ill patient refused life saving treatment because of her religious beliefs. She discussed how helpless she felt as a professional when a Jehovah's Witness refused a blood transfusion because she didn't understand the beliefs and values of a religion which placed its tenets before one of the aims of nursing that is non-maleficence:

RG1 (A): *I think you always feel really angry in a way because you think 'why are you doing this?' kind of thing.*

This participant went on to reflect that it may be difficult for someone with a keen awareness of her own beliefs to care for someone who believes differently:

RG1 (A): I think you're not always that aware of your own like, spirituality. You're not really aware of your own. But if you are it can also get in the way in the care for a patient. It's like trying to respect their beliefs and things but you can't always block out your own, like how you feel and what you know against what these people feel for themselves. ...

Knowing that the patient had a legal right to refuse treatment and that the appropriate professional response must be to uphold that right did not lessen the dissonance that the student felt in terms of the morality of the decision. Neither did participants commend the actions of a family who supported the patient's decision to put religious beliefs before life itself:

RG1 (L): And even like the family standing by and watching. Well obviously the patient I had, they understood why she was doing it and they thought that she should be doing it. But it's still hard. I don't know that I would be able to stand by and even anything about my religion and watch one of my family, like dying, just because of religious beliefs and things.

Students found situations whereby a family put their religious beliefs before the life of a loved one particularly difficult to comprehend. It was not easy to put their thoughts and feelings 'completely out of the picture' as was suggested above, when patients acted in ways that contravened students' personal belief systems. This dissonance may have been because there was a dilemma over conflicting professional values about, on the one hand, withholding life saving treatment and, on the other hand, respecting the patient's autonomy. This is likely as the students obviously had difficulty reconciling their aim as nurses to provide healing along with the legal and professional boundaries on

their role. Even a thorough checking of the consent form was undertaken in an attempt to find the authority to overturn the patient's decision:

RG1(A) You've got their consent form and you can have a look at it. But even looking at that, it's kind of like, 'What on earth?' Because we were reading through the consent form and it says nobody can override the decision ...it is a distressing situation for all the staff because they can't do anything.

But another reason why the above situation was unpalatable for participants was that they themselves did not tend to seek authority for their beliefs and values from religious organisations but rather, sought affirmation and spiritual support from their family and friends. So students who sought validation for their feelings from their own family and friends found it difficult to concur with others who, because of their beliefs, did not appear to offer such support to their own loved one – even to the extent that they were prepared to see them risk their lives to honour a personal belief.

Summary

The above exploration of beliefs and values about spirituality and attitudes towards spiritual care suggests that students believed that:

- Spiritual care is difficult to provide because, in contrast to physical care, the spiritual dimension is hidden, individually expressed, cannot be generalised and is concerned with uncertainties which have no prescriptive answers.
- The spiritual dimension has both individual and collective characteristics. Students thought that their own spiritual health, and that of their patients, depended on both individual life experiences and the support of friends and family. It was easier to provide spiritual care when the nurse knew the patient well, had an understanding of

the patient's belief system, and shared the same values with patients and their families.

- The spiritual dimension is embedded in ethical principles. In particular, students highlighted respect for others including the right of patients to autonomous decision making, compassion and having the best interests of the patient in mind.
- Students wrestled with the problem of pain and suffering and some said that their personal beliefs were challenged by patients' suffering. There was expression of bemusement at the injustice of why some, and not others, including themselves, had to endure great suffering.
- Students found meaning in their own lives and motivation to care for others through a spiritually emergent experience.

In this chapter I have explored some key beliefs, values and attitudes about spirituality and spiritual care expressed by students during this study. In so doing, Aim 3 of the study has been addressed as I have gained a deeper awareness of students' understanding of spiritual matters. In the next chapter, the focus of the findings and discussion will be on addressing issues relating to Aim 4 by way of explicating some of the personal abilities that students thought they required in order to provide spiritual care.

7. Findings and Discussion Part 2: The Language of Spirituality and Spiritual Care

Chapter 6 presented the findings and discursive commentary pertaining to the beliefs, values and attitudes that students held about spirituality and spiritual care. These understandings of the phenomenon under investigation were gained by analysing the interview and journal data. This analysis was undertaken through the process of constant comparison of the qualitative data generated from both the reflective group interviews (5) and the reflective journals (7). These research methods provided the substantive data from which the findings of the study emerged in the form of 5 themes. In this chapter I turn to exploring the theme 'The language of spirituality and spiritual care' by presenting the findings pertaining to students' understandings and experiences of spiritual discourse.

What words and concepts did students use when discussing matters that they considered to be spiritual or feature in spiritual care giving? How did they approach a spiritual conversation? Asking such questions of the data during the initial stage of coding resulted in the identification of codes or concepts from key texts. This process is illustrated in table 5. The right hand column signifies coded texts with the corresponding categories in the left hand column. In keeping with the procedures for constant comparison each section of the data was compared with all other sections for similarities, differences and connections and sorted, or reassembled, in the form of groups of concepts or categories. As table 5 indicates the constant comparative analysis revealed 15 categories which were grouped together to form the major category or theme, 'The language of spirituality and spiritual care'.

Table 5: Categories for theme 2: The language of spirituality and spiritual care

Sequence	Category	Reflective Journal	Reflective Group	Coded text
Language 1	Talking is a means of coming to terms with illness/events	M2	RG2 (P + Mat) RG2 (P) RG5(M)	'talk to them because that I think was their way of coming to terms with what was happening' RG2 (P) 'such a shame that staffing levels are so low because patients don't get the support' RG2 (P)
Language 2	A willingness to listen and talk	AH4	RG1 (G) RG4 (A+L) RG2(P)	'just being there so they can maybe talk to you' RG1 (G) She just sat and talked. She would have talked all day to me' RG2 (P)
Language 3	Nurses are reluctant to communicate with family		RG3 (Pat + R) RG5 (M)	'at visiting time... the majority of nurses absolutely hide' RG3 (Pat)
Language 4	Family identify patient's spiritual needs		RG3 (R) RG2 (K)	'I think a lot of the time it comes from the family' RG3 (R) 'But I think it's the family' RG2 (K)
Language 5	Initiating the conversation	AH4	RG5 (T + M)	'You'd go in at night and 'Do you want to talk to anybody?'' RG5 (T)
Language 6	Words can give hope and inspiration		RG5 (M)	'he's told lots of people that the only thing that gave him hope at that time of his life was when I said well the good thing was that they can do something fro you' RG5 (M)
Language 7	Finds strength/feels guilt by comparing own life to those worse off	M2	RG2 (P) RG4 (A)	'And my problems are nothing in comparison to that. ...when you look at other peoples situations you know that life's not that bad' RG2 (P) 'Guilt at feeling this relief' M2
Language 8	Negative experiences can have positive effects	M1, 2, 3. AH2, 3	RG2 (P)	'you have your whole life ahead of you. It's not the end of the world' RG2 (P) 'The whole incident adds to personal life experience. ...perhaps in some way enhances it, compared to someone who has not experienced anything like this' M2
Language	Confident and able		RG2 (P + Mat)	'I think it's

9	communicator		RG4 (A)	communication, communication, communication.'RG2 (P)
Language 10	Able to pick up cues	AH4	RG2 (Mat + P) RG5 (C +M) RG4 (J)	'it's more intuition and like picking up triggers and cues' RG2 (Mat) 'knowing when the right time is' RG2 (P)
Language 11	Being present with someone in silence		RG1 (Dy) RG2 (Mat and P) RG4 (A) RG5 (M)	'if you feel a bit more comfortable with someone then it's OK to sit in silence' RG1 (Dy) Because there's nothing you could say. ...But sort of in a presence sort of way... RG2 (Mat)
Language 12	Emphasising the positive		RG4 (J) RG5 (M)	'Try and point out things, positive things to them.' RG4 (J)
Language 13	Offering affirmation of worth	AH4	RG4 (L) RG3 (Pat)	'Give them the reassurance that they've done the best that they can' RG4 (L)
Language 14	Don't know what to say		RG1 (L) RG3 (R and S)	'knowing what to say. I think it's quite hard sometimes' RG1 (L) 'I wouldn't know how to go about saying' RG3 (R)
Language 15	Hard to talk to someone you don't know		RG3 (R) RG4 (J) RG1 (L)	'people find it hard to talk to someone they're not familiar with' RG3 (R) 'I don't feel very confident about it' RG4 (J)

These categories have been synthesised to highlight some key concepts students used in their language about spiritual care bearing in mind the aims of the study. A consistent view across the groups was that being a confident and able communicator was an essential attribute for the spiritual carer. Another prominent thread was that of student comportment within these conversations in that their intent was to affirm the worth of patients and could therefore be considered a moral endeavour. These key findings help to address Aim 4 of the study as they describe personal abilities that students thought they required in order to provide spiritual care.

7:1 A Confident and Able Communicator.

One participant recalled how she made it part of her work to speak to patients she met in an oncology ward when she was a student on a 2 week observational placement. These conversations could be lengthy, lasting in one case, for up to 45 minutes. She considered these conversations to be part of nursing care:

RG2 (P) ... there was an awful lot of people who every so often you just had to go and sit down and talk to them because that I think was their way of coming to terms with what was happening. They were all in getting their chemo done or being set up for radiotherapy. Just sitting listening.

The above participant described how having and making the opportunity to talk with patients was essential as it helped patients come to terms with what was happening to them, a way of making sense of their experience of ill-health. To help someone come to terms with what was happening to them was considered an essential aspect of spiritual care as it was thought to assist the patient find meaning in the context of ill-health. This participant also pointed out that she was able to find the time to talk with patients as she was on an observational placement but that overstretched nurses couldn't always provide the support that patients needed:

RG2 (P) *The observational placement was really good for being able, because you weren't tied up in a lot of nursing duties. And I felt after this 2 weeks that it's really such a shame that staffing levels are so low because patients don't get the support that they need. Because I was an extra body I could go and speak to a patient when the rest of the staff, you know were busy.*

It was thought that there had to be a willingness on the part of staff to make themselves available to listen and talk:

RG1 (G) *...just being there so they can maybe talk to you.*

However there was also criticism for nursing staff when they deliberately avoided conversing with patients and their families and the following participant commented on how the qualified staff left her, the student, to face the relatives:

RG3 (Pat): I was just going to say, I don't know if it will be different when I'm qualified but I just think the family just need reassuring, they just need to know what's going on all the time. Because I just know that at visiting time you know, not everyone, but the majority of nurses absolutely hide they don't want to be - the nurses don't want to be seen. I think that's truly sad.

RG3 (S): We'll go and do the handover you sit at the nurses' station. So of course I'm the first person they pass.

There was recognition that nurses did not always include the family in their caring role. Indeed some qualified nurses made themselves invisible to the patients' families. This could create a tension in the provision of spiritual care as several participants expressed the view that it was the family who directed the spiritual care of patients. One student described how one family sought spiritual help when the patient, a young distraught woman was facing her death in a palliative care setting:

RG2 (K) I found that just in general a lot of patients were turning towards the minister and that kind of thing and asking. But I think it's the family. Em there was one family who kept asking for the minister to come in and just pray with them.

Another student described how feeling unable to converse with the family about religious practices led to uneasiness about how best to meet a patient's spiritual needs:

RG3 (R): I think a lot of the time it comes from the family. Like, I had a patient in em like this morning when we were talking about what spiritual need was em my last placement there was a patient in the ward who was a stroke patient and she was just like basically there for, like, tender loving care type of thing. And em, like, the family were in and they would put, like, the rosary beads on her bed and things like that and there was, like, the holy water sitting beside the bed. But they didn't speak to us about it and say you know I want you to, when you're leaving her in the room put holy water on her or anything like that. So we were all kind of, like, you know, what do we do here? But it comes more from the family I think rather than from the patient. Or in that instance it did anyway.

Reluctance among the qualified staff to speak about spiritual matters could result in students being left in the position of feeling ill equipped to deal with the spiritual concerns of the patient and/or the family. However if nurses do not communicate with family and friends about spiritual care and spiritual practices, it is unlikely that they will be able to meet patients' spiritual needs.

On the other hand there were reports from qualified nurses participating in the study of actively anticipating and responding to patients' needs to converse about deeply felt matters. The following participant described how she took the initiative with a seriously ill patient by creating an opportunity for a conversation to emerge:

RG5 (T) You'd go in at night and 'Do you want to talk to anybody?' And as time went on it got to sort of jokes. He had quite a dry sense of humour. And you could repeat some of it.

One of the in-service students, who was an experienced ward sister, showed how she ably dealt with a patient who had received the news that his only hope of surviving bladder cancer was through radical (and mutilating) surgery. The ward sister found a way of caring for the patient's spiritual needs and he moved from despair to hope:

RG5 (M): And he took this to be the absolute end and did not see this as being in any way a cure to his illness. And I was with him when the consultant told him that this was the only chance that he had and as I always do I went back and spoke to him after he had been given his diagnoses and he said to me "Well this is it isn't it?" and well I says to him "Well no, this isn't it. The important thing to remember here is that they can do something for you." And I did tell him about the patients that sometimes the tumour is so advanced that there is nothing they can do and ultimately it is just palliative treatment that they've got for these patients. But in his case the fact that they can actually go in and remove his bladder and at the same time give him a life was a good thing and he's done fine - he's still alive and that's us talking about 6 years ago now. And he's been in, been back in the ward since then and unbeknown to me, he's told lots of people that that's the only thing that gave him hope at that time in his life was when I said well, the good thing was that they can do something for you and he knew that there was people whereby bladder cancer becomes so advanced when it's spread outwith the bladder these people are not offered as a form of treatment. And I think that was basically a turning point for him because he was ready to just throw in the towel that that gave him a lot of inspiration and I was quite touched to think 'oh god you know, they wee talks that you have with the patients sometimes do the world of good'.

It is interesting to note that the sister's means of challenging the patient's feeling of despair was by pointing out that in comparison with some others who couldn't benefit from any treatment, he was one of the more fortunate ones. She didn't 'jolly along' the patient neither

did she appear overly sympathetic rather she exhorted him to change his way of thinking about his situation. Finding one's own good-fortune in the face of others' misfortune may not appear to be a particularly admirable motivation for feeling hopeful but it did feature in the study as one way that participants talked about finding hope for themselves and, as the above example illustrates, instilling hope in others. It is difficult to identify a moment when spiritual recovery begins but the moment when hope enters a person who has just been given a poor prognosis may justifiably be described (as it is by the above participant) as 'a turning point'.

In a similar vein the following student described how friends helped her move on from a broken relationship and how this restoration was assisted by comparing her own situation with that of a patient who died leaving behind teenage children:

RG2 (P). ...And em my problems are nothing in comparison to that.... when I see what else is going on in the world my problems were nothing in comparison. You felt rubbish at that point in time but when you look at other people's situations, you know that life's not that bad. You'll get there eventually. People are right when they say you'll get there you have your whole life ahead of you. It's not the end of the world.

Thus, a perhaps surprising finding from this study was that some participants found hope for themselves as well as the motivation to care for others by comparing their own good health with the poor health of their patients. It may be that in order to feel sympathetic towards the plight of others we must feel that they are worse-off in some way to ourselves.

Contemplating how much worse their lives could be by comparing themselves to their suffering patients resulted in a mixture of feelings that participants described using various concepts such as relief, guilt

and gratitude. A reflective journal entry described how a participant experienced these mixed emotions following a traumatic incident. He recalled the day he heard that a health care professional had been stabbed to death in the surgery where his wife worked and explained how he felt relief, gratitude and selfishness on hearing that his wife was safe:

M2 I felt a relief that my wife was unhurt. …My wife was safe, physically unhurt and I was able to get home to her quickly after being alerted.

Further on in the journal the participant analyses and lists the complex features of the situation:

A man dies in tragic circumstances. My wife was safe (personal selfishness!). …Guilt at feeling this relief

Coupled with his feelings of relief that his wife was safe was his recognition that he felt guilty at these feelings which seemed selfish when compared to the misfortune of the murdered man and his family. He also commented on how everyone has to move on irrespective of the horror of the events:

M2 A tragic life event and learning experience, but everyone has to move on – accept and adapt.
I feel immense relief that several years on, my wife has come through this incident "apparently" unscathed and a much stronger person.... The whole incident adds to personal life experience. (Not everyone can tell this story!) Perhaps in some way enhances it, compared to someone who has not experienced anything like this.

In this journal entry there is a clear expression of the view that suffering can make people stronger because, although tragic and

painful, it was viewed as a developmental process. Both the participant and his wife had, in some way, learned from the experience and used this learning in a way that enhanced their own life experience. One consideration from this analysis is questioning whether at least in some spiritual experiences there is a sense of awakening, in that even though the situation or experience itself was far from welcomed, without it, perhaps life would be less fulfilling.

It would also seem that life was more fulfilling for participants because they recognised that others were in worse situations than their own. Participants talked of relief and gratitude that it was not themselves or their loved one who was sick or dying and yet concomitantly felt guilt that they were not the ones suffering. There is resonance here with some aspects of 'survival guilt', a term first coined by Aaron Hass (1996) to describe concentration camp survivors. It has come to encompass any situation where people (including patients, families and health care providers), have been involved in a life-threatening event and survived. Survivor guilt explores the question of 'why did I survive when others did not' and survivors may feel a debt towards those who did not survive. This debt may account for the motivation of survivors to succeed by living a fulfilling life and it may also motivate nurses to care for those less fortunate than ourselves:

RG2 (P) 'my problems are nothing in comparison'

Participants wrestled with some serious spiritual issues including those relating to despair, loss and guilt. This suggests that there is a legitimate place in nurse education for exploring theological concepts such as guilt, forgiveness and recovery from suffering.

Other prerequisites considered essential for spiritual conversations were personal qualities such as intuition, sensitivity to when the time is right and active listening:

RG2 (P): 'I think it's communication, communication, communication. (laughs). I think as well knowing when the right time is.'

Other comments included that nurses had to be perceptive enough to pick up cues from patients about spiritual concerns, sensitive to when patients wanted to talk and recognise when silence was the best form of communication:

RG2 (Mat): *'it's more intuition and like picking up triggers and cues'*

Being comfortable with silence is not always easy and one participant, a self-confessed 'talker' admitted that and learning when and how to sit in silence wasn't always easy:

RG2 (P) 'when it really matters I think I know, you know, it's ok, you don't have to be speaking all the time. Sometimes it can be a bit uncomfortable. You know, patients can look at you as if 'Can you say something?' and you just don't know what to say. But again that's something that I would imagine you'll pick up, you'll start to pick up on things'.

One participant agreed that although there were times when words were redundant, spiritual needs can be met by being physically with the patient:

RG2 (Mat): 'Well, I thought that afterwards. I thought well I did all I could have done. Because there's nothing you could say. I mean his wife is still going to die and there's nothing I can say to change that so. So, maybe I've met his needs to an extent although he probably wasn't all that spiritual and although I didn't say very much. But sort of in a presence sort of way, in taking him there.'

The above is an example of 'presence' which at root requires the nurse to be with someone in such a way that acknowledges or participates in the person's experience (Watson, 1985; Sandelowski, 2002). As the student demonstrated, such care need not involve doing something for someone as the student supported the husband by being with him and acknowledging his feelings. Such reassurances are far from the bland (and sometimes false) statements made to patients that everything will be all right. Rather by being with the person both physically and emotionally the student acknowledged and valued the husband's experience by supporting him at a time of suffering.

The value of presence to patients and families at times of spiritual distress is noted and encouraged (Aldridge, 2000) although it is also acknowledged that obstacles such as time-constraints, a failure to listen to patients and not having answers to offer patients can all prevent nurses providing spiritual care (Govier, 2000; Corner, 2002). Although there were examples of presence in students' practice, there was also evidence of the above constraints on students' ability to provide this facet of spiritual care.

7:2 The Purpose of Spiritual Conversations was to convey Reassurance of Worth

What did students try to convey to patients during conversations of a spiritual nature? A few participants stated that they tried to point out to patients the positive things in their lives and, similarly, others offered reassurance to patients that in they had done the best they could in life:

RG4 (J): *I think I've tried to be positive with them. Try and point out things, positive things to them. In the way if they've got some positive prognosis, things are going to get better. But sometimes they're not going to get better but yes, positive things about their relationships maybe with other people.*

Another student suggested that there are circumstances when terminally ill patients might have a spiritual need for a sense of closure on their lives:

RG4 (L): I think that spiritual needs [tape inaudible] a sense of completion. ... they know that they're going to die but they want to make sure that everything's done that needs to be done and I think if you can help in any way. I mean there's things that you're not going to be able to. Things like wills and bank details but if you can make sure things are in place and give them reassurance that they've done the best that they can and that, you know, people will be taken care of when they're not there to do it for themselves then that's, like, that's helping them along the way because it almost like a, as I said to you earlier, you know, I've achieved what I wanted to.

However several participants indicated that they struggled to find the right words:

RG1 (L) I still find it quite hard - like sitting with someone when they're dying. I think as X said it's like knowing what to say. I just think it's quite hard sometimes.

Facilitator: So would you identify that as needs of your own?

RG1 (L): Yeah, I think it is nice if their family is there. But obviously if you're sitting there with them until the family comes, you know, em, I just think it's better to know what's appropriate to say and things like - it can be quite hard sometimes. But I suppose it's nice for the patient to know there is like someone there with them.

Students found it particularly difficult to know what to say when they didn't know the patient very well:

RG1 (Dy): ...It's the same thing you come across sometimes if you don't know them that well... If you feel a bit more comfortable with someone then it's OK to sit in silence.

RG4 (J)*: That I'm able to cope if people are expressing a, that kind of spiritual need to me? No I don't, I don't feel very confident about it. But I think, you know, like I say, you only know a person for a couple of days perhaps, and sometimes I think I've got the answers but, I mean, how can you, how can you even provide the answer for someone after a lifetime. When you've only known them for a few days it's very difficult.*

RG4 (A) I think it's important to spend time talking to folk. Sometimes that's all they do need is just to talk to somebody. Or sometimes maybe, just, they want to cry to you or you want to cry with them. Or they want you to take their hand or give them a hug or they even want to laugh with you or have a joke with you. Some people, just, that's the way they want to deal with things they want to have a laugh and a joke and talk about other kinds of things. And I think as long as you're

there. I think everybody's got it within them to be able to do that at some point. It's just that realising that you are able to do that. I think some people that look good at it, it's just because maybe they just feel more comfortable in communicating in different ways with people and that's why they appear to be more but I think everybody somewhere in them has got some way of communicating at some level with somebody that's going to give them some kind of spiritual care.

Students were very uncomfortable in the role of judge or priest and this may explain their hesitancy to enter into the arena of exploring with patients their spiritual needs. This may result in a tendency to avoid the negative and simply glide over these areas of someone's life. The tendency to attempt to 'jolly patients along' when nurses feel ill-equipped to delve deeply with a patient's spiritual concerns is understandable but patients may have a real need for a sense of meaning, restoration, forgiveness or even reconciliation.

Not everyone is able to talk about the existential questions that form part of 'spiritual language' but it is important to prepare nurses to recognise that patients may need to explore these areas - if not with them then with someone who can.

Summary

- In order to initiate and engage in spiritual conversations it was necessary to be a confident and able communicator. This included being able to pick up on cues from patients including when to be silent and being sufficiently confident to open up spiritual conversations with patients and their families.
- It was necessary to have both the opportunity to talk to patients and the willingness to get to know patients for spiritual conversations to take place. Participants could find it difficult to know what to say especially when they didn't know the patient well.

- The family were a source of information and education about patients' religious and spiritual needs and ought to be consulted about spiritual care provision.
- Students' intent during spiritual conversations was to convey reassurance to patients of their personal worth and the value of their life achievements.
- It was thought that spiritual conversations could help patients make sense of, or find meaning in, their experience of ill-health. Conversations could provide a turning point for patients, for example, from despair to hope.
- The ability to perceive others as worse off than themselves motivated some participants to a greater appreciation of their own lives and enhanced care for others.
- Moving on from times of suffering can lead to a more fulfilling life and possibly a sense of awakening. This sense of fulfilment may be accompanied by guilt at another person's misfortune.

In this chapter I have highlighted some key concepts students used in their language about spiritual care bearing in mind the aims of the study. Two key findings were discussed. The first was that being a confident and able communicator was an essential attribute for the spiritual carer. The second was that within these conversations the intent of students was to affirm the worth of patients. These key findings help to address Aim 4 of the study as they describe the personal abilities that students thought they required in order to provide spiritual care. In the next chapter, the focus of the findings and discussion will be on the theme, 'Telling Spiritual Stories: biographical and autobiographical accounts'

8. Findings and Discussion Part 3: Telling Spiritual Stories: Biographical and Autobiographical Accounts

AH4 *He would tell me stories about his life*

As discussed in the preceding chapter, so much of spiritual care depends on being able to communicate with others. Speck et al (2004) suggest that patients value spiritual care from nurses that includes not just listening and talking but sharing experiences with patients. This chapter is an exploration of the shared experiences that students recounted.

In this study participants were asked to discuss spiritually significant accounts or events either through the medium of reflective group interviews or through reflective journals so an explicit attempt was being made to capture what they considered to be spiritually significant in terms of their personal experiences.

Participants explored spirituality, spiritual events and spiritual care largely through the medium of storytelling, either about their own experiences in the form of autobiographical accounts or by telling patients' stories by means of biographical accounts. This was such a powerful means of discussing spiritual events that it constituted a substantive theme in itself.

Analysing these stories according to the constant comparative method revealed interesting codes and enabled categories to be formed from the data. This, according to Holloway and Wheeler (2002), is a perfectly legitimate means of analysing narrations. However I felt that, at times it would have been possible to gain additional insight into students' understandings of these experiences were analytical procedures less reductionist thereby permitting their stories to remain more intact. Nonetheless open and axial coding of data was

undoubtedly revealing in terms of generating comparative analysis of all the data. One of the criticisms directed at the constant comparative method of analysis (indeed qualitative analysis in general) is that if one compresses data too much, the very point of maintaining the integrity of narrative materials during the analysis phase becomes lost (Polit and Hungler, 2006). In so doing a general picture acquired from all the participants may be the result and the uniqueness of each participant's contribution diminishes. In order to ameliorate this effect, in this chapter in addition to discussing the emergent categories arising through constant comparison, two of the participants' journal stories have been explored more holistically.

I found the data from the reflective journals least suited to constant comparative analysis largely due to the completeness of the stories told, the structure of which consisted of a beginning, middle and end and each part was integral to the others. My reluctance to 'intrude' on such data by editing these stories through 'cutting,' sequencing and so on (Cohen et al, 2000) was due to recognising that in editing the stories, some of the meaning could be lost - the sum of the whole story being greater than the parts. Therefore the two stories from the students' reflective journals have been subjected to a lighter editorial touch.

However as indicated above these spiritual stories were analysed using the constant comparative method. Reading the data from the reflective group interviews (5) and the reflective journals (7) stimulated questions such as: What were the key characteristics of the stories that student told? And what were the feelings and actions of the protagonists? Asking such questions of the data during the initial stage of coding resulted in the identification of codes or concepts from key texts. This process is illustrated in table 6. The right hand column signifies coded texts with the corresponding categories in the left hand column. In keeping with the procedures for constant comparison each section of the data was compared with all other sections for

similarities, differences and connections and sorted, or reassembled, in the form of groups of concepts or categories. As table 6 indicates the constant comparative analysis revealed 11 categories which were grouped together to form the theme, 'Telling spiritual stories: Biographical and autobiographical accounts'.

Table 6: Categories for theme: Telling spiritual stories: Biographical and autobiographical accounts

Sequence	Categories	Reflective Journals	Reflective Groups	Coded Text
Accounts 1	Patients tell nurses their stories.	M1, 2, 3 AH1,2,3,4	RG4 (A) RG2 (K) (Mat) RG3 (R) RG4 (J+L) RG5 (M+T)	'you are the person that person is probably going to ask because you are about the closest' RG4 (A) 'he would tell me stories about his life' AH4
Accounts 2	Stories are told within a stranger relationship		RG4 (J) RG3 (R)	'they share them with, well, we basically we're strangers' RG4 (J)
Accounts 3	Spiritual experiences are remembered	M1,2	RG4 (L) RG5 (M)	'I haven't forgotten about it' RG4 (L)
Accounts 4	Patients share their spiritual lives with nurses in times of deep physical and/or emotional crises		RG4 (J) RG2 (K) RG2 (P) RG5 (C)	'only at times of stress do they share them' RG4 (J) 'she was very distraught' RG2 (K)
Accounts 5	Students' lives may be touched by patients	M1,2	RG3 (K) RG4 (L) RG5 (M)	'certainly it made a difference to me' RG3 (K) 'I think that they can touch your life though as well' RG4 (L)
Accounts 6	Spiritual care has long term outcomes for patients	M2	RG4 (A) RG5 (T)	'if your spiritual needs are met that will have a knock on effect for years on people' RG4 (A)
Accounts 7	Spiritual care requires a holistic gaze	AH2	RG5 (M) RG4 (L)	'looking at the big picture and looking at what's going on in the patient's life' RG5 (M)
Accounts 8	Reflecting back on the meaning of life		RG4 (J) RG5 (C)	'Life's got an end and so you can look back and sort of add things up.' RG4 (J)
Accounts 9	The spiritual needs of staff are unrecognised	M2,3	RG5 (M)	'You don't mind them take, take, taking all the time, but you *do*' RG5 (M)
Accounts	Staff don't report		RG2 (P)	'I don't know whether she had raised it with anyone

10	patients' spiritual needs to each other		RG5 (M)	else' RG5 (C)
Accounts	Students able to share own life changing events	M1,2,3,	RG3 (R + K + S) RG4 (L + A) RG2 (P + Mat) RG1 (A + Nor + L) RG5 (M + T +C)	

These categories have been synthesised to highlight significant concepts students used when telling their stories about spiritual experiences and care.

The key features of spiritual stories will be explored in terms of how they illustrate the understandings that students held about spirituality and spiritual care thus addressing Aim 3. In addition the spiritual stories revealed the presence of certain personal characteristics within spiritual experiences thereby also informing Aim 4.

8:1 Key Features of Spiritual Experiences.

One of the features apparent in those stories was that patients' disclosures arose from the nurse's close proximity to the patient. Quite simply the nurse had to be sufficiently close in order for the patient to confide about spiritual matters. Another feature that was present in those stories was that the patients involved were distressed at the time:

RG4 (A*) You are the person that person is probably going to ask because you are about the closest.*

RG2 (K) *She was very distraught*

RG4 (J) *I mean people have spiritual needs all the time but so often only at times of stress do they share them with - well we - basically we're strangers aren't we?*

Therefore contextual features of the stories participants told included the patient's distressed state and the nurse's closeness to the patient.

Participants considered these stories to be memorable situations that touched their own lives. Further these spiritual experiences could hold life-changing significance for both themselves and their patients:

RG4 (L) I haven't forgotten about it

RG3 (K) *You could say that was her spiritual needs, you know, how I responded. But certainly it made a difference to me I think.*

RG4 (L) *I think that they can touch your life though as well. They can do something for you and it might have been just that they can pick up that you have a need and they might say something to you that can be*

just what you're looking for. So I think that can be another study (laughs)

RG4 (A) *I think, sometimes as well, I think that if your spiritual needs are met that will have a knock on effect for years on people.*

Meeting a person's spiritual need was characterised as having significance for the person in that it was remembered and had long-term benefits for individuals. As the above quotes illustrate the stories could contain an element of symbiosis in that both the patient and the participant benefited in terms of their well-being. This feature of spiritual care is explored more fully in chapter 6.

Another key feature present in the stories was that participants engaged with patients from within a holistic framework. For it to be possible to meet someone's spiritual needs there had to be a shift in the focus of care from one kind of nursing knowledge that is, the physical, to include other kinds of knowledge such as the ethical, the personal, the aesthetic and the social. One participant described this facility as:

RG5 (M) '...it's looking at a situation and looking at the big picture and looking at what's going on in that patient's life. Looking at what's going on and knowing what's going on amongst their family and things as well. It's not just like when you look at a wound and you know, 'Oh, right, put that product on and that product on and it will be fine.' ... it's knowing what to say and when to say it. ... It's a whole load of things, ...and your own life experience as well, I feel too.'

The features of spiritual stories discussed above such as remembering, the nurse being present for the distressed patient, the long term effects of meeting a person's spiritual needs, and symbiosis can be illustrated and confirmed through the journal accounts.

The following story incorporates these features and relates also the shift that nurses have to make from one form of knowledge to another in an effort to provide holistic care. This participant shifted the focus of her care to the spiritual and emotional as she came to know the patient's own story and the parallels in her own. She starts by explaining where she first came to learn of the poem, 'In Flanders Fields', by John McCrae when on holiday, aged 11 years, in Belgium with her family. Her parents took her and her brother on a day trip to Flanders and Ypres:

AH4 'As part of the trip, we visited a museum of war in the centre of Ypres. There were many remnants of war, bits and pieces found on the battlefields, which I had vague interest in, and then, in the centre of one room, the poem 'In Flanders Fields'. I remember reading through it with my mum at my side, explaining its significance. I found it just so sad. The second verse made me want to cry, even at eleven years old. From then, it has always stuck in my head.

As I grew older, I came across the poem again and again, mainly through my English and History classes at high school. When I was about 14, I was a member of St Andrews Ambulance Association, and every November I took part in Hamilton's remembrance service. The poem was read out at every service, seemingly more poignant every time.

After leaving school I didn't really encounter the poem again until, in my last community placement, when I encountered an elderly male patient. He lived on his own and had no family. His living room was full to the brim of various antiques and bric-a-brac. I visited him regularly and each time I went he would tell me stories about his life. Towards the end of my placement I noticed various medals on the wall. When I asked him about them, he began to tell me of his times in the war, showing me a scar on his arm where he had been hit by shrapnel. He had an old scrap book of various cuttings and pictures to

do with the great war, when we came across a handwritten version of the poem. I told him how much the poem had always moved me, and he became very tearful, saying how much it had always meant to him, and how lucky he felt to have been spared during the war. He said he had lost many of his friends, and he felt this poem helped him to deal with his feelings about them and his losses.

After a good cup of tea and a blether, I left the house, feeling that I had helped him by sharing an interest with him and listening to his feelings. The next time I returned, he was happy to see me, and told me the day I left he had prayed to God and thanked him once again for sparing him so he could experience life.

The above illustrates how time seems to affirm what people consider to be spiritually significant to them. What is meaningful to a person can be nurtured through reflection, further experience and the willingness to express the sense of the spiritual to others. In the above story, both participant and patient held individual memories surrounding the poem 'In Flanders Fields' but it was their willingness to share them that enriched their lives in the present through their relationship. The student was clearly interested in the patient as a person and sought ways to connect with him and she 'struck gold' when she found their mutual interest in the poem. This story illustrates the lengths that nurses go to in an effort to establish what Morse (1991) refers to as a connected relationship. In a connected relationship the nurse views the patient as a person first and foremost and secondly as a patient. Further in this kind of relationship the patient trusts the nurse's judgement, believes that the nurse has gone the 'extra mile' and feels grateful for her care. The relationship is mutual in that the nurse believes that her care has made a difference to the patient. In the account above the participant was a young woman and the patient an elderly man and so it was unlikely that they would have many common interests beyond their professional relationship. However it is important to note that without the student's holistic view

of the patient and a genuine interest in him as person and what was important to him in life, spiritual care would not have taken place.

8:2 Spiritual Practices as a form of Therapeutic Healing

Spiritual experiences and spiritual care were rarely discussed in participants' professional lives. This silence surrounding the noumenal is discussed in more detail in the next chapter. However the silence that surrounds spiritual experience does not necessarily mean that participants do not engage in spiritual practices as a method of nursing care. As the following account illustrates this participant considered that her spiritual beliefs, expressed through her religious beliefs not only gave meaning to her personal life but that she had come to an understanding of how these beliefs might provide enhanced meaning to her nursing care. In her reflective journal she describes a situation in which she used her personal faith as a means of providing spiritual care for another. A patient was dying and, as a second year student, she was asked to sit with the patient until her son could get to the hospital. The student described how she 'felt helpless' and that it was this feeling that caused her to pray for the patient:

AH2 One morning while on this ward, myself and another nurse found one of our female patients in an unresponsive state. Before I knew it, there seemed to be a whole team of medical staff in the ward performing CPR and using emergency treatment on this frail, elderly lady. After she regained consciousness and her cardiac problems were more stable, the doctors were doubtful whether this lady would survive this traumatic event.

The patient was then moved into a side room and her son had been called to come and spend some time with his mum.

AH2 I was told by another nurse that it would be a while before the son arrived so I was asked to sit with the lady. The doctors had decided that no further treatment should be given to this patient as her

condition was extremely poor – can't remember the exact situation whether the son had been informed and agreed to this – not sure.

As I sat with the lady on my own, I remember feeling scared and anxious at the thought that I could be the one sitting with her when she died. I recall watching and counting her respirations and sat holding her hand and feeling for a pulse at the same time. The patient was in an extremely poor condition and I really felt helpless.

It was this feeling that led me to bring this situation before God and while I was sitting there with the patient, I prayed for her and asked that God would be watching over her and that her son would arrive in time to spend some time with his mum. ...

My Christian faith has been an essential part of my 3 years, so far, in nursing and I think that this situation was one of the first times I had realised the importance of it. ...

A positive experience which resulted from this experience was that I came to appreciate God's help in my work life as well as other aspects of my life that I had already known him in.'

The student was drawing on her personal spiritual resources – a belief in the Christian god and the power of prayer because she felt helpless and there were no other resources open to her at that time. But the story moved on to another dimension as the student considered the effect of her prayer and the answer to it, on the patient:

AH2 After a while, I was relieved by another nurse and I was asked [to] go for a break. I couldn't think of anything else all tea break, and when I returned to the ward and went to see how the patient was, it came as a surprise to me to find this same lady, who had been so

lifeless just half an hour before, sitting up in her bed with her son by her side.
I can't remember much about the lady's recovery, but the difference in that space of time was amazing – and there's no doubt in my mind that God took over in that situation.

A significant feature of this story is that neither the patient nor her son, or other staff ever knew of the student's experience as she kept her own counsel. It may be that the student was reluctant to pass on this information knowing that her interpretation of events could be challenged by other interpretations and so her silence was perhaps a way of protecting her experience - and herself. The fear that others may not value the experience and perhaps judge the student pejoratively could result in a reluctance to disclose spiritual experiences in a professional context. This is an area which requires further exploration. As the reflective journals were more revealing of participants' spiritual experiences than the group interviews and the participants willingness for self disclosure more pronounced it may be that a similar approach to data collection would be revealing in further study.

In the account cited above, the participant was describing the transferability of her personal belief system to her professional life. This raises the question as to whether educators could, and should, be seeking ways of encouraging students to relate their personal beliefs to patient care, even, as in the case under discussion, a belief in miracles. Certainly self-awareness is viewed as an essential attribute for nurses to develop if they are to understand others and, for example, beliefs and values clarification exercises are considered helpful ways of promoting this self-awareness (Burnard, 1990). More precisely, Narayanasamy (1999: 276) promotes self-awareness because it can provide an avenue for exploring spiritual awareness:

'Through self-awareness nurses could be helped to explore their own spiritual dimensions whereby they could reflect on their own beliefs and values, sources of love, hope and strength, meaning and purpose'

Now it may well be the case that self-awareness helps students understand the values and beliefs of others and indeed that self-awareness can help students explore their own spiritual dimension - which in turn may help them understand the spirituality of others. However the implications of nurses using their spirituality (which includes their personal beliefs and values) as a means of practice must be considered. For example, would all patients or relatives feel comfortable when nurses prayed for them if the nurses subscribed to a different belief system? Does it make it a less thorny issue if the patient is unaware of the nurse's actions, as in the above illustration? After all, in that situation there was no opportunity for the patient to consent to spiritual care. Arguably in the face of a miracle many would be more than content with the prayers of a nurse whatever her religion but some may not wish spiritual care from outwith their own belief system.

So what if it were decided that nurses should not use their beliefs in the sense of providing therapeutic spiritual care but that spiritual therapy should be left to those who hold professional spiritual care roles such as chaplains or religious leaders? And even if it was considered better for patients that nurses did not engage in spiritual care, could such a nursing role be prevented? Having argued in the literature review that spirituality is an individual, universal, human characteristic essential to the provision of holistic care it hardly seems to be in either nurses' or patients' interests to require of nurses that they ignore their own spirituality when providing care for others. If spirituality is the means by which a person achieves a sense of integrity it could well be harmful to expect nurses to ignore their spirituality when assuming a professional role. As MacLaren (2004) argues the spirituality of nurses is equally as important as the

spirituality of patients and both nurses and patients ought to be free to practise their spirituality. MacLaren (2004) considers that it is problematic, if not impossible, for nurses to provide spiritual care when nurses' personal beliefs differ strongly to those of the patient. If this is the case then it might be suggested that nurses should only practise their spirituality with those whose spiritual beliefs are similar to their own. However this is quite impractical particularly in a multi-cultural society whereby nurses encounter a great deal of diversity and differences in terms of beliefs and values. But this is an important point because it may account for the silence that surrounds spiritual care in professional practice and the hesitancy of some nurses to engage in spiritual care.

If both patients and nurses have a right to spiritual freedom it seems that, in the context of the nurse-patient relationship, both patients and professionals must move beyond hyper-individualism (even in this most subjective of areas) and find a means of respecting one another's spirituality that acknowledges the personal and collective responsibilities of spirituality care.

There is always the possibility that some unscrupulous or ignorant nurse might practice spiritual care in ways that could be detrimental to patients perhaps by foisting her own beliefs and practices on the patient or practising in an unethical manner. This suggests that spiritual care cannot be taught or practised without the concomitant teaching and practise of ethical care or, to express this differently, spirituality and spiritual care have of necessity an ethical dimension. Ethical principles such as informed consent and respect for persons (thereby protecting a patient's autonomy), as well as fairness, beneficence, non-maleficence (so for instance, it would be wrong to pray malevolently) would hopefully restrain those who wished to impose their personal beliefs on another.

spirituality of patients and both nurses and patients ought to be free to practise their spirituality. MacLaren (2004) considers that it is problematic, if not impossible, for nurses to provide spiritual care when nurses' personal beliefs differ strongly to those of the patient. If this is the case then it might be suggested that nurses should only practise their spirituality with those whose spiritual beliefs are similar to their own. However this is quite impractical particularly in a multi-cultural society whereby nurses encounter a great deal of diversity and differences in terms of beliefs and values. But this is an important point because it may account for the silence that surrounds spiritual care in professional practice and the hesitancy of some nurses to engage in spiritual care.

If both patients and nurses have a right to spiritual freedom it seems that, in the context of the nurse-patient relationship, both patients and professionals must move beyond hyper-individualism (even in this most subjective of areas) and find a means of respecting one another's spirituality that acknowledges the personal and collective responsibilities of spirituality care.

There is always the possibility that some unscrupulous or ignorant nurse might practice spiritual care in ways that could be detrimental to patients perhaps by foisting her own beliefs and practices on the patient or practising in an unethical manner. This suggests that spiritual care cannot be taught or practised without the concomitant teaching and practise of ethical care or, to express this differently, spirituality and spiritual care have of necessity an ethical dimension. Ethical principles such as informed consent and respect for persons (thereby protecting a patient's autonomy), as well as fairness, beneficence, non-maleficence (so for instance, it would be wrong to pray malevolently) would hopefully restrain those who wished to impose their personal beliefs on another.

8:3 The Spiritual Needs of Staff

The hidden nature of spirituality has an impact on the staff too in that the spiritual needs of staff often go unrecognised:

RG5 (M): I know that, like now, we're all kind of focusing or centering our spiritual care on patients and relatives but I know that in my ward myself sometimes you need spiritual care for you staff as well. Sometimes that's a big need. You need to give it there too. ...

Facilitator: Do you think it's important to have time out? Do you think that's important for nurses?

RG5 (T): To recharge your batteries.

RG5 (M): Aye. There is sometimes you just feel as if you're - people are just take, take take. You don't mind them take, take, taking all the time, but you do

Unlike many of the participants who were either about to become registered nurses or who had recently qualified, this participant was a ward sister who held responsibility for other staff as well as patients. The above statement indicated that there were times when she was so burdened by the concerns of others that felt she had nothing left to give. The spiritual needs of staff working in health care have only recently been recognised. Such needs are no longer the province of religious organisations as most people have little contact with such organisations. Responsibility for supporting staff, patients and carers has shifted from the religious to the secular. Thus, the guidance document on Spiritual Care in NHS Scotland issued by the Scottish Executive (2002), requires of NHS boards that they develop and implement a spiritual care policy. These policies must take cognisance of the spiritual care needs of staff as well as patients and carers.

Interestingly although participants recounted stories which included the bleaker side to human experience such as suffering, pain, violence, facing death and grief, there were no examples of stories which did not contain at least a glimmer of the triumph of the human spirit. However it could be that students felt they were not being asked for such negativity and this needs to be explored in a further study.

Summary

- The journal entries proved to be particularly rich sources of spiritual stories perhaps because participants felt able to describe spiritually significant events more freely through this medium. The journal also offered participants the opportunity to re-draft their stories so journal entry stories tended to be more structured and comprehensive than those that arose from the group interviews.
- Spiritual experiences were valued by students as memorable events that touched their own lives which may hold life-changing significance for themselves and patients.
- Key features of spiritual stories included remembering, the nurse being present for the distressed patient, the long term effect of meeting a person's spiritual needs, and transference or symbiosis of spiritual significance.
- For spiritual care to take place the nurse has a genuine interest in the patient as a person and what is important in his life. This requires a connected relationship with the patient and a holistic approach to care.
- Spiritual experiences and spiritual care were rarely discussed in participants' professional lives. However spiritual care was sometimes being practised discretely in a therapeutic way. There is a need for further research to investigate the extent and reasons for nurses' reluctance to share spiritual experiences and spiritual care.
- There is a need to investigate the extent to which the different beliefs of patients and nurses can affect spiritual expression and care.
- The spiritual needs of staff were identified.

- One of the difficulties with the constant comparative method was the feeling that it tended to provide a unifying view of experience and this could be at the expense of the uniqueness of the storyteller's tale. It is important to find ways of analysing spiritual stories that creates a means of attending to them that helps preserve their uniqueness and completeness.

In this chapter I have examined the key features of the spiritual stories that students told, including the experiences of the participants as the protagonists in these stories. In the following chapter I turn to discussing the participants' experiences of learning about spirituality and spiritual care.

9. Findings and Discussion Part 4: Learning about Spiritual Care.

In chapters 6-8 I explored the findings from the case study as they relate to aims 3 and 4. This exploration revealed insights into students' understandings of spirituality and spiritual care. It also produced an account of some of the personal abilities that participants thought they required in order to produce spiritual care. These understandings of the phenomenon under investigation were gained by analysing the interview and journal data although the NGT also provided a means of accessing these understandings at a more surface level. So the deep analysis of the phenomenon was undertaken through the process of constant comparison of the qualitative data generated from both the reflective group interviews (5) and the reflective journals (7).

In relation to the subject of this chapter, 'Learning about spirituality and spiritual care', the reflective group interviews continued to provide relevant and rich data while data from the journals was less significant. However the students' evaluation questionnaires (SEQ) were pertinent to understanding students' learning experiences. Therefore in addition to examining the findings from the constant comparative method of analysis, the findings from the SEQ will be discussed in section 9.2.

In this chapter I will address Aims 1 and 2 by examining whether students considered their understandings of spirituality and spiritual care had developed, if at all, as a result of participating in the short course. During the reflective group interviews, students were asked 2 questions pertinent to their learning experiences. Do you think that this short course on spirituality has, or, will help you to meet your own spiritual needs? Do you think that this short course on spirituality will help you to provide spiritual care to others?

The open or initial stage of coding resulted in the identification of codes or concepts from key texts. This process is illustrated in table 7. As described in previous chapters, the right hand column signifies coded texts with the corresponding categories in the left hand column. In keeping with the procedures for constant comparison each section of the data was compared with all other sections for similarities, differences and connections and sorted, or reassembled, in the form of groups of concepts or categories. As table 7 indicates the constant comparative analysis revealed 11 categories which were grouped together to form the major category or theme, 'Learning about spirituality and spiritual care'.

Table 7: Categories for Theme 4: Learning about spirituality and spiritual care

Sequence	Category	Reflective Journal	Reflective Group	Coded Text
Learning 1	Greater understanding of the concept spirituality		RG1 (K) RG2 (Mat) RG5 (C)	'You don't actually know what it means and I think today it's kind of altered it a wee bit' RG1 (K)
Learning 2	Spirituality is not just about religion	M1	RG4 (F) RG1 (K) RG2 (P) RG2 (Mat) RG3 (R)	'before I always thought spirituality was to do with religion but I can see how after today it's not only that' RG4 (F) 'I would automatically have thought before that spirituality would be religion' RG1 (K) 'I thought it was all about respecting people's religion ...' RG3 (R)
Learning 3	More aware when on the wards'		RG4 (R) RG3 (S) RG1 (G)	'But I think you now have more of a wider awareness' RG4 (R) 'there are wee things, simple things that you can do' RG3 (S)
Learning 4	Don't know enough about religious practices.		RG3 (Mol) RG1 (L) RG3 (R)	'as long as I knew exactly what to do and I wasn't doing anything wrong' RG3 (Mol) 'but if you've not got a proper understanding of why people won't take blood and things like that' RG1 (L) 'would you like us to do

				more here?' RG3 (R)
Learning 5	Feeling of letting the patient down	M3	RG5(C)	'my inability to state the patient's wishes more persuasively led to feelings of guilt' M3 'And I feel as if I've kind of let her down' RG5 (C)
Learning 6	Staff don't report patients' spiritual needs to each other		RG5 (C) RG2 (P)	'I wondered if she had managed to speak to somebody else in those days' RG5 (C) 'I don't know whether she had raised it with anyone else' RG2 (P)
Learning 7	Differences in beliefs can effect spiritual care		RG3 (K) RG1 (Nor)	'she was quite staunchly in the opposite direction... she actively she said refused to go' RG3 (K)
Learning 8	Learned from other students' experiences		RG2 (K) RG1 (K) RG1 (G)	'I can think of patients who have had that situation but I just wouldn't have thought of it in that sense' RG2 (K) 'I can identify with that' RG1 (K) 'you'll be kind of looking out for it now' RG1 (G)
Learning 9	Spiritual development is a personal journey of self awareness	M1 AH2, 3	RG2 (Mat) RG2 (P)	'it's more a journey yourself' RG2 (Mat) 'Knowing what makes you happy and things that will lift your spirit' RG2 (P)
Learning 10	Theory to practice: the gap of sufficient experience		RG4 (A) RG1 (K) RG2 (Mat) RG1 (G)	'we can only get better at that the more experience we do have' RG4 (A) 'I find it hard to make the change from actually reading it into doing it' RG1 (K) it definitely takes a lot of situations like that before you really know how to deal with it' RG2 (Mat)
Learning 11	The course encouraged students to reflect		RG2 (K) RG4 (L) RG5 (C)	'if I could go back and do it again, I'd probably do it differently' RG2 (K) 'I'll go home and I'll reflect upon the way I treat other people RG4 (L) 'it's just like this little bit of hope' RG4 (L)

Discussion of this theme is structured under three headings. Firstly, students' understanding of what they had learned during the course and the gaps that remain in their knowledge; secondly, their opinions about how the teaching methods had enabled learning; and finally, the developmental nature of learning about spirituality and learning to give spiritual care will be highlighted.

9:1 What Students considered they had Learned from the Course

Students felt that the course had enabled them to explore what spirituality and spiritual care meant. One student elaborated on how difficult she found it to understand concepts and felt that the course had given her the opportunity to gain some understanding of the concept of spirituality:

RG1 (K): I think you hear the, well for me, personally, you hear the word spirituality and stuff like that. It's like a buzz word. It's like you hear it but you don't actually know what it means and I think today it's kind of altered it a wee bit. Because it's like, holistic care and all that kind of stuff - and it's all written down. Sometimes I find it hard to make the change from actually reading it into actually doing it and knowing that you're doing it.

Concepts are generally considered to be about the meaning of a word or term. According to the Concise Routledge Encyclopaedia of Philosophy (2000: 159) 'concepts are often thought to be the meanings of words...' As in all learning, some students will grasp the meaning of particular concepts more readily than others but if students are to relate theory to practice it is essential that they have learned the meaning underpinning concepts (such as holism and spirituality) that are commonly used to depict nursing. The Fontana Dictionary of Modern Thought (1988: 159) clarifies this point well: '...people can share concepts (indeed they must do so if they are to communicate), but the items of their mental furniture are distinct and proprietary to each of them. To possess a concept, then, is not to own some easily identifiable article but to be able to do something, specifically to recognise instances of the concept in question ...'. Now, as discussed in earlier chapters, one of the difficulties inherent in learning about the concept of spirituality (along with other concepts) is that it has many

different meanings and individuals provide different interpretations. Nonetheless as the above definitions illustrate, if students do not develop their conceptual understanding of spirituality they will not be able to recognise the variety of interpretations of the concept as it is revealed in practice.

One reason why people have difficulty in conceptualising spirituality is that the qualities which are intrinsic to it are qualities of art rather than qualities associated with science. Qualities such as transcendence, mystery, hope, empathy, peace, beauty, are intuitive rather than empirical in nature. They do not fit well in a culture of evidence-based practice and they are extremely hard to uncover and explore in practice. And yet these qualities are essential facets of how people make sense of their world and therefore should be taken seriously when people face the challenge of ill-health.

For many students, their conceptual understanding of spirituality was fairly limited when they first started the course. For them spirituality simply meant religion and the two terms had been regarded as synonymous prior to the course:

RG4 (F) *Before I always thought spirituality was to do with religion but I can see how after today it's not only that.*

RG1 (K)... *I would automatically have thought before that spirituality would be religion. I just put the two together and today it has opened it up a bit wider.*

Some said that they had learned to move their interpretation of spiritual needs as well as spirituality beyond religious matters and described having learned to have a much wider interpretation of spiritual needs:

RG4 (R)*: I think you now have more of a wider awareness of what they actually are rather than thinking oh well it's all about religion. Because that to me was what I thought, looking at them, well we're looking at spiritual needs today. I was like oh it will be religion. But I think now you know it's a lot wider than that and there's a lot more to it than just sort of praying.*

RG3 (S): But now that I know that, though, it's, there are wee things, simple things that you can do. You can be in a ward and just like even plait someone's hair, they feel better about it.

RG3 (R)*: See, I would never have put that down as being a spiritual need as uplifting somebody, like, as in making someone feel better. I thought it was all about, like, you know respecting people's religion and all that kind of stuff.*

Some students had learned that spiritual care could be about a nurse's comportment, the way that she cared for people rather than carrying out specific spiritual or religious procedures. Hudson and Rumbold (2003: 85) concur with this when they state that 'The quality of the relationship is the key to spiritual care'. Bradshaw (1994) too believes that spiritual care is embodied in the nurse's manner of care exemplified in her respect for the patient's dignity and conduct within the nurse-patient relationship.

Although students took on board the idea that spirituality is wider than religious beliefs and practices they also felt that their lack of knowledge about religions was detrimental to their understanding of the spirituality of patients who practiced a faith. One of the students who had been involved in the care of a patient who was a Jehovah's Witness argued that a proper understanding of the beliefs of that religion would have helped her understand the patient's decision:

RG1 (L): If you were in that religion then you'd probably understand it a lot better but if you've not got a proper understanding of why people won't take blood and things like that, then it's quite hard to stand by and watch them not take treatment for their illness.

RG1 Facilitator: So have you not actually covered religious beliefs yet or?

RG1 (L): We haven't really covered it.

Another group were asked by the facilitator if they would feel comfortable participating in the practice of last rites:

RG3 Facilitator: Would you all feel comfortable doing something like that even if you're not religious?

RG3 (Mol): Probably as long as I knew exactly what to do and I wasn't doing anything wrong.

At the time of the data collection phase of the study there was no provision in the university for teaching about religious practices in the nursing curriculum and its inclusion is one of the recommendations arising from this study. In the same vein, not knowing about the meanings underpinning religious practices can inhibit ability to provide spiritual care. For example, one student described how family members would carry out detailed religious observances in private for an elderly terminally ill patient. In their absence the nursing staff did not participate in these although the student wondered if this was a deficit in their care:

RG3 (R)... you respect their religion and all the rest of it. But a lot of people don't know why they're doing that. And you know, like the holy water and stuff. We didn't know like, 'Do you want us to do anything

with it or is it just something for you to have? And is it a family thing that you want to do?' We just left it...but then they never said to us either. But then we didn't know.

RG3 Facilitator: Do you think on reflection that maybe someone should have asked?

RG3 (R): Yes. Maybe said to them 'Oh you see that sitting there'. Like they had statues and paintings and stuff up on the wall as well. You know, obviously, yes, maybe somebody should have said to them, would you like us to do more here?

Lack of knowledge, then, about religious beliefs and practices led to silence with patients and their families on the subject of religious practices. However there could be more complex reasons for participants' reluctance to speak about religious and spiritual care. Hay and Hunt (2000) identified a general shyness about admitting to spiritual experiences amongst those surveyed. Although their survey revealed that admitting to spiritual experiences is much more likely in the year 2000 than 1987 the shyness with which people broach the subject remains. Hay and Hunt (2000) make some suggestions as to why more people felt able to tell of their spiritual experiences in recent years. These include the desire to move away from the disappointment of the materialism of the 1980s and the possibility that there is more social permission today for the public admission of what was until recently something too intimate or embarrassing to be shared. However in relation to the study described in this dissertation while it was the case that participants were forthcoming in their discussions about spirituality in the classroom it was also evident from some of the data that there was a silence surrounding the subject in the health care institutions in which they practised. As the findings from this study reveal, students certainly had what they perceived to be

spiritual experiences in the clinical setting but they did not seem to discuss them with their colleagues.

9.1.1 Different contexts: the academic and the clinical environments

On the whole students were willing to discuss spirituality and spiritual care in the classroom. This willingness to talk of spiritual matters was not reflected in their experiences in practice. However I am conscious that this is a small qualitative study and this finding is tentative indeed and may apply only to those whose voices were heard in this investigation. Further study within a wider context and larger sample may shed light onto issues relating to reticence and willingness to speak of spiritual matters. Nonetheless in this study participants did not report informing other staff if patients had spiritual concerns. It appeared that on identifying such a need they felt it appropriate to keep it private. There were perhaps worthy reasons such as patient confidentiality but this meant that they didn't know if the patient had sought spiritual support from another staff member or indeed if the patient's spiritual needs had been addressed. For example one of the qualified nurses recounted a night duty in which a patient who knew she had a life-threatening illness asked to speak to her prior to theatre the following day. The nurse was busy and had postponed the talk:

RG5 (C)...But when I went back she was sleeping so I had just left her...And by the time I went in the next night, - because I only do two nights - she had actually died. And I was really upset at that because I thought, what does she want to speak to me about? - because she never actually said. And, I think it was she wanted a proper talk. She didn't just want to ask me about her tablets or something. She wanted to talk to me. And I felt that I had really let her down and I wondered if she had managed to speak to somebody else in those days and

because it was very sudden her death. No-one expected it. And I feel as if I've kind of let her down.

The study presently under discussion took place in a particular cultural context and the significance of this context cannot go unmentioned. Sectarianism in the form of Protestants' and Roman Catholics' intolerance for one another has a long history in the west of Scotland and I would suggest that the fear of stirring up any feelings of religious antagonism among staff or patients presents yet another reason for being silent about spiritual matters.

In the following conversation between participants it is interesting to note that they disapproved of sectarianism in the sense that they thought that nurses should be willing to attend to religious practices that fell outside their own belief system. However as illustrated in the following account, it would appear that sectarianism does seem to feature in clinical practice. In the context of her reflective group, one participant criticised a Protestant member of staff who had refused to attend the Roman Catholic religious ceremony of the last rites. The situation arose in a nursing home run according to Roman Catholic precepts:

RG3 (K):... If that was your shift then you went to the last rights. You had no choice, that was just what was expected of you.

RG3 (S): And if you were there you went, kind of thing, yeah?

RG3 (K): The girl that I actually worked with she was quite staunchly in the opposite direction. And she, I mean, I would actually go as far as to say was like, 'bitter orange'. Like screamingly. I better not go into it - I don't claim to be any sort of church goer or anything like that but she was very, you know, went all the way sort of - her

husband did all the orange marches and things like that. And she actively she said refused to go which I think...

RG3 (R): If you take on a job in a place called 'XXXX' she could hardly expect anything other than

RG3 (K): Well that's the way I felt. I thought 'Well, if you're happy enough to take the pay...

RG3 (K): So she wouldn't go to church if they died. I mean she was a good friend of mine and she would not she wouldn't go. She was waiting outside the church at my father's funeral and went to the entertainment so to speak afterwards. And see like a christening we went to, she wouldn't go to church and then went to the entertainment.

The language used in the above transcript shows the strength of feelings about religious affiliations in certain sectors of Scottish culture. It would appear that while students spoke in positive terms in the classroom about supporting patients from other faiths and denominations, this accommodation may be much more difficult to achieve in practice. To some extent this is not surprising as it is one thing to value something and quite another to act according to that value. But it did raise some questions for me as a teacher. As discussed in the literature review Caldwell (1997) stresses that the development of curricula cannot be viewed in isolation from the socio-political context within which it exists. Glossing over the problem didn't seem an option. Should I announce my own religious upbringing in the interests of an honest teacher-student relationship? So far one of the steps I have taken is to employ the help of a colleague whose religious background is different to my own and who can, where appropriate, suggest her own perspective in these difficult matters. Another way of tackling the socio-political context has been to take classes of students to art exhibits and religious centres. This

inevitably leads to discussions of tolerance and intolerance within a multi-cultural but local context.

9:2 How Students learned and the efficacy of the Teaching and Learning Methods

Students stated that they learned from other students' voicing their experiences of spiritual care. This helped them to reflect on their own experiences of patients' needs and re-examine them in relation to what they had learned about spiritual needs. In a sense, then, students were re-framing their experiences within what they had learned from the course about spirituality and spiritual care:

RG2 (K): *I think all of the ideas that got flagged up this morning. A lot of them, I wouldn't have thought of, but now I can see that they are issues. I can put them to patients now but I wouldn't have thought of them as being, you know, a spiritual need at the time.*

In this section, data from the Student Evaluation Questionnaire (SEQ) will be referenced to support students' views of their learning experience of the course. Comments from the SEQs were collated according to the criteria laid out in the student evaluation questionnaire, that is, each teaching session was evaluated by students for positive and negative learning experiences. Students were also given the opportunity to suggest improvements to the course. Extracts from the SEQ which are pertinent to the findings and discussion in this chapter are included in table 8. Appendix 10 provides a full table of collated comments.

Table 8. Extracts from the SEQ

Nominal Group Techniques

- Able to bounce ideas off one another and felt that by discussing you would have a better understanding
- Lots of different perspectives, ideas, thoughts which maybe differed from your own
- Gave students knowledge and understanding of what spiritual needs are
- Was able to learn from fellow class members. My knowledge was very limited and all the issues flagged up were all relevant and very significant issues.
- The session was very thought-provoking and opened my mind to different aspects of spiritual needs. I think this was due to the 'brain-storming' nature of it.
- Unsure of what spirituality actually meant therefore unsure of what to say
- Bit of a big group for people to go in depth about the spiritual needs they nominate
- Some people didn't feel comfortable sharing with the whole class

The Audio tape

- V appropriate, inspiring
- Allowed active listening, think about different ideas, perspectives - an ongoing reflection
- I found it hard to concentrate on as it was a bit too long
- We ran a bit short on time for discussion
- Video-tape - easier to imagine the situation

The Reflective Group Interview

- Very beneficial to share and reflect on similar experiences with others
- Good to hear different perspectives
- Sharing experiences with my friends is very helpful. You can always learn something and perhaps be made to feel better about a weakness you find common.
- Confidential and private small groups
- Let you know you had learned something that you could use for yourself as well as patients and families
- This made me more aware of my practice concerning spirituality and I will be more aware of the spiritual needs of patients in the future
- Made me reflect on the way I care for patients
- Taping made me apprehensive about talking

The lecture

- Gave good grounding of meaning and background to spirituality
- This gave us a theoretical background to the issues which were raised in the morning

The above extracts from the (SEQ) support the view that students learned about spirituality and spiritual care from one another and the teaching methods facilitated this.

The NGT was thought to introduce students to different ideas about spiritual needs as illustrated in comments about learning from the nominal group technique:

- Able to bounce ideas off one another and felt that by discussing you would have a better understanding
- Lots of different perspectives, ideas, thoughts which maybe differed from your own
- Gave students knowledge and understanding of what spiritual needs are
- Was able to learn from fellow class members. My knowledge was very limited and all the issues flagged up were all relevant and very significant issues
- The session was very thought-provoking and opened my mind to different aspects of spiritual needs. I think this was due to the 'brain-storming' nature of it

Similar ideas about the value of learning from others were expressed in relation to the RGI:

Very beneficial to share and reflect on similar experiences with others

- Good to hear different perspectives
- Sharing experiences with my friends is very helpful. You can always learn something and perhaps be made to feel better about a weakness you find common

With the exception of the lecture all of the teaching methods used were designed to encourage an appreciation of others' experiences. The NGT, listening and discussing the audio-tape 'Spoonface Steinberg', and the reflective groups were all aimed at stimulating interaction with other people within the classroom. The purpose of these sessions was to help students identify and develop their own personal and professional understandings of spirituality and spiritual

care as well as an appreciation of the ideas of others. Students commented on how the NGT and the RGI were particularly useful in advancing their own understanding of spirituality and spiritual care by way of providing a forum for discussing various interpretations of the concept. Also by sharing their experiences with one another, they could appreciate the affirmation that those with similar experiences could bring. At the same time listening to those who recounted different experiences to them expanded their understanding of the concept and their appreciation of spiritual care in practice.

There were comments in the SEQ returns that the lecture provided useful theory about spirituality and spiritual care. Further comments indicated that this knowledge may be of use in future personal and professional lives indicating that what they had learned in the classroom could have value to practice. For example, evaluative comments on the last session of the course the RGI included:

- Let you know you had learned something that you could use for yourself as well as patients and families
- This made me more aware of my practice concerning spirituality and I will be more aware of the spiritual needs of patients in the future
- Made me reflect on the way I care for patients

The practical arrangements of some of the teaching methods were criticised by students in that time restricted some of the discussion. Student feedback from the SEQ indicated that this was particularly problematic with the large year 3 group of undergraduate students. To counteract this problem, since the study and where possible, I have enlisted the help of other lecturers for large groups when teaching this subject.

The tape 'Spoonface Steinberg' was considered on the long side for some students and yet others found it inspirational. The suggestion that a video might be preferable to an audio tape has since been acted

on and this has proved worthwhile although time restrictions remain a consideration. Students found participating in the RGIs particularly useful in that all the groups were small and confidential thereby encouraging the sharing and learning of one another's experiences. There were however a few comments about feeling apprehensive about talking during the RGI because the session was taped. Some commented that they would have appreciated the classes earlier on in their course and others suggested that their hesitancy in participating in the NGT was due to feeling uncomfortable in discussing spiritual matters with the whole class and difficulty in understanding the concept in the first place. Brainstorming has since become the teaching method of choice for the first session with large classes although the NGT remains the method of choice with smaller groups or when I have a colleague's assistance.

9.3 The Developmental Nature of learning to become Spiritually Aware

Spiritual awareness was recognised by participants as a developmental process:

RG2 (P): I think it's a continuum. Experience. I think just as you go on. I've become a totally different person now than I was when I started this course. And likewise going maybe 5 years from that I was a different person, just continually change. I've made more mistakes! Knowing what makes you happy and things that will lift your spirit when you need your spirit lifted.

Learning about spiritual care was difficult to relate to practice and some participants agreed that it would take considerable experience of spiritual care situations before they felt proficient:

RG4 (A) we can only get better at that the more experience we have.

In keeping with some comments from the SEQ, another suggested that teaching spiritual care earlier on in the programme would enhance awareness of spiritual matters when in clinical practice:

RG1 (G) *if it was maybe introduced earlier on maybe in the first year you'd be more aware of it.*

Other participants concurred with the view that learning about spirituality and spiritual care was a developmental process, a personal journey through which they tested the value of different belief systems for themselves. Just as participants believed that they chose their own spiritual path, there was recognition that patients too had the right to make that choice.

Reflection was an effective method of learning. Students were not only able to reflect on their personal and professional experiences of spiritual situations and care one participant commented on how the course encouraged her to reflect further:

RG4 (L) Whereas now I think I'll go home and I'll reflect upon the way I treat other people and the way that I would like to be treated by them in a spiritual sense. And I think my faith and my spirituality have been strengthened by today...
I think on a personal level I've come away, especially after the 'Spoonface Steinberg' tape. I come away and this might sound strange but just listening to it, you come away and you just think 'It just like this little bit of hope' and it's the hardest thing to try and explain to you. But just, like, coming out of the room you just thought... Well I don't know, it's hard for me to explain it. But it was going to be, it was this feeling that it was going to be OK. And I can't explain it to you.

Summary

- A wider understanding of spirituality was perceived as a result of the course. This included the view that spirituality was not expressed solely through religion.
- The idea of comportment was apparent in participants' learning in that spiritual care was thought to be grounded in the nurse-patient relationship and practiced through acts which helped patients feel uplifted.
- Students learned about spirituality and spiritual care in the classroom as a result of the course and the teaching methods were appropriate to students' learning needs.
- There seems to be a reluctance to discuss spiritual and religious matters in practice and this needs to be investigated further.
- A lack of religious knowledge was a deficit which, if addressed, would enhance understanding of patients' spiritual needs and beliefs.

- Understanding one's own spirituality and learning to provide spiritual care are both developmental processes which expand through experience.

10. Conclusions and Recommendations

This is a small-scale qualitative case study bounded by participants' experiences of a short course within a particular context. As such there is no guarantee that, were the study conducted in a different context with different people, the data collected and conclusions drawn would match. Nonetheless in this dissertation I have clearly laid out the reasons for the educational and research processes which have led to the trustworthiness of these conclusions and recommendations. Further in chapters 5-9 the findings arising from this study were, where possible, supported by theoretical positions from other literature and so it is feasible to maintain that the findings from this study have a wider import in terms of theory if not populations. In this study data were collected in several different ways from four different participating groups. The research was conducted rigorously and fulfilled Stake's (1995) essential purpose for case study, that is, I maximised what could be learned.

This study was furnished with specific aims designed to answer two pressing questions: Was it possible to learn about spirituality and spiritual care in the classroom? What understandings, if any, did students have of spirituality? These questions represented a knowledge deficit in nurse education and generated the impetus for the study.

10.1 Conclusions from the Study

The major conclusions in respect of the aims of this study are:

1. It is possible to learn about spirituality and spiritual care in the classroom.

2. The short course was sensitive to the learning needs of nursing students at different stages of their educational and professional development. In particular students valued teaching methods which encouraged them to reflect on spiritual matters and share their ideas and experiences with one another as they furthered their understanding of spirituality and spiritual care.

3. Ideas about spirituality and spiritual needs were evident in students' thinking and experiences. There were common understandings among the variety of ideas expressed about spiritual needs and their importance one to another.

4. Providing spiritual care was challenging for students.

This study contributes to the kind of nursing knowledge Carper (1978) describes as personal and aesthetic. This type of knowledge is difficult to define, investigate, teach and learn. And yet if we are to offer students an education, we need to attend to what they believe, think and value. Until the conduct of this study little was known of the efficacy of teaching spiritual care in the classroom as only one evaluation account had been published (Bush 1999). This study presents evidence to support the view that spiritual care can be taught in the classroom and need not be left solely to the haphazard nature of 'catching' it from a role model on placement.

10.1.1 Further conclusions relating to Aims 1 and 2

Students signified that they had learned to have a wider understanding of spirituality as a result of the short course. This included gaining an understanding of spirituality that was not solely expressed through religion and that spiritual care could be practised through caring acts which helped patients feel uplifted. Students identified gaps in their learning about spirituality and spiritual care. Some considered that their lack of religious knowledge was a deficit as it led to a lack of confidence in providing spiritual care for those who practised a religious faith. Student evaluation of the course indicated that more classroom time was required for discussion of spiritual matters. There was also a desire to have spiritual education earlier in their programme of study.

10.1.2 Further conclusions relating to Aims 3 and 4

The study revealed that students held beliefs, values and attitudes in relation to spirituality and spiritual care. Spiritual care was thought challenging because it was difficult to find appropriate answers to existential and spiritual questions. Spirituality was considered individually expressed although family and friends were believed to play an active part in the spiritual support of both participants and patients. Ethical principles were evident in discussions about spiritual care and respect for persons and religious freedom were valued. However respect for people who did not share the same value system as students could result in dissonance and conflict. Conflict was also evident when students' personal beliefs, such as faith in a good god or medical science, were challenged by the suffering of others.

Students identified several personal abilities as necessary for spiritual care. Compassionate comportment was identified as a characteristic of

spiritual experiences and the intention underpinning spiritual conversations was to affirm the worth of a patient.

The facility to make relationships with patients and their families was necessary for spiritual and religious conversations. Relationships that enabled spiritual care required students to be willing and able to get to know patients, to view patients holistically and to be confident and able communicators. Able communication was extended to family members who were perceived to be an important source of information and education about patients' spiritual and religious care. There were some surprising findings from this study. These relate to the effect that spiritual experiences had on the students themselves. Several students described spiritual experiences as memorable events that touched their own lives and could hold life-changing significance for both themselves and patients. There were reports of finding meaning in their own lives and motivation to care for others through a spiritually emergent experience and the idea of transference or symbiosis was apparent in several journal accounts and interview data. The idea that both the person caring and the person being cared for are influenced by a spiritual experience is not unique to this study (Price et al., 1995; Hoover, 2002). However as I had not come across this idea in my professional practice until this study (and reading for it) I must confess to surprise at finding it in my 'own backyard'. Transformative experiences could have significant personal and professional import in terms of job satisfaction in that they promote nurses sense of self-worth and increase their motivation to care. As such they are worthy of further study.

A further surprising finding, also to do with the relationship of spiritual matters to motivation, concerns the times when participants compared their own privileged health status to others less fortunate than themselves. Such comparisons motivated students to care for others and to lead a personally more fulfilling life but it also led to guilt at their own prosperity in contrast to the suffering of others. This

conflict of interests could lead to supererogation of nurses on the one hand or contribute to staff burnout on the other. It does suggest that supervision or spiritual care would be of value to staff. Again an area worthy of further investigation

10.2 Recommendations for Educational Practice

An early response to some of the recommendations arising from this study has already taken place. In order to provide students with the education necessary to meet the challenge of spiritual care I designed 2 modules in the field, one at level 3 and another at level 4. They were validated in 2004, have run twice and are responsive to the student evaluations from this study. Content includes an introduction to 3 major world religions, and the spiritual aspects of care are blended with significant ethical principles and emotional concerns. Student numbers are 'capped' at 50 to facilitate small discussion groups, visits to religious centres and museums, and experiential learning methods. Reflection is encouraged throughout the module and students produce reflective accounts similar to the reflective journals analysed in the study. Like those in the study, these can be deeply meaningful to individuals. While clinical supervision is unavailable (and probably inappropriate in an educational institution), each student is allocated to a personal tutor for the duration of the module should support be required.

The provision of spiritual education requires teachers who are versed in both content and methods of teaching. While I have several colleagues involved in the course who are accomplished teachers it takes time to develop subject knowledge. Thus another recommendation would be for the institution to facilitate staff development in this area.

It has not yet been possible to respond to the suggestion from students that teaching takes place at an earlier point in their course of study but it is a future possibility and recommendation.

10.3 Limitations of the Study and Recommendations for Further Research

One of the limitations of the study arose because of its small scale. The SEQ response rate of 61% from students meant that evaluation of the course was limited to those who completed the evaluation form and those who discussed their learning in the group interviews. It left questions about the learning experiences of those students who did not contribute to the evaluation. Thus there is ample scope for further evaluative research, perhaps an action research study designed to specifically capture the learning experiences of more students in an effort to enhance the student experience. With strong student numbers in the modules now running in spiritual care this should be possible in the near future.

In terms of evaluating spiritual education, the collective case study could be usefully employed to investigate the efficacy of spiritual education for nursing students' learning in other cultures perhaps in other parts of the UK or even internationally. This would facilitate comparisons both within and across cases and provide answers about how nursing students in different cultures experience spirituality and learning about spiritual care.

Having discovered that it is possible to learn about spirituality and spiritual care in the classroom, the next step would be to find out if spiritual education affected spiritual care and if so in what ways. One of the tentative findings from this study was that while students were willing to discuss spiritual matters in the classroom they seemed reluctant to do so in practice. While participant accounts revealed that spiritual care was taking place in practice, it was conducted discretely and students did not appear to share this with their colleagues. If spiritual care is a legitimate aspect of nursing work as considered by the NMC (2004) and the Scottish Executive (2002) then it is necessary

to explore reasons for nurses' reluctance to share therapeutic spiritual care with colleagues. This would require a study more in keeping with a longitudinal perspective preferably including patients as well as students and their colleagues. Such a study would be qualitative in design and seek individual accounts of receiving and giving spiritual care with negative cases actively sought for comparison. These qualitative accounts could be subject to narrative analysis, both in terms of their content and structure. This would address my concern that using the constant comparative method of analysis tended to produce a unifying view of participants' experiences which could be at the expense of the individual storyteller's contribution. In the case of individual accounts it would be possible to enhance the validity of the study through member checking in relation to researcher interpretation rather than, as in the present study, member checking for accuracy of data. Although not without its problems, full member checking in this most subjective and personal of investigative areas extends beyond courtesy and accuracy and could help to present a more accurate picture of what participants mean.

10.4 Professional and Academic Development

In professional terms this study has led to new ways of working both across professions and with other institutions. For example one of my tasks in the last 3 years was to act as consultant to the Health Care Chaplaincy Training and Development Unit in the academic accreditation of their pastoral care courses. My own institution too has recognised the value of my work and I am the project leader for the development of a Centre for Spiritual and Pastoral Care Studies. During the course of this study I have benefited in terms of my academic development. Firstly my interest in spiritual matters has been renewed and like my students I now have a much wider view of what constitutes the spiritual dimension and spiritual care. I have learned a great deal from my constant literature searching and from my students whose insights and willingness to share them with me and one another have been a constant inspiration throughout the study.

I have learned a great deal too about research methodology and methods and experienced the highs and lows of conducting an exacting investigation. In a sense this study has served as an apprenticeship to the practice of research and I now feel prepared and able to contribute to professional knowledge about spiritual education.

References

Aldridge, D. (2000) *Spirituality, Healing and Medicine: return to the silence.* London: Jessica Kingsley Publishers

Ashworth, P. and Morrison, P. (1991). Problems of competence based nurse education. *Nurse Education Today,* 11, 256-260.

Atkins, S. and Murphy, K. (1993). Reflection: A review of the literature. *Journal of Advanced Nursing*, 18, 1188-1192.

Baldacchino, D. and Draper, P. (2001). Spiritual coping strategies: A review of the nursing research literature. *Journal of Advanced Nursing*, 34(6), 833-841

Bash, A. (2004) Spirituality: the emperor's new clothes? *Journal of Clinical Nursing* 13(1) 11-16

Bassey, M. (1999). *Case study research in educational settings.* Buckingham: Open University Press.

Beckingham, C. R. (1982) Science, the humanities, nursing research and nursing practice. *International Nursing Review* 29, Mar-Apr, 41-45

Bell, D (1976) *The coming of post-industrial society.* Harmondsworth: Penguin

Benner, P. & Wrubel, J. (1989). *The primacy of caring: Stress and coping in health and illness.* Menlo Park, California: Addison-Wesley.

Bevis, E. O., & Murray, J. P. (1990). The essence of the curriculum revolution: Emancipatory teaching. *Journal of Nursing Education*, 29(7), 326-331.

Bradshaw, A. (1996). The legacy of nightingale. *Nursing Times*, 92(6), 42-43.

Bradshaw, A. (1997). Teaching spiritual care to nurses: An alternative approach. *International Journal of Palliative Nursing*, 3(1), 51-57.

Brierley, P. (ed) (2000) *Religious Trends* 1999/2000. Carlisle: Paternoster Publishing

Burnard, P. (1993). Giving spiritual care. *Journal of Community Nursing*, 6(10), 16-18.

Burns, N., & Grove, S. K. (2001). *The practice of nursing research : Conduct, critique, and utilization* (4th ed.). Philadelphia: W. B. Saunders.

Burns, R. B. (2000). *Introduction to research methods* (4th ed.). London: Sage.

Burton, A. J. (2000) Reflection: nursing's practice and education panacea? *Journal of Advanced Nursing* 31 (5) 1009-1017

Bush, T. (1999). Journalling and the teaching of spirituality. *Nurse Education Today*, 19(1), 20-28.

Caldwell, K. (1997). Ideological influences on curriculum development in nurse education. *Nurse Education Today*, 17(2), 140-144.

Callister, L. C., Matsumura, G., Bond, A. E., & Mangum, S. (2004). Threading spirituality throughout nursing education. *Holistic Nursing Practice,* 18(3), 160.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 13-23.

Carper, B. A. (1992). Philosophical inquiry in nursing: An application. In Kikuchi, J. F. and Simmons, H. (Ed.), *Philosophic inquiry in nursing* (pp. 71-80). London: Sage.

Cavendish, R., Luise, B. K., Russo, D., & Mitzeliotis, C. (2004). Spiritual perspectives of nurses in the united states relevant for education and practice / commentaries / response. *Western Journal of Nursing Research,* 26(2), 196.

Cawley, N. (1997). Towards defining spirituality. an exploration of the concept of spirituality. *International Journal of Palliative Nursing*, 3, 31-36

Chapman, H. (1999). Some important limitations of competency-based education with respect to nurse education: An Australian perspective. *Nurse Education Today*, 19(2), 129-135.

Chinn, P. L. and Watson, J. (1992). *Art and aesthetics in nursing*. New York: National League for Nursing.

Chuengsatiansup, K. (2003). Spirituality and health: An initial proposal to incorporate spiritual health in health impact assessment. *Environmental Impact Assessment Review*, 23, 3-15.

Cicero, Marcus Tullius (1928) *De Re Publica* London: William Heinemann (Loeb Classical Library) Translated by Clinton Walker Keyes. BK 6, Ch. 24

Cohen, L., Manion, L., & Morrison, K. (2000). *Research methods in education* (5th ed.). London: RoutledgeFalmer.

Coyle, J. (2002). Spirituality and health: Towards a framework for exploring the relationship between spirituality and health. *Journal of Advanced Nursing,* 37(6), 589-597.

Crossan, F. (2003). Research philosophy: Towards an understanding. *Nurse Researcher*, 11(1), 46-55.

Darbyshire, P. (1994). Reality bites... the theory and practice of nursing narratives. *Nursing Times*, 90(40), 31-33.

Data Protection Act 1998: Chapter 29; HMSO.

Delbecq, A. L., van de Ven, A. H., & Gustafson, D. H. (1975) *Group techniques for programme planning: a guide to nominal group and Delphi processes.* Glenview, Ill.: Scott, Foresman

Denzin, N. K., & Lincoln, Y. S. (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks: Sage Publications.

Draper, P., & McSherry, W. (2002). A critical view of spirituality and spiritual assessment. *Journal of Advanced Nursing*, 39(1), 1-2.

Duchscher, J. E. B. (2000). Bending a habit: Critical social theory as a framework for humanistic nursing education. *Nurse Education Today*, 20(6), 453-462.

Easterby-Smith, M. (1997). *Management research: An introduction.* London: Sage.

Emblen, J. D. & Halstead, L. (1993) Spiritual needs and interventions: comparing the views of patients, nurses and chaplains. *Clinical Nurse Specialist* 7: 175-182

Eraut, M. (1994). *Developing professional knowledge and competence.* London: Falmer Press.

Flick, U. (2002). *An introduction to qualitative research* (2nd ed.). London: Thousand Oaks, Calif.: Sage.

Fonteyn, M. E. & Cahill, M. (1998) The use of clinical logs to improve nursing students' metacognition: a pilot study. *Journal of Advanced Nursing* 28 (1) 149-154

Fry, A. (1998). Spirituality, communication and mental health nursing: The tacit interdiction. *Austalian and New Zealand Journal of Mental Health Nursing, 7*, 25-32

Gaydos, H. L. (2005). Understanding personal narratives: An approach to practice. *Journal of Advanced Nursing*, 49(3), 254-259.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Pub. Co.

Glen, S. (1995). Developing critical thinking in higher education. *Nurse Education Today*, 15(3), 170-176.

Govier, I. (2000) Spiritual Care in Nursing: A systematic approach *Nursing Standard* 14: 32-36

Green, J. (1998). Qualitative research and evidence based medicine. *British Medical Journal*, 316(4), 1230-1232.

Greenstreet, W. M. (1999). Teaching spirituality in nursing: A literature review. *Nurse Education Today*, 19(8), 649-658.

Grindle, N. C., & & Dallat, J. (2001). Northern ireland - state of the arts? an evaluation of the arts in teaching caring. *Nurse Education Today*, 21(3), 189-196.

Guba, E. and Lincoln,Y. (1989). Fourth generation evaluation. London: Sage.

Hall, Lee (1997) *Spoonface Steinberg*. One of four plays known as God's Country. [radio broadcast]. BBC Radio 4. 27 Jan, dir. Kate Rowland

Hammersley, M. (1993). *Social research : Philosophy, politics and practice.* London: Sage Publications; Open University Press.

Hand, H. (2003). The mentor's tale: A reflexive account of semi-structured interviews. *Nurse Researcher*, 10(3), 15-27.

Harrington, A. (1995). Spiritual care: What does it mean to RNs? *Australian Journal of Advanced Nursing*, 12(4), 5-14.

Harrison, J & Burnard, P. (1993). *Spirituality and nursing practice.* Aldershot: Avebury.

Harrison, T. (1992). Creativity in nurse education. *British Journal of Nursing*, 1(15), 774-777.

Hasegawa, H., Reilly, D., Mercer, S. W. Bikker, A. P. (2005) Holism in Primary Care: the views of Scotland's general practitioners. *Primary Health Care Research and Development* 6 (4) 320-328

Hass, A. (1996). In *the shadow of the holocaust: The second generation.* Cambridge: Cambridge University Press.

Hay, D. and Heald, G. (1987). Religion is good for you. *New Society*, 80. 17 Apr, 20-22

Hay, D. & Hunt, K. (2000). *Understanding the spirituality of people who don't go to church.* research report. Nottingham: University of Nottingham.

Haydon, G. (1987) Introduction In: *Education and Values The Richard Peters Lectures, delivered at the Institute of Education, University of London, Spring term, 1985.* London: Institute of Education, University of London, 1987.

Heaven, C. M., & Maguire, P. (1997). Disclosure of concerns by hospice patients and their identification by nurses. *Palliative Medicine*, 11(4), 283-290.

HMSO (1983) *The Nurses, Midwives and Health Visitors Act 1979. Statutory Instruments* 1983 668 C.20 London: HMSO

Holloway, I., & Wheeler, S. (2002). *Qualitative research in nursing* (2nd ed.). Oxford: Blackwell Science.

van Hooft, S. (1995). *Caring: An essay in the philosophy of ethics.* Colorado: University Press of Colorado.

van Hooft, S. (1999). Acting from the virtue of caring in nursing. *Nursing Ethics*, 6(3), 189-201.

Hoover, J. (2002). The personal and professional impact of undertaking an educational module on human caring. *Journal of Advanced Nursing*, 37(1), 79-86.

Hudson, R. & Rumbold, B. (2003) Spiritual Care. In O'Conner, M. & Aranda, S. (eds) (2003) *Palliative Care Nursing: A guide to practice* Melbourne: Ausmed publications 69-86

Jacobs-Kramer, M. Chinn, P. (1988). Perspectives on knowing: A model of nursing knowledge. *Scholarly Enquiry for Nursing Practice*, 2(2), 129-139.

Jasper, M. A. (1999) Nurses' perceptions of the value of written reflection. *Nurse Education Today* 19, 452-463

Jones, C., & Lyons, C. (2004). Case study: Design? method? or comprehensive strategy? *Nurse Researcher*, 11(3), 70-76.

Kellehear, A. (2000). Spirituality and palliative care: A model of needs. *Palliative Medicine*, 14(2), 149-155.

Kelly, B. (1992). Professional ethics as perceived by American nursing undergraduates... senior baccalaureate nursing students. *Journal of Advanced Nursing*, 17(1), 10-15.

Kemmis, S. (1980). The imagination of the case and the invention of the study. In H. Simons (Ed.), *Towards a science of the singular: Essays about case study in educational research and evaluation* (pp. 96-142). Norwich: University of East Anglia.

Kemmis, S. & McTaggart, R. (eds) (1988) *The Action Research Planner* 3rd ed Geelong, Victoria, Australia: Deakin University Press

Kirk, G. (1982). *Curriculum and assessment in the Scottish secondary school. A study of the Munn and Dunning reports*. London: Ward Lock Educational.

Kitson, A. L. (2001). Does nursing education have a future? *Nurse Education Today*, 21(2), 86-96.

Knight, P. T. (2002). *Small-scale research. pragmatic inquiry in social science and the caring professions*. London: Sage.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. Oxford: Oxford University Press.

Kuuppelomaki, M. (2001). Spiritual support for terminally ill patients: Nursing staff assessments. *Journal of Clinical Nursing*, 10, 660-670.

Lafferty, P. (1997). Balancing the curriculum: Promoting aesthetic knowledge in nursing. *Nurse Education Today*, 17(4), 281-286.

Le Vasseur, J. (1999). Toward an understanding of art in nursing. *Advances in Nursing Science*, 21(4), 48-63.

Lewis, J. (2003) Design Issues in Ritchie, J. & Lewis, J. eds. (2003) *Qualitative Research Practice. A guide for Social Science Students and Researchers* London: Sage 47-76

Lincoln, Y. S. and Guba, E. G. (1985). *Naturalistic inquiry*. Beverley Hills, California: Sage.

Lyons, J. (1999). Reflective education for professional practice: Discovering knowledge from experience. *Nurse Education Today*, 19(1), 29-34.

MacDonald, B. (1974). Evaluation and the control of education. In MacDonald, B. and Walker, R. (Ed.), *Safari 1: Innovation, evaluation, research and the problem of control* (pp. 9-22). University of East Anglia: Centre for Applied Research in Education.

MacLaren, J. (2004) A kaleidoscope of understandings: spiritual nursing in a multi-faith society *Journal of Advanced Nursing* 45 (5), 457-464

van Maanen, H. (1990). Nursing in transition: An analysis of the state of the art in relation to the conditions of practice and society's expectations. *Journal of Advanced Nursing*, 15(8), 914-924.

Marks-Maran, D. (1999). Network. reconstructing nursing: Evidence, artistry and the curriculum... including commentary by Nyatanga L and Johnson M. *Nurse Education Today*, 19(1), 3-11.

Marland, G., & McSherry, W. (1998). The reflective diary: An aid to practice-based learning. *Nursing Standard*.1997 Dec 17-, 12(13-15), 49-52.

Martsolf, D. S. and Mickley, J. R. (1998) The Concept of Spirituality in Nursing Theories: Different World-Views and Extant Focus. *Journal of Advanced Nursing* 27, 294-303

McGilloway, O. and Myco, F. (1985). *Nursing and spiritual care.* London: Harper and Row.

McSherry, W. (2000). *Making sense of spirituality in nursing practice.* Edinburgh: Churchill Livingstone.

McSherry, W. (2000a). Education issues surrounding the teaching of spirituality. *Nursing Standard*, 14(42), 40-43.

McSherry, W. (1998). Nurses' perceptions of spirituality and spiritual care. *Nursing Standard*, 13(4), 36-40.

McSherry, W. (1997) *A Descriptive Survey of Nurses Perceptions of Spirituality and Spiritual Care.* Unpublished MPhil Thesis, The University of Hull, UK.

McSherry, W. (1996). Raising the spirits. *Nursing Times*, 92(3), 48-49.

McSherry, W., & Beech, C. (2005). Commentary on Bash A (2004) Spirituality: The emperor's new clothes? Journal of Clinical Nursing 13, 11-16... including author response. *Journal of Clinical Nursing*, 14(8), 1019-1025.

McSherry, W., Cash, K., & Ross, L. (2004). Meaning of spirituality: Implications for nursing practice. *Journal of Clinical Nursing*, 13(8), 934-941.

McSherry, W., & Draper, P. (1998). The debates emerging from the literature surrounding the concept of spirituality as applied to nursing. *Journal of Advanced Nursing*, 27(4), 683-691.

McSherry, W., & Ross, L. (2002). Dilemmas of spiritual assessment: Considerations for nursing practice. *Journal of Advanced Nursing*, 38(5), 479-488.

Miles, M. B. & Huberman, A. M. (1994) *Qualitative Data* Analysis (2 ed.) Thousand Oaks, CA.: Sage

Milligan, F. (1998). Defining and assessing competence: The distraction of outcomes and the importance of educational process. *Nurse Education Today*, 18(4), 273-280.

Moore, C. M. (1987). *Group techniques for idea building*. Newbury Park CA: Sage.

Morse, J. M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. Journal of Advanced Nursing, 16, 455-468.

Morse, J. M., & Field, P. *Nursing research: The application of qualitative approaches* (2nd ed.) Chapman and Hall.

Mulhall, A. (1997). Nursing research: Our world not theirs? *Journal of Advanced Nursing*, 25(5), 969-976.

Munn, J. (1977). The structure of the curriculum in the third and fourth year of the Scottish secondary school. Report of the consultative committee on the curriculum. Edinburgh: HMSO.

Murray, R. B. and Zentner, J. B. (1989). *Nursing concepts for health promotion.* London: Prentice Hall.

Narayanasamy, A. (1999). ASSET: A model for actioning spirituality and spiritual care education and training in nursing. *Nurse Education Today*, 19(4), 274-285.

Narayanasamy, A. (1993). Nurses' awareness and educational preparation in meeting their patients' spiritual needs. *Nurse Education Today*, 13(3), 196-201

Narayanasamy, A. (1991). *Spiritual care: A practical guide for nurses.* Lancaster: Quay Publishing.

Narayanasamy, A., & Owens, J. (2001). A critical incident study of nurses' responses to the spiritual needs of their patients. *Journal of Advanced Nursing*, 33(4), 446-455.

Nursing and Midwifery Council. (2004). *Standards of proficiency for pre-registration nursing education.* London: Nursing and Midwifery Council

Nursing and Midwifery Council. (2004a). *The NMC code of professional conduct: Standards for conduct, performance and ethics*. London: Nursing and midwifery council.

Otto, R. (1950) *The idea of the holy: An inquiry into the non-rational factor in the idea of the divine and its relation to the rational.* London: Oxford University Press.

Paloutzian, R. F. & Ellison, C. W. (1982) Loneliness, spiritual well-being and the quality of life. in Peplau, L. A & Perlman, D. eds. *Loneliness: A source book of current theory, research and therapy*. New York, Wiley and Sons 224-235

Paterson, B. L. (1995) Developing and maintaining reflection in clinical journals. *Nurse Education Today* 15, 211-220

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Newbury Park, Calif.: Sage Publications.

Pesut, B. (2003). Developing spirituality in the curriculum: Worldviews, intrapersonal connectedness, interpersonal connectedness. *Nursing Education Perspectives*, 24(6), 290-294.

Pesut, B. (2002). The development of nursing students' spirituality and spiritual care-giving. *Nurse Education Today*, 22(2), 128-135.

Polit, D. F., & Hungler, B. P. (2006) *Nursing research: Principles and methods* (6th ed.) Philadelphia: Lippincott

Porter, S. (1996). Qualitative research. In Cormack, D. F. S. (Ed.) *The Research Process in Nursing* (3rd ed.) 113-122. Oxford: Blackwell Science.

Proctor, S. (1998). Linking philosophy and method in the research process: The case for realism. *Nurse Researcher*, 5(4), 73-90.

Price, J. L., Stevens, H. & La Barre, M. C. Spiritual caregiving in nursing practice. *Journal of Psychosocial Nursing* 33, 5-9

Reinharz, S. (1992). *Feminist methods in social research*. New York: Oxford University Press.

Richards, L. (2005) *Handling Qualitative Data. A Practical Guide* London: Sage

Robb, A. J. P., & Murray, R. (1992). Medical humanities in nursing: Thought provoking? *Journal of Advanced Nursing*, 17(10), 1182-1187.

Robbins. (1963). *Higher education (report of the committee under the chairmanship of Lord Robbins*). London: HMSO.

Robson, C. (1993). *Real world research: A resource for social scientists and practitioner-researchers*. Oxford, UK: Blackwell.

Rolfe, G. (1998). *Expanding nursing knowledge: Understanding and researching your own practice*. Oxford: Butterworth-Heinemann.

Ross, L. (1997). The nurse's role in assessing and responding to patients' spiritual needs. *International Journal of Palliative Nursing*, 3(1), 37-42.

Ross, L. (1995). The spiritual dimension: Its importance to patients' health, well-being and quality of life and its implications for nursing practice. *International Journal of Nursing Studies*, 33(5), 457-468.

Rutty, J. E. (1998). The nature of philosophy of science, theory and knowledge relating to nursing and professionalism. *Journal of Advanced Nursing*, 28(2), 243-250.

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312(7023), 71-72.

Salsberry, P. J. (1992). Caring, virtue theory, and a foundation for nursing ethics... including commentary by Watson J. *Scholarly Inquiry for Nursing Practice,* 6(2), 155-67, 169-71.

Sandelowski, M. (2002). Visible humans, vanishing bodies and virtual nursing: Complications of life, presence, place, and identity. *Advanced in Nursing Science*, 24(3), 58-70.

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. *Image*, 23(3), 161-166.

Saunders, M. N. K., Lewis, P., & Thornhill, A. (2003). *Research methods for business students* (3rd ed.). London: Financial Times/Prentice Hall.

Sawatzky, R., & Pesut, B. (2005). Attributes of spiritual care in nursing practice. *Journal of Holistic Nursing*, 23(1), 19.

Scammell, J., & Miller, S. (1999). Back to basics: Exploring the conceptual basis of nursing. *Nurse Education Today*, 19(7), 570-577.

Scanlon, J. M., Care, W. D., & Udod, S. (2002) Unravelling the unknowns of reflection in classroom teaching *Journal of Advanced Nursing* 38 (2), 136-143

Schon, D. A. (1987). *Educating the reflective practitioner: Towards a new design for teaching and learning in the professions*. San Francisco, CA: Jossey-Bass.

Scott, P. A. (1995). Care, attention and imaginative identification in nursing practice. *Journal of Advanced Nursing*, 21(6), 1196-1200.

Scottish Executive Health Department. (2002). *Guidelines on chaplaincy and spiritual care in the NHS in Scotland*. (NHS HDL (2002) 76) Edinburgh: Scottish Executive.

Silverman, D. (2005). *Doing qualitative research* (2nd ed.). London: Sage.

Simons, H. (1987). *Getting to know schools in a democracy: The politics and process of evaluation*. Lewes: Falmer Press.

Smith, M. (1992). Is all knowing personal knowing? *Nursing Science Quarterly*, 5(1), 2-3.

Speck, P.., Higginson, I., Addington-Hall, J. (2004) Spiritual Needs in Health Care. *British Medical Journal* 329(7458) 123-124

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks: Sage Publications.

Stoll, R. I. (1979). Guidelines for spiritual assessment. *American Journal of Nursing*, 79(9), 1574-1577.

Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research : Grounded theory procedures and techniques*. Newbury Park, Calif.: Sage Publications.

Swinton, J. (2001). *Spirituality and mental health care: Rediscovering a 'forgotten' dimension*. London: Jessica Kingsley.

Tanyi, R. A. (2002). Towards clarification of the meaning of spirituality. *Journal of Advanced Nursing*, 39(5), 500-509.

Tuckett, A. G. (2005). Part II. Rigour in qualitative research: Complexities and solutions. *Nurse Researcher*, 13(1), 29-42.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1999). *Fitness for practice: The UKCC commission for nursing and midwifery education*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000 - a new preparation for practice.* London: UKCC.

Valiga, T. M. and Bruderle, E. R. (1997). *Using the arts and humanities to teach nursing. A creative approach.* New York: Springer Publishing.

Walter, T. (2002). Spirituality in palliative care: Opportunity or burden? *Palliative Medicine*, 16(2), 133-139.

Watson J. (1985). *Nursing: Human science and human care.* Norwalk, CT: Appleton Century-Crofts.

White, C., Woodfield, K. & Ritchie, J. (2003) Reporting and Presenting Qualitative Data in Ritchie, J. & Lewis, J. eds. (2003) *Qualitative Research Practice. A guide for Social Science Students and Researchers* London: Sage 287-320

Waugh, L. A. (1992). *Spiritual aspects of nursing: A descriptive study of nurses' perceptions.* Unpublished PhD thesis. Edinburgh: Queen Margaret College

Wilson, H. S. (1974). A case for humanities in professional nursing education. *Nursing Forum*, 13(4), 406-417.

Woods, L. (2003) Getting it right. *Nurse Researcher* 10 (3) 4-6

Woods, L. P. (1997). Designing and conducting case study research in nursing... including commentary by Jowett S. *NT Research*, 2(1), 48-58.

Woods, N. F., & Catanzaro, M. (1988). *Nursing research: Theory and practice.* St. Louis: Mosby.

World Health Organisation (1948) Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p.100) and entered into force on 7April 1948.

Wright. S. (1997). Freeing the spirit. *Nursing Times*, 93(17), 28-29.

Yin, R. K. (2003). *Case study research: Design and methods* (3rd ed.) Newbury Park, CA: Sage Publications.

Yin, R. K. (1994). *Case study research: Design and methods* (2nd. ed.). Newbury Park, CA: Sage Publications.

Appendix 1.

Overview of Lecture content

Title: Why learn about spirituality?

Point 1. ***Difficult to define***

Spirituality is a difficult dimension to define with precision and learning about spirituality is a deeply personal, sensitive and highly subjective area (Bradshaw, 1996; McSherry, 2000).

Although it is almost impossible to find any precise definition, Kellehear (2000) argues that a certain level of definition is possible and desirable - not in terms of capturing the spiritual essence of self but in describing the pattern of its desire and direction.

Point 2. ***Some reasons for being spiritual***

Spirituality - a response to suffering? What sense can we make of suffering? (Are there any benefits to be gained from suffering?). If it makes sense to suffer eg the pain of an injection is meaningful but contrast with chronic pain.

Eric Erikson remarked from his experience as a concentration camp doctor:

'Man is not destroyed by suffering but by suffering without meaning'

Kellehear's (2000:150) concept of spirituality is based on:

'the idea that human beings have a desire to transcend hardship and suffering. In other words, people need to seek and find meaning in situations beyond their current suffering that allows them to make sense of that situation. This transcendence may be achieved by searching for meaning in situations, moral or biographical contexts, and/or in one's inherited or chosen religious beliefs and ideas'.

So some would say that spirituality is about the sense or meaning that we make of our life and death (whether or not we believe in a life hereafter). Therefore spiritual beliefs may be very much tied up with this world and/or the world hereafter.

The beliefs or non-beliefs which a person holds may affect profoundly how he or she copes with universal life events like birth or death. For some, a religious dimension to their lives may be seen as an attempt to make sense of life and its significant events eg rights of passage - birth, baptism, coming of age, marriage, death.

Religious beliefs and practices may be aspects of spirituality but they are not the whole of someone's spirituality eg aesthetic appreciation.

What emotions/sensations might we consider to be part of our spirituality? (Awe, desire, peace, awakening.) Consider what it is like to be struck by the meaning of music. How do we *feel* and *express* this?

Spirituality may be viewed as an integral part of being human Bradshaw, 1996) and therefore an essential dimension of holistic care. McSherry and Draper (1998: 688) see spirituality as central to **holism**: *'a unifying force at the foundation of holistic philosophy'.*

Therefore spiritual care is part of the goal of holistic care.
If nurses are to provide holistic care that is sensitive to the spiritual dimension of patients then they must learn to do it themselves (Burnard, 1993).

Murray and Zentner's (1989: 259) definition of spirituality is used widely in texts:

'A quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in any god. The spiritual dimension tries to be in harmony with the universe and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death'.

Spirituality - described as **a personal search for meaning and purpose** - is common to both Murray and Zentner's (1989) and Kellahear's (2000) description of spirituality. It is possible to see an aesthetic dimension to Murray and Zentner's (1989) definition as people strive for inspiration and harmony.

Point 3: ***Spirituality is not synonymous with religion.***

Nowadays few authors would view spirituality as synonymous with religious belief and practices. This recognises that many agnostics and atheists do not express their spirituality in terms of religion. Indeed the spirituality of religious people is not solely revealed through their religion.

'From a nursing point of view, spiritual care would be relatively straightforward if it were confined to religious practice. There is a certain security in formality. However, spiritual activity can never be restricted to mere religious practice, nor can spiritual need be fulfilled successfully in a scientific, planned way.'
(McGilloway and Myco, 1985: 139))

In what way(s) are nurses trying to help people meet their spiritual needs?

The starting premise is that each individual has a spiritual dimension, with certain values and beliefs that are unique.

'Spiritual care involves valuing individuals for themselves, each person having his or her own values and beliefs with the absolute right to be an individual needing affirmation of the person they are, and acceptance of their personal views and attitudes to life.' (Stoter, 1995: 159)

Point 4: Some existential questions

Spiritual care may introduce difficult questions which have few answers.

Questions such as:

Why? Why me?

What have I done?

Is there life after death?

Is there a God - is so what is He like?

Other expressions may be heard such as

I've done nothing worthwhile with my life

Who will remember me when I've gone?

It is important to remember that the patient may not wish to enter any relationship other than the professional one.

However for those who do the patient may express his or her more hidden thoughts and emotions.
eg the patient's impending death - what it may be like to die and be dead, the fear of the unknown.

The importance of confidentiality - the personal revelations of the patient are seldom meant to be common knowledge.

Point 5: Why should nurses learn about spiritual care?

There is a professional recognition that spiritual care is part of the work of nursing.

The latest UKCC requirements for pre-registration nursing programmes identifies spirituality as a competency necessary for entry to the register: *'Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities' (UKCC 2001: 13).*

Furthermore, newly qualified nurses must be able to:
'Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences' (UKCC 2001: 17).

Therefore, nurses must not only be able to carry out spiritual care but also be able to provide a justification for that care.

This suggests that nursing students must have time in their programme to gain an understanding of what constitutes spiritual care, the theoretical perspectives that inform such care and the opportunity to develop the capacity to become skilled in the practice of spiritual care.

References

Bradshaw, A. (1996) The legacy of Nightingale. *Nursing Times* 92 (6), 42-43

Burnard, P. (1993) Giving spiritual care. *Journal of Community Nursing* 6 (10), 16-18

Kellehear, A. (2000) Spirituality and palliative care; a model of needs. *Palliative Medicine*, 14(2), 149-155.

McGilloway, O. and Myco, F. (1985) *Nursing and spiritual care.* Harper and Row: London

McSherry, W. (2000) *Making sense of Spirituality in Nursing Practice.* Churchill Livingstone: Edinburgh

McSherry, W. and Draper, P. (1998) The debates emerging from the literature surrounding the concept of spirituality as applied to nursing *Journal of Advanced Nursing* 27(4), 683-691

Murray, R. B. and Zentner, J. B. (1989) *Nursing Concepts for Health Promotion.* Prentice Hall: London

Stoter, D, in Penson, J. and Fisher, R. (1995) *Palliative Care for people with Cancer* 2nd ed. Hodder Arnold: London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2001) *Requirements for pre-registration nursing programmes.* London: UKCC April

Appendix 2

Synopsis of the audio tape 'Spoonface Steinberg'

Spoonface Steinberg is a play by British playwright Lee Hall, first broadcast as a dramatic monologue in 1997 on Radio 4. Subsequently the play went on to sell thousands of copies on cassette and was also published as part of the anthology Spoonface Steinberg and Other Plays in October of 1997.

Spoonface is a seven year old autistic girl who is terminally ill with cancer. She questions the meaning of life and what death will be like. Spoonface finds hope through the people who come into her life; the Jewish doctor who introduces her to the opera (particularly Maria Callas) as well as Mrs Spud, the cleaning lady whose kindness and beliefs help Spoonface make sense of her short life and what is to come of her.

Overall the play looks at the big issues and mysteries of life - compassion and love, disappointment, religion, transcendence, music and art. It reminds listeners of the essentials of our common humanity.

Appendix 3

Course Outline

Time-table for the theme Spirituality

Aims

Throughout the theme students will be given the opportunity to:

Aim 1: Identify and articulate their personal understanding of 'the spiritual dimension'.

Aim 2: Prioritise what they hope to learn in order to provide spiritual care.

Session 1

Interactive learning 'Spiritual needs and spiritual care'

Content: Q1. Can you think of a time when a patient has expressed a spiritual need?

Method: Question and answer. Discussion in small buzz groups, verbal feedback to whole class

Content: Q2. What are spiritual needs? These may be identified either from your own experience or the experience of others.

Method: Nominal Group Technique

(i) Silent generation of ideas - individually (5 Mins)

(ii) Round-robin recording (flip-chart) of ideas (15 Mins)

(iii) Serial discussion of the list of ideas (15 Mins)

(iv) Each student selects 5 items that are most important to her/him, lists them on a card and rank orders them. (5 Mins)

(v) The votes are recorded on the flip chart (15 Mins)

Session 2

Seminar 'An illustration of a perspective on spirituality'

This seminar will take the form of:

a) Discussion of the themes/ideas of spirituality as revealed through the audio-tape, 'Spoonface Steinberg' by Lee Hall

b) An examination of the themes/ideas of spirituality generated previously by the class.

Session 3

Lecture 'Theoretical perspectives of spirituality'

Session 4

Reflective Group Discussion 'Reflecting on spiritually significant events'

Students should come prepared to discuss either

A) a reflective account of an event of spiritual significance concerning either themselves or a patient.

And/or

B) a reflective account of a poem/short story that has spiritual significance to personal or patient experience

Please refer to your 'Guidelines for Reflection' to help in the construction of your reflective accounts.

Appendix 4

Student Evaluation Questionnaire

Please reflect on the strengths and weaknesses of each session

Session 1

Discussion in small buzz groups, verbal feedback to whole class.
Followed by Nominal Group technique: Q. What are spiritual needs?

Strengths:

Weaknesses:

It would have been better if:

... ...
... ...
... ...
... ...

Session 2

A discussion of the themes/ideas of spirituality as revealed through the audio-tape, 'Spoonface Steinberg' by Lee Hall alongside those themes/ideas previously highlighted by the class.

Strengths:

Weaknesses:

It would have been better if:

... ...
... ...
... ...
... ...

Session 3:

Lecture 'Theoretical perspectives of spirituality'

Strengths:

Weaknesses:

It would have been better if:

... ...
... ...
... ...
... ...

Session 4

Student discussion of:

A) a reflective account of an event of spiritual significance concerning either yourself or a patient.

And/Or

B) a reflective account of a poem/short story that has spiritual significance to personal or patient experience.

Strengths:

Weaknesses:

It would have been better if:

... ...
... ...
... ...
... ...

Thank you

Appendix 5

Guidelines for reflection

There are various models of reflection. However most encourage an approximation of the following process. Try using this process to construct your 'reflection' for the seminar.

1. Description

What happened?

2. Thoughts and Feelings

What were you thinking?

What knowledge and assumptions did you have?

What were you feeling?

What beliefs and attitudes influenced your feelings in the situation?

What did you do?

3. Analysis

What was positive about the experience?

What was negative about the experience?

Give reasons/try to make sense of the positive and negative aspects of the experience.

4. Evaluation

What else could you have done?

What would have been the consequences of these alternative actions? Ask yourself the following:

(i) How do you think the experience might influence future practice?

(ii) How do you feel now about the experience?

Appendix 6

Question guide for reflective interview session.

1. Can you think of an occasion when you came to realise that a patient (or family member or friend) was expressing a spiritual need – and you tried to do something about it?

2. Can you think of anything that wasn't done that might have made it easier for the patient to meet his/her needs?

3. What do you think enables you as a person and/or nurse to provide spiritual care?

4. Are there times when you feel you need help to meet your own spiritual needs?

5. Do you think that this short course on spirituality has/will help you:
   - meet your own spiritual needs
   - provide spiritual care to others

APPENDIX 7

CALEDONI
UNIVERSITY

Professor Barbara A Parfit
PhD MSc MCommH ALBC RGN SCM
Head of Department of
Nursing & Community Hea

Ref: PMcQ/IMcN

3rd December 2001

Ms Beth Seymour
NCH
Glasgow Caledonian University

Dear Beth

Your proposal has now been scrutinised by the departmental Research Ethics Committee and I am pleased to inform you that this has been approved.

I would draw your attention to one of the reviewer's comments as under:-

"It would be clearer to potential participants if within the 'Information Sheet' the participants right to withdraw without prejudice at any time was clearly stated. (This statement already appears on the consent form.)"

I wish you well with your study.

Yours sincerely

Patrick S McQuillan
Deputy Chair
Departmental Research Ethics Committee

WHO COLLABORATING CENTRE
FOR NURSING AND MIDWIFERY

City Campus
Cowcaddens Road
Glasgow G4 0BA
Telephone 0141 331 8311
Facsimile 0141 331 8312

Appendix 8

Consent form for the use of reflective journals for research purposes.

I understand the purpose for which these diaries are going to be used in this study.

I understand that I may withdraw from this study at any time and without prejudice.

I understand that I will have the opportunity to negotiate the content of my diary prior to its use for publication purposes.

I consent to take part in this study

Signature:

Date:

Appendix 8

Consent to interview form

I understand the purpose for which these interviews will be used in this study.

I understand that I may withdraw from this study at any time and without prejudice.

I understand that I will have the opportunity to negotiate the content of this interview prior to its use for publication purposes

I consent to take part in this interview. Yes No

I agree to this interview being tape-recorded. Yes No

Signature:

Date:

Appendix 8

Information for participants

I am conducting a study into the teaching and learning about spirituality in nursing. The principal aim of the study is to:

Describe and explore the impact of an educational intervention on nursing students' development of knowledge, understanding and practice in spiritual care.

I would be delighted if you would agree to participate in this study.

Your views will be sought on the structure, process and outcomes of the educational intervention; reasons for any success and/or limitations of your experiences of learning about spiritual care and, also, how you think spiritual care is/might be developed in your practice.

The materials to be used for the study include class work, evaluation data and reflective diaries. At a later date, I will be seeking volunteers to participate in interviews. With your permission, the interviews will be tape-recorded.

Data will be handled in accordance with the provisions of the Data Protection Act 1998. Data from the reflective diaries, classroom work, evaluations and interviews will be anonymous. All data will be entered onto an electronic database and stored on computer within the Nursing and Community Health Department (NCH) at Glasgow Caledonian University. Following completion of the study a summary of the findings will be stored and archived within the NCH department. All data collection forms will be destroyed. It is hoped to publish the results in a professional refereed journal.

Please remember that consent to this study is on-going and you are free to decline to participate at any time.

Beth Seymour

Appendix 9

Open coding

RG3 Reflective Group Interview **Code**

Facilitator: So you've both expressed experiences where you feel that you have actually made an attempt to meet, you've recognised what their needs were because in your instances we would try to provide appropriate food for people and we would obviously try to find appropriate doctors to look after patients if they have very sort of specific needs. Any other occasions?

Identified religious practices

RG3 (J): Well, what I shared about in the, in the first sort of group meeting we had. System. About people saying that they don't understand what's happening to them. You know, they can't see the point any more. Things like that. I mean people have spiritual needs all the time but so often only at times of stress do they share them with - well we - basically we're strangers aren't we? When you're a nurse, nursing someone, really you are a stranger to them.

lack understanding/ meaning

Feeling pointless

Share spiritual needs with strangers

Paradox - nurse is stranger yet patients share spiritual needs (in times of stress)

Facilitator: I think you're right. I think what you're saying, these things are more intangible as opposed to talking about spiritual needs that are tangible, get a

CODE

doctor, get a diet, do that sort of thing then it's easier to address than someone who says 'I don't understand what's happening' when they're not actually talking about 'I don't know what surgery' or 'What's wrong with me'. That's not what they mean. It's about the whole situation they've arrived in or as I say the sort of hopelessness of you know, I don't feel it's worth going on or I don't feel it's worth putting up with all of this. How have you addressed patients when they've asked and say those sort of things. 'Cos I think you're right - these are spiritual needs that they have to be met and sometimes people don't address them and sometimes they do. How have you reacted?

RG3 (J): I think I've tried to be positive with them. Try and point out things positive things to them. In the way if they've got some positive prognosis, things are going to get better. But sometimes they're not going to get better em but yes, positive things about their relationships maybe with other people. You know.

Emphasises the positive

recognises the importance of their relationships

Facilitator: ... Do you feel personally that you're able to cope with that?

CODE

RG3 (J): What, that I'm able to cope if people are expressing a, that kind of spiritual need to me? No I don't, I don't feel very confident about it. But I think, you know, like I say, you only know a person for a couple of days perhaps, and sometimes I think I've got the answers but, I mean, how can you, how can you even provide the answer for someone after a lifetime? When you've only known them for a few days, it's very difficult.

Student lacks confidence in providing spinhal care

can't always provide answers

needs to know patient to give spiritual care

Facilitator: What about the rest of you?

RG3 (A): I think sometimes I think in this country as well that as a country isn't a very, we're not very good at expressing em feelings and I think that if you'd made it medical. Like we just like to come in and look at the medical problems. And a lot of the time they don't look at the psychological or spiritual problems because I think like you said there are afraid because they maybe don't know how to deal with them. They don't have the answers for it because if you were a doctor in [tape inaudible] 9 times out of 10 you've got a good reason why and you can explain it and that's easy for you. But if you don't have the answers for them it's hard. And I think a lot of the time they just try to ignore it, forget it.

not good at expressing emotions

Afraid to see psychological/spiritual needs because don't know how to meet them

No answers

No explanations

Ignore them

CODE

But I think that if you're a nurse then even if you don't know that person, you are the person that person is probably going to ask because you are about the closest thing you get when they're in there and even when you haven't known them all their life and you haven't maybe had that much experience either. You might not realise it but you might be doing them some good just by even listening to what they're saying. And I think we can only get better at that the more experience we do have but I still think that we need to kind of address that as nurses or as a profession because I think we don't look at that aspect of people. I think, sometimes as well, I think that if your spiritual needs are met that will have a knock on effect for years on people. I think as well, a lot of the time, you have to also not just be on the patient, look at all the other people round about them as well. There are families either.

patients ask nurses because of situation (& nurses' role?)

Nurses can do some good by listening

Get better at spiritual care with practice

Spiritual care is a nursing role but don't pay sufficient attention to it

Spiritual care has long term benefits for people

Family involved

Appendix 9

Example of Data Sorting and Categorisation

Text	Category
Facilitator: So you've both expressed experiences where you feel that you have actually made an attempt to meet, you've recognised what their needs were because in your instances we would try to provide appropriate food for people and we would obviously try to find appropriate doctors to look after patients if they have very sort of specific needs. Any other occasions?	
RG3 (J): Well, what I shared about in the, in the first sort of group meeting we had. System. About people saying that they don't understand what's happening to them. You know, they can't see the point any more. Things like that.	Belief that life events have reason & purpose (Beliefs 11)
I mean *people have* spiritual needs all the time but so often only at times of stress do they share them with - well we - basically we're strangers aren't we? When you're a nurse, nursing someone, really you are a stranger to them.	Stories are told within a stranger relationship (Accounts 2)
Facilitator: I think you're right. I think what you're saying, these things are more intangible as opposed to talking about spiritual needs that are tangible, get a doctor, get a diet, do that sort of thing then it's easier to address than someone who says 'I don't understand what's happening' when they're not actually talking about 'I don't know what surgery' or 'What's wrong with me'. That's not what they mean. It's about the whole situation they've arrived in or as I say the sort of hopelessness of you know, I don't feel it's worth going on or	

CATEGORY

I don't feel it's worth putting up with all of this. How have you addressed patients when they've asked and say those sort of things. 'Cos I think you're right - these are spiritual needs that they have to be met and sometimes people don't address them and sometimes they do. How have you reacted?

RG3 (J): I think I've tried to be positive with them. Try and point out things positive things to them. In the way if they've got some positive prognosis, things are going to get better. But sometimes they're not going to get better em but yes, positive things about their relationships maybe with other people. You know.

Emphasising the positive (language 12)

Facilitator: ...Do you feel personally that you're able to cope with that?

RG3 (J): What, that I'm able to cope if people are expressing a, that kind of spiritual need to me? No I don't, I don't feel very confident about it.

But I think, you know, like I say, you only know a person for a couple of days perhaps, and sometimes I think I've got the answers but, I mean, how can you, how can you even provide the answer for someone after a lifetime? When you've only known them for a few days, it's very difficult.

Hard to talk to someone you don't know (language 15)

Don't have all the answers to spiritual questions (Beliefs 3)

Facilitator: What about the rest of you?

RG3 (A): I think sometimes I think in this country as well that as a country isn't a very, we're not very good at expressing em feelings and I think that if you'd made it medical. Like we just like to come in and look at the medical problems.

Medical problems emphasised and spiritual problems ignored (Beliefs 2)

CATEGORY

And a lot of the time they don't look at the psychological or spiritual problems because I think like you said there are afraid because they maybe don't know how to deal with them. They don't have the answers for it because if you were a doctor in [tape inaudible] 9 times out of 10 you've got a good reason why and you can explain it and that's easy for you. But if you don't have the answers for them it's hard. And I think a lot of the time they just try to ignore it, forget it.

Don't have all the answers to spiritual questions (Beliefs 3)

But I think that if you're a nurse then even if you don't know that person, you are the person that person is probably going to ask because you are about the closest thing you get when they're in there and even when you haven't known them all their life and you haven't maybe had that much experience either.

Patients tell nurses their stories (Accounts 1)

You might not realise it but you might be doing them some good just by even listening to what they're saying.

A willingness to listen (language 2)

And I think we can only get better at that the more experience we do have but I still think that we need to kind of address that as nurses or as a profession because I think we don't look at that aspect of people.

Theory to practice The gap of sufficient experience (language 10)

I think, sometimes as well, I think that if your spiritual needs are met that will have a knock on effect for years on people.

Spiritual care has long term outcomes for patients (Accounts 6)

I think as well, a lot of the time, you have to also not just be on the patient, look at all the other people round about them as well.

Valuing family + friends as spiritual care givers (Beliefs 6) +

There are families either.

Spiritual care requires a holistic gaze (Accounts 7)

Appendix 10

Collated student evaluation questionnaire

Comments	Session 1	Session 2	Session 3	Session 4
Positive	Able to bounce ideas off one another and felt that by discussing you would have a better understanding Good to share different opinions and thoughts Good discussing with others Lots of different perspectives, ideas, thoughts which maybe differed from your own Could bring personal aspects into discussion Helped to define what spirituality is and raised my awareness of the subject by highlighting the fact that spirituality does not equal religion Generated a lot of ideas Attempts to prioritise spiritual needs Small groups allowed us to share more as you felt more at ease Less boring than just lecturing because we were talking about real life experiences	Excellent to make you relate what you think spirituality is to an actual scenario Very thought provoking – really made you think about spirituality It was a different method of teaching Allowed active listening, think about different ideas, perspectives – an ongoing reflection. Personal account of how a person feels gave a realistic picture Raise awareness of issues discussed previously and pit some of them into a more understandable context V appropriate, inspiring Valuable to gain insight into spiritual needs Interesting, prompted things to talk about, interesting from a child's perspective Provided the students with a scenario enabling them to relate to the spiritual needs of the girl and her family It was a different method of teaching that was good for a	Provided with good references that can be looked at in your time Different approaches discussed It gave us a basis of spirituality. The handout was a good idea so we can read up on it later Gave good grounding of meaning and background to spirituality Good references Provision of handout allowed me to concentrate and think about what was being said instead of rushing to write everything down Didn't attend – got confused about time/was spaced out. Sorry. Provided a	*Excellent for pulling the whole day together. Let you know you had* learned something that you could use for yourself as well as patients and families Very beneficial to share and reflect on similar experiences with others Groups were small enough so you felt happy discussing. We were allowed to choose our own group Allowed you to explore in small groups, own ideas, beliefs Were able to give our own personal account of situations Allowed discussion of all issues covered in previous sessions as well as allowing exploration of personal experiences Good to hear different perspectives Allowed us to share experiences Felt it was good to know other people had similar experiences Enabled the students to discuss situations that they had been involved in

Appendix 10

Collated student evaluation questionnaire

Comments	Session 1	Session 2	Session 3	Session 4
Positive	Able to bounce ideas off one another and felt that by discussing you would have a better understanding Good to share different opinions and thoughts Good discussing with others Lots of different perspectives, ideas, thoughts which maybe differed from your own Could bring personal aspects into discussion Helped to define what spirituality is and raised my awareness of the subject by highlighting the fact that spirituality does not equal religion Generated a lot of ideas Attempts to prioritise spiritual needs Small groups allowed us to share more as you felt more at ease Less boring than just lecturing because we were talking about real life experiences	Excellent to make you relate what you think spirituality is to an actual scenario Very thought provoking – really made you think about spirituality It was a different method of teaching Allowed active listening, think about different ideas, perspectives – an ongoing reflection. Personal account of how a person feels gave a realistic picture Raise awareness of issues discussed previously and pit some of them into a more understandable context V appropriate, inspiring Valuable to gain insight into spiritual needs Interesting, prompted things to talk about, interesting from a child's perspective Provided the students with a scenario enabling them to relate to the spiritual needs of the girl and her family It was a different method of teaching that was good for a	Provided with good references that can be looked at in your time Different approaches discussed It gave us a basis of spirituality. The handout was a good idea so we can read up on it later Gave good grounding of meaning and background to spirituality Good references Provision of handout allowed me to concentrate and think about what was being said instead of rushing to write everything down Didn't attend – got confused about time/was spaced out. Sorry. Provided a	Excellent for pulling the whole day together. Let you know you had learned something that you could use for yourself as well as patients and families Very beneficial to share and reflect on similar experiences with others Groups were small enough so you felt happy discussing. We were allowed to choose our own group Allowed you to explore in small groups, own ideas, beliefs Were able to give our own personal account of situations Allowed discussion of all issues covered in previous sessions as well as allowing exploration of personal experiences Good to hear different perspectives Allowed us to share experiences Felt it was good to know other people had similar experiences Enabled the students to discuss situations that they had been involved in

	Gave students knowledge and understanding of what spiritual needs are Gave an insight to other peoples' views on spiritual needs Allows for more ideas to be generated amongst the group. Was easier to feedback variety of thoughts to whole class Gave everyone the chance to voice their opinions Gave a basic idea of what spiritual care was. Made you think of spirituality and needs both on a personal level and nursing. Clarified what spiritual needs actually were. Was able to learn from fellow class members. My knowledge was very limited and all the issues flagged up were all relevant and very significant issues. It's nicer to do it in that interactive method than a more 'boring' lecture where you're just given them. Gave a more clarified view of what spirituality is	change Tape allowed time for personal thoughts and different interpretations of feelings in response to the story It identified several different issues Was easier method of taking in what spirituality was as it was in the form of a story Again was thought provoking Gives a very separate view from what us, as the carers can see. Very moving due to a child being used, but the simplistic nature due to this makes it have a better impact The tape was a good insight into the mind of an autistic child and shows the complexities of family relationships Interesting tape. Easy to listen to – gave child's perspective Easy and interesting to listen to. Can relate to patients needs Good story for discussion of spirituality	brief outline Good handout Gave background knowledge of spirituality Handout given for further reading The handout was good as it allowed you to go home and examine the issues identified today Good handout/able to listen instead of taking notes A lot of good information Gave some ground to the discussions made earlier and for those to follow. Good to have for reference This gave us a theoretical background to the issues which were raised in the morning Good outline Went through aspects of spirituality	This made me more aware of my practice concerning spirituality, and I will be more aware of the spiritual needs of patients in the future Allowed discussion of own feelings whilst being aware of other peoples' experiences/emotions Confidential and private small groups Small groups easier to be open/speak out Very enjoyable. Helped draw together a lot of experiences Sharing experiences with my friends is very helpful. You can always learn something and perhaps be made to feel better about a weakness you find common As the groups were small and included people I knew well I felt able to be open about different aspects of my personal and professional life. This gave rise for a good discussion to take place. The questions given were also very valid and appropriate and helped the debate flow Able to discuss in groups easily. Able to share experiences easily Gives an idea of other colleagues opinions Open discussion

	and cleared up peoples' misconceptions Encouraged group to discuss personal views on what 'spirituality' has now been explained to be. The session was very thought-provoking and opened my mind to different aspects of spiritual needs. I think this was due to the 'brain storming' nature of it. Interactive method less boring than just lecturing because we were talking about real life experiences			helped us to understand more about spirituality and what is classified as spirituality Made me reflect on the way I care for patients
Negative	Some people don't feel comfortable sharing with the whole class The nominal group technique was quite rushed Unsure of what spirituality actually meant therefore unsure what to say Group was too large. Lack of time. Bit of a big group for people to go in depth about the spiritual needs they nominate Difficult to identify spiritual needs and get started	Bit too long Was a bit too long to listen to the whole tape Again there was not enough discussion time The need to concentrate on the content of the tape by ignoring the presence of other students and staff (i.e. by closing your eyes) seemed to induce sleep in some people, so perhaps, conducting this session on a placement study day, following a week of shift work, is not to benefit the session. Is it a problem that it is fiction? However it is very factual – rings a bell	Because we didn't have much time it was quite rushed so it was difficult to take in Too many overheads Late running of previous session led to this session being quite rushed Quite difficult to understand concepts Quite short Not enough time Not very clear, lack of	Taping made me apprehensive about talking Presence of tape recorder may have slightly stifled the discussion Maybe more time to reflect – think about our practice Felt quite put on the spot to discuss and explain things Audio-taped The focus on one event I found quite hard. I had plenty of little scenarios only involving one or two little issues but no one significant event We had a bit more time to prepare as we didn't really know what to expect from

	Not enough time for discussion Spirituality can be quite personal I think, and some may not feel comfortable talking out at this point in big groups Felt a bit pressurised to have an answer, but realised after that that wasn't the case The class was slightly too big Could have went in to more depth regarding nominal group categories Too many people in class Seemed to require agreement that all emotional, physical, mental, personal needs and requirements are now called 'spiritual needs' rather than holistic care of the individual (as taught throughout this degree)	A bit too long, near the end it was difficult to stay focussed I find it hard to concentrate on as it was quite long Not enough discussion about the themes in the tape We ran a bit short on time for discussion, needed provoking a lot to discuss I think. Difficult to relate to Only gave a child's view which was perhaps overly simplistic Was quite long Tape was too long (we weren't informed how long it would be)	time for explanation Was a bit 'over my head' as it was given quite quickly and I couldn't take it in at that rate, will need to read when I get home It was a bit confusing as it felt slightly rushed V brief, better if it had been longer Quite brief Was quite dry A bit like a list of quotes being read out	the session Sometimes difficult to think of examples Can be intimidating It seemed quite repetitive of human needs we have already learned about before
Developmental suggestions – It would have been better if...	We'd had more time with the nominal group technique Began with definition, idea of what spirituality was and so what it meant to us Smaller groups There were smaller groups More time	Lessened to shorter segments and then discussed in small groups and then feedback to the whole class There had been about 30 minutes at the end of the tape to discuss our thoughts and feelings Conducted during semester as part of the academic/theoretical component of the module	The lecture had been longer Began with definition, perspectives initially before interactive learning More in depth longer session Could have been	No recording The whole day was earlier on in the course Write down what we experienced and how we felt I could have expressed these little scenarios and would have liked to have feedback on them We had a bit more time to prepare as we

	More sessions We could possibly had an introduction to the subject before we began discussing what we think it was More in depth The session had been longer We were told there was no pressure to give an answer/suggestion We had more time to consider each subject brought up If the class was split in to groups for whole session	Include anonymous case studies Video tape – easier to imagine the situation ? video tape Could have split the tape into small sections and discussed each of them individually, rather than playing the tape straight through. Video tape – if able to see child, more empathy Story was shorter Tape was shorter. Person in tape was an adult as we are doing adult nursing (although it did get the children's viewpoint/perspective across clearly.	incorporated into session one in some way I don't know how to correct that (*too brief*) as it is better that time is spent interacting than having a lecture. Maybe the important bits e.g. definitions and UKCC quotes been emphasised so I would have remembered those at least We had more time and more depth and explanation were given Perhaps more in-depth There was more discussion involved	didn't really know what to expect from the sessions