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Spiritual Dimensions of Advanced Nurse Practitioner Consultations in Primary Care through the Lens of Availability and Vulnerability.

A Hermeneutic Enquiry.

Melanie Rogers

PhD 2016

Spiritual Dimensions of Advanced Nurse Practitioner Consultations in Primary Care through the Lens of Availability and Vulnerability.

A Hermeneutic Enquiry.

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PhD Thesis

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Submitted April 2016

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Glossary:

ANP Advanced Nurse Practitioner

A&V Availability and Vulnerability

DoH Department of Health

FP Family Physician

ICN International Council of Nurses

GMC General Medical Council

GP General Practitioner

PA Physician Assistant

NC Northumbria Community

NMC Nursing and Midwifery Council

NP Nurse Practitioner (Title used up until 2008 now ANP)

RCN Royal College of Nursing

Abstract:

Introduction:

There is a scarcity of research examining spirituality and spiritual dimensions of Advanced Nurse Practitioner practice. This thesis explores the findings of a hermeneutic enquiry into the spiritual dimensions of Advanced Nurse Practitioner consultations in Primary Care through the lens of Availability and Vulnerability. The findings include Advanced Nurse Practitioners' understandings and conceptualisation of spirituality, the place of spirituality in practice and some of the concerns related to integration in practice. The participants' interviews explored their own personal and professional experiences which added to their conceptualisation of spirituality. The lens of Availability and Vulnerability (A&V) was used intentionally and openly to explore, in depth, spiritual dimension of practice with the participants. The utility and effectiveness of the concepts of A&V in this context was explored.

Methods/Methodology:

A hermeneutic phenomenological enquiry was chosen to explore spirituality through the lived experiences of the Advanced Nurse Practitioners (ANPs).

Eight participants were interviewed face to face during 2 in-depth interviews spaced 18 months apart. The concepts of A&V were introduced to the participants before the second interviews. The lens of A&V was utilised within these interviews to discover whether or not these concepts were helpful for operationalising spirituality in practice. The prolonged engagement allowed dialogue to occur between the researcher and participants allowing data to be captured which provided a thick description of the phenomenon of spirituality. A thematic analysis was chosen to interpret the data in order to enable a deeper understanding of the spiritual dimensions of ANP consultations to be gained.

Findings

The participants recognised that spirituality can be difficult to conceptualise and operationalise in practice. However, many of the participants were able to articulate the meaning of spirituality for themselves and gave examples of when they had witnessed a spiritual dimension occurring in practice. Particular themes were expressed in the interviews in relationship to spirituality. These included the context for spirituality to be integrated into care, the emotional engagement needed and the emotional impact on the ANP and the patient. Having introduced the concepts of A&V to the participants, after deep exploration, they recognised and identified that A&V were concepts which could be a useful lens for understanding spirituality in ANP consultations.

Conclusion

This study has uncovered new knowledge and understanding in the realm of spirituality in ANP consultations in Primary Care. The conceptual understanding of spirituality and the framework of Availability and Vulnerability provides a new approach to spirituality within ANP consultations in Primary Care.

Chapter 1: Background to Study

1.1 Introduction:

This PhD thesis presents a hermeneutic enquiry into the spiritual dimensions of Advanced Nurse Practitioner (ANP) consultations in Primary Care through the lens of Availability and Vulnerability (A&V). This first chapter presents the rationale for the study with a brief overview of the context, both personal and professional. It introduces the role of the ANP, the difference between the ANP role and general nursing practice and holistic practice where spirituality finds its natural home. Chapters 2 & 4 include in depth discussion and analysis of spirituality in healthcare and the current literature on spirituality in ANP practice. Chapter 3 provides the rationale for the intentional use of the lens of A&V which was presented to the participants prior to interview 2.

1.2 Context

1.2.1 Personal Context

My interest in spirituality in nursing care has developed throughout many years working as a nurse in a variety of secondary care settings and as an Advanced Nurse Practitioner (ANP) working in Primary Care over the last 17 years. Additionally, this interest has been explored through my relationship with the Northumbria Community as I have sought to integrate a way of living they aspire to of A&V in my life and work (see Chapter 4). Spirituality has become more of a focus for me as I continue to wrestle with the ongoing challenges to providing truly holistic care to patients within a very short consultation of 10 minutes. Care provided by an ANP in primary care aims to integrate nursing and medical models (Royal College of

Nursing (RCN) 2008). This routinely encompasses a biomedical approach where spiritual care is frequently omitted (Kliewer & Saultz 2006).

In practice I have witnessed over time an increase in patients presenting with complex medical and mental health problems which have led to more regular patient contact to support their health needs. I was aware that this allowed me an opportunity to develop effective therapeutic relationships with patients and their families, over extended periods of time. For some patients there appeared to be a sense of hopelessness relating to their diagnoses and health needs. I found in these consultations that I was often helping patients explore questions of meaning about their lives, illnesses and experiences. Often I found myself supporting them to explore many of their existential questions relating to these areas. Taking time to listen, support and encourage patients to explore these questions and to make positive changes in their own lives appeared to help them to find a sense of hope and peace. Feeling and expressing empathy towards patients presenting with complex problems created a conscious questioning of whether I as an ANP could do more to support and help them to meet not just their physical and emotional needs but also their spiritual needs as part of truly holistic care.

During these consultations when patients shared their struggles I also noticed that a deeper connection with my patients occurred which appeared to have what I perceived to be a spiritual dimension. This sometimes occurred after self-disclosure by the patient about an issue which was impacting on their life physically or emotionally or as they began to explore questions about their illness and life such as why me, what will happen to me or how can I get through this. I began to look for literature that might explain or validate what I witnessed happening in my practice. It is not uncommon during times of suffering for patients to seek to find meaning in

their existence or release from their distress (Puchalski 2001). Patients need someone who is willing to listen to their questioning and help them explore some of their deeper concerns; spirituality appeared to me to be a domain where this could happen. Rohr (2003) suggested that true seeing of an individuals' distress and suffering is the heart of spirituality and often requires just our willingness to be present and to listen. It is also important to recognise that many patients feel isolated in what appears to be a thrust towards individualism in society (Brown 2010). King (2011) asserted that society has hit a spiritual crisis leaving individuals isolated and alone as they deal with relationship breakdowns, financial pressures, a hunger for materialism and broken communities. Rohr (2003) coined the term affluenza suggesting that the propensity to an individualistic and materialistic society affects the ability of people to find any sense of peace or purpose. As an ANP, offering patients time to find themselves and explore existential questions not through analysis but through our relationship appeared to enable them to find a degree of peace and purpose. It also appeared to bring a deeper level of connection which may have helped them feel less isolated. The experiences in my own practice led to many questions for me about the experience of spiritual dimensions in patient consultations and I wondered whether other ANPs had similar experiences and whether they perceived spirituality as important in their practice.

There has been much written about the essence of nursing, nurse-patient relationships and intimacy in caring (Benner et al 1989; Downey 2004; Kirk 2007) which may be relevant to the experience of a spiritual dimension. Additionally, holistic care provided by ANPs has been written about (Shuler & Davis1993; Mezey et al 2003) but spirituality as a domain remains scarcely mentioned in the ANP literature. This appears to be different in other nursing roles (for example, Mental

Health (Greasely et al 2001; Swinton 2006; Gilbert 2011) and Palliative Care (Bryne 2007; Hayden 2011) and other caring professionals (Occupational Therapy (Egan & DeLaat 1997; Mayers 2010) and Social Work (Crisp 2010; Holloway 2014) where spirituality has been more widely discussed in the literature.

My exploration of the literature revealed that spirituality is an important aspect of holistic care which is frequently overlooked owing to difficulty conceptualising spirituality and confusion about how to integrate it into nursing care (Coyle 2002; Agrimson & Toft 2008; Cook 2011). When I started to explore the literature relating to ANP consultations, rather than nursing as a whole, I found a scarcity of research which, coupled with my personal interest, prompted this study.

My personal experiences with patients and my interest in spirituality influenced the context for this study. I desire to provide holistic care which integrates spirituality. Experience has led me to believe that this makes a difference to patient well-being. Recognising this in my practice and also exploring and embracing my own spirituality have given me a true sense of vocation in my practice as an ANP.

1.2.2 Professional Context

The role of the ANP has developed significantly in the UK over the past 2 decades. There are increasing numbers of ANPs working in Primary Care (RCN 2008; 2010). The role is diverse, challenging and aims to integrate the “best of nursing and medicine” to offer patients care previously provided by a General Practitioner (GP) (Walker et al 2007: 1). The development of the ANP role could be seen as pioneering nurse progression to enhance patient care. However, there has been

debate about whether ANPs are just responding to the needs of patients unmasked by a lack of medical provision and pressure to reduce health costs (Kings College 2007). Despite these reservations, patient outcomes are good and satisfaction high for ANPs (Mundinger et al 2000; Venning et al 2000; Horrocks et al 2002).

1.2.2.1 What is an Advanced Nurse Practitioner (ANP)?

Internationally an ANP is defined as a "registered nurse who has acquired the expert knowledge base, complex decision making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice" (ICN 2009: 1). A Master's degree is recommended for all practicing at this level (RCN 2012). In the United Kingdom (UK) an ANP has been defined as a nurse who is autonomous in their practice, able to make clinical decisions, instigate treatment and is fully accountable for their practice. They are able to practice in this way through advanced education and training (RCN 2002; 2008; 2012). In 2008 the RCN refined the level of practice relating to advanced clinical practice, education, research and leadership (RCN 2008) (Table 1). The specific expertise of a primary care ANP is related to their ability to operate as a generalist providing complete episodes of care for patients of any age and with a wide variety of presenting problems and health and social care needs (RCN 2012). Specifically, in primary care ANPs see patients with undifferentiated and undiagnosed conditions, make diagnoses, examine, investigate, prescribe and initiate treatment or referrals to secondary care. ANPs undertake consultations traditionally undertaken by GPs. Although the ANP title is not a protected title in the UK it is regulated for nurses by the Nursing and Midwifery Council (NMC) Code of Conduct (NMC 2015).

Table 1: Advanced Nurse Practitioner Practice:

ANP practice should encompass:
➢ "Making professionally autonomous decisions, for which they are accountable
➢ Receiving patients with undifferentiated and undiagnosed problems and making an assessment of their healthcare needs, based on highly-developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination
➢ Screening patients for disease risk factors and early signs of illness
➢ Making differential diagnoses using decision-making and problem-solving skills
➢ Developing with the patient an ongoing nursing care plan for health, with an emphasis on health education and preventative measures
➢ Ordering necessary investigations, and providing treatment and care both individually, as part of a team, and through referral to other agencies
➢ Having a supportive role in helping people to manage and live with illness
➢ Having the authority to admit or discharge patients from their caseload, and refer patients to other health care providers as appropriate
➢ Working collaboratively with other healthcare professionals and disciplines
➢ Providing a leadership and consultancy function as required"
RCN (2008: 4)

An ANP working in primary care performs an advanced nursing role. The role, supported by education at Masters level, focuses on the bio-medical assessment of patients who present with undifferentiated and undiagnosed conditions. The primary role is to make a comprehensive assessment of the patient usually leading to diagnosis and management of the presenting problem by the ANP. Inevitably, involvement with the patient includes physical, social, emotional and psychological support. The ANP's nursing skills continue to be fundamental and are bound by the same code of practice but in the ANP role the nursing skills are integrated with skills historically associated more with the medical profession. These include building the relationship with their patient, interpersonal skills and holistic assessment of the presenting problem. The ANP in Primary Care normally only has 10 minutes to see the patient, although they can bring them back for further assessment and review appointments. The challenge for an ANP is not to lose their nursing values by focusing on the bio-medical model but to integrate the two, offering the patient "the best of nursing and medicine" (Walker et al 2007:1). This difference in role to that of a general nurse impacts the way spirituality is operationalised as will be discussed in further chapters.

1.2.2.2 Development of the Advanced Nurse Practitioner Role

The development of the ANP role has been long and complex (Barton et al 2012). A constant driver for the development of the role has been lack of access to health services (Fairman 2008). In the UK this has been particularly evident in primary care. The pioneers of the ANP role are thought to be American paediatrician Dr Henry Silver and public health nurse Loretta Ford. They introduced a new primary healthcare service for paediatrics to a rural area where access to health care was poor. In a media interview Ford described how in rural Colorado she was responsible

for all aspects of care including epidemiology, sanitation and health care needs (CNN 2011). It could be argued that her role was not necessarily different to nurses throughout history, including Florence Nightingale. Military, missionary and outpost nurses have always done what was needed for their patients, far exceeding the scope of general nursing practice. What made Ford a pioneer is that she went on to develop the first ANP programme internationally to ensure that nurses had the skills to provide care which integrated nursing and medicine.

In the UK several pioneers of the ANP role have been recognised for their work in the 1980's. Barbara Stillwell and Barbara Burke-Masters both worked with deprived patient groups and developed assessment, diagnostic and management skills to provide autonomous care to patients who did not have access to a GP (Eve 2005; Barton et al 2012). These pioneers in the UK were involved in the development of the first nurse practitioner course in the UK which was started in the 1990's by the RCN.

The ANP role still evokes controversy with differing views about whether the role is a surrogate medical role, cost saving enterprise or an expansion of the nursing role (Horrocks et al 2002). Despite this, the ANP's goal is to provide complimentary care of a high standard to patients for whom they are autonomously responsible (RCN 2012). Additional frustration has arisen from the lack of regulation of the ANP role in the UK which is one of the only countries not to protect the title and regulate the role formally (ICN 2015). Currently some nurses use the title NP and ANP without the necessary qualification which could affect patient care and safety. Both the RCN and NMC oppose nurses using specialist titles without the appropriate training. In

addition, the RCN gives advice about those wishing to develop as an advanced practitioner (RCN 2012). The NMC have considered title protection and regulation of advanced practice over many years. Their current position is that the advanced practitioner represents no greater risk to the public than any other registrant, the NMC code of conduct fully covers nurses of all levels and identifies that nurses should not be working at an advanced level without the necessary educational preparation (NMC 2008; 2015).

The healthcare arena is constantly developing and changing in the UK, with nurses taking on more extended roles which expand their practice. In order to enhance service delivery advanced nursing roles have now become embedded in nursing practice (RCN 2012). There is evidence that suggests nurses can offer care similar to that of a GP saving costs and maintaining quality (Kings Fund 2001). In addition, patient satisfaction has been found to be high for ANPs (Mundinger et al 2000; Venning et al 2000; Horrocks et al 2002). Patient satisfaction appears to relate to ANPs practicing holistically and integrating medical skills with their nursing skills.

1.2.2.3 Advanced Nurse Practitioners and Holistic Care

ANPs are in an ideal place to provide holistic care by the nature of their daily practice (Shuler & Davis 1993). They are often privy to all aspects of the patient's life and can support them to address many of their concerns. In 2010 the NMC stated that holistic care "considers physical, social, economic, psychological, spiritual and other factors when assessing, planning and delivering care" (NMC 2010: 148). Despite this definition of holistic care, the most recent NMC code of conduct does not mention spirituality. The code of conduct now states that nurses should "make sure that

people's physical, social and psychological needs are assessed and responded to" (NMC 2015: 5). At first glance this omits spirituality which could lead to some nurses viewing spirituality as unimportant or being more confused about the place of spirituality within nursing care. However, it could be argued that spirituality is integral to all aspects of care and flows through the bio-psycho-social model to make it truly holistic.

ANPs align themselves to the bio-psycho-social model where spirituality comfortably finds its place if recognised and integrated into practice by the ANP. It is of concern that the new code appears to rely on nurses' consciously viewing spirituality as an important aspect of care and having to consider its place within each interaction and/or consultation. It will fall upon educators and nurses who advocate and practice holistic care to see the fuller picture and to ensure that spirituality is viewed as being as important as other aspects of care.

To be fully holistic necessitates listening patients to elicit their concerns and anxieties in order to understand how their illness impacts their lives. Patients' concerns and anxieties are important aspects of spirituality that can be addressed through holistic approaches to care. McSherry and Jamieson (2013) found that spirituality for many nurses is a fundamental and integral aspect of holistic nursing. Chrash et al (2011) suggested that ANPs were in the ideal position to provide holistic care. They attributed this to the unique relationship developed with a patient who had chosen to see them (because of need and/or preference) and with whom they had engaged regularly through intensely private and life changing events. The holistic approach drawing from the "best of nursing and medicine care" appears to offer integrative healthcare (Walker et al 2007: 1). Mezey et al (2003) suggested that

ANPs have a particular way of addressing holistic care by integrating their nursing and medical skills with the psychosocial influences on health and illness. Holistic care can be impeded by the ANP's need to focus on the presenting problem in a 10-minute consultation. This may lead to omission of the psychological, social, cultural and spiritual needs (Shuler & Davis 1993).

Holistic care has been defined as "all nursing practice that has healing the whole person as its goal" (American Holistic Nursing Association accessed 2014: 1). The World Health Organisation (WHO, 2007) suggested that holistic and compassionate care go hand in hand and are necessary to build an effective partnership between clinician and patient. ANPs, by the nature of their training and their model of working, can offer a holistic approach to care seeing their patients through from assessment to management and follow up whilst focusing on psychological, social and cultural aspects of the whole patient (RCN 2008). To work holistically as a nurse needs recognition and integration of the "body-mind-emotion-spirit" approach (Montgomery-Dossey & Keegan 2013:71).

The omission of spiritual care is significant in the ANP literature with Shuler & Davis (1993) being the only authors to propose a holistic model of care which included the spiritual dimension. Leathard and Cook (2008), writing from a general nursing perspective, suggested holistic care led to attainment and maintenance of the wellbeing of the body, mind and spirit. Some have asserted that spiritual care must be integrated into practice and be seen as integral to holistic care (Miner-Williams 2005; Narayanasamy 2006; Agrimson and Toft 2008; Lewinson et al 2015) though as discussed the NMC Code specifies the potentially less encompassing physical, psychological and social domains of assessment (NMC 2015). Clarke (2013)

proposed that holistic nursing care was epitomised by spirituality which remained at its heart; without this ANP's are in danger of aligning themselves with the medical model which guides some of their practice. Although, to be fair to the medical profession, the General Medical Council (GMC) does require doctors to take into account spiritual factors when assessing patients (GMC 2013a).

1.3 Questions which Informed the Aim and Objectives of this Study:

In order to refine the study's aim and objectives a number of questions informed this process:

- How do ANPs conceptualise spirituality?
- Is spirituality an important aspect of ANP consultations?
- How is spirituality operationalised in ANP consultations?
- Can ANPs identify spiritual dimensions of practice?
- Are there any barriers to integrating spirituality into practice?
- Is Availability and Vulnerability a useful lens to help understand and operationalise spirituality within ANP consultations?

1.4 Aim and Objectives:

Aim:

This thesis aims to explore the spiritual dimensions of ANP consultations in Primary Care and the utility of the concepts of A&V in operationalising spirituality.

The Specific Objectives were:

1) To undertake a phenomenological enquiry into the spiritual dimensions of ANP consultations

2) To develop a shared understanding of the phenomena of spirituality through the lens of Availability and Vulnerability
3) To develop a conceptual understanding of spirituality for ANP practice.

1.5 Outline of Thesis Structure:

This thesis is organised in ten chapters:

- Chapter 1 provides an introduction to the thesis and the rationale for the study. It includes the personal and professional context for the study.
- Chapter 2 explores some of the literature around spirituality, in particular its relationship to nursing. This chapter explores some of the current key debates and research around spirituality in healthcare. This includes the quest to define spirituality, the relationship to religion, and the health benefits of integrating spirituality into clinical practice as well as some of the barriers to and facilitators for doing so.
- Chapter 3 explores the origins of, and a review of the concepts of Availability and Vulnerability which were developed by a Celtic Christian community (the Northumbria Community). A philosophical approach explores meaning from the concepts and considers their possible application to ANP practice. A personal narrative reflective approach explains why these concepts became a lens for the study and their significance to me.
- Chapter 4 critically reviews the empirical literature related to spirituality in ANP consultations. In view of the scarcity of literature this also was expanded to include General Practitioner consultations since these consultations are similar to the ANP's practice.
- Chapter 5 describes and critiques the chosen hermeneutic phenomenological methodology offering a rationale for this approach.

- Chapter 6 describes the methods of this study using a standard presentation.
- Chapter 7 presents the key findings of this study. These include some of the difficulties conceptualising and operationalising spirituality, the fundamental humanness of spirituality, interactions and ways of practicing that can be seen as spiritual, issues of boundaries and emotional connection with patients and finally whether A&V is a useful lens for understanding spirituality in ANP practice.
- Chapter 8 critically discusses the findings and explores the key themes in relation to the literature. A model case study is utilised to illustrate a proposed conceptual understanding of spirituality. Finally a framework for operationalising ANP practice using the concepts of Availability and Vulnerability is presented. This chapter identifies how the aim and objectives of the study have been addressed.
- Chapter 9 presents the conclusion of this study including a review of the contribution to knowledge particularly related to the conceptual understanding and framework for practice. In addition, recommendations for practice and future research opportunities in this field are identified.

"If claiming to have read all that is written about spirituality makes one a braggart and a liar, then claiming to know how to define the subject makes one a fool." (Eire 1990)

Chapter 2 Theoretical Perspectives Relating to Spirituality:

2.1 Introduction:

This chapter critically evaluates the theoretical perspectives related to spirituality in healthcare. It includes the debate about defining spirituality in healthcare, the current health care drivers for integrating spirituality into practice, the connection to religion (especially in many research papers), operationalising spirituality and ethical issues. There is a large and diverse literature on the history and meaning of the term spirituality. In this chapter I have not attempted to explore this history but rather to understand how the literature suggests spirituality is understood in healthcare. The aim of this chapter is to contextualise spirituality in health care before the study is presented. Contextualisation of some of the general themes was important before a full empirical review of spirituality from the ANP and Primary Care literature was undertaken to guide the interviews.

Over the past few decades, spirituality has received heightened interest in the healthcare arena (Treloar 2000; Miner-Williams 2005; Pesut et al 2009; Milligan 2011). Nursing has entered into the many discussions and debates around spirituality. However, the focus often remains on the challenges of both conceptualising and operationalising spirituality (Miner-Wiliams 2005; McSherry 2006a; Reinert & Koenig 2013). There has been significant criticism of some of the nursing literature on spirituality suggesting it is not robust and lacks critique (Swinton 2006; Clarke 2009; Koenig 2008). Additionally, the gap in terms of empirical studies

has increased criticism aimed at nursing scholars (McSherry & Ross 2002; Swinton 2006; Sessanna et al 2010). There are still ongoing debates in the literature about how to define spirituality, with spirituality and religion sometimes viewed as synonymous and often seen as overlapping concepts (Burkhart 2001; Koenig 2000; 2004, 2009, Monroe 2003; Miner-Williams 2005; Hubbell et al 2006; Curlin et al 2007; Chrash et al 2011). It is probably an impossible task to arrive at a definition of spirituality that is universally acceptable, especially if it is accepted that spirituality is unique for each individual (Narayanasamy 2006; Chrash et al 2011).

There may be aspects of spirituality that are universal and shared regardless of the presence or absence of a specific religious form of belief and expression (Murrey & Zetner 1989; Tanyi 2002; Miner-Williams 2005). This view appeals to some authors whilst others regard this as secularising spirituality and omitting to include the rich heritage that may be gleaned from religion (Clarke 2009). Despite a lack of clarity around spirituality, research does suggest patients want healthcare practitioners to integrate spirituality into their practice (Puchalski 2001; Ellis et al 2002; Ellis et al 2004). However, there seems to be an acute anxiety felt by those in caring professions about spirituality (Tacey 2004); often related to the lack of conceptual clarity, concerns about the relationship between spirituality and religion and difficulty understanding how to operationalise spirituality.

Spirituality appears to be becoming more important to individuals and society. One possible reason is because many have become apathetic with secularisation and modernity and seek alternative ways of living which offer more meaning and purpose. Berger (1969) and Brown (2010; 2012) have suggested that modernity

(with its materialistic world-view) has been swallowed hook, line and sinker. This has now given rise to postmodernism which "views human experience as incoherent, lacking normative approaches for truth and meaning" (Dockery 2001: 12). Many people have all the material possessions they could want yet feel spiritually or emotionally empty leading to a psychological malaise sometimes referred to as *affluenza* (Rohr 2003; James 2007; Brown 2010). Clarke (2013: 3) suggested that "society is full of people hungry for an acknowledgement of what makes them valuable". Nouwen (1972) asserted that spirituality was a way of accepting the complexities of our inner lives and connecting with our very centre. Hinton (1992: 5) proposed that spirituality described the part of ourselves that lay deepest within, that influenced our decisions and the course of life - hidden yet extremely powerful. Glasson (2009: vii) wrote of "spirituality born out of the struggle." This is in relation to trauma and abuse but the suggestion was that our own spirituality could only be understood through struggle, challenges and grappling with life issues. The existential and ontological issues of life are important to acknowledge in the search for an understanding of spirituality.

The rationale for exploring some of the general themes is to:

- To discuss the difficulty contextualising and defining spirituality in healthcare
- To examine why spirituality and religion are sometimes linked in the literature and in practice;
- To understand some of the drivers for spirituality;
- To consider how to operationalise spirituality in practice;
- To inform the research design and methods for this empirical study

2.2 Defining Spirituality in Healthcare:

Extensive reading, research and reflection initially helped with finding a definition that felt comfortable and applicable in my practice. As will become evident spirituality was further defined and developed through the conceptual understanding and the deliberate integration of Availability and Vulnerability as a framework for operationalising spirituality as presented in Chapter 8.

For clarity, the simple definition of spirituality from the nursing literature which initially resonated with me defined spirituality as the “essence of being, giving meaning and purpose to our existence” (Narayanasamy 2004: 1141). However even a simple, universal definition such as this is controversial since what gives a person meaning and purpose may be contrary to social norms. As Swinton (2006) reminded us Hitler had meaning and purpose which almost destroyed Europe. Despite being a definition I felt comfortable with, it was never viewed as an absolute. Critical analysis of some of the discourse around spirituality and the inconsistent, differing and contradictory definitions allowed exploration of the complexities of defining spirituality. Tacey (2009: 38) suggested that we are able to define spirituality less and less “because it includes more and more becoming a veritable baggy monster containing a multitude of activities and experiences”. White (2006) echoed this stating that the danger was that spirituality was becoming so broad that it included everything that brought a feeling of warmth. It is difficult to see how a definition can have meaning yet not become so inclusive that its meaning is lost. Even the simple definition I initially aligned to was so wide and broad that it could end up meaning very little.

Spirituality appears to be an emotive concept polarising opinion. Some see spirituality and religion as synonymous or significantly overlapping, especially for purposes of research (Koenig 2000; 2004; 2009; Stranahan 2001; Burkhart 2001; Monroe 2003; Hubbell et al 2006; Narayanasamy 2006; Curlin et al 2007). Others adopt a wider perspective relating spirituality to concepts of meaning, hope and purpose (Tanyi 2002; Narayanasamy 2002; Narayanasamy 2004; Cook 2004; Pesut 2009). It is difficult to understand how one definition can encompass the multitude of views, opinions and concepts linked with spirituality. For some it is the ethereal attributes of spirituality connected to the transcendent which increases confusion and resistance to spirituality (Milligan 2011), whilst others see this as a way of bringing more clarity to the concept of spirituality (Coyle 2002; Miner-Williams 2005; Tacey 2009). Others have recognised literature on the secularisation of spirituality in health care (separating it completely from religion) with the aim of finding common ground (Sessana et al 2007; Pesut et al 2008). This may result in spirituality "being undistinguishable from psycho-social care" (Clarke 2009: 1666; Vermandere et al 2011). The many definitions and meanings evoked by the term spirituality can create ambiguity and it has been argued that this may lead to reluctance to explore the topic (Agrimson & Toft 2008).

Contemporary discussion papers and empirical studies in the nursing literature offered contradictory definitions of spirituality and used a plethora of terms when talking about spirituality i.e. spiritual care, spiritual dimensions, spiritual behaviour, spiritual needs and spiritual assessment which are often not defined (Stranahan 2001; Maddox 2001; Hubbell et al 2006; Helming 2009) adding to confusion. This is echoed in other health and social care literature with definitions of spirituality varying from the vague to the specific, the diverse to the spurious in an attempt to box in the

concept. Cook (2011: 1) argued that some of these definitions “offered no scientific basis and could represent a dangerous crossing of professional boundaries whilst others were too confusing to be useful”. Reinert and Koenig (2013) have criticised nursing scholars who attempted to define and discuss spirituality suggesting that there was no rigorous analysis of spirituality in nursing. This was echoed by a number of authors who suggested much nursing literature lacks critique (Swinton 2006; Clarke 2009).

The difficulties in defining spirituality and offering rigorous critique may stem from not just the ethereal attributes but also the nebulous nature of the concept (Coyle 2002; Gilbert 2011; D’Souza 2007). These difficulties include ensuring spirituality is understandable enough to be operationalised in practice. If spirituality is watered down too much it may become vague and over-inclusive (Clarke 2009). Conversely, Swinton & Pattinson (2010) suggested that being vague about defining spirituality may be its strength and value in practice, presumably because of the ability to translate spirituality individually. This confusion leads to a paradox; the danger of an over-inclusive definition is that it becomes cumbersome and defies operationalising for research and practice; however, the danger of not embracing spirituality within practice is that we miss the deep interpersonal compassionate connection with our patients which epitomises the heart of nursing care (McSherry 2010).

Sessanna et al (2010) encouraged seeing all our patients as spiritual by virtue of their being human. In the Greek Spirit is expressed as pneuma meaning breath (Oxford Dictionary 2014). The very part of us which gives life, without pneuma one cannot exist. If this is accepted, then spirituality may simply mean what is at our very being and what makes us human. Miner-Williams (2005: 813) suggested that despite spirituality being universal it’s “depth and profoundness make it beyond the human

vocabulary". He also suggested that it was not possible to fully articulate or understand spirituality as it affected individuals so uniquely. What does appear a compelling argument is that as clinicians we can determine what is important to patients individually by listening to them and recognising spirituality as being unique and experienced differently by each individual (Baldacchino 2006; McSherry 2006b; Milligan 2011). The unique ways of understanding and experiencing spirituality may add to the difficulty in defining and operationalising spirituality.

Spirituality may be expressed in the way we live, relate and perceive the world around us and be linked with positive attributes (Johnston & Mayers 2004). These attributes are often described in terms of what gives us hope, meaning and purpose in life (Tanyi 2002; Miner-Williams 2005; Milligan 2011; Reinert & Koenig 2013). Complexity occurs because for some this may be related to belief in God or a higher power leading to a synergy between religion and spirituality. Nevertheless, those without a belief in God or a higher power may be equally spiritual. They may be more focused upon integration of mind, body and spirit in terms of relationships and connectedness to nature and the world (Johnston & Mayers 2004).

Tacey (2009) linked spirituality with the sacred which he suggested might or might not be God or a higher power. He viewed spirituality as a sensitive, contemplative, transformative relationship with the sacred which can sustain uncertainty. Uncertainty is a constant companion for humanity but an anchor can be provided in terms of spirituality. Interestingly Tacey's definition of spirituality focused upon the mystery of spirituality and a sense of acceptance of an evolving spirituality which was uniquely reflected in each person's journey in life. Tanyi (2002) suggested part of our evolving spirituality was the importance of connectedness. She echoed others

by arguing this may not just be with God but could be connectedness with ourselves, others or nature also. Tanyi (2002) also identified this connectedness as being what gave meaning to life and what helped people achieve their optimal being.

It is clear that spirituality can evoke deeper connection to existential and ontological questions especially when dealing with uncertainty. Many, when dealing with illness and crisis, will ask themselves why they are suffering, what the suffering means and how can they deal with it (Rogers & Wattis 2015). For some this connects with a desire for transcendence, a desire not to be alone in our struggles. Many definitions include transcendence as the core element of spirituality (Coyle 2002; Pesut et al 2008). In general transcendence is linked to a deep connection to God or a higher power (Chrash et al 2011) whilst others talk of transcendence as escape from the self (Foley 2010). Transcendence is defined as "existence or experience beyond the human experience" (Oxford Dictionary 2014, Para 1). For some transcendence appears to increase confusion and at times leads to more links to religion. The Royal College of Psychiatrists (2011) suggested it may be more helpful to view the concept of spirituality as individual and more subjective and experiential. This allows for those who view transcendence as being an important aspect of spirituality and those that don't.

Finally, when considering definitions of spirituality, hope, meaning and purpose are recurrent themes (Murrey & Zetner 1989; Tanyi 2002; Miner-Williams 2005; Milligan 2013; Reinert & Koenig 2013). Murrey and Zetner (1989) suggested that the existential debate about life, connection to the universe and understanding of the infinite were often undertaken to understand and discover what brought hope, meaning and purpose. They suggested that these came to the fore when a person

was faced with stress, illness and terminal certainty. Helping patients connect to what gives them hope, meaning and purpose was a motivator when life became difficult (Cook 2011; National Center of Continuing Education 2015). Reinert and Koenig (2013) suggested that nearly all definitions of spirituality include elements of positive emotional states when talking about hope, meaning and purpose. This may well be the case but as Swinton (2006) and Clarke (2006) reminded us these may be related to a negative motive and lead to the heinous acts of Hitler or paedophiles.

The large numbers of definitions of spirituality in nursing suggest there is a lack of conceptual clarity (Reinert & Koenig 2013). Despite this it is helpful to remain flexible in defining spirituality as what is important to the individual and recognising the uniqueness of each patient we care for (Milligan 2011). Equally ensuring any definition we align to is flexible and vague may make operationalising spirituality easier (Swinton & Pattison 2010).

Spirituality is frequently linked to religion and empirical studies often use religious parameters to assess spirituality. The next two sections will provide a very brief overview of religion and some of the research surrounding religion and health in order to address some of the criticisms made about this linkage. It does not include a presentation of religion as a whole or address theistic and non-theistic discussions as "religion" is not the focus of this thesis.

2.3 Religion:

Religion for many is a well-established construct based upon legal, political, societal, historical and sacred values. The Oxford English Dictionary (2014, Para 1) gives the primary meaning of religion as "belief in a superhuman controlling power especially in a personal God or gods". This prescriptive definition implies negativity and belittles

the dynamic and individual meaning that can be found with religious belief and relationship to the sacred (however the individual defines this). It has been suggested that religion is a construct which is both individual and institutional (Hill & Pargament 2003). Religion may be viewed as the politics of spirituality and in the midst of current world issues it could be argued that recent atrocities in the name of religion have added to negativity around religion (Rausch 2015), even though many may see many of these acts as misinterpretations of religious doctrine. Pesut et al (2008: 2806) suggested that religion is a "narrow band construct concerned with institutionalised beliefs and rituals whilst spirituality is seen as a broad band experiential journey". Again the implication could lead to religion being viewed less positively than spirituality. Viewing religion in this way may be unfair as many with religious beliefs would identify this as integral to their expression of spirituality (Kilpatrick et al 2005). Others, though, seek differentiation as noted by Clarke (2006) and Hill and Pargament (2003) who suggested that spirituality is often seen in more positive terms than religion. A differentiation between the two concepts may not be possible due to the many interpretations and definitions of religion which often reflect those of spirituality.

Clarke (2006a) argued that reductive and functional definitions of religion may lead to increased negativity and are limiting. One of these reductive definitions recognised by Hill & Pargament (2003: 64) is the view that religion is a "fixed system of ideas of ideological commitments". They suggested that this view negates the deep spiritual expression that can transpire for those with religious belief. Other views arise from sociological factors which have impacted the change of Christian religious belief in the United Kingdom. This includes the impact on how communities interacted, even

as recently as the Victorian era, to the more individualised, driven, materialistic culture of today (Rohr 2003; James 2007). Many seem drawn to something which appears more universal and encompassing than religion. However, the decline in religious belief and expression may leave some floundering for meaning and purpose in their life (Rohr 2003). Others see religion as much more vibrant, flexible and expansive, for example religion could be seen as that which incites passion and interest and builds community. It has been described as “the human quest to relate to an immaterial dimension of beatitude……” (Rose 2013: 12).

Historically religion was a community and societal practice where those without belief were seen as heretical. In recent history religion appears to have become a more individual practice and those with religious belief sometimes being viewed in the UK as almost heretical or deluded (Dawkins 2006). Recent polls suggest the UK population is more aligned to secularism rather than a Christian society with 57% not aligned to any religion (You Gov 2014). In comparison only 16% or those polled in the United States aligned themselves to no faith with three quarters identifying themselves as Christian and 53% of those attending a religious service at least monthly (Gallup 2014). Some of these cultural differences may partially explain the synergy with religion that some North American writers make with spirituality as viewed from a religious perspective. In a multicultural and increasingly secularised society it may be helpful to view spirituality and religion as distinct concepts whilst acknowledging that for some religion may be a means of expressing their spirituality. As previously discussed faith in God or a higher power may be integral to someone’s spirituality and may not be differentiated. Religion normally equates to a concept of God, however this is viewed, whether as sacred and transcendent or as part of self.

It is apparent that one can be religious without being spiritual and vice versa and that that many follow a religion purely for “social, political or cultural reasons without deriving much spiritual value from it” (Stevens Barnum 2011: 1).

French sociologist and philosopher Emile Durkheim postulated that “religion is a unified system of beliefs and practices relative to sacred things…..beliefs and practices which unite into one single moral community called a church and all who adhere to them” (Durkheim 1912: 44). The frequently quoted definition by Karl Marx proposed that “religion is the sigh of the oppressed creature, the heart of a heartless world and the soul of soulless conditions. It is the opium of the people” (Marx et al 2008: 255). This definition is often viewed negatively due the parallel drawn between religion and opium. However, Marx can be regarded as at least partly sympathetic to religion by recognising the need for solace in an oppressed society (Cline 2016). A more comprehensive and balanced view of religion offered from sociology proposed that religion includes personal beliefs and actions, in addition to those of institutions. These beliefs and actions assume the existence of a supreme being (Bruce 2009). This definition is valid for most religions and assumes a moral purpose of belief in this being. What is clear is that in the midst of multi-cultural society a definition needs to firstly have meaning but more importantly be substantive and inclusive enough to warrant acceptance. Definitions may stem from a particular religious tradition emphasising a core belief for example in an eternal God or it may be functional describing the attributes associated with religion. Harrison (2006) suggested that, like spirituality, religion is impossible to define because of its varied meaning and potential to cause division and contention. She proposed that it might be simpler to

describe religious tradition as this may be a more sensitive approach to the diversity of belief in a multi-cultural society.

McSherry and Cash (2004) prompted us to remember the religious factors which led to the historical heritage in nursing. There is a rich heritage in nursing passed down the generations from religious orders who founded the first hospitals. Traditionally spirituality was rooted in religious experience and relationship with God (O'Brien 1999; Pesut 2008) yet in the struggle to make spirituality more secular it is apparent some have stepped away from its religious roots. Florence Nightingale held deeply religious beliefs which guided her vocationally. She was the first nurse to advocate holistic care and suggested that spiritual needs were at the heart of nursing (O'Brien 2008: Young & Koopson 2011). Nightingale (2009) reminded us that the spiritual needs of a patient were as vital to health as the bodily organs. Distancing spirituality from its historical roots for wider usage in a multicultural and secular society may be causing too much dilution.

Clarke (2006a), in a literature review, found that religion was often seen as being about comfort and ritual, it included expression of spirituality and it could be seen as a social activity. Some of the literature suggested a narrower and more restrictive view of religion compared to spirituality. Clarke suggested that these views were reductive and often defined without reference to expert sources such as theology, anthropology and sociology. (Clarke 2006a: 782) reminded us of the heritage of religion stemming from "spiritual longings of cultures" who have formed many practices to "talk about God, usher God into everyday life and prepare the ground for his entering". Clarke (2006a) goes on to cite Berger's (1973: 34) definition; "Religion

is the human enterprise by which a sacred cosmos is established……" which she suggested was more meaningful.

It is important to recognise how religion in the UK has changed with the advent of differing religious beliefs stemming from multi-culturalism and also the increase in secularism. Multi-Culturalism continues to be a predominant trend in the United Kingdom with 12% of the population identified as an ethnic minority (ONS 2011). Historically Christianity held prominence and definitions of religion evolved out of that context. The need to present more inclusive and positive definitions could be argued in view of changing society. Pesut et al (2008), writing about spirituality and religion, have attempted this by focusing on what they view as a healthy outworking of religion. They described this as being transcendent through acts of compassion, focusing on the suffering of others, by acting as an individual and society. Finally Pesut et al (2008) suggested that recognising commonality as humans whilst accepting difference is paramount within religion. This description of religion could be widely accepted.

2.4 Religion and Spirituality in Health Research:

Despite the cultural drift from religion to a more secular society and the growth of a more diverse population due to migration, research has shown the importance of religion and spirituality to people's perceived health and wellbeing. The impact of health and illness in connection to religion and spirituality has been widely researched. Koenig et al (2011) undertook a comprehensive review of the international literature. From their extensive work it is clear that religion, religious practices and beliefs have a significant influence on the aetiology of illness, the

ability for a patient to heal and the ability of the patient to endure serious debilitating illness with a sense of hope and purpose. Out of the 1200 studies and 400 reviews they examined, the majority suggested a positive correlation between health, religion and spirituality despite many of the trials not setting out to show whether religion and spirituality affected health. Some showed a negative correlation between religion, spirituality and health but these were minimal when compared to the vast number showing positive correlations. Hill and Pargament (2003) also reviewed earlier studies into religion and spirituality with similar outcomes but identified that the reasons for these correlations are unclear. Many of these positive findings could be only indirectly linked to religion and spirituality. For instance, those with religious and spiritual beliefs might have healthier lifestyles (not smoking, not drinking, monogamous etc.). They might have a tight community of friends from their place of worship supporting them. They might positively rate mood in questionnaires as they believed not to do so might be seen as lacking faith. It is clear that some of the findings are anecdotal and tenuous when subjected to more rigorous study. However, the authors concluded there is enough strong empirical data to support the importance of religion and spirituality for many patients and its positive impact on illness and recovery. Koenig et al (2011) concluded that patients with a religious belief remain generally healthier and more resilient to managing and living with health issues. King (2014) challenged these findings suggesting that many of the studies were poor, methodologically weak and influenced by researcher bias. Koenig et al's (2011) review mainly focused on religious belief and religious practice (largely Christianity) as being more measurable than spirituality. The concepts of religion and spirituality were viewed by the authors as largely interchangeable in this context.

It is difficult to measure spirituality. The studies reviewed by Koenig et al (2011) show that many attempts to do so use religious practice as an indirect indicator of spirituality. These studies often have a Judeo-Christian focus (Hill & Pargament 2003). Hill and Pargament (2003) suggested that attempting to use religious and spiritual indices misjudges the complexities of these concepts including the plethora of definitions and interpretations.

Empirical research to date has mainly examined religious practice and health outcomes; this is often located in the prevailing culture studied (Hill & Pargament 2003). Many have utilised measures to do so focusing on global indices for example religious affiliation, belief and practice (Hill & Pargament 2003). Attempts have also been made to measure spirituality directly using various rating scales. Modod et al (2010) conducted a systematic review which identified thirty-five such scales. These were characterised as measuring general spirituality (N = 22), spiritual well-being (N = 5), spiritual coping (N = 4), and spiritual needs (N = 4). In healthcare research the two measures most commonly used included FACIT-Sp (Peterman et al 2002) and the Spiritual Well-Being Scale (SWBS) (Paloutzian et al 1982). Both of these scales include subscales relating to religious and existential dimensions. For example, the SWBS has two sub-scales, one for religious well-being (RWB) and the other for existential well-being (EWB). This may have more value than focusing on religious affiliation, belief and practice alone (Hill & Pargament 2003). The scores when summated give the overall SWBS score which gives a general indicator of perceived well-being (including spiritual well-being and spiritual quality of life as well as relationship with God and life's purpose and satisfaction). The SWBS was developed in North America and reflected the researchers' perceptions of spirituality influenced by the predominant culture. It could be argued that the inclusion of the

EWB improves applicability for those without a religious belief. Face validity is present for items which score in a positive direction in both subscales, for example “I believe that God loves me and cares about me” (RWB) and “I feel that life is a positive experience” (EWB). The RWB scale (which relates to God or a higher power rather than a specific set of religious beliefs) tends to have a ceiling effect in communities with strong religious beliefs. Moberg (2010: 107) criticised some of the scales used because they only gave a snapshot of information at a set time. He also suggested that statistical analysis “waters down complex feelings”.

Spiritual measurement scales may be helpful for specific research in specific groups. However, these will always have limitations as they are dependent on how spirituality is understood by researchers and participants. At the practical level in healthcare, as Gordon et al (2011) assert, it is more important when considering spirituality and spiritual care to understand what it means to the person being cared for.

In research it may sometimes be appropriate to separate spirituality from religion but this distinction was often found to be lacking in nursing and healthcare studies of spirituality (Sessanna et al 2010). McSherry et al (2004) suggested moving forward with more qualitative research on spirituality and conceptual discussions to examine more about spirituality in practice. Hill and Pargament (2003) and Moberg (2010) supported this stance by criticising the measures often used which suggest religion and spirituality are fixed constructs when in fact they are constantly evolving and dynamic. There has been a continuing move towards more qualitative approaches to researching spirituality. Moberg (2010) viewed qualitative methods as a way of capturing the richness of spirituality. Qualitative approaches can be used to understand further the relationship for the participant in terms of their spirituality and

how it connects to their own sense of meaning, hope and purpose (Moberg 2010). Reinert and Koenig (2013) still support the empirical research especially when considering religious involvement but in studying spirituality they recommended a broader, more inclusive definition of spirituality to be considered when providing spiritual care. As I understand Koenig's position, he believes that religion and religious practice are easier to define in a way that facilitates quantitative research (Koenig 2014). He believes there is sufficient commonality between spirituality and religion to mean that quantitative research reflects positively on spiritual issues but he also believes spiritual care in practice (as opposed to as a subject for research) should be heavily focussed on the individual (Koenig 2014). Qualitative research may be more useful for answering questions related to the individual and spiritual care. From the research perspective both quantitative and qualitative approaches have merit. For education and practice the issue for clinicians is how to operationalise spirituality at an interpersonal level and here the knowledge gained from the qualitative approach is particularly appropriate.

2.5 Why Spirituality? The Drivers:

Nursing and medicine recommend embedding spirituality into practice (NMC 2008: 2010; GMC 2013; ICN 2012). In nursing, good practice can be seen by the integration of spirituality into practice (NMC 2009; 2014; ICN 2012). It has been suggested that the omission of spiritual care could be seen as negligent (Tanyi et al 2009). Many nurses have struggled with this as they do not understand what spirituality is and how to operationalise it in practice (Miner-Williams 2005; McSherry & Jamieson 2011). The confusion about spirituality and how to operationalise it has led to nurses not engaging with spirituality in practice (Agrimson & Toft 2008; Chrash

et al 2011). As discussed in Chapter 1 it is possible that the omission of spirituality in the new NMC code of conduct will also have an impact on this.

A number of policy documents have acknowledged that spirituality plays a significant role during illness and in the healing process (Department of Health (DoH) 2008; NHS Scotland 2009). Not engaging with spirituality in nursing care “may be detrimental to the provision of high quality nursing care” (McSherry 2010: 15). Consequently, there has been a significant increase in publications around spirituality in recent years (Treloar 2000; Pesut et al 2009) especially in health and social care. Healthcare policies have begun to view spirituality as an important aspect of care which needs to be addressed. Robinson et al (2003) saw the increase in policies discussing spirituality as positive though they suggested they needed to be much clearer and more specific about integrating spirituality into healthcare.

NHS Scotland (2009) offered clarity about spirituality and suggested that spiritual care was essential to healthcare practice. They advocated an approach that accepted uniqueness, was inclusive and was individualised. In 2004 the Department of Health launched the final draft of the NHS Knowledge and Skills Framework (KSF) which specified the knowledge and skills staff needed in the NHS to provide high quality care (DoH 2004). Within this extensive document there was a clear message that all staff working in the NHS should provide spiritual care in its broadest sense. Although it stated that spiritual care should be offered there was no clear definition of what this meant. What was apparent was that in order to provide holistic care we needed to provide compassionate care which addressed emotional, mental, physical, social and spiritual dimensions (DoH, 2004).

In order to provide spiritual care NHS Scotland published a resource for all NHS staff entitled Spiritual Care Matters (NHS Scotland 2009). This aimed to demystify spirituality and give staff a clearer understanding of what their role should be and how to operationalise spirituality. NHS Scotland suggested that spiritual care was:

> *"that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply to be a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires*" (NHS Scotland 2009: 6).

Within this Spiritual Care Matters resource, spiritual care and compassionate care were seen as going hand in hand and were highlighted as integral to holistic care, alongside psychological, social and physical care. They alluded to spiritual care as being different to psychological care although this was not expanded upon. Compassion is high on the agenda of the NHS with rising media coverage about substandard care and failings of healthcare professionals to provide high standard care (NHS Scotland 2009). Nolan (2011) saw spiritual care and psychological care as sharing many of the same attributes and skill sets. He suggested that good spiritual care focused on the soul which seems to connect with the essence of a person as described by Narayanasamy (2004). Compassion was integral to holistic care and could be viewed as an operational way of demonstrating care for a patient's suffering in all its manifestations. Compassionate approaches to care ensured the relationship between patient and clinician was based upon respect and dignity with an empathic stance maintained (Cummings & Bennett 2012). Working in this way

allowed opportunities to be aware of patients' holistic needs and not to focus purely upon the initial presenting problem.

There are clearly significant links between spirituality and compassion. Compassion is an inherent aspect of spiritual care and includes listening to, understanding and valuing patients as unique individuals with differing needs. It also encompasses respect and dignity which many policies associate with compassionate care (Cummings & Bennett 2012). Pfeiffer et al (2014) suggested that spiritual care is deeply compassionate care. The DoH (2008) identified that by practising compassionate care, healthcare clinicians can significantly improve a patient's life. Clinicians should listen and talk to their patients as a fundamental aspect of basic care and compassion. This was echoed in several recent DoH publications Compassion in Practice (DoH 2012), NHS Constitution for England (DoH 2013a) and Treating Patients and Service Users with Respect, Dignity and Compassion (DoH 2013b) where patients are at the heart of all we do. However, as the Francis report reminded us lack of care and compassion was at the root of many of the incidents at Mid Staffordshire Hospital (Francis 2013). Although none of these recent policies and documents identified spirituality separately they all alluded to core aspects of spirituality through a call to NHS staff to maintain a culture of compassion and care.

In addition to Government policies the NMC highlighted spirituality within their standards for nurse education (NMC 2010). Additionally, spirituality was acknowledged as part of holistic practice by the NMC and the RCN which included five spiritual competencies (NMC 2005; RCN 2008). Evidence suggests that many nurses find discussing spiritual dimensions of care with patients, family members and fellow clinicians challenging. Potential barriers to embedding spirituality into

practice includes time constraints, lack of education and understanding of what spirituality is, lack of confidence, personal discomfort, not wanting to intrude on something seen as private or fear of proselytising and belief it is not the clinician's role (Stranahan et al 2001; Maddox et al 2001; Ellis et al 2002; Ellis et al 2004; Hubbell et al 2006; Lewinson et al 2015; McSherry and Jamieson 2013; Tanyi et al 2009).

In the UK a survey of nurses' perceptions of spirituality and spiritual care was carried out with 4054 respondents (McSherry & Jamieson 2013). This study discovered that although there was a struggle for many nurses to conceptualise spirituality they could recognise its importance to patients. It was evident that nurses felt that spiritual care should be offered to patients with 92.6% of the nurses' surveyed agreeing to this statement; but only 5.3% felt they could meet spiritual needs of patients all the time. Despite this 92.2% of the nurses identified that they could sometimes address spiritual needs. There was no information about how they would do this and lack of training in this area was highlighted. The findings suggested that nurses needed more education and specific guidance about spirituality and spiritual care, clarification about boundaries and help to pick up the clues that might indicate a spiritual need. In addition, they felt they might need support in dealing with spirituality and knowledge of when to refer on. It was clear that taking time to listen and presence with a patient was an important aspect of spiritual care (McSherry & Jamieson 2013). In response to the survey the RCN (2011) produced a pocket guide - Spirituality in Nursing Care (RCN 2011) offering nurses a definition, exploring what spirituality is and is not and guidance of how to provide spiritual care and when to refer on.

University teachers mainly from nursing but also other healthcare professions found that whilst around 90% agreed or agreed strongly that spiritual values were relevant to their subject area and over half thought it was integral to teaching and learning, only 17% agreed it was actually integrated into their curricula (Prentis et al, 2014). It is important that educators embrace spirituality as part of holistic care and integral to the curriculum to support nurses and other healthcare clinicians to be able to understand and offer spiritual care.

There is clearly a drive to integrate spirituality into practice and policy drivers with clinicians and educators viewing this as important. The challenge is how to do this in a way which meets patients' needs. Being clear about what spirituality means can make addressing this subject with patients much easier. Including spirituality within the nursing curriculum is an important way of ensuring nurses have the opportunity to explore what spirituality is and how to address it in practice.

2.6 Spiritual Care in Practice:

Many robust studies have shown that spirituality is fundamental for patients (Ellis et al 1999; Koenig et al 2001; Koenig 2004; Ellis et al 2004; Burkhardt 2007; D'Souza 2007) in helping them regain hope, meaning and purpose in the midst of illness. There is growing evidence to show that addressing spirituality improves comfort levels (emotionally and physically) and has a positive effect on patients' responses to illness and treatments (Koenig 2004). Thus failing to address these issues may be exposing patients to more suffering.

Spiritual Care is how spirituality is operationalised in practice. Pfeiffer et al (2014) proposed that spiritual care was fundamentally compassionate care which was deeply respectful and needed intentional connection between nurses and patients. McSherry (2006b: 917) suggested that “spiritual care permeates and integrates all aspects of care provision just as spirituality integrates and unites all dimensions of the individual”. Nursing has engaged partially with the debate about how to provide care which is not just physical and emotional but also spiritual. Nevertheless, this may have been reduced to asking about whether a patient has a faith rather than what are their spiritual needs (Eagger 2011). Agrimson and Toft (2008) and Young and Koopson (2011) suggested that being in touch with our own spirituality was the first step to being able to provide spiritual care for others. This reflected Treloar’s (2000) paper which stated that the breadth and depth of the spiritual care offered reflected the nurse’s own spiritual maturity. In order to be a spiritually competent practitioner it appears necessary to explore one’s own spirituality.

Addressing the spiritual dimension with respect for patients’ values and dignity is vital. An individualised, holistic approach emphasises that one of the main aspects of providing spiritual care is to understand what spirituality means for the patient being cared for (Gordon et al 2011). This is likely to be the only approach one can take when recognising spirituality in a multi-cultural society where there are a variety of religious beliefs and a significant proportion of the population who do not consider themselves to be religious at all.

Some patients want to talk about spirituality with clinicians (Ellis et al 2002; Ellis et al 2004). Additionally, some nurses assert that spirituality is important in their practice (Stranahan 2001; McSherry &Jamieson 2013). Listening attentively to patient cues may lead naturally to discussions about spirituality (Ellis et al 2004: Helming 2009).

When nurses are open, accepting and compassionate patients may find it easier to open up about deep concerns. McSherry and Jamieson (2013) found that 90% of the participants surveyed about spirituality felt that listening to and allowing patient's time to talk and explore their anxieties, troubles and fears was part of spiritual care. They also found that spiritual care included the nurses giving support and reassurance to their patients.

A review of spirituality from within occupational therapy practice suggested it may be easier to describe spiritually competent practice than to define spirituality (Jones 2014). A more generic consideration of spiritually competent practice was published last year:

> "Spiritually competent practice engages a person as a unique spiritual being, in ways which will provide them with a sense of meaning and purpose, connecting or reconnecting with a community where they experience a sense of wellbeing, addressing suffering and developing coping strategies to improve their quality of life. This includes the practitioner accepting a person's beliefs and values whether they are religious in foundation or not and practicing with cultural competency" (Rogers & Wattis 2015: 53).

Puchalski (2001) asserted that illness, especially life-threatening or disabling illness may challenge the understanding that patients have built for themselves about the meaning and purpose of their lives. Serious illnesses often involve losses, including loss of income, abilities and role. They may even result in a feeling of loss of meaning and purpose and readjustment of life goals. If we accept spiritually competent practice as a useful way of being able to operationalise spirituality, then

one of the functions of the spiritually competent nurse is to recognise these challenges and to support patients in responding to them.

As nurses continue to strive to offer holistic care they need to be aware that when patients are faced with illness, pain, vulnerability and distress they often want nurses to address issues related to spirituality (Rogers & Wattis 2015). Nurses are in the ideal place to listen to patients as they ask often deeply spiritual questions and invite us into their questioning. A number of spiritual assessment tools have been developed for practice including “FICA” and “HOPE” (Puchalski & Romer 2000; Anandarajah & Hight 2001) (Appendix 1). However, in an individualised approach to spiritual care a questionnaire is not necessarily the best way to approach the issue and may not be helpful in a ten-minute primary care appointment.

Leathard and Cook (2008) suggested spiritual care is about being with a patient and simply listening attentively to these cues, taking time and prescencing. Listening has been shown to be a common feature of spiritual care (McSherry & Jamieson 2013; Pfeiffer et al 2014). Simply allowing a patient to tell their own story and to listen empathetically with suitable prompts to give the patient an opportunity to discuss what illness means for them and to understand how it may be disrupting their sense of purpose in life may be the most important aspect of spiritual care. These fundamentals of nursing practice lead nurses towards spiritual care if they take time to recognise it as such. In order to feel comfortable an individualised approach to spiritual care is needed in addition to cultural sensitivity and an ability to discern what is important to patients (Rogers & Wattis 2015). This is often different depending on a patient’s age, upbringing, values and beliefs. Additionally, there may be different hopes and expectations and different ideas about meaning and purpose in life to that

of the nurse. Nurses' self-reflection, self-awareness and an ability to be non-judgemental and open with patients are important (Rogers & Wattis 2015).

Following the Francis Report which found multiple failings in NHS care specifically around care and communication, the 6 C's (care, compassion, competence, communication, courage and commitment) of nursing were proposed (NHS 2012). The 6 C's are now well established in nursing and should ensure patients receive consistency in the care they receive as nurses commit to working to embedded values (NHS 2014). The advent of the 6 C's of was a timely reminder of the core of nursing as these characteristics are needed to provide supportive relationships with patients during times of difficulty (DoH 2012). Additionally, they are key to spiritual care which is part of holistic care and is not an additional task, laborious or complicated; in fact it is integrated with all other aspects of nursing (McSherry 2006a; Pfeiffer et al 2014).

To operationalise spirituality in practice it is necessary for nurses to adopt a positive attitude. A key starting point is recognising that patients do want to talk about spirituality and that it is important in their recovery. Ellis et al (2004) in a study of patients and spirituality found that patients will not begin to talk about their spiritual needs unless they felt honoured and respected. Nurses therefore need to value patients and spend time building up a good rapport. If spirituality was not addressed some patients believed that it would adversely impact the healing process. Clinicians who already integrated spirituality into their own practice appeared to be those who were aware of their own spirituality and listened to patient cues (Treloar 2000; Stranahan 2001; Ellis et al 2002; Hubbell et al 2006).

Spiritual care is fundamental to holistic practice. It appears to include the core skills of nursing for example compassion, prescencing, individual care, listening and respect. It is integrated in the way nurses interact with patients. It requires a level of maturity and recognition of the importance of spirituality to patients.

2.7 Ethical Issues in Operationalising Spiritual Care:

The autonomous nature of the ANP role makes ethical issues and appropriate boundaries particularly relevant for ANPs when addressing spirituality. Fundamentally all practitioners work within a code of conduct and are accountable for their own practice. Integrating spirituality into practice is no different to any other area of healthcare and demands the same levels of professionalism.

Tacitly a level of trust must be present in all patient consultations with the expectation that nurses are committed to, and work within, the code of conduct laid out by the NMC (NMC 2015). It is important to practice in a way which is validating of the patient and non-judgmental, with the core aim of altruism rather than professional status.

The NMC have stated that personal beliefs should not be expressed to a patient in an inappropriate way (NMC 2015). Many patients draw comfort and support from their spirituality and some by shared religious values and beliefs. Patients may ask directly about nurses' personal beliefs. Even when initiated by the patient there is a need to be prudent to share appropriately and not to proselytise.

Spirituality is an area where nurses appear to be concerned about crossing boundaries and ethical issues (McSherry & Jamieson 2013). Studies confirm concern about not imposing one's own values and relate to a fear of projecting one's

own belief onto a patient which is seen as an abuse of the relationship (Ellis et al 2002, Monroe et al 2003 and Ellis et al 2004). Many will recall the nurse who was suspended for offering to pray for a patient in 2009 (BBC 2009) and this may have increased reticence to explore spirituality for fear of being accused of proselytising.

If the patient has initiated the conversation it could be interpreted as giving consent as they have broached the subject. Thus consent is implied through the initiation of the conversation. The RCN (2011) suggested that nurses consider issues of patient initiation, consent, compliance with the NMC code of conduct, in addition to patient safety, appropriateness and not causing offence when addressing spiritual needs. They also suggested that nurses consider whether they feel comfortable and have the knowledge to support their patient with their spiritual needs (RCN 2011). It is also important to consider the appropriateness of one's response and whether it could cause offense. Cook (2011) reinforced this and suggested that, when discussing religious beliefs or spirituality, consent should be elicited from patients before entering into discussions. Patients should never be put under pressure to share their own beliefs and never be put under any pressure to adopt practitioners' beliefs; doing so I believe could be considered a breach of the code of conduct (NMC 2015). The General Medical Council (GMC) (2013a) makes it clear for doctors that personal expression of beliefs to potentially vulnerable patients is not following the tenets of good medical practice. On the other hand it specifically expects doctors in clinical practice to "adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values" (GMC 2013b: 1).

In order to act in the best interests of patients in judging how much to say about spirituality it is worth bearing in mind fundamental ethical principle of beneficence.

Clarke (2013: 43) stated that “being aware of the other person and recognising their worth and value….is the basis of spiritual care. This she suggested is simply “being human…..built on the desire for the welfare of the other” (Clarke 2013: 43).

2.8 Summary:

This chapter has presented an introduction to the theoretical perspectives of spirituality in relation to health care. It has engaged with the contemporary discussions around how to define spirituality and the often presented link to religion. A brief overview of the research into religion and health has been presented in order to balance the argument regarding lack of empirical studies on spirituality. Consideration has been given to the drivers for spirituality in healthcare in addition to operationalising spirituality in practice. Despite the many challenges surrounding spirituality it is expected that nurses offer spiritual care as part of their holistic practice.

Chapter 3 Availability and Vulnerability- The Philosophical Context and Lens for this Study

3.1 Introduction:

This chapter introduces the origins of the concepts of Availability and Vulnerability (A&V) including the rationale for using them as a lens for this study. I reflect on the concepts of Availability and Vulnerability (A&V), how they have come to have personal significance for me and my clinical practice as an ANP and why this may be a useful lens for the exploration of spirituality in this context. Sections of the chapter written in the first person reflect my own spiritual journey and the historical context of the development of the concepts of A&V developed by the Northumbria Community. Finally, a critique of the concepts of A&V is offered from a theological, nursing and psycho-social view point.

The Northumbria Community is a dispersed Celtic Christian monastic community with a “mother house” based in Northumberland. I became a companion in the Northumbria Community seventeen years ago and have chosen to integrate a concept which they live by of Availability and Vulnerability into my own life and work including my role as an ANP. Choosing to utilise A&V as a lens for this study immediately leads to bias as my own presuppositions and subjectivity will be evident within the research. The strategies used to acknowledge and manage this bias are explored and justified in the methodology chapter.

The significance and purpose of this section is to tell the story of my journey to becoming available and vulnerable and my reasons for linking this concept with spiritual dimensions of ANP consultations. From a phenomenological point of view it is realistic to include these reflections in the research. Sections 3.2 & 3.6 of this chapter are descriptive and resonate for me with the Celtic tradition of story-telling

which is a key aspect of Celtic spirituality (Stewart 2000).

3.2 My Journey:

My interest in spirituality stemmed from an early age although at that time I would not have labelled it as such. I grew up in a family affected by severe depression which had a significant impact on my childhood. I learnt at an early age that my inner journey held a way to understand some of the inconsistency and challenges that faced me in my outer journey. There was no Christian influence in my family. However, I became involved in my local church through the Brownie and Guide movement where I was active. I am not sure I thought hugely about God or even listened at the church services but something about the liturgy gave me solace and opened up many of the ontological and existential questions of life. As I grew up I often thought about the purpose of my life and had a childlike faith, thinking that life without God seemed to have no meaning. I did not consider what it meant to have a strong faith or what this God meant for me until I went to nursing school.

Throughout my teens I spent much of my time seeking achievement. I became a young leader for the Guides; I worked as a shop assistant and waitress from the age of 14, attained my Duke of Edinburgh Awards up to Gold, was selected to represent Yorkshire on two Sail Training expeditions and also represented my school on an expedition to the Himalayas. As a teen I was sociable and keen to find out about others' lives through the experiences and adventures I had. I always had a nurturing, caring and compassionate personality and naturally followed my vocation as a nurse to St Bartholomew's Hospital in London. On completing my nursing studies I went on to work in Africa for a charity on a hospital ship before commencing my nursing career in London followed by Canada then Leeds. These teenage experiences and

varied work experiences led me to see the world in a different light, I saw poverty, affliction and struggle as well as the human determination to face trials and live in a way that cultivated the human spirit. This was seen in the expeditions I undertook, working in developing countries, voluntary work in the community, my family life and working with young people. I developed a vision to care for others and walk alongside them in their suffering. This vision later became a source of deep reflection as I worked with many patients and their loved ones facing illness, adversity and death.

Throughout my formative years I remember significant people who mentored and inspired me to consider my inner journey. They helped me see the way my life, work and developing spirituality could make a difference to those around me. At the time I don't remember deep ontological discussions but a number of significant encounters, occurring well into my adult life, challenged my way of thinking, living and working. These people radiated an altruistic view of the world. They lived their spirituality by their caring, compassionate, understanding of struggle in humanity and the pain associated with being human. They helped to nurture me in a way that cultivated my deepest compassion for others and led me to fulfil my vocation as a nurse which has been the focus of my working life for over twenty-five years.

These formative relationships, my childhood and the expeditions to differing cultures led me to consider the meaning of life throughout my life. At eighteen this led to an exploration of Christianity and I made a commitment to become a Christian at nineteen. In many ways my faith journey created more questions than answers. The deep belief when I was younger was that God and spirituality was synonymous. This has been challenged and refined to a completely different stance now in my forties

where I see that for some faith and spirituality are synonymous but for many their spirituality comes from relationships, hobbies or nature for example. As a young woman I found a level of safety in what seemed to be the black and white Christian values that were taught to me through different courses and groups I attended. As life in my early years had seemed inconsistent and at times chaotic I clung to the safety of this Christian box that I kept myself safe in. The values of Christianity then as now deeply influence my view on life and my care for others. However, I have moved to a deeper spirituality rather than a religious way of living in that my faith is an inner journey rather than the outer aspects of church attendance and following doctrine for example. The black and white values I held to are now very much grey which has created many more challenges in my life but has led to much more richness.

My journey through faith to what I now see as spirituality has been the hardest adventure of my life. It has challenged my core beliefs, values and moral compass. I have seen how within church settings people can become disillusioned. Some individuals within a church setting seem to feel they need to put on a mask of Christian living whilst they struggle with the challenges we all face which make us human; love, fear, pain, selfishness, jealousy, lust, betrayal, loss, sexuality and morality for example. Often, I witnessed those involved in a church setting feel as though they couldn't be real for fear others might think they did not have enough faith. Some of my work in church settings was supporting and counselling those who came onto a course I ran about relationships, sexuality and trauma. Through this I helped to foster a place where people could be vulnerable and real in a place of safety. I found many people had felt trapped by their belief that they had to be a certain way which seemed to stem from church politics rather than the life Jesus

talked of and lived, according to the New Testament accounts. I became passionate about being authentic in my life and faith which led me to explore how this was expressed in my own day to day living.

Part of this journey led me out of “church” towards other faith communities who were struggling with what it means to have a faith and live authentically. My faith journey had been a rollercoaster with times of major activity within church settings to becoming disillusioned and frustrated about the chasm that often existed in people’s day to day life, appearance and attitudes on a Sunday at church. Personally I felt I had been seeking something external to bring me a place of authenticity in my faith rather than considering my inner journey.

3.3 The Northumbria Community:

I came across the Northumbria Community seventeen years ago through a chance conversation with an acquaintance. Having just finished facilitating a year-long course on the deeper issues of life I felt burnt out, I went to the Northumbria Community for a week’s retreat not knowing what to expect. On arrival I was surprised to find a diverse group of people including a homeless man, two Goths, several academics, families and church leaders who were struggling with organised church and were seeking companions to be authentic with in their questioning of organised religion. What I found at the Northumbria Community was an embracement of others irrespective of their life journey. During the first ten years of being a companion of the community I was never asked about my occupation, people were interested in me for me; a revelation as nursing formed part of my sense of self. Part of the values of the Northumbria Community is “the conviction that who a person is counts far more than what a person does…” (Miller 2003: 34). I also

found an acceptance for my faith journey reinforced on my first visit by one of the house team who said “you are where you are on your journey and that’s ok”. What struck me was that this community of people were wrestling with the issue of how to live authentically as a Christian. When I first attended the community it was embryonic; there was little written guidance for the people who visited or became “companions”. Individuals focussed on reflecting on their own journeys, experiences and challenges, following a rhythm to the day which included time to read, pray, work, reflect, eat and live together.

The Northumbria Community’s mother house was a house deep within the beautiful countryside of the Cheviots where people could go to retreat. There was a rhythm of the day based on monastic practices of prayer, work, rest and community with specific influences of a rich Northumbrian Celtic Christian heritage in order to integrate faith into daily life. As the Northumbria Community grew it formed a dispersed community of people with a similar vision and ethos; with most companions living across the country and only a few based at the house which was a place for companions to come together to meet, to retreat and to take time out of their busy lives for contemplation. I often would go for a retreat to give me time to reflect on my own life and explore my questions I had about my own spirituality with people who would listen and could relate to some of my questioning. What often struck me were the advantages of living as a dispersed community (part of the NC vision for a church without walls) where relationship rather than denomination or place was the priority. The Northumbria Community has steadily grown from when I joined when there were around 50 members into a larger community with 375 companions worldwide, 1700 friends and around 1000 visitors (Askew 2014). Many people become friends and others visit the Northumbria Community new “mother

house" which is now in Felton where retreats are held giving time to study specific areas including spiritual formation and ways of living the Rule. Individual retreats are offered weekly where companions, friends and visitors can come for a time to seek God and find space for reflection and inner refreshment. When I joined the community it was organic. There was no written information about the community; there was a freedom to explore the community's ideas with no set guidance. There is now a formal process involved in becoming a companion where a number of core modules are followed with a mentor to discern the vocation as a companion and understand the ethos and vision of the Northumbria Community. Additionally, a number of texts have been published, the most well-known being Celtic Daily Prayer to guide readers through the rhythm of daily life. I think this is inevitable when a community grows to the numbers it now has but the NC has tried to ensure that the guidelines still offer individuals creativity and flexibility in following the modules and they are just a guide rather than a rule.

The Northumbria Community described itself in terms of being an ecumenical new monastic community. New monastic in terms of a fresh expression and authentic living out of the Christian faith within a community setting and in the sense of drawing from the traditional monastic lifestyle of living within a Rule of Life. The Northumbria Community's Rule of Life was developed for companions to follow integrating the concepts of Availability and Vulnerability into their daily lives (Appendix 2). The Rule was and still is the fundamental backbone of the Northumbria Community which companions choose to embrace within their own lives. Similar to other monastic communities the Rule of Life is made up of vows. The two vows taken by companions of the community are Availability (to God and others) and intentional, deliberate Vulnerability (before God and others). The Rule is key to

being a new monastic community and reflects who the community is and their story. I felt drawn to this as it is not set to be prescriptive but rather provocative; a challenge as to how to live one's day-to-day life with the flexibility and adaptability needed for individuals' varied journeys. The Northumbria Community (2004:8) suggested that the Rule "serves as a framework for freedom - not as a set of rules that restrict or deny life".

For me the simplicity of the Rule of Life is a framework for a way of living authentically which resonates with many of my personal inner struggles. Other monastic communities also live by a Rule however some are prescriptive like the Iona Community whilst others are more complex and possibly unwieldy for those outside a monastic life, focusing on principles of religious life and behaviour like the Benedictines. To be part of a community that welcomes questions and indeed encourages them is freeing. A community where all are valued and status is not sought, where a real spirituality is reflected in daily life and where the value of being authentic is nurtured enabled me to reach a place where the dissonance between my faith and my way of living was no longer so great. Spirituality for companions of the community is grounded in the Rule and comes out of each individual's difficult and challenging life journey; it comes out of deep questioning including "How do I live with myself? How do I live with others? How do I relate to the world around me? How do I find time and space for God?" (Northumbria Community 2004: 10).

3.4 Availability and Vulnerability:

Trevor Miller, one of the founders of the community, suggested that A&V are the key to authentic living (Miller 2014). Being available is defined as being accessible, at the disposal of another and serving others (Northumbria Community 2004). Miller (2014)

takes this further embracing hospitality as an outworking of availability in the Christian context. His descriptions of availability resonate as they call companions to be hospitable by welcoming others; in doing so he suggested we welcome Jesus into our own lives. Availability is then extended into care and concern for others through action, prayer and intercession; being hospitable to others and following Jesus in our own vocation (Miller 2014). This definition of availability if taken literally has far reaching consequences for one's life and work. Companions are encouraged to work this out in their own way within the context of their own lives.

Choosing availability as a bedrock for their approach to others evoked a significant question for the community which continues to be a place of exploration and grappling for companions. The question that follows from the principle of availability is "How then shall we live?" It is all very well choosing availability but if one is to be authentic this decrees vulnerability and not just embracing, but living out of these vows. This is something I continue to reflect upon as I have values and beliefs that are fundamental to my life and I want to live authentically by these. What I often struggle with though is my own selfishness that means I do not want to be available and vulnerable at times! However, the Rule recognises that we are human and that this is a journey not a destination. This gives me hope that as I continue to mature and reflect my ethos can be evolving. At present I acknowledge it would not be possible to live in a way that is consistently available and vulnerable.

The marrying of A&V significantly brings with it a desire and willingness to fully connect with others and God. Vulnerability for many is seen as weakness and a place of being hurt (Herrick & Mann 1998). Indeed, Thompson (1995) defined vulnerability as being exposed to damage from wounding or to be harmed. The

Northumbria Community suggested a position of choosing to be intentionally vulnerable thus exposing oneself to, or being willing to risk being harmed and wounded. Counter-intuitive though this may seem the community asserted that embracing vulnerability in this way can lead to extraordinary freedom and connection with others. Herrick & Mann (1998) suggested that it takes courage to risk being vulnerable but by doing so we engender hope in others. Rolheiser (2004) talked about not becoming a doormat by becoming vulnerable and going to the extreme of letting every aspect of our lives hang out. He suggested true vulnerability is held within the strength of being able to be present to another without the “false props” we often use to bolster our egos. Vanier (1982) talked about how our choice of vulnerability over ego can transform those in our care by creating the safety for them to feel loved and accepted; able to lift their masks and risk being vulnerable themselves. These viewpoints speak significantly to me and have helped me to understand more about vulnerability and the power of embracing this attitude and stance in my own life. Many times through illness and difficulties patients come to see me and are already vulnerable; it is part of my job to acknowledge this and create the safety for them to feel held.

The Northumbria Community is attentive to how embracing A&V can impact companions positively and adversely. They encouraged accountability through soul friends (a Celtic tradition of walking alongside another sharing intimately about one’s journey with God and in life). In this relationship companions can be authentic, accountable and share the ups and downs of the journey with someone who sees, accepts and supports them for the beauty of who they really are. The Northumbria Community (2005: 10) suggested that a soul friend is “someone you choose to be there for you on that inner journey; to be there for you in the good and bad times”.

The soul friend sees your best and the worst in you and is committed to supporting you. Choosing a life embracing A&V is risky and to be able to talk through the implications and experiences of living this way and to be seen as you are can be, in my experience, profoundly helpful. Reflection and discussion with a soul friend has often helped me to discern how to live out the values of the Northumbria Community in a healthy way at home and at work. Herrick and Mann (1998) cautioned that you can't be vulnerable with every person in every situation and discernment must come into play to be able to be vulnerable in a healthy, life-giving way. Within this, boundaries need to be established not to prevent relationships developing but to actually give them more freedom within the limits individually set. An example for me has been in my support offered to friends struggling with addiction. I have supported friends through alcoholism, sex addiction and eating disorders and have been there with and for them over long periods of time. It would not have been helpful for me to at every point of need to drop everything and come to their physical aid. There was a need to establish some boundaries in order to attempt to empower them to address their issues; however consistently affirming acceptance and care was profoundly helpful for them in their journey. If I had dropped everything at each point of need I would have ended up exhausted, bitter and burnt out. The boundaries laid and the discernment of when to be there physically and when to support from afar was what enabled me to truly offer care and support within the context of A&V. Nouwen (1998) suggested that without boundaries the needs of others can become overwhelming; in order to remain in a place of mutuality one must hold onto one's own identity for example not try to be everything to everyone. Availability and Vulnerability involve a measure of control in order to relate in a healthy way (Herrick & Mann 1998). The intention of holding to A&V as one's ethos and working this out is actually

strengthened through healthy boundaries rather than diminished.

For the Northumbria Community being vulnerable also included being willing to be teachable, being willing to learn and willing to change. This is often in the context of prayer and scriptures but also, through dialogue with others, being willing to adapt many of their convictions away from potentially judgemental stances. Faith in God is seen as an absolute. However, understanding other people and being accepting and open to differences encouraged companions of the community to allow their convictions to be challenged and sometimes changed. Life as a companion included being open to change whilst remaining in the context of the stability of relationship with God. Being open and willing to be teachable and also to consider changing or refining my views has been important in my own journey which, as mentioned, began in the black and white context of an evangelical church. The move to uncertainty in many aspects of my life whilst holding the certainty of my faith in God has been freeing and has enabled me to continually reflect and review my own experiences and conceptions of life. Interestingly it has brought more colour and life in addition to an expectation that I am constantly evolving and journeying which is exciting at times. Vulnerability and willingness to learn and adapt stem from companions being asked to embrace the Heretical Imperative for self and others (Northumbria Community 2002). This is practiced through “challenging the assumed truth, being receptive to criticism, affirming that relationship matters more than reputation…” (Miller 2014, no page number). Accepting to live in this way making a choice to challenge rather than just accepting the status quo at times can be a very vulnerable position to take.

3.5 Context for Using Availability and Vulnerability as a Lens for this Study:

As I have chosen to be available and vulnerable in my professional practice, I have seen how this has impacted on my connection with patients and how it has enabled me to integrate spirituality into my practice. Personal reflection, observation of clinical practice and study of the literature has highlighted the difficulty in operationalising spirituality. Holistic ANP practice includes spirituality yet ANPs struggle to know what spiritual care actually means. The decision to use A&V as a lens for this study was an attempt to explore whether A&V could be transported to settings where faith, religion and spiritual beliefs of those concerned cannot be assumed, offering structure and direction in ANP practice. There is a precedent for this in the example of how mindfulness has been adapted from Buddhism to be integrated into secular healthcare as a recognised treatment option (Williams & Penman 2011).

Translating A&V into my life and work has meant giving not just time to my patients and those in my own life but truly being present through listening, care and compassion. It has meant choosing to be hospitable when I have not wanted to be, when I am stressed, burnt-out or distracted by my own issues in life. It has involved being intentional in my work and life relationships to try to be there, to understand, to give of myself unconditionally within the boundaries of context. It has necessitated standing up when I have seen injustice and standing alongside others as they struggle to be heard. It has led to saying yes to being human especially in the context of the consultation allowing my patients to see me as a person and not just their ANP. This has required at times sharing of myself within the boundaries of the code of conduct as a nurse and, in my view, appropriately. For example, after

diagnosing a patient with bowel cancer we talked about his treatment and prognosis; I shared with him that my dad had been through similar and I understood some of how he may be feeling. This helped this particular patient to feel held and cared for by someone who could empathise rather than sympathise. What was important from me in my sharing was that my emotional distress about my dad was not present; he had had bowel cancer 10 years previously. I don't think it would be appropriate to share something which could lead to the consultation becoming about my distress; the aim in my sharing was to be supportive and empathise appropriately. Other times I have tried to offer patients hope when going through significant illness by sharing learning from other patient's experiences (anonymously) which I have witnessed and what helped others at times like this. Occasionally my sharing may be something seemingly small and incidental like a recent trip to somewhere they too may have been or a connection with a hobby they may also have. The times I share something of myself are often spontaneous though within me there is a strong sense of boundaries and not confusing the professional relationship. This means that the aspects shared are often from the past where the emotions for me have been worked through and I feel contained in my sharing or something which is not at a depth where it would have an adverse impact on me. It would not benefit my patients if I became distressed about aspects of my life whilst trying to support them or if the consultation lost focus from them. However, the sharing of myself and my experiences has repeatedly shown me that patients appreciate this and feel more understood and able to trust me when they recognise my humanity within my professional role.

In these choices and ways of practicing with my patients I have chosen to be available and vulnerable and I have seen how this has impacted on my connection

with patients and how it has enabled me to integrate spirituality into practice. Using A&V as a lens for this study will enable exploration of whether this may be similar for other ANPs.

3.6 Review of Availability and Vulnerability:

In view of this thesis using a conceptualisation of A & V from a Celtic Christian monastic community it is necessary to review these concepts from a broader perspective. A&V is central to the thinking of a number of Christian theologians and is also evident in philosophical positions taken in nursing and the psycho-social literature. This section aims to locate A&V in this wider literature, justifying its value as a lens for this study.

3.6.1 Theological Perspective:

From the foundations of Christianity two fundamental texts, the Sermon on the Mount (Matthew 5: 1-12) and Jesus's response of loving the Lord your God with all your heart, soul and mind and loving your neighbour as yourself to the question about the greatest commandment (Matthew 22: 36-40) have influenced Christian life. These texts are alluded to throughout this section in view of their relationship to availability and vulnerability. The central concept that God is love leads Christians to caring for their neighbour.

Vanier (2004b) and Reynolds (2008) are two embodied theologians who have written widely about caring for those in society with disabilities. Their texts reflect the essence of A&V and both of them speak of the need to engage with others with compassion and humanity. Hospitality leads as a strong theme in both their messages; an active welcome for the stranger (the other) where they can experience

full acceptance for themselves and where they are viewed as someone with fundamental value who is created in the image of God and loved fully (Vanier 2004; Reynolds 2008). As previously discussed Nouwen (1973) also wrote widely on hospitality and the need to retain humanity in relationship with others. He suggested we come into our full humanness by giving and offering others our care, compassion and presence (Nouwen 2002). Hospitality is the starting point of availability. Establishing a connection with other people requires us to listen, to be fully present and to acknowledge our common humanity. This enables trust and acceptance to develop (Reynolds 2008). Relating in these ways reflects the teachings of Jesus who embodied A&V in his life, for example the kenotic model of ministry (Philippians 2) where Jesus emptied himself by taking on a servant heart and ultimately gave his life for humanity to be reconciled with God. Jesus' strength is manifested in his brokenness, his weakness and revealed through his vulnerability (Reynolds 2008). In some ways it seems to be axiomatic that being hospitable and accepting is good practice and the contrary point of view is rarely if ever taken.

A further theological example of the outworking of A&V is reflected through the teachings of the Sermon on the Mount. Bonhoeffer (1995a) reflected that newer expressions of monasticism (like the NC) will live according to the Sermon on the Mount as disciples of Jesus. For the NC the life of Jesus serves to reflect A&V in action. Stringfellow (1973: 59) signalled that monastic communities should offer "a fearful hope for human life in society". He recognised that in monasticism "there lives a confessing movement dynamic and erratic, spontaneous and radical, audacious and immature, committed if not altogether coherent ecumenically open, and often experimental, visible here and there, now and then, but unsettled institutionally" Stringfellow (1973: 60). A&V, for the NC, offers hope. It comes out of living in a way

that is dynamic, spontaneous and radical in relationships and love for others and God. The offer of hope is reflected throughout the scriptures and church history and is fundamental to those who are facing illness, distress or brokenness. The Sermon on the Mount calls Christians to be poor in spirit, to mourn, to be meek, merciful, pure in heart, peacemakers, persecuted for righteousness's sake and finally accept insult and persecution. In short this passage reflects moral teachings with a devotion to God emphasised by righteousness and enduring affliction with the knowledge that blessing will come to those who live in this way. Aspects of being available and vulnerable for the NC stem from this passage. Bonhoeffer (1995b) suggested that in following the teachings of Jesus Christians need to choose to follow with integrity and simplicity. Earlier his writings revealed that there is much doubt and suffering in living as a Christian. However, blessings come from relationship with God and others and by viewing others not in terms of their actions but in terms of their suffering (Bonhoeffer 1971). Merton (1983) echoed this, reminding Christians not to judge others but to love them as they are. Reynolds (2008) believed this reflected the inherent value of each person. A&V allows for relationships at this level but also can lead to much questioning and doubt as one reconciles the commitment and implications of choosing to live in this way.

Buber (2000) also reflected aspects of A&V in his writings. He proposed the concept of "I -Thou" suggesting that relationships which are human and authentic reflect God and God's call on Christians. He suggested that only in relationships where each person is seen and related to in openness as "I" will the other be viewed as truly human and related to as such. By being available and vulnerable in these relationships, connection can occur as the other is seen as truly human. In order to

relate in this way sacrifice and risk must occur (as witnessed in A&V). Reynolds (2008) proposed that wholeness is not about self-sufficiency and independence but about community and relationship with others. It is only when sharing ones humanity occurs that wholeness and connection can be found (Reynolds 2008). Buber (2000) stated that this is a spontaneous act and not one of will; it stems from compassion which asks each person to enter into the other's suffering. However, the Northumbria Community (2005) Nouwen (1998), Herrick (1997) and Reynolds (2008) suggested that this must also be an act of will (intentional vulnerability). An alternative response to another's suffering and distress is to seek a quick solution or leave the situation, which may be appropriate on occasion. The choice not to do this, to be present with the other can lead to deep communion, connection and growth. Nouwen (1998), also reflecting on the teachings of the Sermon on the Mount, suggested that a choice can be made in order to be truly compassionate to mourn with those who are lonely, afraid, distressed and weak. He advised that being present in terms of being available and vulnerable with those who are suffering is where humanity comes to life completely. Vanier (2004b) suggested that this is love and acceptance in its purest form and enables others to begin to be themselves, to trust and to feel accepted and valued for themselves.

Fundamentally the full embodiment of A&V, as understood by Christian theology, is manifested in God's love for humanity. Jesus' life and care for the lost, the marginalised, the hopeless and his death on the cross revealed his chosen vulnerability and sacrifice. Searle (2015) stated that God wants to connect and be in relationship with his children. A&V allows for relationship and connectedness with God and also for deep connection with others based on shared humanity. Searle

(2015) suggested that only in being vulnerable can one truly be known, accepted and valued even though it means risk. Intentional vulnerability is a choice with an acceptance that it can lead to misunderstanding, hurt, criticism and rejection. But, as Nouwen (1973) and Vanier (2004b) identified, it is the place where true freedom and acceptance can be found.

A&V is clearly manifest in Christian Theology as reflected in Jesus's life and teachings. It can we witnessed in the scriptures and in acts of hospitality, compassion and connecting human to human. It is not without its risks and each has a choice whether to live in this way or not.

3.6.2 Nursing Perspective:

Much has been written about the related concepts of the essence of nursing, nurse-patient relationships, prescencing and intimacy in caring (Benner et al 1989, Downey 2004, Kirk 2007 and Watson 2012). There has also been specific exploration of A&V in a number of theoretical texts (Rogers 1997; Martinsen 2006; Thorup et al 2012; Lindström,Nyström & Zetterlund 2014 and Alvsvåg's 2014) often influenced by a Christian perspective. Martinsen (2006) a nurse and philosopher who greatly influenced Nordic nursing theory suggested that nursing is founded on caring for life and on neighbourly love as reflected in Jesus's commandment. She was not alone in this suggestion which was echoed by fellow Norwegian Katie Eriksson who talked of caritas (Latin, Greek ἀγάπη, *agápē)* suggesting that nurses offer, love, charity and caring communion to their patients. Within the concept of caritas (the theological virtue of love), prescencing (being available) is paramount (Lindström, Nyström & Zetterlund (2014). Alvsvåg's (2014) understanding of Martinsens' work suggested that the love offered is coupled with discernment which is moral, practical and

professional. This discernment necessitated emotional involvement which is an aspect of vulnerability (Martinsen 2006). Other Nordic nurses echoed Martinsens' theories, asserting the deep connection and care that occurs between human beings must stem from emotional involvement as opposed to professional distance (Thorup et al 2012). In order to provide this care based on love a nurse must have the sense of being a complete human being with their own personal attributes and sensitivity in order to be able to relate to other people.

Thorup et al (2012) recognised the sensitivity with which nurses may view vulnerability. They suggested that it can be an eye-opener for nurses or it can cause them to shut down and avoid personal vulnerability leading to the professional distance nurses historically were encouraged to develop. This stance limits the ability to connect and care for patients. Thorup et al (2012) recognised that it is courageous to enter fully into relationship with one's patient. Although this is risky in terms of being open to hurt, the return is an increase in nurses' commitment and hope in their work. Connecting with patients and caring involves human relationship based upon trust, honest communication, hope and compassion (Martinsen 1993 in Alvsvåg 2014). It demands something from the nurse and is part of vocation rather than task orientated care.

Martinsen (2006) identified caring as practical, relational and moral. Included in these concepts are reflection and empathy. The other is seen as a neighbour and actions must be accounted for, and learnt from, in order to grow as a person and become more compassionate. Her suggestions about care echo the NC in that they must be intentional; choosing to act in such a way which is open, loving and merciful offering hope and a trusting relationship to patients. One of the influences guiding

her practice was the parable of the Good Samaritan which encouraged Martinsen to coin the term “the eye of the heart” where the nurse is moved to see the other through “participatory attention based on a reciprocation that unifies perception and understanding, in which the eye’s understanding is led by the senses” (Alvsvåg 2014: 156). Seeing others in this way relates to nurses being compassionate empathic and caring, fully engaged with their patients.

In the UK nurse theorists Heaslip and Ryden (2013) suggested that nursing is a privileged role where the suffering of others is witnessed, where compassion and care can be offered to help patients to feel less vulnerable themselves. They suggested that an element of mutual vulnerability must be present partly due to the caring role but also because of shared humanity. Rogers (1997) writing about vulnerability in health care identified that all are vulnerable to differing extents and that this can this can have negative consequences leading to harm, hurt and neglect. She recognised the mutual vulnerability of caring which can be positive or negative depending on the situation because of the emotional investment needed to care for others. Her work mainly focused on what should be done to recognise the negative effects of vulnerability and also reduce the vulnerability of those caring for others. However, like the NC, Rogers (1997) recognised that a truly therapeutic relationship required commitment and emotional investment. She acknowledged that emotionally distancing from patients is unhelpful and suggested that feeling vulnerable may be a facet of good quality care (Rogers 1997). Denying emotional engagement with patients to reduce the nurse’s personal vulnerability may unintentionally increase vulnerability in patients as it can reduce the therapeutic connection.

3.6.3 Psycho-Social Perspective

Theorists in psychology and sociology often present conceptualisations that resonate with A&V (Rogers 1959; 1961; Schmidt 2001; Van Deurzen & Arnold-Baker 2005, Brown 2010; 2012). Perhaps most well-known would be the psychotherapist and researcher Carl Rogers. He detailed and explored the core conditions needed in therapeutic practice; empathy, congruence and unconditional positive regard (Rogers 1959). Schmidt (2001), Van Deurzen and Arnold-Baker (2005) considered these core conditions as necessary to connect with another as human to recognise their uniqueness, their inherent worth and to love and respond to them with understanding and solidarity. Schmid (2001) recognised Rogers' concepts of prescencing, authenticity and empathy as fundamental in building a relationship with another where they can feel truly accepted. The unconditional positive regard Rogers' talked about must be free from "buts" and "ifs" in order to allow the other to experience acceptance in a way they may not have experienced before. Rogers (1961 :4) reminded therapists that the offer of emotional warmth does not lead to "emotional over-involvement" but in the other being able to "actualise". Schimdt (2001) like the theologian and nursing theorists discussed above values the individual as a fellow human being of inherent worth who deserves to be loved and accepted as they are. The fundamental acknowledgment of a shared humanity and a call to love, care and accept others echoes A&V and as Rogers (1961) stated this can lead to being misunderstood. It is counter cultural in many ways to be available and vulnerable with another through intention yet it can lead to a realisation from the other that they are accepted, authentically loved and understood by another human (Rogers 1962).

Authenticity is the key to wholehearted living and is evident in A&V. Pollard (2005) and Brown (2012a) suggested that authenticity is what makes meaningful relationships. It involves being willing to be seen, being available to others and being real; it necessitates vulnerability. Schmid (2001) proposed that being authentic comes out of prescencing and is the place where the other recognises congruence, unconditional positive regard and empathy; it is being fully human and fully open. In being authentic one learns to encounter the other as fully human. He suggested that a person is created to be authentic, to be open, to be transparent, in order to enter into dialogue with others and acknowledge their need (Schmid (2001). This is not without its difficulties; for many reasons it may not be appropriate to share at this level with every person. Herrick and Mann (1998), Nouwen (1998) and Rolheiser (2004) recognised that boundaries are needed in order to maintain one's own identity and not to become overwhelmed and fully enmeshed in another's suffering.

Brown (2012a) from a sociological perspective discovered the importance of vulnerability. This reflects the work previously cited of Carl Rogers and Martinsen. In her work on vulnerability Brown (2012a) asserted that humans are "hard wired" for connection and stressed that empathy fuels connection whilst sympathy drives disconnection. Her research identified vulnerability as the precursor to wholehearted living. Human to human connection is present when we meet with all our vulnerabilities. Browns' (2010) extensive research on vulnerability suggested that those willing to be connected, authentic, available and vulnerable live a life more wholehearted and connected than those who see vulnerability as a weakness. She suggested that blocking authenticity and vulnerability occurs by striving for perfection (not allowing others to see our weaknesses) and numbing emotions through alcohol,

drugs, eating or shopping, for example. In her research the participants who chose to be authentic about their own vulnerabilities and who connected with others with the willingness to not have any guarantees were more joyful, more hopeful, and more secure (Brown 2010). Being willing to be authentic and courageous is from her perspective the most vulnerable but freeing and wholehearted way to live (Brown 2012b). She suggested that true belonging only happens when presenting our authentic imperfect selves to the world, our sense of belonging can never be greater than our level of self-acceptance (Brown 2010).

Van Deurzen and Arnold-Baker (2005) have written widely on existential therapy and again aspects of A&V can be seen which are fundamental to the therapist/client relationship. They suggested that the spiritual dimension is the most controversial of all human experiences yet it is the dimension which allows the fullness of individual uniqueness, values and experiences to be explored with a therapist who listens fully, respects the individual, is authentic and communicates and values humanness (Van Deurzen & Arnold-Baker 2005). An offer of therapeutic love and mutuality leads to a deep relationship where the other can be fully accepted, valued and supported in whatever difficulties they are facing. This is often a journey together where therapist and client both face the challenges of vulnerability (Van Deurzen & Arnold-Baker 2005). Jacobson (2005) also recognised that in order for authenticity and trust to develop in relationships there needs to be the intentional giving of love, understanding and tolerance.

Gilson (2014) offering a feminist critique focused on the ethics of vulnerability reiterated that to be human is to be vulnerable. She stated that this cannot be

avoided; it is fundamental to being human and something we share. Gilson recognised the dangers of vulnerability in that it can be unpredictable and uncontrollable leading to many actively avoiding it. However, she asserted that, depending upon the view point held about vulnerability, it can be an ethical imperative for human connection (Gilson 2014). If the view of vulnerability is that it denotes weakness, powerlessness and harm it will be actively avoided; if it is seen as part of the human condition it will lead to ethical and moral action, a shared humanity. This recognition of shared humanity continues to drive the ethos of A&V for the NC.

Having reviewed some of the literature from Christian theology, nursing and the social sciences it appears that some of the authors who write in terms of availability and vulnerability, or offer conceptualisations that are similar or sympathetic to this view have a grounding in a Christian ethic. Notwithstanding this, many authors do not espouse Christian views or underlying assumptions of A&V. Furthermore, their justifications in terms of human interaction and compassion strongly suggest that the A&V concepts have the potential to transcend a simply theological explanation.

3.7 Summary:

The aim of this chapter has been to offer the reader an understanding of my own spiritual journey through to becoming and living as a companion of the Northumbria Community. It has described the concepts of A&V within the Northumbria Community Rule of Life and provided a declaration of my personal position and influences in order to ensure transparency and the influence on this study. Finally, a critical review of the concepts in relationship to theology, nursing and the psycho-social literature is offered to justify the use of the concepts of A&V.

Chapter 4 Critical Review of the Empirical Data on Spirituality in ANP and General Practitioner Practice:

4.1 Introduction:

In the earlier chapters the focus has been on defining and understanding the concept of spirituality generally and in relation to healthcare practice. The place of A&V in my life and professional practice has also been explored, identifying why it has been chosen as a lens for this research. In addition, these early chapters have acknowledged my own beliefs and experiences, locating the place of these within the scope of the study. This chapter seeks to redress these limitations and biases through a critical review of the 13 papers reviewed which are of specific relevance to spirituality in ANP's.

4.2 Method:

The aim of this literature review was to identify and critically review the research related to spirituality and ANP practice. Initial searches indicated that the literature specific to ANP was limited, so a decision was made to extend this to General Practitioners (GPs). The justification for this extended search was that the ANP caseload has a close similarity to that of the GP within UK primary health care practice. The role of the ANP is very different to that of the registered nurse in that the day to day practice does not involve what would be seen as traditionally nursing care. The ANP, as discussed in Chapter 1, works autonomously seeing patients with undifferentiated and undiagnosed conditions focusing on history taking, clinical examination, diagnosis and management as historically undertaken by GPs. The role, however, does bring together the best of nursing and medicine integrating nursing skills to ensure holistic care. However, the operationalisation of spirituality for

an ANP is likely to occur in ways more similar to a GP than a general nurse hence the focus on GP literature. In view of this the empirical review has not looked at nursing papers (other than those referring to NPs). The results are presented initially paper by paper followed by a synthesis of all the papers (Joanna Briggs Institute 2014).

4.2.1 Aim and Objectives:

This review aimed to explore spirituality in ANP and GP practice.

The objectives were to:

1. Explore what has been researched and written about spirituality in ANP and GP practice
2. Identify and summarise the research that has explored spirituality in ANP and GP practice
3. Ascertain whether there is commonality in findings across the literature on spirituality in ANP and GP practice
4. Describe and explore the key barriers and facilitators to integrating spirituality in ANP and GP practice

4.2.2 Critical Appraisal:

A critical appraisal assessment tool was utilised (and adapted for quantitative papers by substituting qualitative for quantitative) to assess the validity, reliability and applicability of each paper (CASP 2014 Appendix 3). The use of this tool enabled a systematic approach to ensure the papers presented in this chapter were of value for this study (Gerrish & Lacey, 2006). Each paper was appraised individually using this

tool and a decision was made whether to include the paper. A score was then generated for each paper by adding up the number of positive responses to each question, a higher number indicating a higher quality, 20 being the maximum score (Table 2). As so few papers were available for appraisal those with a slightly lower score have been included. Discussion papers were not suitable for CASP scoring.

4.2.3 Search Strategy:

In order to ensure a full literature search was carried out the electronic databases - Metalib, Summon, Cinahl, Medline, PubMed and Psychinfo have all been utilised and accessed in addition to the Cochrane reviews, National Institute of Clinical Excellence guidelines, Department of Health Policy documents and the National Electronic Library of Health. The searches have been limited to English language, peer reviewed, empirical with application to healthcare. No restriction of dates was made as some early papers may have included significant seminal works. The selection criteria included books, scholarly articles, unpublished work and some discussion papers due to the paucity of research papers. The studies excluded after critical appraisal were those focusing predominantly on religion, religious belief and religious expression and those studies lacking robust research methods. A mixed method review was chosen as many of the studies use qualitative methods to provide a fuller picture of spirituality.

The question used to interrogate the literature was:

"Is the focus of this work spirituality or the spiritual dimension of practice in an ANP or GP setting?"

The searches were undertaken utilising individual keywords with the Boolean terms And/Or. The following key words were searched: “Nurse Practitioners (NPs) and Spirituality”, “Advanced Nurse Practitioners and Spirituality”, “Primary Care and Spirituality”, “General Practice or GPs’ and Spirituality”, “Family Physicians and Spirituality”.

There were few empirical studies in any of the keyword searches. The majority of the literature found was narrative, discursive or anecdotal. There were some interesting papers on conceptual analysis of spirituality and literature reviews which are helpful in conceptualising and adding to the healthcare literature about spirituality but these were not related to ANP or GP practice. The few research papers included in the review focus on clinician’s attitudes, beliefs and practices, three studies addressed the patient’s perceptions of their spiritual needs or spirituality. The searches revealed a number of matches including a few studies for each of the key words. However, on reviewing the matches and studies many had no relationship to the key words, interrogation question or research focus.

Out of all the empirical studies reviewed ten are included in this chapter in addition to three Nurse Practitioner (NP) discussion papers. Very few high quality empirical studies have been carried out which exclude religious belief and practice possibly due to the lack of a consensus of a definition for spirituality. This is difficult especially when medical science demands relevant evidence to support practice.

4.2.4 Classification of Papers

The papers were classified according to their methodology as follows:

- Discussion where the predominant approach was discussion or opinion (Treloar 2000; Maddox 2001; Helming 2009)
- Quantitative survey – where quantitative survey methods were used (Stranahan 2001; Monroe et al 2003; Holmes et al 2006; Hubbell et al 2006)
- Qualitative – where recognised qualitative methods were used (Ellis et al 2002; Murray et al 2003; Ellis et al 2004; Tanyi et al 2009; Carron et al 2011)
- Qualitative Evidence Synthesis (Vermandere et al 2011)

4.3 Limitations:

The limitations of this review include the number of studies included, the bias to United States of America (USA) studies with the majority of participants being Caucasian with a Judeo-Christian belief or heritage. Additionally, the majority of papers reviewed failed to include a sufficiently critical approach and, due to the context of the studies, often reflected religious, cultural and societal norms. In the few patient studies (Ellis et al 2004; Holmes et al 2006) the focus was on patients with a terminal or chronic illness which might as Ellis et al (2002) suggested increase the likelihood that respondents would wish to explore spiritual issues with clinicians. There was only one study (Ellis et al 2004) that determined patient's expectations of ANPs to provide spiritual care. This was limited, with only 3 patient participants. Some of the studies (Ellis et al 2002; Murray et al 2003; Ellis et al 2004; Carron et al 2011) with small numbers may include response bias and the larger samples are limited by self-reporting. All the qualitative studies sought to present and challenge theoretical concepts associated with spirituality and many drew out implications for practice (Ellis et al 2002; Murray et al 2003; Ellis et al 2004; Tanyi et al 2009).

Carron el al (2011) developed a conceptual model for implementing spiritual care but this was based upon a small study and personal interpretation of spirituality in the consultation.

4.4 Findings:

Studies reviewed are presented in Table 2. These papers have been classified by date; a brief description and a summary of significant findings (Appendix 4). Originally, studies that included religion or religious practice as the main focus were excluded from this review. However, this proved impossible since much of the literature focussing on spirituality included reference to religious practice and often linked the two concepts. Four quantitative papers, five qualitative papers, three discussion papers and one qualitative evidence synthesis were reviewed.

Table 2: Studies Reviewed:

	Papers in Date Order:	Type of Paper	CASP Score
1	Treloar L (2000) Integration of Spirituality into Health Care Practice by Nurse Practitioners. Journal of the American Academy of Nurse Practitioners, 12 (7) 280-285.	Discussion	N/A
2	Maddox M (2001) Teaching Spirituality to Nurse Practitioner Students: The Importance of the Interconnection of Mind, Body and Spirit. Journal of the American Academy of Nurse Practitioners 13 (3) 134-139	Discussion	N/A
3	Stranahan S (2001) Spiritual Perception, Attitudes about Spiritual Care, and Spiritual Care Practices among Nurse Practitioners. Western Journal of Nursing Research 23 (1) 90-104	Quantitative	19
4	Ellis M, Campbell J, Detwiller-Breidenbach A & Hubbard D (2002) What do Family Physicians think about Spirituality in Clinical Practice? The Journal of Family Practice 51 (3) 249-254	Qualitative	19
5	Monroe M, Bynum D, Susi B, Phifer N, Schultz L, Franco M, Maclean C, Cykert S & Garrett J (2003) Primary Care Physician Preference regarding Spiritual Behaviour in Medical Practice. Archive Internal Medicine 163 2751-2756	Quantitative	19
6	Murray S, Kendall M, Boyd K, Worth A & Benton T (2003) General Practitioners and their Possible Role in Providing Spiritual Care- A Qualitative Study. British Journal of General Practice 53, 957-959	Qualitative	18

7	Ellis M & Campbell J (2004) Patient's Views about Discussing Spiritual Issues with Primary Care Physicians. Southern Medical Journal 97 (12) 1158-1163	Qualitative	19
8	Holmes S, Rabow M & Dibble S (2006) Screening the Soul: Communication regarding Spiritual Concerns among Primary care Physicians and Seriously Ill Patients approaching the End of Life. American Journal of Hospice and Palliative Medicine 23 (1) 25-33	Quantitative	19
9	Hubbell S, Woodard E, Barksdale-Brown D & Parker J (2006) Spiritual Care Practices of Nurse Practitioners in Federally Designated Nonmetropolitan Areas of North Carolina. Journal of the American Academy of Nurse Practitioners, 18 (8) 379.	Quantitative	19
10	Helming M A (2009) Integrating Spirituality into Nurse Practitioner Practice: The Importance of Finding the Time. Journal for Nurse Practitioners (8) 598-605.	Discussion	N/A
11	Tanyi R, McKenzie M & Chapek C (2009) How Family Practice Physicians, Nurse Practitioners and Physician Assistants Incorporate Spiritual Care in Practice. Journal of the American Academy of Nurse Practitioners (21) 690-697	Qualitative	19
12	Carron R & Cumbie S (2011) Development of a Conceptual Nursing Model for the Implementation of Spiritual Care in Adult Primary Healthcare Settings by Nurse Practitioners. Journal of the American Academy of Nurse Practitioners (23) 552-560	Qualitative	15
13	Vermandere M, De Lepeleire J, Smeets S, Hannes K, Van Mechelen W, Warmenhoven F, Van Rijswijk E & Aertgeerts B (2011) Spirituality in General Practice: A Qualitative Evidence Synthesis. British Journal of General Practice Nov 2001, 749-760	Qualitative Evidence Synthesis	N/A

Only seven papers were reviewed which met the ANP and NP[1] and Spirituality criteria. All studies reviewed were from the USA and included two studies examining the spiritual practices and spiritual perception among NPs (Stranahan 2001; Hubbell et al 2006), a paper on integrating spirituality into NP practice (Treloar 2000), a paper discussing teaching spirituality to NP's (Maddox 2001), a paper discussing finding the time to integrate spirituality into practice (Helming 2009), a paper looking

[1] The term NP and ANP are synonymous. In the UK the Royal College of Nursing (RCN) published their updated competencies for advanced practice in conjunction with the Nursing and Midwifery Council (NMC). Up until this time the title NP was used in practice. Since 2008 most nurses working at this advanced level have adopted the title ANP to reflect their level of practice and education

at NP, physician and physician assistant[2] (PA) incorporation of spiritual care into practice and, most recently, a paper offering a conceptual nursing model for implementing spiritual care for NPs (Carron et al 2011). The review begins with the first and most robust pieces of NP empirical studies (Stranahan 2001; Hubbell et al 2006). The rest of the papers are reviewed in date order with the NP and ANP articles presented first followed by the GP articles.

4.4.1 Stranahan 2001:

Stranahan (2001) examined the relationships between spiritual perception, attitudes and practices about spiritual care in a quantitative non experimental cross sectional study with NPs in Indiana. 102 NPs responded (40% response rate) to a two part questionnaire. Part one elicited whether NPs provided spiritual care in their practice and part two NPs' attitudes to offering spiritual care. Stranahan considered spiritual care to be concerned with well-being, relationships, coping and growth whilst spiritual needs were any factor that was perceived important in establishing, or maintaining a relationship with God (as the patient defined God). Although the NPs endorsed the idea that spiritual care was an important part of their practice half of the respondents (57% n=58) never or rarely provided any aspect of spiritual care. Many of the NPs reported praying privately for their patients with 50% of the respondents stating they did this often or always; moreover praying appeared to be one interpretation of what spiritual care meant for the respondents. The dissonance between belief and practice was apparent in this study. This was tentatively related to the inadequacy of education on spirituality or being uncomfortable providing this

[2] Physician Assistants support doctors in the assessment and management of patients; they work closely with doctors and are not autonomous in their practice.

type of care. 57% (n=53) felt that the educational preparation on spirituality was inadequate and did not give them the knowledge, confidence or skill to provide care in this area.

Stranahan (2001: 91) highlighted the inclusion of two definitions by the North American Nursing Diagnosis Association which nurses in the USA should be aware of, and consider in their assessments: “distress of the human spirit” and “potential for enhanced spiritual well-being”. In order to acknowledge these diagnoses nurses would need to understand what they actually meant and also to feel confident in addressing spiritual issues with patients. She suggested that NPs who responded to patients in spiritual distress were those who were aware of their own spirituality, had been through significant personal crises and were willing to be personally involved with their patients. There was a sense that issues related to spirituality are private and even though the NPs defined themselves as spiritual (74%) or very religious (59%) there was an acknowledgement that they should not share their private beliefs with patients unless asked to do so. Those NPs with a spiritual or religious belief were more likely to include spiritual care for patients than those without. Holistic approaches to care by NPs is widely acknowledged (Shuler et al 1993) and as Stranahan asserted can be historically seen throughout the development of nursing theories and practice. Despite this her research revealed that NPs still lacked confidence and competence to provide the spiritual aspects of holistic care.

Stranahans’ (2001) seminal study provided recommendations about increasing education on spirituality in ANP programmes, consideration of the barriers of time within consultations as well as carrying out further research into patient’s expectation of NPs in regard to spirituality. Although clear distinctions for religion and spirituality

were made when looking at how NPs implemented spiritual care there was a regression to religious behaviour in practice (praying, reading the scriptures and referring patients to clergy). Indeed, spiritual care which appeared to be restricted to meeting religious needs seemed to be the focus of the study rather than spirituality itself. It was clear that even when attempts were made to conceptualise both terms that they did seem to consistently become connected and possibly confused in clinicians' minds. Stranahan acknowledged this and suggested that professional nursing theories may have encouraged this tendency towards meeting religious care needs rather than spiritual care. She suggested that the terms should be conceptualised and operationalised more clearly

The methodology for Stranahans' study was robust. The statistics, which were presented descriptively, led to the tentative conclusion that education and discomfort around spirituality were key barriers to providing spiritual care. This study cannot be generalised since the majority of the NPs described themselves as spiritual (74%) and/or religious (59%) which may be related to the demographical make up of Indiana's population and further studies are warranted in more diverse populations. It seems likely that expression of spirituality is somewhat determined by local culture and religious practice norms. No definitions were provided for participants which may have contributed to confusion and encouraged the connection of spirituality and religion. As the first study of spirituality and NPs with a good response rate this appears to be a good basis for further work considering the issues impacting spiritual care provision by NPs. The mean age of the NPs was 50 with the majority of respondents being Caucasian females; this too may have skewed some of the findings in view of the NPs life experience. A wider international study might provide more generalizable findings.

4.4.2 Hubbell et al (2006):

Hubbell et al (2006) followed up Stranahans' research in their quantitative non-experimental cross sectional study which included a systematic sampling of eligible NP's. A questionnaire sent to 101 NPs asked for self-reported responses to questions about spiritual care practices and the NPs attitudes to spiritual care. 65 NPs returned the questionnaire looking at spiritual care (65% response rate). Although Hubbell claimed to have used the Stranahans' questionnaire three extra questions were evident in part 2 of the questionnaire, a copy of these questions was not provided in their paper. Most of the NPs felt spiritual care was important in their practice yet 73% of the respondents did not routinely provide this care. Further similarities with Stranahans' findings were that 72% (n=52) NPs described themselves as spiritual and 65% (n=42) as religious with a large proportion 76% (no number given) of NPs praying often or always privately for their patients. Hubbell et al described spiritual care[3] practices where prayer, scriptural readings and referral to clergy appeared to be the focus, again conflating spirituality with religious practice.

An additional open question was asked of the NPs about what spiritual care meant to them. The findings suggested that most NPs felt spirituality was part of holistic practice which included an element of active practice. This active practice included prayer and testimony (religious practices), but also more basic expressions of caring for another person including holding hands, comforting patients, hugging patients and listening to patients. There was also an acknowledgement of spirituality being

[3] A summary of spiritual care includes practices that promote wellbeing, coping, growth, relationship, expressing love and compassion, supporting patients' beliefs, sharing of self, prayer and reading of scriptures. Spiritual care is simply responding to patients' spiritual needs and includes attention to the "whole being" (Hubbell et al 2006).

about a faith belief and acknowledging a higher power in one's life. These findings were not discussed in the paper and represent an area which would benefit from further study to ascertain whether these responses were because NPs viewed religion and spirituality as interchangeable or whether the two concepts had become linked because of personal experiences and/or nursing theories and education. Hubbell et al's findings supported the recommendations and findings of Stranahans' study. However, the paper was not as robust, giving an overview rather than in depth statistical analysis. The study recruited mainly Caucasian (98% n=64) women with a mean age of 45 with only 35% NPs working in a primary care setting which limits the generalisability of the findings to primary care. The questionnaire used has only been included in two NP studies both in the USA and does not appear to have been piloted. Its reliability and validity remain to be established in a wider context.

The following three discussion papers have been included in this review as they focus on NPs and spirituality:

4.4.3 Treloar (2000):

Treloar (2000) cited a number of papers in her descriptive paper supporting the integration of spirituality into NP practice. She proposed that NPs should be leading the way for other healthcare practitioners in modelling spiritual care for patients. She encouraged NPs not to think of spiritual needs as merely psychosocial needs, and not to ignore them due to personal embarrassment or discomfort; however, she failed to define spiritual needs.

Treloar reminded NPs that misunderstanding the distinction between religious needs and spiritual needs could impact patients' wellness and that educational courses

should integrate spirituality into their programmes. It was unfortunate that this misunderstanding was perpetuated in her paper with her definition of spiritual care[4] and also in her opening abstract: "One's view of self in relation to a Supreme Being, and one's existence and purpose for life is central to health" (Treloar 2000: 280). She concluded her paper with a powerful personal anecdote showing how addressing spiritual needs could take very little time but required the NP to listen, respect and respond to patient cues and argued (without providing more than anecdotal evidence) that this response could have a powerful outcome that benefited the patient and the NP. Treloar suggested being present (not just physically) was an essential component of spiritual care and she also included touching, listening, silence, time and asking open ended questions as practices which tended to spiritual needs. Her paper provided some useful definitions of spirituality and looked at how this was intertwined with health. The religious connotations of her own beliefs are apparent and could be argued to bias this paper.

4.4.4 Maddox 2001:

Maddox (2001) addressed the educational component of spirituality within NP programmes in a short narrative paper. She stated that this area was often ignored and when introduced in teaching programmes the advice was to refer patients to the clergy. She acknowledged that NPs reported discomfort in this area and recommended teaching that addressed the interconnection of mind, body and spirit and how this impacted on health as the best approach in NP education programmes. Her paper focused on how she implemented spiritual assessment tools in her own

[4] Treloar (2000) states that spiritual care includes scripture reading, meditation, attending religious services, referral to clergy, music/singing and support groups

teaching with NPs to encourage them to develop skills in “listening for meaning”, to “take time”, “be available” and “develop a mutually sharing environment with the client” (Maddox 2001: 136). This paper described her integration of teaching spirituality to NP students and mainly the use of a cumbersome spiritual assessment tool which she did acknowledge to be too detailed for routine practice. This tool included many humanistic questions about hope, laughter, peace, relationships, and dealing with anxiety and stress as well as religious practice including prayer, scripture reading and rituals. There was no analysis of the effectiveness of this tool and she concluded by suggesting a four question spiritual assessment tool be used in NP routine practice which focused on religion. It appears that no matter how some researchers conceptualise spirituality in their mind they then connect it to religious practice when trying to define it in operational terms.

4.4.5 Helming 2009:

Helming (2009) developed some of Treloar’s ideas about integration of spirituality into NP practice and reviewed the issues impacting NPs in this area. This paper begins with the statement: “it must be reiterated that being spiritual may not simply imply the same thing as being religious” (Helming 2009: 599). Helming wrote of spirituality as being about what permeates relationships and “infuses our unfolding awareness or who we are, our purpose in being, our inner resources” (Helming 2009: 599). She suggested that religious practice may be part of the spiritual care offered, which in the USA is often prayer, possibly due to the majority of the population espousing a faith belief. Her main themes and discussion emerged as the lack of educational preparation for NPs and the need for robust studies in this area. She made a powerful assertion that “many nurses enter this profession due to

a sense of love and caring for others, a sense of compassion, the need to alleviate human suffering and a call to do spiritual work" (Helming 2009: 601). She supported this by drawing on Florence Nightingale's work but failed to establish whether there was a robust basis to her assertion. She identified other authors who call for nurses to embrace spirituality. Whilst supporting the sentiment of the assertion it is unwarranted to assume that it is correct. This paper did bring out many interesting issues, some of which have been supported by other nurse theorists (Benner et al 1989). The main practices Helming called NPs to embrace were "doing" and "being". She suggested that "being present" for a patient was a powerful spiritual action. It could be argued that this is a basic tenet of nursing rather than a "spiritual act". However, taking Treloar's (2000) and Maddox's (2001) assertions that spiritual care may be about being and listening to patients, what has to date been conceptualised as aspects of effective communication, and/or empathy might indeed be also seen as a spiritual act. Helming's views of spirituality moved away from Stranahan (2001) and Hubbell et al's (2009) findings of how NPs practice spiritual care (i.e. religious practices) and encompassed the communication skills of listening, touching, using silence and asking open-ended questions. However, these may be regarded as basic tenets of nursing rather than spiritual acts.

4.4.6 Tanyi et al 2009:

Tanyi et al (2009) included NP views on incorporating spiritual care in practice in combination with other participants including physicians and PA's. This well-structured paper clearly stated the aim, methodology, findings and implications for practice of this research. It included 3 disciplines of practitioners all from family practice who were recruited via word of mouth in a non-random way. Ten

practitioners were included in the study with varying amounts of experience in primary care (9 months - 33 years). All participants had a religious heritage though it was unclear whether all were practicing. The study had 5 men and 5 women (ages 33-58). A phenomenological qualitative approach was chosen to seek “lived experience” and ascertain new themes in the area of study which Tanyi had been involved in for many years.

The aim of the research was to “investigate how primary care family practice providers incorporate spirituality into their practice despite documented barriers” (Tanyi et al; 2009: 690). The barriers included in the introduction are highlighted in the studies analysed in this thesis. They included: time, fear of proselytising, discomfort around the topic and inadequate educational preparation (Stranahan 2001; Ellis et al 2002). Tanyi (2002) had previously conceptualised spirituality and acknowledged the difficulties in doing so. She stated that spirituality was often displayed through religious practice (Tanyi 2002). The inclusion of three disciplines was aimed at obtaining a clearer picture in family practice as more NPs and PAs are now directly involved in patient care in the USA.

The methodology was clear, identifying ethical approval, consent issues and use of semi-structured interviews with an idea given of the questions involved. The participants were all asked how they incorporated spirituality into their practice; assuming that they all understood what spirituality was. They then were asked for specific examples of how they did this and an explanation of their perceptions, thoughts and feelings in these situations. The researcher stated they “set aside prior knowledge of the phenomenon” (Tanyi et al 2009: 691) which was a difficult task when they are specialists in this area. Data analysis using thematic analysis led to

five major themes being presented. The themes included “discerning instances of overt spiritual assessment; displaying a genuine and caring attitude; encouraging the use of existing spiritual practices; documenting spiritual care for continuity of care and managing perceived barriers to spiritual care” (Tanyi et al 2009: 692).

All participants were able to identify examples of when they had carried out a spiritual assessment and identified the need to understand how to do this. It was apparent that chronic illness and bereavement often led to existential questions which gave the practitioner an opening to discuss spirituality. Some participants would wait for patients to provide a cue before they engaged in spiritual assessments and all acknowledged a patient must be comfortable for the discussion to continue.

The authors discussed each theme with participant quotes to support the findings. Attitudes that were genuine and caring appeared to be a facilitator for addressing spiritual issues with participants talking about being non-judgemental, listening to patients and being honest as key attributes they used in consultations. All participants felt that reminding patients of spiritual practices that had helped them in the past was a useful way to provide spiritual care. Although it was noted that the practitioner would only do this if they viewed the past practice as positive, revealing that there was a judgement on spiritual activities that were deemed helpful and healthy for patients. One judgmental quote from a participant stated “If it’s some ritual and I think there’s something bizarre about it then I am not going to encourage it…” (Tanyi et al 2009: 693). Documentation was briefly discussed with some participants suggesting documenting that they have discussed spiritual issues might aid continuity for the patient. The key message was that providing the care was more

important than documenting it. Some of the perceived barriers were challenged by participants one of whom stated “it is built into my care” and another who stated “if it’s important to them (patients) and…their treatment I will find time for it” (Tanyi et al 2009: 694). It appeared that possessing the attitude that spiritual care was important in family practice was fundamental to integrating it into patient care and in this study all participants believed this.

Tanyi et al (2009) acknowledged their study was small and not generalizable, However, they asserted that their findings supported other studies of the benefit to patients, despite their own study not directly involving patients. In this study all practitioners believed spirituality to be important, all had a religious heritage and some had specific judgmental attitudes about what was helpful for patients with regard to spirituality. A new finding suggested that the participants seemed to hold the view that spiritual practices by patients “must be positive and health engendering” (Tanyi et al 2009: 695) Clinicians seemed to believe that they, rather than patients, should decide which practices might be helpful.

Overall this study was helpful in providing an understanding of some different perspectives from NPs, physicians and PA’s from one small area. It supported some previous findings in the literature including the importance of the practitioner’s attitude to the patient, the practitioner’s way of being and presence. The findings suggested that practitioners could overcome barriers to spiritual care if they believed it was important. Assumptions were made by practitioners that they should decide which spiritual practices were to be supported might not be acceptable to patients and could be potentially considered not to respect patient autonomy

4.4.7 Carron et al 2011:

The most recent NP paper addressed the development of a conceptual nursing model for implementing spiritual care in NP consultations (Carron et al 2011). This descriptive qualitative research used a variety of methodologies; phenomenological and grounded theory approach. The study included a purposive sample which included a number of participants known to the researcher (number not identified). There was acknowledgment of the potential bias but attempts were made by the researcher to limit this through use of bracketing her own biases and suppositions, though it is unclear how this was done. Participants were Caucasian with a Christian heritage which was acknowledged as a bias as all believed in "God". Strangely this study included 14 participants described as "five adult patients, three Family Nurse Practitioners (FNPs)[5], four community spiritual leaders and educators and two Benedictine nuns" (Carron et al 2011: 555). The rationale for this is unclear. The study received ethical approval and followed a standardised approach to qualitative research looking at common themes and lived experiences. The conduct of the research was clearly identified. However, it appears not to be robust due to the slurring of methodologies and the lack of clarity about identification of participants. Confusion for the reader comes from the variation of participants and a lack of clarity about their inclusion particularly the spiritual leaders and Benedictine nuns. There is no explanation as to how their inclusion and responses led to the development of the NP and patient conceptual model. One of the authors does state that her theoretical framework includes St Benedict of Nursia which may be why these additional participants were chosen. The authors do state their aim was " to gain an

[5] Family Nurse Practitioner is the term used in the USA to described ANPs who care for the whole age range, often described as "womb to tomb".

understanding of spiritual care perceptions by adults and the role of the NP in response to these identified needs so that we could propose a conceptual nursing model for the implementation of spiritual care in adult primary health care settings" (Carron el al 2011: 554). However, from the thematic analysis it is far from clear how this then developed into the model suggested.

Key to this paper is that spirituality is integral to patient care. This paper assumes that spirituality "permeates and infuses the development of caring-healing NP-patient relationships (Carron et al 2011: 554). It seems the data was collected by interviewing all participants together (although this not clear). It appeared that the 14 interviews focused upon lived experiences of spiritual care in practice but it is unclear what data was collected and whether the interviews were semi-structured or unstructured.

The results reflected other studies in that there was a concern expressed by practitioners regarding the role of religion and about proselyting or offending patients. All of the patients felt they wanted the NP to ask about their spiritual wellbeing however they believed the NP and patient relationship needed to be established prior to exploring spirituality. A conceptual model was presented which suggested there was an inter-spiritual relationship that could develop between the NP and the patient which might provide a supportive resource for the patient. The authors acknowledged that for this to happen the NP must recognise and acknowledge their own spirituality. Themes which were perceived as related to spirituality within the NP and patient relationship included "kindness, compassion and gentleness from a caring, personal relationship with NPs" (Carron et al 2011: 555) although one NP suggested this was nursing and not spirituality. There was

also a sense that being welcomed and feeling listened to with the NP being present was an important aspect of spirituality for patients.

In the paper the authors stated they had developed a demographic tool with 40 activities relating to spirituality which they showed to the participants, there is no explanation of what this included or why or if it was relevant to the development of their conceptual model.

Finally, prior to presenting the conceptual model the authors acknowledged that spiritual care seemed to develop from a caring relationship though they suggested this was reciprocal. They then moved on to suggest that “as the NP and patient developed their relationship they could grow into spirit by understanding the meaning of spirit and spiritual support systems for both NP and patient” (Carron et al 2011: 557). They then suggested this spirit becomes a supportive element during illness. At this point the study seemed to become even more confused and unclear. What if the NP and/or patient did not have the same understanding of spirit or feel it should be acknowledged as important? Were there other important psychosocial and biomedical factors which might have more importance in living through illness? If the relationship was reciprocal where did the boundaries exist? The model suggested that within the NP and patient relationship spirit became a conduit for the caring relationship which benefited both parties. Whilst this is an interesting assertion it cannot be seen to be derived from the research. This paper offered some interesting insights from a phenomenological perspective and credit could be given to the authors for offering a unique standpoint. However the study does lack clarity and rigour.

All the NP studies reviewed have limitations and certainly cannot be generalised. Several of the papers reviewed did not distinguish between spiritual care giving and religious expressions of faith - praying, reading scriptures and speaking to clergy. This may be partly attributable to cultural difference between the USA and UK and creates a barrier for those clinicians who like me view spirituality as broader than religious affiliation. What they do offer is an attempt to refine, articulate and encourage the integration and practice of spirituality within NP practice. They emphasise the need for consensus in defining spirituality and increasing the education input during ANP training.

The lack of research in spirituality and ANP practice necessitated a review from General Practice. Studies related to spirituality and General Practice was also found to be scarce. In the US the term “family physician” or “primary care physician” is equivalent to GPs in the UK. Four American studies and one UK study have been reviewed which may have some relevance to ANPs.

4.4.8 Ellis et al 2002:

Ellis et al (2002) published their qualitative study of 13 family physicians (FP) studying the context in which FPs addressed spiritual concerns of patients. All participants were Caucasian, half were Christian (n=6), five held other religious beliefs, one was agnostic and one had no religious beliefs. This qualitative study was carried out via semi structured interviews in Missouri. The interviews focused on the facilitators and barriers to addressing spirituality. Six participants reported regularly addressing spiritual issues with patients and six did not, one physician was opposed to addressing spiritual issues describing it as an “invasion of patients’ privacy” (Ellis et al 2002: 251). The findings suggested that FPs who addressed spirituality did so

because of their own interest in spirituality; however this was not explored in depth. This assertion was made from Ellis et al's analysis of the transcripts but focused on only two respondent statements. The majority (11/13) of the respondents also reported a religious affiliation which could have influenced the findings. The main discussion focused on five themes: the appropriateness of physicians in addressing spiritual concerns; situations in which physicians focus on spiritual issues; how physicians address spiritual issues and finally the barriers and facilitators to spiritual assessment which was the focus of the study. This paper also discussed the context for spiritual discussions which often came out of patient's struggles with chronic illness, palliative care and life stressors. The authors attempted to rule out bias by asking for honest reflections and acknowledging their own preconceptions in the hope of increasing reliability. A purposive sample was recruited in an attempt to include the range of language, spirituality, demographic characteristics and practice settings. Almost 50% of the respondents regularly discussed spirituality because they believed the evidence supported improved health outcomes when spirituality was addressed - they did not state what evidence they had read. All respondents felt that listening, validating spiritual beliefs and remaining with patients during times of need was an important aspect of their role and one respondent acknowledged connecting with the patient is a healing experience. It was clear that all the participants believed that patients should initiate the conversation, yet clinicians should integrate spirituality within the consultation to show patients that they were open to discussing these areas.

Consistent with the NP research, lack of time and educational preparation were some of the key barriers found, in addition to personal discomfort and fear of imposing the physician's own beliefs. This paper added additional data about what

was perceived to facilitate spirituality discussions; rapport over time, interest in patients' lives, knowledge of spiritual coping techniques and normalising the discussion. The study met its aims of exploring this important area. As a small study it cannot be generalised but may be transferable as its findings do support many other studies in this area. It does build upon a previous study (Ellis 1999) which found FPs did not deal well with spirituality and he challenged FPs to address patients' issues of shame, love, loss and ultimate meaning as a way to understanding spirituality.

4.4.9 Monroe et al 2003:

A quantitative study by Monroe et al (2003) addressed primary care physician attitudes to spiritual behaviour in practice. The criticisms they made about other studies having non-specific questions to address spirituality also appeared to apply to their own study. They tried to determine the willingness of internists (equivalent to junior hospital doctors in the UK) and family physicians (FP)[6] to be involved in spiritual behaviours in clinical settings. There was a good sample of 476 respondents (62% response) across six hospital sites from North Carolina, Vermont and Florida with 84.5% stating that they thought they should be aware of patients' spirituality. All were currently undertaking an educational programme but this was not identified. The research method included a previously validated spiritual wellbeing scale which also quantified religious attendance. Additional material collected included demographics, speciality and religious affiliation in addition to attitudes and preferences concerning involvement in patients' religious or spiritual needs. The majority of participants were white with almost half described as Christian. Whilst 84.5% agreed they should be aware of patients' religious and spiritual beliefs less

[6] Family Physicians in the USA are the equivalent of a GP in the UK

than a third would enquire routinely. Most would not enquire about spiritual issues unless their patients were terminally ill. Spiritual issues were not defined. The survey answered by physicians included their involvement in patients' religious and spiritual issues, education in spirituality as well as their own religious or spiritual practices. Significantly over half of the respondents 55.6% would pray with a patient in a routine appointment but at the patients' request. This might be seen to equate to religious practice with spirituality but it could be argued that this is respecting patients' own belief systems by responding to their request. In bivariate analysis it was statistically significant that more FPs wanted to be aware of their patients' beliefs than the internists. However both groups said they would only ask a patient about these issues if they were dying (74.2%). In general the FPs were more likely to pray with a patient (silently or vocally) or ask about their beliefs. In addition FPs were more likely to have had education in addressing spiritual issues (31.4%) compared with the internists (15.4%). Reasons to avoid spirituality discussions were time, lack of training, concerns about projecting one's own beliefs and not knowing how to address spiritual issues raised by patients. Although the title suggests a study of spiritual behaviour the study does not distinguish this from religious behaviour.

4.4.10 Murray et al 2003:

Murray et al (2003) is the only UK research paper found for this review. This qualitative study included analysis of 40 GP telephone interviews and explored their care of specific patients with terminal illness with regard to holistic needs and spiritual care. Each GP was interviewed every three months for up to a year. Spiritual needs for this study were defined as the needs and expectations of people to find purpose, meaning and life values. However, the respondents were not given this definition unless they specifically asked for clarity about the term. The two

questions studied were whether GPs felt they had a role in providing spiritual care and what might hinder or help GPs to assess spiritual need and provide spiritual care. All the GPs felt they had a role in providing spiritual care but some respondents felt it was up to the patient to provide a cue. Most GPs believed they should address these issues but did not do so in clinical practice (numbers were not given). The findings agree with the other FP and PCP studies with the GP recognising that their (in this case terminally ill) patients had spiritual needs but that because of time or not having the strategies to address these needs that this care was often omitted. The GPs did conceptualise spiritual needs as more than religious needs but a few (no number given) felt uncomfortable or ill prepared to address this area of care. An interesting theme about the facilitators to providing spiritual care emerged regarding whether the patient was "the right or wrong person" to address these issues with. Comments made about "not with this patient", "I don't actually like her very much" and "some people are very open to it and others are like a brick wall" (Murray et al 2003: 958) might reveal more about the GP's ability to judge receptivity than the patients responsiveness to having their spiritual needs met. The article was very concise due to the journal style and does not provide the full results or discussion which limits analysis of this study. However, it appears to the first UK study in general practice in this area.

4.4.11 Ellis et al 2004:

Ellis et al (2004) built on their previous studies in primary care looking at patients' views about discussing spiritual care issues with their physicians. Ten chronically or terminally ill patients were purposively chosen and invited to participate in a semi-structured interview. The themes raised in the interviews included spirituality within the physician-patient relationship; the physicians practice in addressing spirituality;

and what were the possible facilitators and barriers to addressing spiritual issues. The respondents were all patients of the physicians interviewed for Ellis et al (2002) study and some of the themes directly reflect this work. Eight of the respondents had a religious belief and were chosen because they were chronically or terminally ill which the researchers felt might make them more likely to discuss spiritual issues. The six themes found after thematic analysis were: rationale for addressing spiritual issues; prerequisites for discussions of patients' spiritual issues; the role of patients and physicians in spiritual discussions; and the principles, barriers and facilitators associated with spiritual assessment" (Ellis et al 2004: 1159). All respondents viewed physical and spiritual health as interlinked. In this study it appears contextually that spiritual issues were regarded as synonymous with spirituality. It may cause confusion when so many terms are used, sometimes interchangeably, when trying to review the literature. Patients felt that if spirituality was important in their lives then they would want a spiritual assessment. To risk addressing spiritual issues with their physician they would need to feel "honoured and respected". Limitations of this study included the number of participants and the fact that all had chronic ill health or terminal illness which may have made them more likely to consider spiritual or existential issues. All respondents felt that spirituality was a resource which was healing and that it was closely related to physical health. It appeared that all respondents felt that rapport and trust were needed to discuss spirituality and if it was not discussed then they thought it could impact adversely on their healing. All respondents felt that physicians should not impose their beliefs on patients but that they should listen attentively to patients' needs and be willing to address the difficult issues. Again barriers of time, clinician continuity and being unwilling or lacking

confidence to discuss these issues were raised in this study. As a very small study generalisability is not possible

4.4.12 Holmes et al 2006:

Holmes et al (2006) also looked at FPs but focused on the communication of spiritual concerns with dying patients. Questionnaires were received back from 65 patients (90% response) and 67 FPs (87% response) exploring the spiritual concerns of patients and the spiritual practices of FPs. 62% of patients and 68% of FPs considered it important that FPs address patients' spiritual concerns. The findings also showed that patients rarely received any spiritual care from their FP and a contradictory finding was that despite 62% of patients considering it important for FP to address spiritual concerns 62% of patients stated that they felt this was not the role for the FP. The link with religious practice was evident as 54% of patients wanted their FP to pray for them in private. FPs felt that they did not have time to address spiritual concerns (82%) with 37% stating they did not feel competent to do so, 21% did not feel it was their job. The main finding was the dissonance between FPs believing it was important to care about patients' spiritual concerns but feeling it was not appropriate to talk about them. The discussion suggested that simply listening and asking about spiritual concerns was enough to support patients in end of life issues. The concerns with this paper are the focus on end of life issues which are often managed in palliative care in the UK rather than specifically in general practice. The authors stated that to avoid cultural and religious bias they included existential questions within the questionnaires about life, purpose, meaning but they still studied religious themes throughout the study.

4.4.13 Vermandere et al 2011:

Vermandere et al (2011) is the final recent GP study on spirituality. This is a qualitative evidence synthesis (review paper) which appeared to have included 113 articles. This is claimed to be the first synthesis of this concept with regard to GPs and the authors sought to analyse the current evidence gained from qualitative empirical work about GPs' role in spiritual care and also the barriers and facilitators to spiritual care. The synthesis was carried out via thematic analysis after critical appraisal of the selected articles using the Joanna Briggs Institute appraisal tool. Unfortunately, at the outset the study appears flawed. It attempted to seek GP data however the authors included empirical papers which investigated multiple disciplines in healthcare; they also included outpatient settings, hospitals and hospices. The authors also do not identify how they define a GP but in the UK a GP would not normally be based in these settings unless working as a GP with a specialist interest. Later in the article characteristics of the thematic matrix table revealed that only 7 articles were actually appraised. Three of these are included in this chapter the others related to advanced cancer care, psychosocial care in the dying patient and mind, body, spirit family physician beliefs.

The paper provided a useful summary of some of the key barriers and facilitators to incorporating spirituality in general practice but did not bring any new findings to this empirical chapter (partly as some of the same articles have already been appraised).

Barriers reflected upon include time, lack of education, fear of proselytising, concerns about invading the privacy of patients, struggle with spiritual language and lack of clinicians' awareness of their own spirituality. Interestingly in several papers there appeared to be the "right and the wrong patients" to discuss spirituality with.

This seemed to be related to patients who were vulnerable or couldn't engage in spiritual discussion despite possibly being in spiritual need (Murray et al 2003 in Vermandere et al 2011). No further clarification was given about how right or wrong patients were characterised..

Facilitators included communication style, being genuine, open, non-judgemental, patient centred, being aware of ethical considerations and being themselves spiritual.

GPs felt they should have a role in being a spiritual care giver and they should facilitate conversations in this area, recognising cues from patients that this was an area they wished to discuss. It was felt that not imposing one's own beliefs and values was important as well as approaching discussions with sensitivity, gentleness, reverence and integrity. Being present with the patient, listening to them and validating their spiritual concerns were also seen as necessary in order to embrace spirituality in the consultation. The studies appraised reflected that GPs felt spiritual care was important in patient care and that there was scientific evidence linking spirituality and positive health benefits.

During the discussion Vermandere et al (2011) reiterated that GPs saw it as their role to address spirituality and that the common barriers and facilitators needed to be acknowledged. Many GPs felt that their approach to patients by being present and listening was akin to spiritual care and the authors questioned whether this was just good communication skills (Vermandere et al 2011: 757). Integrating these qualities with questions around patients' relationships was suggested as being more about spiritual care. This fits with many definitions of spirituality including connection to others. This however was fleetingly mentioned and not expanded upon.

This was a succinct synthesis but limited owing to the inclusion on only 7 empirical studies over half not within a primary care setting.

4.5 Discussion:

Having reviewed thirteen papers there appeared to be four key findings:

1) Spiritually and Religion are often linked.
2) Barriers in the clinical setting to providing spiritual care interventions are consistent including; time, personal discomfort, lack of education, fear of proselytising.
3) Facilitators in the clinical setting to providing spiritual care interventions are consistent including; clinicians own spirituality and belief that addressing spirituality is part of their role, openness, being willing to address these issues and education.
4) Patient expectations and desire for spirituality to be addressed are recognised though conflicting data is presented including some patients believing that their clinician would be uninterested in addressing their spiritual needs

4.5.1 Spirituality and Religion:

As discussed in Chapter 2 there are some inherent difficulties in defining spirituality and also understanding how spirituality and religion are connected. The papers reviewed included quantitative and qualitative studies in addition to discussion papers. Treloar (2003), and as previously noted, Hill and Pargament (2003) challenged the assumption that religion and spirituality can be measured by empirical scales. Nevertheless, this has been done in a number of the studies in this review with findings that add to current knowledge on spirituality in ANP and GP

practice (Stranahan 2001;, Monroe et al 2003; Holmes et al 2006; Hubbell et al 2006). Hill and Pargament clarified their stance by suggesting the need to see religion and spirituality as evolving concepts. If this is accepted the alternative research designs provided by the qualitative studies may have led to a greater understanding of spirituality and religion which they partly appear to have achieved. Moberg (2010: 101) confirmed the difficulty in measuring spirituality quantitatively but also suggested that many researchers excluded investigating spirituality as it was seen as being “too ephemeral, mystical, theological, ineffable, or transcendent to be a researchable subject”. With this difficulty in mind, a number of authors and researchers in the area of spirituality (as well as Stranahan 2001; Monroe et al 2003; Holmes et al 2006; Hubbell et al 2006) have used religious belief and practice either as a surrogate for spirituality or a way of making spirituality less ephemeral (sometimes quite knowingly, sometimes apparently accidentally) (Paloutzian et al 1982; Ellis M, Vinson D & Ewigman B (1999); Anandarajah G & Hight E (2001); Peterman et al 2002; Hill and Pargament (2003); Daaleman T & Kaufman J (2006); Koenig et al 2011). Good quality qualitative research is an alternative and potentially more fruitful way of understanding and evidencing spirituality in view of the criticisms about quantitative studies (McSherry et al 2004; Moberg 2010). Several qualitative studies included in this review provided significant data from clinicians and patients (Ellis et al 2002; Murray et al 2003; Ellis et al 2004; Tanyi et al 2009; Carron et al 2011). Some of these studies, for example, Carron et al (2011) were limited in their findings and resulting discussion. However, the others provided useful data on clinicians’ and patients’ understandings of spirituality, spiritual needs and the connection between spirituality and religion. In addition they suggested barriers and facilitators to be addressed in operationalising spirituality.

As discussed previously and following this review it was clear that the concept of spirituality was often confused with or linked or with religion. However attempting to define them as two distinct concepts might aid research as well as bringing clarity to practice. The view of spirituality that within each person is the potential to have hope, meaning and purpose were common themes throughout the literature (Burkhart 2001; Tanyi 2002; Narayanasamy 2004; Daaleman et al 2006; Helming 2009). For some people spirituality might be linked with a faith belief but for many this was not the case. Rohr (2010: 381) suggested that for most people in the world the question is not, "Is there a life on the other side of death?" It is, rather, "Is there life on this side of death?". The search for meaning, purpose and hope is often the essence of this life question. Many patients especially when faced with illness, stress or life crises appear to be searching for what can bring them life (Ellis et al 2002); possibly this is the essence of spirituality. As clinicians seek to support patients in this search it might be prudent not to confuse this search for spiritual meaning with religion. In a healthcare setting, Wattis and Curran (2006: 14) characterised religion as the "politics of spirituality: the rituals, beliefs and power structures found in different religious creeds - or more succinctly, as a means by which we relate to God" whilst Helming (2009) viewed religion as the structure where those with shared beliefs and values came together. She was careful to reiterate that being spiritual was not the same as being religious but then confused the concepts in her paper by using spiritual and religious interchangeably. Being able to separate the two concepts may enable clinicians to feel more comfortable to support patients with their spirituality as the literature points to clinician discomfort in addressing religious belief and practice which is seen as private (Treloar 2000; Ellis et al 2002; Carron et al 2011).

A growing number of healthcare practitioners in the discursive literature attempt to conceptualise spirituality and encourage clinicians to ensure that they consider integrating it into their practice (Treloar 2000; Coyle 2002; Henery 2003; McSherry et al 2004; Burkhart 2007; Helming 2009). Attempts have been made to secularise spirituality especially in the healthcare arena with the aim of finding common ground, aiding research and removing the association to religion (Pesut et al 2009). It is not just healthcare practitioners who are grappling with spirituality. In an increasingly secularised society people are actively looking for meaning and purpose in their lives. Whilst church attendance in the UK had reduced there has been a surge of interest in spirituality in recent years (Treloar 2000; Pesut et al 2009; Helming 2009). Scholarship in this area has also increased in healthcare with authors from nursing, social work, occupational therapy and medicine researching and contributing to the debate around spirituality (Narayanasamy 2004; Johnston et al 2004; Gilbert 2011; Buckhardt 2007; Kerry 2007; Rabow 2007).

The studies in this review often connected religion with spirituality in order to provide a concrete area to study; as religious practice is more easily defined operationally (e.g. attendance at worship services at least once a month); or because authors or respondents confused the two concepts. One potential reason for the small number (and often low quality) of studies is the difficulty in defining spirituality separately from religion. Whether it is possible to firmly separate the two concepts in practice is debatable when numerous authors routinely appear to link them (Burkhart 2001; Koenig 2000; 2004; 2009; Stranahan 2001; Monroe et al 2003; Narayanasamy 2006; Hubbell et al 2006; Curlin et al 2007). The consistent weaknesses of the studies reviewed were the conflicting definitions of spirituality, the plethora of terms used i.e.

spiritual care, spiritual dimension, spiritual needs, spiritual behaviour and spiritual assessment and the connection with religion. The terms used in the studies are seen as a weakness as they often lacked any definition and were usually operationalised as religious practice. Several examples of conflicting definitions which interlink spirituality and religion included Treloars' view of spirituality relating to a supreme being (Treloar 2000) as opposed to Stranahan (2000) who recognised spirituality could be about well-being, relationships, coping and growth but then also included a relationship with God. Hubbell et al (2006) described spirituality in terms of spiritual care practices where prayer, scriptural readings and referral to clergy appeared to be the focus whilst also suggesting that spirituality included basic expressions of caring for another person including holding hands, comforting patients, hugging patients and listening to patients. These conflicts may be justifiable in view of the cultural context in which the studies were conducted. However, there is a need to be more transparent and to discuss these issues fully to avoid confusion.

Consequently, it may be that it is not possible to separate fully the two concepts but it may aid the research if authors were clear themselves about what they wanted to study and justified the interchangeability of the terms. A number of the studies reviewed included prayer as a spiritual need and utilised research to suggest that religion improved health again linking and perpetuating the sense that spirituality and religion were the same thing (Treloar 2000; Stranahan 2000; Maddox 2001; Monroe et al 2003; Holmes et al 2006; Hubbell et al 2006). Koenig (2000) supported his linkage of both concepts by suggesting that most Americans do not make a distinction between the two concepts of spirituality and religion which Treloar (2000) echoed. Koenig (2001) acknowledged that most of the research carried out in

healthcare measures religious practices and beliefs rather than spirituality, making it difficult in this literature review to find any empirical studies on spirituality alone.

Stranahan (2001) acknowledged that linking spirituality and religion usually comes from respondents' understanding of spirituality in terms of religious belief and practice. Often in the research, definitions were not provided to respondents. How a clinician conceptualises and separates out the definitions is extremely difficult when prominent researchers like Koenig state it is easier to operationalise spirituality for research purposes in terms of religious expression (Koenig 2001; 2014).

International and National nurses codes of conducts and professional competencies for advanced practice all talk of addressing patients spiritual needs yet the frequency of ANPs doing this remains unclear and practice inconsistent (Stranahan 2001). For many nurses addressing these needs appears to be asking about religious beliefs and or dietary needs. The International Council of Nurses (2005: 2) stated that "In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected." Although this is an important statement, the use of spiritual beliefs may hide a lack of clarity about the relationship of spirituality with religion. Spirituality is not just about beliefs. It is about the whole person, and may be manifest in behaviour as well as belief. In the UK the Royal College of Nursing (RCN) and the Nursing and Midwifery Council (NMC) (2008) collaborated to produce the domains of practice for ANPs which include: respecting patients' spiritual beliefs, assisting patients and their family to meet their spiritual needs, assessing the influence of patients' spirituality on their health and incorporating their beliefs into their care. These domains, although acknowledging spiritual needs, when read closely appear to link spirituality and

religious belief or faith so it is no wonder that ANPs also do. Other nursing associations have stated that spirituality is an integral dimension of health care provision (Canadian Nurses Association 2010). Considering the express guidance in these codes there needs to be further investigation about what it is that hinders or facilitates this care being provided.

4.5.2 Spirituality and Education:

In a survey of 4000 nurses undertaken by the RCN 80% (n=3200) of the nurses surveyed felt that spirituality should be taught in nurse education and that it was integral and fundamental to core practice (McSherry & Jamieson 2013). The papers reviewed concurred with this view with an implication that if education on spirituality was provided ANPs and GPs would better integrate this area into their practice. From the previous key finding it would be a prudent to help clinicians to define spirituality and religion for themselves and then consider their application to practice. Hubbell et al (2006) suggested that NPs did not address spirituality because of the lack of education on this area in their training. Stranahan (2001) suggested that education in spirituality might furnish the surest route to providing spiritual care which is how she operationally defined spirituality. A number of authors presented a strong argument to include spirituality in education and affirmed the role of spiritual care in practice (Stranahan 2001; Ellis et al 2002; Monroe et al 2003; Ellis et al 2004;, Holmes et al 2006; Hubbell et al 2006; Tanyi et al 2009; Vermandere et al 2011) but declared that practitioners felt ill prepared and incompetent to provide this care (Maddox 2001; Stranahan 2001; Monroe et al 2003; Holmes et al 2006; Hubbell et al 2006). There was also a suggestion that lecturers should encourage individual spiritual growth as findings suggested that clinicians who are more confident in their

own spirituality are more likely to provide spiritual care (Stranahan 2001; Ellis et al 2002). Treloar (2000) suggested that educationalists must promote spiritual health in students by modelling and demonstrating their own spirituality; there were no suggestions as to how this should be done and no evidence to demonstrate how it would change clinicians' behaviour in assimilating spirituality into practice. Maddox (2001) asserted that even when NP programmes did offer teaching on spirituality this was operationalised as referring patients to clergy or considering religious diet which clearly addressed religious needs but possibly not spiritual needs.

Helming (2009) highlighted changes in medical education in the USA which may indicate that spirituality may be more readily accepted as an important part of holistic care. Out of 150 medical schools in the USA 100 were reported to integrate spirituality into their programmes (Booth 2008). Helming (2009) compared this to an informal audit of NP organisations (including NP teaching schools) where she found none were integrating spirituality into their NP programmes despite the NP nursing codes and NP theorists saying this was an important part of NP practice (Shuler et al 2003; NONPF 2006).

The studies also revealed a degree of dissonance between belief and practice which may or may not be related to lack of education. Monroe et al (2003) revealed that 84.5% of the respondents believed spiritual care was important in practice yet only a third actually provided this; other studies echoed this finding (Stranahan 2001;Ellis et al 2002; Holmes et al 2006; Hubbell et al 2006). Stranahan (2001) tentatively related the dissonance of belief and practice to the inadequacy of education on spirituality (in addition to personal discomfort addressing these issues). It seems unlikely that this dissonance between what clinicians believe and what they practice is purely related to educational preparation, given the other findings of the studies about

personal discomfort or spirituality being a private matter for patients. This warrants further study. One study made no mention of the need for education around spirituality but stated that NPs should have knowledge of their own spirituality (Carron et al 2011).

An interesting new suggestion based on the findings of Tanyi et al (2009) was that practitioners should be teaching colleagues themselves rather than necessarily accessing specific education around spirituality. They agreed that education for primary care practitioners was important in managing some of the barriers which other studies have suggested might prevent incorporation of spiritual care but suggested they could educate colleagues about effective techniques they have used to help them feel more comfortable about spiritual care. There is no doubt that sharing experiences may be a non-threatening and helpful way of addressing concerns around spirituality in practice just as in other areas where practitioners may feel uncomfortable.

4.5.3 Addressing Spirituality - Spiritual Care in Practice

The majority of the studies presented specific interventions which respondents identified as spiritual care practices. A number of barriers and facilitators to assimilating these practices were proposed. The most consistent practices identified in the studies were prayer and referral to the clergy. Praying with, or privately for, a patient was a theme in a number of the studies (Stranahan 2001; Monroe et al 2003; Hubbell et al 2006). Stranahan (2001) and Hubbell et al (2006) found that many NPs would routinely pray silently for their patients and were more likely to do this rather than interventions which were more directly observable and clearly religious practices (i.e. praying with patients or reading scriptures). Monroe et al (2003)

reported that physicians would be more likely to pray privately for a patient if they were dying or if the patient requested them to. Stranahan (2001) and Maddox (2001) both suggested that clergy referrals were often offered to patients as it was felt they would be in a more appropriate position to discuss spirituality and were seen as the experts in this area. Whether this was a way of avoiding the personal discomfort of addressing these issues remains to be investigated. A number of authors suggested clinicians were personally uncomfortable dealing with spirituality which they believed should be a private issue (Treloar 2000; Maddox 2001; Ellis et al 2002; Monroe et al 2003). This might limit spirituality being addressed and spiritual needs being met.

A number of barriers to addressing spirituality included the lack of time within the primary care consultations. This was confirmed by experience in UK ANP and GP practice (Vermandere et al 2011). Stranahan (200) found that one of the difficulties in addressing spirituality was the urgency imposed by quotas (i.e. capitation and managed care) which left little time for holistic care. In the UK quality outcome frameworks (QOF) add pressure to primary care clinician consultations to provide data and patient information to improve public health to the detriment sometimes of listening to the patient and providing holistic care (including addressing spirituality). Stranahan and Tanyi et al (2009) suggested that in order to address spiritual needs NPs and practitioners needed to give this area equal priority to physical illness. Further studies have supported the perceived time barrier (Monroe et al 2003; Holmes et al 2007; Helming 2009).

Treloar (2000); Maddox (2001); Monroe et al (2003); Helming (2009) and Vermandere et al (2011) suggested that in addition to time pressures, a clinician might experience personal discomfort addressing spirituality as it was an area considered private and individual. This might be a way of understanding the

dissonance of belief and practice. If the practitioner felt this was a private issue it might not be addressed unless the patient actually raised the subject. The discomfort expressed also appeared to relate to a fear of projecting one's own belief onto a patient which was seen as ethically wrong (Ellis et al 2002; Monroe et al 2003; Ellis et al 2004).

FPs, GPs, PA's and ANPs consistently embraced a biomedical approach to care although holistic practice was advocated to improve patients' healthcare (Treloar 2000; Stranahan 2001; Monroe et al 2003; Hubbell et al 2006). Hubbell et al (2006) suggested that the pressure to provide symptom and disease specific care often reduced the time to provide holistic care, one of the so-called tenets of NP practice. This reflected research into the work of ANPs in the UK which showed that some were moving towards a biomedical approach rather than a holistic approach to care (Venning et al 2000). This approach to care clearly limits the potential to address spirituality. Though it might legitimately be argued that, at times, diagnosis of serious illness was a priority for the clinician, the patient might have different priorities (Ellis et al 2002). Vermandere et al (2011) suggested that inclusion of spirituality fitted into the biopsychosocial-spiritual model of care which was more truly holistic.

Cultural sensitivity might be another barrier to addressing spirituality when a strong dominant culture was present (Ellis et al 2002). This might mean that religious practice became a focus for meeting spiritual needs (for example in North America) and it might be deemed unreasonable to operationalise spirituality in wider terms. On the other hand, the more secular UK culture and the multi-cultural setting in which many of us work mandate a different approach. In a pluralistic society one either needs to have an adaptable definition that uses the patients 'own terms or a very wide one which may not be amenable to quantitative research methods.

It appeared more likely that spirituality will be discussed if the patient was dying (Monroe et al 2003), chronically ill (Ellis et al 2002; Ellis et al 2004; Tanyi et al 2009: Vermandere et al 2011) or under stress (Stranahan 2001; Ellis et al 2002). Several papers suggested that listening attentively for patient cues would naturally lead into spirituality discussions (Ellis et al 2004; Helming 2009; Tanyi et al 2009). Those clinicians who already integrated spirituality into their own practice appeared to be those who were aware of their own spirituality and listened for patient cues (Praill 1995; Treloar 2000; Stranahan 2001; Ellis et al 2002; Hubbell et al 2006; Carron et al 2011; Vermandere et al 2011). Stranahan (2001) argued that there was a relationship between nurses' perception of their own spirituality and the tendency to provide spiritual care (Hall & Lanig 1993; Ross 1994 cited in Stranahan 2001). Treloar (2000) stated that the breadth and depth of the spiritual care offered reflected the nurse's own spiritual maturity. Treloar's statement must be seen as tentative as there was little supporting evidence for this but it would be expected that if a clinician held firm personal beliefs (whether religious or spiritual) that aspects of this would influence their practice. This must be considered by the clinician as it might have grave implications as was seen in 2009 when the case of British nurse who prayed for her patient hit the news after the patient's family complained. The nurse was suspended from practice whilst an investigation ensued (BBC 2009). This prominent case highlighted the importance of being aware of the boundaries in practice relating to individual beliefs and not proselytising. The code of conduct is clear about not pushing one's personal religious beliefs onto patients (NMC 2015). However, because many of the authors in the literature review have suggested that spiritual needs may equate to religious needs the danger is that nurses may become more hesitant about exploring spirituality with their patients in case they get it wrong. The

story in the USA appeared very different with an increase in parish nursing and an encouragement to integrate personal faith into care (O'Brien 2008; Helming 2009).This may be related to the higher levels of espoused belief in a God in the USA with 90% of Americans stating they believed in a God (Stranahan 2001) and may also have impacted on the findings in those studies that included a majority Judeo-Christian participant bias.

4.5.4 Patients' expectations:

The three studies that focused on patients or included patient perspectives revealed some interesting and often contradictory findings Ellis et al 2004; Holmes et al 2006; Carron et al 2011). Ellis et al (2004) found that whilst patients affirmed the importance of their own spirituality and their health they believed that physicians would be uninterested or hostile to addressing spirituality. In order to change this view Ellis et al (2004) and Carron et al (2011) suggested that asking about spirituality over time may facilitate greater discussion about spiritual issues. Although this might be helpful in showing patients that the clinician was interested in talking to them about spirituality it was also recognised that patients would not begin to talk about their spiritual needs unless they felt honoured and respected by the physician or NP (Carron 2011). Therefore, showing respect to patients whilst opening up the conversation about spirituality needed to be done sensitively and in a way which was authentic and honouring. If spirituality was not addressed some patients believed that it would adversely impact the healing process. Helming (2009) and Carron et al (2011) suggested attentive listening, caring and presencing to patients in order to meet their spiritual needs however Holmes et al (2006) found that 60% of patients did not want their FP to have a spiritual discussion with them and 31% believed it was not their job to do so. The respondents in Ellis et al's (2004) study thought this

was because the physicians had a biomedical focus and lacked time rather than it not being their job. This was contradicted in Carron et al's (2011) study which found patients wanted their NP to connect with them spiritually. This could be a reflection of the participants interviewed.

Contradicting the findings that 60% of patients did not want the FP to have a spiritual discussion with them 54% of patients revealed that patients did want their clinicians to pray for them on their own, not with them. They wanted their FP to care about their spiritual needs but not necessarily to address them; this could be done with family, friends or clergy. Ellis et al (2004) corroborated these finding that patients wanted their physician to care about their spiritual needs but felt uncomfortable initiating the conversation for fear of feeling vulnerable. They wanted the opportunity to discuss spirituality as, if they did not, they felt it would impact their recovery.

Koenig (2001) has prolifically researched spirituality and has shown that patients do want to discuss these areas with physicians and that religious practice increases health. The difficulty with Koenig's work is the focus on religious needs and practices as a surrogate for spirituality despite his transparency about this. With many contradictions and confusion in the literature concerning clinicians' beliefs and practices and patients' expectations it is not surprising that research in this area is problematic. As will be discussed in the methodology chapter, qualitative research may be the most useful approach to help practitioners understand how to conceptualise spirituality and operationalise it in practice.

4.6 Conclusion:

Finding studies which focus on spirituality in the context of ANP practice has been difficult. However, limiting the search to ANP and GP practice remains justified as the aims of this research was to explore and establish a research base for ANP practice. The small number of studies located mostly lack rigour owing to a number of factors including, in some papers, the limited numbers of participants, the linkage of spirituality and religion, bias from predominately US literature with a strong Judeo-Christian heritage and some authors' personal view points. The broad working definition of spirituality as being about what gives a patient meaning, hope and purpose makes it hard to operationalise in research terms. Contemporary healthcare perspectives have engaged partly with the debate about how to provide care which is not just physical and emotional but also spiritual. Often this has been reduced to asking about whether a patient has a religious belief or faith and whether they need specific care to enable them to practice their religion (i.e. diet, place for worship, to see a member of the chaplaincy) rather than what are their spiritual needs.

This chapter has reviewed nine empirical studies, one qualitative evidence synthesis and three discussion papers in the area of the work of ANPs (and family physicians) in primary care. It has found that, on the available evidence, that the distinction between spirituality and religion is not always clear; that educational preparation for clinicians to address spirituality is sparse; and that there are a number of additional barriers and facilitators to addressing spirituality in practice. Patient studies in primary care have been even harder to locate. However, the very limited evidence available suggested that patients do believe that their spiritual needs are important and some would value their clinician addressing these areas in practice whilst some would not.

There was only one study from the UK with the rest from the USA. This thesis will add to the UK research on the spiritual dimension of ANP practice. It will also provide a rich analysis of the circumstances within the consultation which aid the integration of spirituality into practice. It is very clear from the review that more study into this area is needed especially in the realm of patient expectations, needs and attitudes towards spirituality in primary care. There is a significant gap in empirical studies researching spirituality and spiritual care in ANP practice in the UK.

Chapter 5 Methodology:

5.1 Introduction:

The overall aim of this study was to carry out a hermeneutic enquiry into the spiritual dimensions of ANP consultations in primary care through the lens of availability and vulnerability. This necessitated a phenomenological approach to fully understand the lived experiences of the ANPs studied. Paley (1997) identified that this approach allows for the unique perspectives of the participants to be discovered as well as discovering meaning of a concept which in this study was spiritual dimensions of ANP practice. This chapter presents a concise overview of hermeneutic phenomenology and the rationale for its use.

Hermeneutic phenomenology was the chosen underpinning philosophical approach for this study because it influenced a “thoughtful reflective attentive practice by its revealing of the meanings of human experience” Van Der Zalm et al (2000: 214). It was appropriate because of the descriptive and interpretative elements of this approach developed by Hans- Georg Gadamer (Gadamer 2006). This approach provided the necessary framework and direction for research into a specific phenomenon in this case spirituality (Fleming et al 2003).

5.2 Qualitative Research:

Qualitative approaches to research provide a framework for exploring and understanding thinking, experiences and behaviours (Munhall 2012). They differ from quantitative approaches which are often reductionist, focused on a single reality, controlled and predicable (Yardley 2000 and Koenig 2011). Qualitative methodologies are appropriate paradigms to explore how spiritual dimensions of

ANP consultations are perceived due to the philosophical and subjective nature of spirituality. Spirituality has been explored through quantitative methods by some authors who have used religious belief and expression to capture data that is quantifiable (Larson & Larson 2003; Koenig 2011). Koenig (2011) is quite open about his linkage of spirituality and religion in order to conduct large quantitative studies but as discussed in chapter 2 there may be a need to distinguish the two concepts so as not to exclude those who do not view their spirituality in terms of religious belief and practice (Pesut 2008). These methods are acknowledged as useful in some areas of spirituality research. However, for this study, working in depth with a small number of experienced ANPs, a qualitative methodology was considered most appropriate to enable a deeper understanding and interpretation of the ANPs lived experiences including their unique perspectives on these experiences (Paley 2000).

Qualitative research is an umbrella term to describe a range of methodologies with different epistemological and ontological positions including grounded theory ethnography, historical research, narrative analysis and action research (Munhall 2012). Qualitative methods range from “positivist to constructivist, to phenomenological and hermeneutic” (Debesay et al 2007: 57). Phenomenology is a philosophy, a methodology and an approach to conducting qualitative inquiry which allows for deep exploration of a concept rather than specifically the development of a new theory (Balls 2012; Munhall 2012). Lopez and Willis (2004) suggested that phenomenology fits well with the philosophy and art of nursing. This in part relates to the ability of the methodology to understand meaning that is unique to an individual which may provide nurses and other clinicians with deeper insights into concepts such as spirituality (Lopez & Willis 2004). Phenomenology is not primarily concerned

with defining a concept but rather with exploring meaning and experience. Perceptions of spirituality are often influenced by society, culture, personal and professional experiences, values and beliefs. The phenomenological approach allows for these aspects to be explored as their lived experience is studied (Balls 2012).

Within phenomenological approaches there are both descriptive and interpretive (hermeneutic) approaches. Initially descriptive phenomenology was considered. However, the need to bracket one's own preconceptions, experiences and understanding of the concept being investigated seemed incongruent with my reasons for the study. Koch (1998) asserted that it was impossible for researchers to detach themselves from interpreting something that impacted on their own lives, such as spirituality and I could not see, given my personal and professional experience, how I could do this. Furthermore, describing a phenomenon does not give it meaning. Moustakas (1994) alleged that in addition to reading the text (data in this study) it was necessary to understand the meaning and intention. It was therefore necessary to use a methodology which also addressed interpretation of the data.

Hermeneutic (interpretive) phenomenology recognises that it is impossible to bracket out personal preconceptions and allows for the researcher to be an instrument within the study (Koch 1995; 2011). Indeed, pre-understandings and prejudices are needed in order to develop an understanding of the phenomenon (Debesay et al 2007). This approach, with its philosophical and religious roots, closely connected in my mind to spirituality and allowed for deep exploration of the meaning of the data.

Hermeneutics derives from the Greek, herméneuein, to understand or interpret and is thought to relate to the Greek God Hermes implying divine truth (Ablett & Dyer

2009). The hermeneutic tradition of study derived originally from the interpretation of biblical texts (Lopez & Willis 2004; Van Deurzen & Arnold Baker 2005). However biblical hermeneutics has a major flaw in that one is attempting to interpret what Christians view as the inspired word of God (Bondor 2010). In current use traditional hermeneutics focuses on the general interpretation of all texts including data analysis. Dilthey (1976) expanded hermeneutics to include the context and questioning the meaning of the interpretation as opposed to Gadamer who developed a more philosophical approach to hermeneutics with its ontological concerns in the midst of the interpretive process (Gadamer 2006). After due consideration this was the method I chose to use.

5.3 Rationale for Hermeneutic Phenomenology:

Hermeneutic phenomenology has become increasingly popular in the past ten years because it enables researchers to gain an understanding of the "life world or human experience as it is lived" Laverty (2003: 7). This is important because it values individual experiences (Munhall 2012). Lopez and Willis (2004) recognised that more clinicians are utilising hermeneutic phenomenology because it connects with human experience. They suggested that the ability to examine subjective human experiences is foundational to knowledge. Phenomenology as a research approach is concerned with depth of understanding of meaning often (but not always) focused on the language of the phenomenon. It goes beyond description towards the depth of meaning and experience (Paley 2000; Lopez & Willis 2004). Hermeneutic approaches are not limited to any one method or specific guidance but allow for the researcher to immerse themselves in the data to enhance understanding of a phenomenon (Debesay et al 2007).

Hermeneutic phenomenology suggests that the understanding and interpretation of the phenomenon is always evolving (Laverty 2003). Analysis of this data will continue to develop over many years. At the final point of this thesis definitive meanings and interpretation are not possible. However, understanding of spirituality as experienced by the participants and the researcher is possible.

In hermeneutic phenomenology prejudice is recognised and accepted with pre-judgment being seen to enhance understanding (Lawn 2006). This prejudice includes the acceptance that as a researcher you will influence the interpretation of the data. This recognition enabled me to acknowledge and explore my own understanding of spirituality through reflexivity. The ability to embed one's prejudices, bias and assumptions is essential to hermeneutic phenomenology and these cannot be set aside or bracketed as in descriptive phenomenological methodologies (Laverty 2003).

Some of the challenges and benefits of hermeneutic phenomenology involve the deeply embedded philosophies from which it developed including how to analyse data and the impossibility of removing researcher bias (Van Manen 2007; 2014; Munhall 2012). As a nurse without a philosophical background I have been challenged to fully understand the methodology. Munhall (2012: 154) clarified that for nurses undertaking phenomenological research the aim was not the same as that of a philosopher but to understand the meaning and experience of the phenomenon as relevant for our profession. Part of my naivety in understanding the methodology actually enabled a deeply thoughtful and considered view of how the methodology worked in practice. By utilising this particular methodology, a potent approach to data analysis developed with myself and the participants being engaged in dialogue to develop meaning. This strengthened the findings considerably.

Koch (1998) suggested that hermeneutic phenomenology was an avenue to exploration without any set commitment to doing the research in a particular way. This leads the research to concentrate on the meaning and understanding of the data rather than a prescriptive approach to methodology. Van Manen (2014) recognised that no method of analysis guaranteed phenomenological reflection and that researchers must continually ensure the complexities of the phenomenon were explored and understood. Goble (2014) encouraged a phenomenological eye and phenomenological pen to be developed to aid the researcher in illuminating important narrative from the data in addition to the complexities and uniqueness of how the phenomenon was viewed. The freedom of the methodology is liberating in allowing for flexibility in the structure of analysis but, in order to ensure rigour, maintaining the focus on the phenomenon under investigation is paramount (Crotty 1996).

Hermeneutic Phenomenology is not without its critics. Laverty (2003) asserted that phenomenological methodologies were often used interchangeably with researchers ignoring the differences between descriptive and interpretive approaches. The approach chosen must be congruent with the methodology. Hermeneutic phenomenology was chosen because it had much to offer in its ability to provide rich interpretation and understanding. Marrying it with other methodologies could have weakened the process, creating ambiguity and confusion.

Others have suggested the lack of structured rules for the methodology leads to questions of rigour and validity (Sharkey 2001). He argued that method in itself does not lead to good interpretation. It was the researchers' ability to explore and understand the nuances of the phenomenon with the participants and engage in

dialogue to confirm the understanding with the participants which appeared to increase rigour and validity (Gadamer 2006).

Another criticism is the subjective nature of hermeneutic phenomenology. Rabow (2007) suggested the health professionals should seek objective evidence to support their practice but Gadamer (2006) argued that positivistic scientific (objective) methodologies often ignored the human condition and experiences making them also subject to questions about validity. There needs to be a balance of evidence from quantitative and qualitative perspectives, with qualitative methods especially useful for areas like spirituality that cannot easily be measured.

Remaining true to hermeneutic phenomenology involves understanding the origins and philosophy of the founder Hans-Georg Gadamer.

5.4 Hans-Georg Gadamer:

Hans-Georg Gadamer (1900-2002), a German philosopher, was heavily influenced by the earlier descriptive phenomenology philosophies of Husserl and Heidegger (Laverty 2003). He was a renowned academic, classicist and educator who developed philosophical hermeneutics (Lawn 2006)

Gadamer's philosophical constructs included dialogue to discover the depth of understanding and meaning, the hermeneutic circle and fusion of horizons. He was passionate about literature, art and music and sought to make sense of these in his own work (Lawn 2006). Hermeneutics originated from the interpretations of bible texts which Gadamer developed to include the understanding and interpretation of not just texts but also any phenomenon he wanted to understand (Gadamer 2006).

Gadamer argued against the 19th century preoccupation with correct methods in research and objective truth. He suggested that all interpretation is through the interpreter's historicity and that "no truth can transcend this central truth" (Hirsch 1979: 245). The integration of one's own pre-conceptions and subjectivity has become a key component in hermeneutic phenomenology. However, integrating these fully with the dialogue and interaction with the participants is vital to develop a "shared understanding" through the "hermeneutic circle".

5.5 The Hermeneutic Circle:

Gadamer's (2006) seminal work "Truth and Method" was a deeply philosophical attempt to bring clarity to the theoretical interpretation of hermeneutics. He described the ontological basis for his work and referred to the "hermeneutic circle" as a way of understanding and interpreting a particular phenomenon. A critique of phenomenology is that the analysis of findings is often from the researcher's view point (Paley 2005). The hermeneutic circle challenges this critique through ongoing dialogue to seek meaning and interpretation with the participants. The use of a hermeneutic circle is not purely a methodology but an ontological stance building on the work of other philosophers Heidegger and Schleiermacher to develop understanding (Gadamer 2006). Debesay et al (2007) suggested that through a circular process understanding occurs through the researchers' interpretations. The hermeneutic circle has been described as "the whole is understood in relationship to the parts, and the parts the whole" (Lawn 2006: 47). In relation to hermeneutic phenomenology this involves dialogue and interaction with the participants to develop a shared understanding of the phenomenon; this occurs during the data analysis stage. Gadamer (2006) encouraged the hermeneutic rule of movement to occur during analysis looking at the whole of the data, then the part and returning to

the whole. Within this research each interview was analysed before proceeding with further interviews and a summary (a part) of the analysis was presented to each participant prior to the second interview allowing for clarification by the participant before being related back to the whole research encouraging the hermeneutic circle to be complete and continuous. This process involved prolonged interaction with the participants in the study as well as classical analysis of the data line by line in order to find meaning. Within this process there was the acknowledgment of presuppositions for the researcher and the participant and the discussions that ensued during the research process could and did challenge these. This led to a fusion of horizons (Gadamer 2006).

5.6 Fusion of Horizons:

Gadamer developed the concept of a fusion of horizons after recognising the benefit of expanding our own horizons by interpretation and analysis of others' horizons (Linge 2008). It is suggested that we all have pre understandings, prejudices and experiences about all manner of things, experiences and people around us. We may try to recognise and acknowledge these and even challenge them (Gadamer 2006). As we try to do this we sometimes are able to widen and expand our horizons. It is important to note that horizons are not static but that they do influence the way we think, react, and live. For example, they are often deeply influenced by our past experiences.

Hermeneutic phenomenological researchers aim to acknowledge and be aware of their own presuppositions, to expand them and to merge them with the findings regarding participants' horizons (Gadamer 2006). The concept of a fusion of horizons is thus this marrying of our horizons with the participants' horizons (Linge

2008). Lawn (2006:70) suggests that some may argue this could end in “gladiatorial combat”, in that conflict may occur which becomes unresolved, however this was not Gadamers’ view of what would happen. It is suggested that as researchers we need to know if our interpretations are correct (Debesay et al 2007). Gadamer suggested that the fusion of horizons is a place of dialogue where a shared understanding can be developed as we test out our interpretations and our horizon becomes expanded (Gadamer 2006).

Ongoing dialogue with the participants during this research process enabled a fusion of horizons to occur leading to a thick description of the phenomenon of spiritual dimensions in ANP consultations. This thick description included sufficient detail which enabled the depth of meaning to be understood, in addition to assisting evaluation of the findings. This occurred by sending summaries of each interview to the participants, inviting them to dialogue with me, leaving a significant gap of 18 months and then talking this through during the second interview. The dialogue was fundamental to the methodology as it challenged my own presuppositions around spirituality and in discussion and analysis of the data a truer fusion of horizons was able to occur.

5.7 Reflexive Summary:

Phenomenological research is not an easy undertaking (Koch 1998). Including personal and epistemological reflexivity assisted the process in that it enabled understanding and awareness of my own contribution to the construction of meaning in the data analysis. As spirituality can be viewed as subjective, reflecting on my own influences, thoughts, beliefs and understanding was paramount to the integrity of the research Reflexivity integrates thoughtful self-awareness of the dynamics between

the researcher and the phenomenon under investigation but it is full of muddy ambiguity (Finlay 2003). The ability to attempt to deconstruct some of my own assumptions, yet also integrate them into the analysis in a meaningful way whilst remaining true to the participants, warranted important consideration. Hermeneutic phenomenology necessitated this self-reflection. Self-reflection was aided by keeping a research journal, in depth analysis of the data, dialogue with the participants and during supervision. Keeping a research journal provided opportunity to "locate the self in the research process" (Koch 1998: 1184). In addition, opportunities to present emergent findings and to discuss spirituality have been sought throughout the study (see page ii-iii) exposing my ideas to debate and challenge.

Aspects of an autobiographical reflexive account of my personal journey including tensions of beliefs and values were explored (partially through the use of a research journal) and re-visited in an attempt to allow the pre-understandings and interpretation of the data to be reflected upon, leading to further knowledge and ability to conceptualise the phenomena. Understanding how personal feelings and experiences affect the research and are integrated this into the study is a vital part of the process (Fleming et al 2003). The ability to be autobiographical lends itself to this aim and allows consistent saturation with the subject matter. Being attentive to the bias this creates encouraged the researcher to become highly critical in her appraisal of the data and analysis as well as encouraging saturation.

In summary the lack of any systematic empirical study of spirituality in ANP practice justified the aims of this research. My close alliance with the participants as fellow ANPs, and my self-declaration of my own spiritual journey, relationship with the

Northumbria community and use of A&V lead to the choice of hermeneutic phenomenology as the best approach.

Chapter 6 Methods:

6.1 Introduction:

This chapter presents the research methods relating to the study. It is presented in the standard way outlining the methods used in the process of data collection and analysis. The Aim and Objectives are presented initially followed by the study setting, ethical approval and methods. The methods are diagrammatically represented by Figure 1. The methods were informed by the hermeneutic phenomenological methodology.

6.2 Aim and Objectives:

Aim:

To carry out a Hermeneutic enquiry into the Spiritual Dimensions of Advanced Nurse Practitioner Consultations in Primary Care through the Lens of Availability and Vulnerability.

Objectives:

1) To undertake a phenomenological enquiry into the spiritual dimensions of - Advanced Nurse Practitioner consultations
2) To develop a shared understanding of the phenomena of spirituality through the lens of Availability and Vulnerability
3) To develop a conceptual understanding of spirituality for ANP practice.

6.3 Study Setting:

This study took place in the United Kingdom between April 2009 and August 2014. This study was undertaken in the North of England where there was a large ANP Forum and several higher education institutions which offered educational programmes for ANPS. At the time of the study the region had approximately 400 ANPs trained to work in primary care many of who were members of the forum. I was the chair of the ANP forum so, in order to remove any degree of perceived coercion, the other members of committee distributed the information about the study to members. I was not involved at all in any discussions with members about the study prior to their expression of interest to participate. This is clearly insider research. I am an experienced ANP; I have taught many of the ANPs in the region; I have an interest in spirituality and also ran the ANP forum. This raises issues of bias in some types of research but, as discussed in chapter 5, it is an acceptable component of the research process in hermeneutic phenomenology.

6.4 Ethical Approval

This study received ethical approval from the Human and Health Sciences' School Research Ethics Panel (SREP) at the University of Huddersfield. Due to the design of the study, the researcher also sought the National Health Service's (NHS) ethical approval through the Research Ethics Committee (REC) and local governance in four Primary Care Trusts.

A favourable response was received but minor alterations were requested. The main stipulation was that participants must be given the Northumbria Community Rule of Life (Appendix 2) prior to the second interview so that participants were clear about

the roots of A&V. All issues were addressed and the proposal re-submitted to REC for final approval which was gained.

6.5 Methods:

6.5.1 Selection and Sampling:

Selection and sampling makes research more manageable (Moule & Goodman 2000). Bowling (2009) suggested that in order to understand a phenomenon purposive, convenience, theoretical or snowball sampling were possible approaches.

The hermeneutic phenomenological process is concerned with understanding a phenomenon from the perspective of the individual, the methods for sampling therefore were non-random but purposive as they aimed to sample participants with a specific characteristic, in this case ANPs in primary care (Bowing 2009).

ANPs were recruited from the ANP forum which at that time had 150 members. This was in effect a purposive and convenience sample which enabled face-to-face interviews to be arranged which were all within an easily accessible 60 mile radius. Purposive sampling was used to ensure participants met the inclusion criteria. Purposive sampling is common in qualitative research (Houser 2015). A two stage process occurred for selection and sampling. Firstly, the forum was approached via email to agree to members being contacted to participate in the study. The forum responded positively to the request to facilitate participant access and agreed to send out the invitations for participants for this study. Twelve potential participants volunteered to participate in the study but only eight met the inclusion criteria (below). Despite the researcher being known to the members, only a small number (12/150) volunteered for the study showing that the researcher's influence did not

lead to coercion into participation. Participants agreed to two interviews over a two-year period. Hermeneutic phenomenology requires that the participants have lived experience of the phenomenon (Laverty 2003). By volunteering after reading the information sheet it was assumed that the participants had some understanding or interest in the phenomenon. A small sample size was acceptable for a phenomenological study as the aim of the study was not generalizability (Munhall 2012).

The data collected from each participant over the two interviews enabled extended interactions with participants to occur in order to refine and clarify meaning and integrate personal interpretation of the data. Additionally, prolonged engagement was planned as this is recommended to support in depth analysis and increase credibility of the findings (Houser 2015).

There was a possibility of selection bias since participation was voluntary. Only one volunteer openly stated that she chose to participate because she was specifically interested in spirituality. Houser (2015) suggested that the recruitment of those with a special interest in the area being researched could create potential bias and could result in misleading findings since the participants might have a great deal of knowledge about the topic studied. In this case, the phenomenon being investigated was the lived experience of the ANPs with regard to spirituality and a range of different levels of knowledge was potentially helpful as the aim was to enquire about experience not to ascertain certainties.

The initial response was encouraging though I had hoped for more volunteers as reflected below:

I was delighted to have 12 ANPs respond to the study even though I had hoped there would be a greater response. I did consider sending out a second invite but after talking to my supervisors it was felt that 8 participants would provide a large amount of data over the two interviews planned. I was a little worried that I knew some of the participants but recognised that as I initially set up the forum and taught the MSc course where many of the local ANPs trained this was to be expected. I was really pleased that one of the participants was a colleague of a member of the forum who was not known to me as this may provide the opportunity to explore spirituality without any researcher bias. I worried that after reading the participant information sheet some may withdraw from the study but all still expressed an interest. Some of the participants had just qualified as an ANP or not working in primary care; they were excluded from the study.

Box 1 Extract from research journal

6.5.2 Inclusion and Exclusion Criteria:

Inclusion and exclusion criteria are helpful within qualitative research to ensure that the most appropriate participants are selected. The inclusion and exclusion criteria identified below increased the likelihood of recruiting participants with some lived experience of spiritual dimensions from their consultations in practice.

Inclusion Criteria:

- Experienced Advanced Nurse Practitioners (5 years post qualification)
- Members or affiliates of the Yorkshire Nurse Practitioner Forum
- Active Advanced Nurse Practitioners working in Primary Care

Exclusion Criteria:

- Advanced Nurse Practitioners qualified for less than 5 years.
- Advanced Nurse Practitioners not working in Primary Care

Figure 1 shows a diagrammatical representation of the method followed:

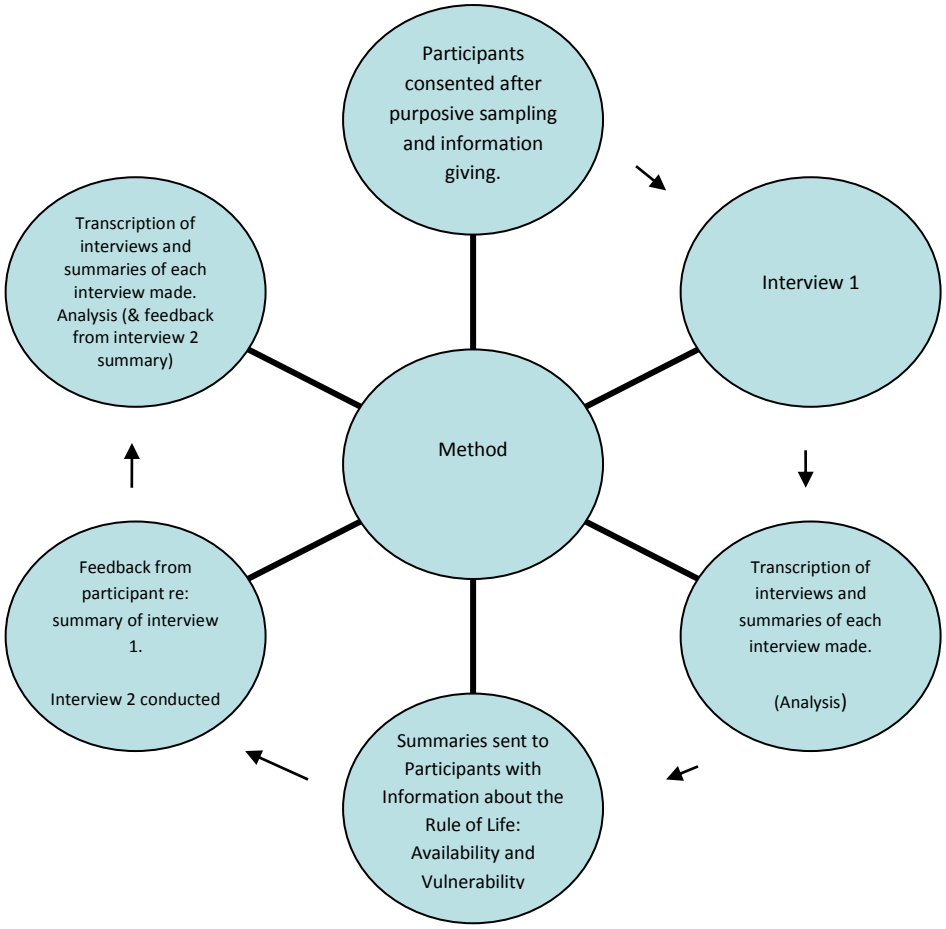

Figure 1 Method

6.5.3 Consent

An information sheet with study information (Appendix 5) was given to all ANPs who expressed an interest in joining the study to elicit consent, those willing to be interviewed were then be asked to complete and sign a consent form (Appendix 6).

Potential risks involved in addressing potentially sensitive beliefs and values of participants were highlighted in addition to participants being clear that they could withdraw from the study at any point. An explanation of hermeneutic research was given as the participant and researcher needed to be in communication throughout the study to share understanding and challenge assumptions derived from the data. This included some communication via email between the two interviews.

It was explained to all participants that two interviews would take place over a two-year period, these would be audiotaped and pseudonyms used to maintain anonymity. It was also explained that, in keeping with research standards, consent forms, identifying data, interview tapes and transcription were to be kept in a locked space accessible only by the researcher (Moule & Goodman 2006).

All participants signed a consent form and no participant withdrew throughout the study.

6.5.4 Data Collection Method:

Interviews are often the primary data collection method used in hermeneutic phenomenology (Moule & Goodman 2006; Munhall 2012). Interviews allow for dialogue between the researcher and participant to explore their thoughts, feelings and experiences with the aim of gaining understanding and clarity of the phenomenon (Laverty 2003). In order to explore the lived experiences of spirituality

the plan was to allow enough time for the interview to go in whatever direction the participant wanted it to. However, I felt that I needed some prompts to guide the interviews to ensure we had opportunity to explore spirituality and also A&V. In light of this a topic guide was developed for use as a prompt but mainly to ensure all participants covered the same areas for comparison.

The aim of the interviews was to enable shared understanding of the dialogue to occur during the interviews but mainly to give the participants the freedom to fully express their own experience of spirituality and the spiritual dimensions of practice. It is common in phenomenology to choose open questioning within the interviews as this allows for the truth to be revealed (Gadamer 2006). The dialogue which occurred throughout the interviews and also during the analysis process was where the fusion of horizons was able to take place. The prolonged engagement and the period of time between the interviews allowed not only for analysis of the data but for ongoing dialogue with the participants which ensured that the hermeneutic circle was completed. Sending participants a summary of their interviews and the themes identified ensured that the hermeneutic rule of movement was maintained. Participants were able to respond with any clarifications, questions, challenges and thoughts about the analysis (and indeed further reflections on spirituality); this was continued throughout the whole research process in order ensure the hermeneutic circle was complete and continuous.

6.5.4.1 Interview Process:

Two in-depth semi-structured interviews took place over two years with each participant. Interviews were arranged at a time and place to suit the ANP. This was

usually at their place of work however one participant felt “emotionally drained” after the first interview and asked for the second interview to take place at her home when she did not have to return to work. In general the interviews flowed well. However, in two interviews there were interruptions by other members of staff or phone calls. This did affect the flow of the interview but each participant who was interrupted was able to re-engage with the discussion quite quickly. The interviews were taped with two recording devices in case of malfunction

Interviews lasted between 40-90 minutes ending when the participants felt they had said all that they had wanted to. The interviews were conducted with an openness and curiosity to gain as much understanding as possible (Debesay et al 2007). The first interviews focused particularly on meanings of spirituality and A&V in addition to issues of boundaries, professional practice and relationships within the consultation which impacted the practitioners at a deep level. Individual experiences and understanding of spiritual dimensions, spirituality and the concepts of A&V were explored with the semi-structured interviews. Participants were then asked to discuss what these terms evoked in their minds. Exploration of how these terms might be related to the consultation followed. Guiding questions were utilised (Table 3), allowing the participant to explore spirituality and lead the discussions (Laverty 2003). Following the hermeneutic approach these questions were intentionally very open to allow the interviews to stay as close to the lived experience as possible (Koch 1998).

Table 3: Guiding Questions Interview 1:

What is viewed as important in an ANP consultation and what holistic practice means to them?

Is there a boundary in practice and do emotional connections occur with their patients?
What is Spirituality and what is it place in practice?
What do the words A&V conjure up?

The second interview occurred after the participants were invited to read through the account written by the Northumbria Community (NC) explaining the concept of A&V and the heritage of these terms (Appendix 2). Further questions attempted to discover any links between their initial thoughts and responses and the concept as defined by the NC (Table 4). Analysis of the data from the second interview was integrated with the data from interview 1 where the participant lacked the conceptual information about A&V and their historical context.

This semi structured interview also used guiding questions but specifically explored the following:

Table 4: Guiding Questions Interview 2:

- What was the ANP view of the “Rule of Life” from the Northumbria Community?
- What did A&V mean to them within the new context of the terms
- Whether their views had changed about Spirituality and whether A&V could be a useful lens to consider spiritual dimensions of consultations

Although I had wondered whether A&V could be an important lens for understanding spirituality I didn’t impose this concept framework on the research participants, but investigated the ways in which they viewed spirituality (Interview 1) and then how

they viewed it through the lens of A&V (Interview 2). A topic guide aided the flow of the interviews and provided a prompt when participants were unsure of what to say (Appendix 7). The two interviews with each participant over a prolonged engagement enabled patterns and relationships of meaning to develop. The methodology utilised encouraged a shared understanding rather than the generation of new theories (Lawn 2006). The interviews were semi structured and interpretive inquiry of themes and patterns were sought through the analysis.

Reflective field notes were made after each interview and through the research process. A particularly reflective field note was made by myself after one interview and reminded me how privileged I felt during the interview process (Box 2):

The first interview was incredible. After obtaining consent to participate in the study the interview started and immediately I felt a good rapport and that the participant had thought about the study's theme. She spoke honestly about her views of spirituality and her role as an ANP. She honestly discussed a patient with whom she felt an emotional connection which impacted her professionally and emotionally and linked this with her concept of spirituality. After the interview I left feeling honoured that she had shared to such a depth and felt that the material gathered would be extremely valuable to analyse.

Box2 Extract from research journal

6.5.5 Data Analysis: (Thematic Analysis and Shared Understanding):

Within hermeneutic phenomenological research, the key to analysis for the researcher is immersion in the data from data collection through to analysis (Moule & Goodman 2006). They suggested that analysis often includes identification of themes in addition to insights gained throughout the process of analysis.

Additionally, the prolonged dialogue with participants throughout the analysis process adds to authenticity and faithful representation of the data. There are a number of recognised approaches to hermeneutic data analysis (Colaizzi 1978; Fleming et al 2003; Van Manen 2007; Munhall 2012) all seeking to find a true interpretation of the data. Fleming et al's (2003) method of data analysis was chosen as it was sufficiently broad to allow flexibility in the process.

All analysis was carried out after verbatim transcription of the audio-taped interviews. The transcription was completed initially by a professional transcriber then checked verbatim by the researcher in order to establish pre-understandings and interpretations in the research process. During the analysis some reading between the lines was necessary according to the principles of hermeneutic phenomenology as verbatim transcripts only focus on what is said and it is possible to miss understanding and meaning if the researcher does not seek to make interpretation. Individual summaries were made after each analysis with the key findings from each participant (Appendix 8). Each summary was then sent to the participant and later discussed face to face after the participants had chance to reflect on the findings. Email correspondence and phone calls occurred on several occasions when the participant wanted to send further reflections. Every summary was deemed by the participant to be an accurate analysis of meaning and understanding.

Colaizzi (1978) supported returning to participants with summaries of key statements after analysis. Ongoing dialogue with the participants was used in this methodology to orientate participants to the study and initial findings, allowing them the opportunity to challenge misconstrued interpretation and understandings made by the researcher. Attempts were made by me continually to be focused on the ANPs perceptions and experiences of spirituality and whether they had experienced this

within their consultations. The aim of this process was to achieve a shared understanding rooting the research firmly in the ethos of Gadamer's hermeneutic phenomenology. This active engagement and clarification with the participants (the fusion of horizons) throughout the research process completed the hermeneutic circle.

The specific analysis process followed was focussed on Fleming et al (2003) 4 step approach to interpretation of data:

- The whole text of data was initially examined for understanding (to ascertain the fundamental meaning).
- Every sentence was then investigated to expose its meaning for understanding of spirituality. Themes emerged at this point which led to a detailed understanding of the phenomena. These themes challenged my previous understanding and allowed ongoing challenge of the themes.
- Every sentence was then related to the meaning of the whole text and the meaning of the whole text was then expanded.
- Finally passages that represented shared understanding between the participants and myself were identified giving insight into spiritual dimensions of consultations and spirituality.

This analysis process is not dis-similar to that described by Van Manen (2007) however it was seen as preferable as it was concise and it ensured a systematic approach. This systematic approach ensured that all analysis enriched the whole research process. Two working examples of sections of participant transcripts illustrate the analysis process (Appendix 9).

After transcription of the interviews interpretive inquiry of themes and patterns were sought via analysis (thematic analysis). The major themes emerged from this textual analysis and recognition of repeated patterns. At each stage the emergent findings were brought to supervision where assumptions were challenged and ideas refined. This process followed Gadamer's (2004) hermeneutic rule of movement looking at the whole of the data, then the part and returning to the whole. Each interview was analysed before proceeding with further interviews and the summary (a part) of the analysis was presented to each participant prior to the second interview allowing for clarification by the participant before being related back to the whole research encouraging the hermeneutic circle to be complete and continuous. A fusion of horizons enabled a thick description of the phenomenon of spiritual dimensions in ANP consultations to be developed (Gadamer 2004). Synthesis of the data and returning a second time to the participants enabled me to discover whether this thick description was accurate and gave the participants time to reflect on the interviews and material presented to them.

The methodology used an interpretive approach to gain insights into participants' opinions, views and understanding of spirituality. Participants' narratives added richness to the data by demonstrating experiences which for them connected with spiritual dimensions of practice. The use of semi structured interviews and the provision of material explaining A&V before the second interview enabled exploration of individual experiences and understanding of spiritual dimensions, spirituality and the concepts of A&V. Participants were asked to discuss what these terms evoked in their minds. Exploration of how these terms might be related to the consultation followed. The first interview gathered data about ANP roles and the ANPs' understanding of and views about spirituality and availability and vulnerability in their

consultations. Further questions attempted to discover any links between their initial thoughts and responses and the concept as defined by the Northumbria Community.

6.5.6 Validity, Reliability & Rigour:

Koch (1998) noted that some researchers viewed hermeneutic phenomenology as being a soft science, unscientific, biased or too personal impacting its validity and reliability. However, in the hermeneutic phenomenological context of this study, rigour was achieved and demonstrated through acknowledgement of bias, prolonged engagement with the participants and reflexivity throughout the study. Set criteria for rigour are problematic and not consistent philosophically with hermeneutic approaches (Witt & Ploeg 2006). However, Yardley (2000) suggested that rigour is attained through the completeness of the data collection and analysis in addition to the interpretation.

Reliability within this methodology was enhanced by the consistent approach to the data collection and analysis in addition to the acknowledgment of my own starting point in terms of values and beliefs around spirituality, developed over many years of personal exploration and professional experience. My starting point was made explicit at an early stage of the research as recorded in Chapter 3. Although the focus of the interviews was on the participants there was no reason to hide or ignore my own subjectivity. To increase reliability, the research was carried out in an explicit and systematic way (Bowling 2009).

The interview process and data analysis aimed at getting as close as possible to the lived experiences of the ANPs. This would never be the exact experiences as I have

interpreted the data and my own pre-conceptions and bias have undoubtedly influenced the findings. Subjectivity with hermeneutic phenomenological research is well recognised (Bradbury-Jones 2007) and integral to the process. However, to enhance rigour, prolonged engagement with the participants over 18 months at and between interviews in addition to presenting the summaries back to each of them allowed for the findings to be as authentic as possible. In addition, my subjectivity has been explored throughout the process during supervision, reflection and use of a research journal and is explicitly integrated throughout the process. Exploration of subjectivity through the use of a research journal with ongoing reflexivity was a key way of demonstrating rigour and enhancing credibility as it identified the interplay between myself and participants in addition to my own reflections (Bradbury-Jones 2007).

As opposed to quantitative research, hermeneutic phenomenology does not fit stringently into the Validity and Reliability methods terminology (Moule & Goodman 2006). Bradbury-Jones (2007: 291) has suggested that credibility is a term most qualitative researcher's use rather than validity or reliability as it "refers to the fit between the experiences of the respondents and the researchers' representation of them".

Credibility can enhance rigour and was possible through the prolonged engagement which has occurred during this study and ongoing reflexivity. Laverty (2003: 23) recognised that rigour is present in hermeneutic phenomenology as the researcher is involved in "multiple stages of interpretation that allow patterns to emerge". The credibility of ensuring that "faithful descriptions" are made and held and that any

conclusions made are “firmly grounded in the data or explained by the researcher’s interpretative scheme” (Koch 1998: 1188). Credibility is an important principle in hermeneutic phenomenology and was enhanced by allowing each participant to review the key findings within a summary of their interview, continued dialogue with participants and the development of shared understanding through the fusion of horizons and completing the hermeneutic circle. Credibility of the research will also be enhanced within the terms of hermeneutic phenomenology by those reading the thesis feeling able to traverse the story easily and decide for themselves concerning its validity and reliability as a “legitimate research endeavour” (Koch 1998: 1182).

6.5.7 Commitment and Transferability:

Within the field of phenomenological research commitment and transferability are also important. Commitment towards the methodology in terms of adhering to the Gadamers’ hermeneutic methodology is important as discussed in the above sub section. However, commitment towards the participant in terms of long term engagement and ongoing dialogue to develop a shared understanding is paramount. Yardley (2000) proposed that this engagement can lead to exploration which is empathic and contemplative which leads both parties to a sophisticated, in depth and well developed analysis and understanding. The faithful adherence to the methodology and detailed description of the findings reveals the commitment that has occurred.

Despite this study having a small sample the findings may have transferability to other populations and settings (Slevin & Sines 2000). Even with unique studies such as this the findings may relate to other settings (Shenton 2004). Yardley (2000) recommended that a detailed account of every aspect of the data collection process

and analysis is presented to enable a convincing transparency in addition to the ongoing reflexivity of the researcher. This is echoed by Slevin & Simes (2000) and Shenton (2004) who suggested that a systematic approach following the chosen qualitative methodology with rich and dense descriptions of findings aids transferability. It is then up to other researchers to consider whether the findings can be justifiably applied to other settings and further study initiated (Shenton 2004). The uniqueness of this study's findings revealed features that are intrinsic to this study. Paley (1997) asserted that many nurses suggested, in their phenomenological studies, that their findings whilst unique were also universal. He stated that this is not possible. It is therefore important to recognise that whilst transferability is feasible, generalisability is not.

6.5.8 Ethical Issues:

Moule and Goodman (2009) identified that in any research the participants' rights, safety, wellbeing and dignity are paramount. Providing the participant information sheet and informed consent allowed for some of these aspects to be addressed (Gerrish & Lacey 2006). Participation was voluntary with clear emphasis on the ability to withdraw at any point from the study. Interviews were arranged at the convenience of the participants and they were given freedom in terms of what they talked about and when the interview ended. Assured confidentiality and the use of pseudonyms to maintain anonymity was also discussed with each participant. There was uncertainty about whether any of the interviews would cause distress to the participants but I was sensitive to this possibility. Reflecting on specific patient relationships and also the challenges of practice was emotional for two of the participants. After the interviews I offered support to both of these participants and

discussed external support mechanisms available if needed. Gerrish and Lacey (2006) recognised the uncertainty that can occur in terms of participants' safety and wellbeing and suggested human judgment needed to be used when conducting research but that researchers could not prepare for every eventuality. The key in this study was ensuring that ethical principles were followed and that the approach to the study recognised these principles.

Specific ethical principles were considered throughout the whole study period. Beneficence and non-maleficence were considered during the proposal period and throughout the study. These were initially assessed through the NHS REC and local research governance processes and through supervision as the study progressed. The intent not to do any harm to the participants was paramount. When one of the participants revealed she felt burnt out in her life we took some time after the interview to talk about this and sign posted her to support in her work. When another participant recognised she felt emotionally drained after the first interview as it was during her working day we made a plan to conduct the second interview at her home on a day off as she felt this would be more comfortable.

Justice and respect were also considered. All participants were treated equally and their needs came before the research (i.e. we stopped for interruptions in practice and after one interview discussed an individual's current stressors with work). The study was open to all ANPs who met the inclusion criteria. Participants were excluded if they did not meet the inclusion criteria to ensure the findings were as credible as possible. Veracity was practiced from the outset with transparency in the recruitment, data collection and analysis process. Participants had ongoing access to me for questions and were each sent copies of the interview summaries after analysis

Confidentiality was maintained by the use of pseudonyms to protect the identity of participants and all identifying information and data from the study was kept in an encrypted software programme or a locked drawer.

6.5.9 Strengths:

The methods followed during this study followed the hermeneutic process fully. Prolonged engagement with the participants and ongoing dialogue enhanced credibility and rigour of the study. The methodology and methods allowed for the lived experiences of each participant to be fully explored and allowed for a conceptual understanding and framework of practice to be developed. This study is the first of its type in the UK.

Whilst the sample was small and purposive, the detailed analysis offers the potential for transferability. This is because the findings may have meaning for others in similar working circumstances nationally and internationally and may form the basis for further research and development (Streubert & Carpenter 2011).

6.5.10 Limitations:

The study has several limitations. Firstly; using a lens of availability and vulnerability as accepted from a small community of faith to understand spiritual dimensions may be seen as narrow. The use of a concept with Christian origins could have led to difficulty in analysis of participants who have very different beliefs or see themselves as atheist or agnostic.

Secondly; the methodology chosen is reflected by my own history, experiences and pre-judgments. This has been taken into account throughout the thesis. This enhances credibility of the study (Laverty 2003); whilst others may view this as a

limitation (Bradbury-Jones 2007). Hermeneutic research creates an unfettered bias where the researcher immerses themselves within the research and integrates their own experiences and beliefs. Personal interpretations are in fact the key to the progression and interpretation of the data and finally the fusion of horizons from researcher and participants.

Thirdly the interpretation of the findings is constantly evolving and this study is only my interpretation (with the participant's agreement) at this moment in time. Debesay et al (2007) suggested that there is a risk of misinterpretation by ending a study too quickly and often data needs ongoing examination. It is hoped that at this point this is an authentic presentation of the findings and that I will return to the data at a further point to seek further meaning and new understanding.

6.5.11 Dissemination of Findings:

This thesis once examined will be held at the University of Huddersfield and will be available publicly via the repository. Conference presentations and publications in refereed journals will continue post submission.

Chapter 7 Findings:

7.1 Introduction:

The key aim of this study was to explore the spiritual dimensions within ANP primary care consultations and to investigate the phenomena of spirituality that emerged from that analysis through the lens of Availability and Vulnerability (A&V). The concepts of A&V as understood by the Northumbria Community were presented to the participants just prior to the second interview.

Eight ANPs participated and were interviewed on two occasions 18 months apart. This chapter sets out the findings that emerged from the analysis of these two sets of interviews. As has been discussed in chapter six, the 18 month period facilitated the fusion of horizons and the hermeneutic circle and gave participants an opportunity to reflect on the meaning of spiritual dimensions and also consider the resonance, if any, of 'Availability and Vulnerability' to their practice.

Firstly a descriptive background of the participants is presented [mostly drawn from interview one], which describes some of the similarities and shared understandings of the participants as ANPs. Following this, two sections explore each interview discretely and sequentially as outlined in Chapter 6. Having analysed both interviews I made the decision to present the interviews as they happened, rather than merging the data. This felt like an authentic presentation of the findings, and allowed for the two sets of data to be seen both separately and as a continuum. Finally, a reflexive summary offers an ongoing opportunity to acknowledge my own thoughts and feelings whilst summarising the key findings.

Gadamer's (2006) hermeneutic framework was utilised to refine the emergent themes. Data analysis has been a challenging process in view of the richness of the data. Understandably there was a wealth of data from the interviews. However, the themes presented in this chapter focus on the Aim and Objectives of the research. Maintaining the phenomenological tradition, the findings are presented descriptively. Interpretation is presented in the subsequent discussion chapter.

Following initial analysis the themes that emerged from individual's interviews were presented to the participants as a summary. Participants then were given the opportunity to respond to the summary in terms of its accuracy. All summaries were considered to represent an accurate overview of their interviews by the participants (Appendix 8). Georgia and Ana emailed further reflections after they had reflected on their summaries after interview 2.

Throughout this chapter extensive verbatim quotes are presented in italics with speech marks. All participants contributed to the findings but some are more frequently quoted than others. Throughout the analysis and the construction of this chapter I have been mindful of faithfully representing their interviews but have selectively drawn on the data that offered the most insight into the key aims of the study. The quotations are identified by a pseudonym allocated to each participant and the number 1 or 2 indicating which interview.

7. 2 Participant Characteristics:

This section describes the ANPs in terms of demographics, education, previous role, specialisms, and reasons for becoming an ANP and includes general characteristics of the consultation and ANP role that were consistent across the participants. A summary of participant characteristics is presented in table 5.

As can be seen from table 5 there is a strong similarity in age, professional background and career trajectory which is consistent with the ANP profession as a whole. Less consistency may be seen in the reasons for their career choice. For example:

Seven participants chose to become an ANP because they wanted to be more "*holistic and deliver a better service for patients".* One saw the "*recruitment crisis of GPs"* as an opportunity to develop her role.

Two participants felt "*bored*" with their previous role and one felt "*frustrated"* about not being able to offer *"full care".* The health visitor felt "*unsatisfied*" with her role and *"missed the practical aspect of* [her] *role".* The majority of participants talked about wanting to develop professionally at the time of starting their ANP training.

All bar one of the participants talked of the desire to "*improve patient care*" and *"continuity of care"* and felt that the ANP course would provide them with the new skills to do this. Two participants talked of the ANP role being a *"natural progression"* which would give them more of a "*challenge"* and enable them to *"use brain more".* One ANP had a high aspiration which had stayed with her through her career; *"you are there to help people live again"* this spurred her on in her work and studies.

Table 5: Summary of Participant Characteristics:

Participant	Demographics	Past Role	Years Qualified	Specialisms	Decision to become an ANP
Ana	40's Female (F) Caucasian (C) Large Practice-suburban (students)	Practice Nurse	10 years MSc	Eating Disorders/Chronic Disease	Natural Progression, wanting to do more for patients
Georgia	50's F C Mid-size practice-suburban	Practice Nurse	13 years PG Diploma	Respiratory, CVS, Women's Health, teaching	Bored of Practice Nurse role, wanted to develop. Saw ANP roles

					as natural development Remembered as a student being told you're there to help people live again and I wanted to do that
Tanya	40's F C Small practice-city	Practice Nurse Hepatitis Nurse	5 years, MSc	Homelessness Addiction Asylum seekers	Wanting to develop role as patients' I was seeing were complex and I wanted to complete episodes of care. Wanted to improve patient care
Tara	50's F C Mid-size practice-suburban (students)	Practice Nurse	10 years, Pg Dip	Diabetes & Respiratory	Frustrated in not being able to offer patients full care Wanted to learn new skills to help patient s have continuity of care
Polly	40's F Black Mid-size practice-suburban	Health Visitor	7 years, MSc	Respiratory	Found HV role unsatisfying Missed practical aspect of role Interested in ANP role
Lucy	50's F C Provides CPD for advanced practice in locality and ANP Locum various practices	Practice Nurse/Practice Manager	10 years, MSc	Cardiology and Women's Health	Wanted to develop role Wanted to offer holistic care Interested in ANP role
Mia	50's F C Mid-size practice-suburban	Practice Nurse	6 years, MSc	Women's Health and Family Planning	Bored of Practice Nurse role Wanted to offer patients more Wanted a challenge
Jane	40's F C Mid-size practice-suburban	Practice Nurse	9 years, MSc but "piecemeal" some in house/advanced practice course but more theoretical	Acute, CVD and Diabetes	Wanted to develop and advance role Saw GP crisis as an opportunity to develop role

7.2.1 General Characteristics of the Consultation:

All of the ANPs recognised that every consultation was different and unique. The nature of a consultation with patients appearing on the first occasion with a specific

(often minor) complaint was recognised as being different from those presenting with more complex needs or concerns i.e. with chronic disease often with co-morbidities, with terminal care needs, or mental health issues. There was a recognition that consultations with patients with 'minor' conditions were often simpler and quicker to deal with but hidden underlying complexity could unravel. One participant stated that *"in an initial approach I always try to be the same….the person with a virus may have a lot of things going on" (Mia1).* Participants recognised that what might appear as a "*minor*" presentation could mask deeper issues. There was a perceived risk associated with "*being very formulaic"* (*Georgia 1*) within consultations and just treating the symptom without enough time to be open to patients as individuals and explore deeper issues.

Most of the participants talked about getting to know patients better over time which led to a *"better rapport"* and sometimes becoming *"more involved in different aspects of their life than what they are presenting with" (Lucy1).* It was acknowledged that the relationship *"changes because you become more involved with them and it gets a bit more personal if you like" (Jane1).* Generally, more complex issues meant the ANP would take time *to "listen to the patient, what their concerns were and what their worries were" (Polly1)* and to offer more *"time and support to patients with more serious illnesses" (Lucy1). Jane* suggested this was because *"patients with complex medical problems are looking for somebody you can confide in and keep the continuity going" (Jane1).* Building a long term relationship appeared to change how the patient reacted to the ANP. A relationship built over time meant the ANPs *"get to know patients very well" (Ana 1)* and this facilitated the patient to appear to "*be confident and trust you" (Lucy1).*

7.2.2 Important Aspects of the ANP and Patient Relationship:

Key aspects of the ANP and patient relationship appeared to be shared by the practitioners. Taking time to build relationships was one of the most consistent factors. Tara said *"I can give patients most of the time 100%...I give them the whole care package and see them through their health journey" (Tara1),* Tanya felt that time gave patients *"time to disclose" (Tanya1)* echoed by Jane who felt it *"led to a better rapport…built from trust" (Jane1).*

The second most common factor was getting to know the patient and connecting with them. ANPs considered how they come across to patients and how patients feel in their company. The ANPs felt that making the patient feel "*safe",* "*listened to and validated"* was in itself "*therapeutic"*. Several of the ANPs talked about this in terms of developing a *"reciprocal"* relationship where the ANP used the relationship therapeutically.

Other concepts that emerged in the interviews about the ANP-Patient consultation included "*self-awareness", "listening", "openness", "encouragement", "empathy", "understanding", "honesty", "integrity" and "being present*". These qualities or behaviours, according to the participants, were used to ascertain the patients' agenda and needs. This was achieved by providing a safe environment where patients felt understood and accepted and could feel comfortable and safe enough to disclose. They suggested that patients knew they were held within a professional boundaried relationship that was patient-focused, and where the ANP aimed to offer holistic care treating the patient as a person and not as a disease. The data suggested that ANPs helped their patients to feel better by being listened to and

heard whilst being offered appropriate treatment and not missing life threatening conditions.

7.3 Key Findings Interview 1:

Analysis identified five key emergent themes within interview 1:

1. Participants definitions of spirituality
2. Participants views of spirituality and Religion
3. Participants understanding and experiences of spirituality in the consultation and openness to spirituality
4. Participants views of boundaries and emotional connection within the consultation
5. Participants conceptualisation of Availability and Vulnerability

A number of powerful stories were shared by the participants and add depth to the findings; one of these will be considered as a model case in chapter 8.

7.3.1 Defining Spirituality:

Some of the participants had no personal definition of spirituality and were confused about what spirituality actually was. Other participants appeared to have a deep understanding of spirituality and were able to offer a clear definition of what it meant to them. Within the first interviews there was some association made between spirituality and religion with participants asking whether or not these were the same, interlinked or separate.

The varying definitions of spirituality offered by the participants included broad definitions with commonalities about our innateness, our humanness and our way of living.

For example, Polly defined Spirituality as*:*

> *"everything that that person believes, almost their way of life…..What is important to them and how they would want to live their life and how they want to impact others around them…..it's how a person likes to live their life" (Polly1)*

A metaphor for spirituality, acknowledging its uniqueness, was made by Lucy. She described it as a "*fingerprint".* She was able to recognise the breadth of spirituality which allowed for individual differences to be included. She suggested that:

> *"Spirituality for me is about the essence of a person…..it's about your essence, it's about your make-up, some of the things you are born with, some things you develop because of your environment and how you are brought up. I think it's probably like a fingerprint really, it's different for everybody….You have to know it's about being who you are" (Lucy1).*

Jane also talked of the innateness of spirituality and acknowledged that it was an internal process:

> *"I think it's* [spirituality] *something that comes from, you know, it's not related to the material things, it's not related to the physical, it is something that comes from inside from whatever you want to call it, whether that be spirit or the soul or whatever……it's about happiness….balance, it's about contentment with where you are and who you are in your life. I don't think it's necessarily about faith…..individual spirituality is more about looking inwards" (Jane1).*

Georgia offered insightful views on spirituality throughout the interviews which culminated in her linking her thoughts with a new way of recognising spirituality by identifying "*soul ache".* She initially talked of spirituality being:

> *"more diffuse, is more broad, it's much harder to define, its maybe just a suspicion or an intuition that we are more than matter….there is more than the dimension you have got, the body, the mind and I would say you have got another dimension which makes us truly human because I believe, my own personal belief is that we are spiritual beings in a physical body……..The other things I remembered is that it's about uncovering that purpose that you have for being here".*

She then developed this by saying that:

> *"I have coined my own term, soul ache"* which she used when presentations were much deeper than the physical and include *"life concerns" (Georgia1).*

She explained this term came from her observation that many people had this ['*soul ache*'] and wanted to talk about their life concerns and be listened to. When consulting she suggested having this awareness of *"soul ache"* in her mind helped her to provide truly holistic care which integrated spirituality.

Tara and Mia appeared to be unsure about what spirituality meant. They offered very interesting views of spirituality which surprised me; Tara talked about *"spirits"* whilst Mia mentioned *"spiritualism"*. The context for the spiritualism comment was in regard to when she felt a spiritual dimension occurred in her practice and it appeared she confused the term as she did not expand to talk about spiritualism as it is defined but

continued to reflect on when she felt a deep connection with a patient during an emotional consultation i.e. terminal care.

Tara suggested that:

> "*Spiritual I suppose would be almost not human, the spirits of the dead and things like that…. the only thing I can think of is you know people having spirits of their relatives coming back to see them so it would be something like that (Tara1).*

Finally there was a real acknowledgment of the difficulty defining spirituality:

> *"It's a term we use but we don't know what we are talking about" (Ana1)*
>
> *"I'm struggling in my own head with definitions" (Ana1)*
>
> *"You can't quite put your finger on it" (Tanya1)*
>
> *"It's woolly isn't it….it's kind of not an easy thing" (Georgia 1)*

7.3.2 Spirituality and Religion:

All of the participants attempted to articulate differences between spirituality and religion. Most suggested there could be a link but four participants made a distinction between the two. Those who differentiated spirituality and religion focused on religion as "*guidance*" and a *"belief in God*". They suggested that religion was:

> *"…a set of guidance and principles which you can adopt and adhere to and there's a church and maybe there's a doctrine and a* ritual" (Georgia1)
>
> *"about people's beliefs but also it's about feeling, it's about I guess following a model in life and beliefs…a set of rules, obviously not rules but I guess a set*

of guidance that gives you value in order to live your life in a way that you do that in a positive way" (Tanya1)

Those who felt that spirituality and religion could be interlinked or that they were the same tried to consider whether there was a difference between the two. Mia and Lucy felt spirituality and religion were the same or almost the same:

"Is there a difference? I don't suppose there is really…..they must be interlinked to a certain extent" (Mia1)

"I don't think there is a difference…." (Lucy1)

Those who saw them as linked but different tried to articulate the difference:

"I do think it's a different thing from religion [spirituality], *religion can be very dogmatic, a set of rules. Spirituality is how you live" (Ana1)*

7.3.3 Spirituality in the Consultation:

During interview 1 exploration with the ANPs considered whether there were particular consultations when spirituality seemed to be apparent. It appeared that this usually occurred with more complex presentations where patients attended a number of times with several issues, often multiple pathology and polypharmacy.

One example given was when seeing patients with depression. Georgia said that patients struggling with depression often appeared to have a level of what she termed *"dis-ease":*

"I can explain to myself that not all is well in their world, there was a sense that they hadn't really found themselves or found a niche for themselves in life, they have got general dis-ease" (*Georgia1)*

She recognised that she often addressed spiritual issues with patients with depression and she noticed that they often lack any "*hope"* that things can be better or different. She suggested that she had confidence in acknowledging that spirituality was part of her holistic practice and she could support patients to find a place of "*hope".*

Jane echoed this saying that she always considered spirituality with those patients presenting with low mood or depression and she recognised the need for spiritual care even when a patient is physically well. She suggested that:

"It seems almost a stunting of life if you're physically well but somewhere something just isn't reaching its potential and I think that's got to be something about the spirit" (Jane1)

At these times she suggested:

"Exploring why their life is out of balance and*….. nurturing the spirit" (Jane1)*

Three other participants commented on when they felt spirituality became apparent within the consultation and whether it just occurred, was constantly present or when the ANP might consider it. Spirituality was often felt to be present unconsciously in a consultation whilst for some it was regarded as part of how they practiced:

Polly recognised that issues of spirituality were not necessarily introduced as a conscious action:

> *"In a consultation I think it's something that sometimes happens. I don't think it's always a conscious effort. I think it comes back to whether you are having time to sit and let the person talk and tell you what's important to them" (Polly1)*

Whilst Lucy felt that:

> *"It's everywhere really* [spirituality] *everyday of your life"* (Lucy1)

Existential issues appeared to be a key area which connected to spirituality. The majority of participants found consultations with terminal patients a natural home for spirituality. They appeared to expect that spiritual questions would come up when talking about terminal issues.

Ana acknowledged that Spirituality:

> *"sometimes comes up when talking about those life and death issues"* (Ana1)

Georgia expressed a similar view:

> *"sometimes with patients who are bereaved or patients who have a terminal illness" (Georgia1)*

Tanya recognised that existential issues connected with spirituality for her much more comfortably:

> *"I do find that I can probably connect much better with thinking that my consultations are spiritually based in those consultations where I am talking about life and death"* (Tanya1)

Four of the ANPs specifically commented on their approach to spirituality within the consultation and acknowledged that it was an area which was important to them professionally. Lucy said that for her it was more than just within her work as an ANP. Rather it was her ethos in life and that for her spirituality infused her being personally and professionally. She said that:

> "*my spirituality is really the way I care and the way I understand….It's more an integrated thing in the way you work. My ethos in life is this…be kind and have sort of inner meaning…that's my spiritual self because who I am and my life force*" (Lucy1)

Ana talked specifically about patients with whom she witnessed a spiritual dimension occurring within the consultation. Ana articulated this by sharing an occasion when she felt spirituality impacted during the consultation. This was with a particular patient she had been seeing who had anorexia whose mum had died suddenly and who was the same age as her daughter. They were coming to the end of two years of consultations as the patient was going to University. Ana said that:

> "*In hindsight that was a set apart moment in time somehow and there was something different about that time which umh in which you almost forgot about all the other things that were going on and you wholeheartedly give yourself in a way to that person but other than that a feeling that it was in some way spiritual" (Ana1).*

An interesting finding which will be discussed in the next chapter was that Georgia described herself as a "*spiritual healer".* This was not suggested by any other ANP and appeared to have been something Georgia had considered very deeply after years of nursing experience, the loss of her mother and her own existential journey. She said that:

> *"I am comfortable in my own skin as a spiritual healer"* (Georgia1).

Another key issue identified in relation to spirituality within consultations was about connection. Tanya recognised the importance of a deep human interaction. She stated that:

> *"you meet someone and you sort of connect with them or you experience something that feels different to just the normal really that makes you feel perhaps comforted or complete"* (Tanya1).

The idea that a spiritual connection with another was comforting or completed the individual does connect to being human and related to many of the views about spirituality being innately human and leading to connection. This appeared deeply significant.

Georgia took the idea of spiritual connections further in stating that ANPs and GPs undertake a role similar to the role priests played in the past:

> *"People tell me all sorts of things in the privacy of the consultation….I suspect in times by gone people would have gone to their priest"* (Georgia1)

She went on to discuss a conversation she had had with a minister about the similarities in their roles, they concluded:

> "*there's certainly an overlap between the ministry and nursing"* but *"you wouldn't say that to a patient, you wouldn't advertise that to a patient but of course there is because you are listening to a suffering human being and you are offering them help, support and healing….that's what a minister does"* (Georgia1)

This sense of the ANP role being akin to "*ministry"* was also raised by Lucy. Both of these participants expressed deeply their sense of vocation in their work. They were

both able to share deeply their experiences as people and also examples of their work where they gave of themselves to their patients.

7.3.4 Boundaries and Emotional Connection:

When the participants talked of emotional connections with their patients they stated that boundaries needed to be understood, considered carefully and held to maintain the professional relationship. This theme is significant because of its connection to the concepts of availability and vulnerability where boundaries are important in order to avoid patient harm and maintain a degree of personal and vocational safety for the ANP.

During the interviews, boundaries were often talked about. A number of the ANPs talked of, or indicated that there was a "*line"* within the role which was the boundary for professional practice. Some ANPs initially wondered whether this should be a set line. Whilst there was an awareness of a definitive line in terms of responsibility to patients there were also contradictory acknowledgements that the *"line"* could and should move depending on different situations. The ANPs appeared comfortable with this.

Several of the ANPs talked about this "*line"* acknowledging that at times they felt they had crossed it and this necessitated them "pulling back" and/or considering the depth of relationship that could or should occur within the consultation. Ana suggested that:

> *"Maybe I have crossed it [the line] or just touched it a little bit too close and then I will pull back a little" (Ana1)*

The "*crossing of boundaries"* could occur for several reasons:

> *"Sometimes we cross boundaries depending on the feedback we get and there are so many influences that we have that are sort of tailored by the way we react or relate to people. I think it's very complicated at times, we're human" (Tara1)*

The recognition of "*being human"* was mentioned by several participants with some suggesting that in order to build a relationship based on trust with a patient there was a need to recognise a "*blurring of the line"* and allow the patient to see you as a human and not just a professional. Lucy recognised that:

> *"it's like trying to keep a professional level but trying to come over as someone who actually does care…you want them to know you have a bit deeper understanding and empathy I suppose for people……. It [*the line] *goes up and down; it's all over the place I think. It depends on the situation I think and it depends on the condition of your patient… I don't think you can actually draw a line as everyone is an individual… " (Lucy1)*

Despite the desire for the participants to come across as "*human"* and someone who cared all acknowledged their professional code of conduct and recognised that there were certain boundaries that should not be crossed. There was an understanding of the issues related to professionalism. ANPs felt uncomfortable when a boundary had been crossed or something impacted on them personally. All of the ANPs recognised that boundaries helped maintain a level of safety for both patient and ANP and were aware of the impact of not retaining boundaries in practice.

Jane reflected that the line was:

> "*tricky… because some of the people have known me for 19 years….. you bring yourself into the relationship but I think there are private issues which need to be kept private as it's a professional role"*

Mia voiced the difficulties sometimes of staying within the professional boundary and recognised that:

> *"there is a line you shouldn't cross, you should keep a distance but doing this sort of job as a nurse I don't think you can stay at the side of the line and be what I would consider a little cool" (Mia1)*

Some participants recognised the emotional impact for them as they worked close to this *"line"* and recognised it could lead them to burnout if they "*gave too much of themselves consistently".* Giving of self, similar to how Ana gave wholeheartedly to a patient with anorexia, can be costly and the extent of giving would not be possible with every patient.

Lucy recognised that to protect oneself you:

> "*can't get overinvolved*" (Lucy1)

Mia suggested there were times when you felt you were becoming too involved and:

> *"I need to wind it up [the consultation] to keep it in that boundary sort of thing"* (Mia1)

After talking about the concept of *"a line"* as a boundary several of the participants gave examples of issues relating to events which they connected with spirituality.

Ana and Tara when considering spirituality both talked about issues related to prayer which had affected them. For Ana this was how she felt personally:

> *"I do remember one lady who wanted to pray with me…..she was the one of those women who wanted to pray with everyone…I said yes because I felt it was rude to refuse….I found that quite uncomfortable" (Ana1)*

Tara discussed the issue of the nurse who had been suspended for praying with a patient:

> *"I remember that doctor or nurse who got struck of or reprimanded because she said she would pray for a patient and that was inappropriate and I suppose it's just about getting the line right for the patient and the nurse and the doctor"*. She *"felt quite sorry for the nurse because I believe she was thinking she was doing the best thing for the patient because of her belief and there is probably many times that I do that in a different way because of my beliefs that things will help" (Tara1).*

Both of these events led to consideration personally of what was and was not spirituality. For Ana she had described spirituality as being separate from religion and something unique and innate. She also told me she had had a faith when she was younger but had lost this, although she still felt envious of those who had a strong faith. Tara initially conflated spirituality and religion and she felt empathy for the nurse struck of for praying, she was able to reflect on times her beliefs may have driven her behaviours and how to get the "*line"* right.

During the discussion about boundaries the interviews led to discussion about emotional connection. There was recognition of the need for self-awareness to

ensure practice remained professional but compassionate. Being aware of boundaries whilst maintaining emotional connection with patients appeared important. Lucy reflected that:

> *"I always wanted to be a nurse…I want to do things for everybody and make them feel better, not just in nursing. It's just that I like to see that everybody else is ok. Sometimes it can be a bit of a detriment in that you can get over involved and then you know you've got to learn when to take a step back…I think you know sometimes it's close because you are a particular way and you are very accommodating sometimes people will try and take advantage because that's who they are and some will get close because they are nice people…I think you have remind people that this is a professional thing" (Lucy1)*

Others also echoed the need to remain professional:

> *"I think the boundary I feel is around maintaining a persona that they trust so I am not a friend…I am still a professional with a body of knowledge I can call on with the skills I can call on to try and help them" (Jane1).*

> *"there is a professional distance or boundary that needs to be kept. I don't find it hard to maintain professional distance it's more accepting that there might be a relationship there because you have been through an important event together" (Polly1*)

Self-awareness was an ongoing theme in the data when considering boundaries and emotional connection with a consciousness being required to consider how to

maintain the professional relationship. An interesting analogy made by Georgia was about not taking on patients':

> "*emotional vomit*….*It's very important you keep a certain distance so you have to protect yourself as well because you know we come across people who can be very sick and maybe very disturbed and you've got to be able to cope with that and you don't want to have all their emotional vomit if you like umh on you. You have got to keep yourself sane and balanced and a certain distance and that's the real tension isn't it" (Georgia1)*

Georgia appeared to use this analogy to recognise the possibility of transference when a clinician may pick up feelings that belong with another person. In this setting Georgia implied that ANPs were vulnerable to taking on other people's emotional distress and that this could impact the practitioner's wellbeing adversely, leading to burnout.

There was, within the data, an ongoing desire for the ANPs to connect with patients as human beings. There was a suggestion that sharing personal experiences might help a patient see you as a person and might help them move forward. This was not about pouring one's own issues out and burdening a patient but connecting, possibly on a trivial basis, about shared experiences like where someone had been on holiday or a hobby for example; but sometimes more deeply about personal trials:

> *"We all share trivial things from time to time…you are sharing something of yourself with that patient…they see you as a person and not just a clinician" (Ana1)*

On sharing with a patient whose father was very ill Tara said:

> *"I tried to share empathy with them you know by saying you know I understand it's difficult and perhaps I can understand a bit more because I am going through the same thing. Now whether that's a good thing or a bad thing would be debatable" (Tara1)*

This sharing of oneself personally and professionally through a choice to connect and journey with patients within a boundary which at times could be "*grey"* and *"moveable"* appeared to have significant emotional impact for the participants. All talked about specific patients or interactions which impacted them personally. The need to be self-aware, self-reflective and acknowledge when one needed support or supervision was discussed by participants. This was sometimes talked about in relation to burnout or when the ANPs felt emotionally vulnerable. Even when events had occurred which caused emotional distress the ANPs still wanted to be human in their interactions and care deeply for their patients. Several participants revealed the depth of emotional impact from patient interactions:

> *"Blinking back tears with a patient showed I was not "like a robot" (Ana1)*

> *"Most of my patients usually die quite suddenly and quite young and that is quite upsetting because then you feel that grief a little bit really…you had a bond with that patient and that you've worked with that patient and know so much about that person but when you lose them it's kind of ok to feel upset by that" (Tanya1)*

The discussions around boundaries and emotional connection were deeply significant for most of the participants and appeared to connect with spirituality. The participants all were able to recognise the need for professional boundaries and their own professional role and responsibilities yet they did not want these to be rigid which might negate human connection where patients felt cared for. Personal experiences for many of the participants were emotionally costly and did impact on them significantly. Despite this the participants still wanted to work in a way which valued human connection. In order to connect with patients and embrace spirituality there was a sense of the ANPs needing to continue to nurture the relationship they had with patients whilst maintaining their professional role.

7.3.5 Availability and Vulnerability:

Participants conceptualised availability in a number of ways, some of which challenged my own conceptualisations and understanding of these concepts which I had developed from my own experience and the literature.

7.3.5.1 Availability:

Participants were asked in the interviews to explore the concepts of A&V. At this point no explanation was given to the inclusion of these concepts from the perspective of the Northumbria Community so their meaning was entirely open to the participants' interpretation. The first interview discussion about availability was quite straightforward as they articulated what it meant for them as ANPs. The responses included being "*there when you're needed", "being open and ready to respond to someone's needs", and "being ready to listen"*. The following definition offered linked the ANPs' availability to limiting the patients' vulnerability:

"If I was truly available to somebody that is have a professional relationship with somebody who could have an element of trust and could actually come and disclose things in a very safe way that makes them not vulnerable" (Tanya1)

There appeared to be some difficulties in being available which Ana articulated. Firstly, there was the recognition that many people needed help day to day and if you gave fully of yourself you could become vulnerable to "*burnout":*

"It's unrealistic to say that you will give every patient all the time they need because you can't and you need to balance their needs against everybody else's" (Ana1).

She went on to suggest that:

"making yourself available could lead to you becoming vulnerable" (Ana1).

For Georgia the tension between being present in the moment and external demands for timekeeping was acknowledged as it then impacted on other patients:

"The only tension I guess is you know if you have got somebody who comes in you know the patient who comes in and they burst in tears before you even before they have sat down and you have only got a ten minute consultation and you have got maybe fourteen patients to see and you are already running late and you have to be available and you have to deal with the presenting problem at the time and make the patient feel a tiny bit better so they can go out there maybe with a little bit of hope or having felt understood and listened to but then I have got to be equally available to the next fourteen patients who

are coming to see me and I have got to keep myself functioning well so that's I suppose a tension between availability" (Geogia1)

Availability clearly had several meanings in terms of physical availability and emotional availability. In the first interview the participants seemed to have a clear understanding of the literal meaning of availability and felt in the main comfortable with this being something they daily worked with. However, they were also able to recognise emotional availability can lead to vulnerability unless balanced by boundaries and self-awareness.

7.3.5.2 Vulnerability:

When discussing vulnerability a much deeper discussion was generated by the participants. Their conceptualisation of vulnerability highlighted some contentious issues which is why this sub-section is lengthy. Vulnerability appeared to be multi-faceted and participants were able to describe many different aspects of vulnerability. As with availability each participant was asked to define and articulate the meaning of vulnerability and what it meant for them.

7.3.5.2.1 Physical Vulnerability

Firstly definitions included physical vulnerability specifically safety and being at risk or harm:

"Vulnerability means that someone's at risk from others, from themselves…and if a patient's vulnerable perhaps they haven't got the ability to say no, to stand up to the other" (Tara1)

"Vulnerability for me is being in a place where you can be vulnerable to what's going on around you. It's a safety word so not quite being safe, perhaps a little threatened" (Polly1)

"Vulnerability that's being quite raw and open and maybe letting down all the barriers and being quite vulnerable to someone else. It's laying myself open or they laying themselves open probably beyond where they should be and making themselves vulnerable to harm in some way" (Lucy1)

Initially the exploration of physical vulnerability was expressed by several participants. Several participants talked about times when they felt threatened and one participant reflected on being attacked by a patient with a knife:

"The violent patient….I have been attacked before so that sticks in my mind…you have got to be guarded don't you so that it doesn't happen again" (Mia1)

but Mia still wanted to be there for her patient and stated:

"that's our role, that's our role in life and medicine" (Mia1)

The attack was traumatic and led to Mia being more guarded in her practice but over time she recognised she didn't want to be so guarded that she could not be present for her patients. She is now able to practice with an awareness of safety but she is still willing to be emotionally vulnerable.

These definitions of vulnerability revealed some of the complexities involved and the feeling that vulnerability was about causing or risking "harm". As the interviews progressed some of the different facets of vulnerability were explored further.

7.3.5.2.2 Patient Vulnerability:

Secondly there was a recognition that patients became vulnerable as soon as they shared with the ANP and that the ANP had a responsibility to "*hold"* that safely:

> *"People are very vulnerable when they are disclosing very sensitive details of their life, they are opening up to me and I need to treat that information with the greatest respect and confidence" (Jane1)*

> *"I guess vulnerability in the context of working with my patients is about* [the patient] *losing some element of privacy and control" (Tanya1)*

Attachment was also raised in relation to patient vulnerability. Tanya worked in a homeless practice where many of her patients were extremely vulnerable, she often reflected on how she wanted to connect with them as an equal but the nature of many presentations led her to taking on a "*paternal"* role when trying to support patients due to the complexity of their situations. She recognised that this could lead to dependency but also how she could become more vulnerable as a practitioner by having a "parental or personal attachment". She said that:

> *"I think it's about real connection that you have where it does change from just being a practitioner and them a patient and the dynamics change slightly then perhaps you feel a bit more sort or parental or personally attached" (Tanya1)*

Being able to recognise that patients are vulnerable was evident with the participants and like Tanya most participants could recognise when a "*line was crossed"* which could involve patients feeling dependent on them or as an ANP them becoming emotionally vulnerable.

7.3.5.2.3 Emotional Vulnerability:

Thirdly, emotional vulnerability appeared to be prominent in the findings. The ability to recognise emotional vulnerability occurred as the ANPs reflected and revealed their use of self-awareness to take care of themselves. All of the participants could recall patients or consultations which had led to a deep emotional response which sometimes made them feel emotionally vulnerable. However, they rarely viewed this as being negative but viewed it as part of being holistic and genuinely caring for their patients.

Tanya gave several examples of when she felt that being "*attached"* to her patients impacted on her emotionally. She described how when several of her patients had died it caused grief similar to when she had lost family members. She recognised that this had affected how she interacted with her patients at the time but that fundamentally she still wanted to offer that level of connection where she felt "*attached"* to her patients as she felt this gave some them "*hope".* She was significantly affected after the witnessing the traumatic death of a patient who was knocked down outside of her surgery Tanya said:

> *"I was genuinely upset by his death….I remember going to the funeral and being there with no-one else there and it took me ages to get over his death really…..I think you can't underestimate often that your patients sometimes if they die it's just as significant as if your friends or family sometimes die" (Tanya1).*

The memory of this evoked deep emotion and a sense of emotional vulnerability for her which had a significant impact. She explained how it changed her practice for a while as she didn't want to experience the depth of loss in that way because of a

patient. She acknowledged that this didn't fit with her ethos of practice and how although she is more guarded she still wants to relate to her patients with a level of emotional depth.

Polly was impacted by the death of a child whilst she was going through a personal bereavement:

> *"I felt very vulnerable when first involved in a child's death. It was the first contact I had had with death since the death of my mother and I think that was very difficult for me as well, it was a difficult time in my life" (Polly1)*

For Polly the closeness of her mother's death and her grief was complicated by the child's death. She felt she was working closely with the family and that because of her own grief she was more vulnerable to the pain involved in the loss of the child.

Again the connection with personal grief was reflected by Ana who talked about a child who had been diagnosed with the same illness her niece had died of. She immediately empathised with the mother and shared a little of her own story but:

> "*immediately I thought oh gosh should I have said that…but the patient appreciated it" (Ana1)*

For Ana her own grief was further away than Polly's and she made a choice to share her experience with the belief it might help the patient. It didn't have the same impact on Ana as it did on Polly but it led Ana to reflect on the appropriateness of her disclosure. There appeared to be something in this reflectiveness and self-awareness of the ANPs which demonstrated their professional status in not wanting to cause harm to their patients but maintaining a human connection.

Lucy reflected that some of the deeper relationships with patients revealed our humanness. Although she recognised that this could lead ANPs being emotionally vulnerable she suggested this is what makes us "*not automatons":*

> *"If you are breaking bad news to somebody or they are really worried about something and they are really upset about something you can make yourself vulnerable to a certain degree by opening up or by being genuinely, you know, physically upset for them…. On occasions you do show your vulnerability and it's not a bad thing to do because it shows you are a human being at the end of the day not automatons, hopefully we are all human…I think you do question yourself a bit don't you having said something and then you think 'oh should I have said that' because you are laying yourself a bit more open"* but *"it has never been a problem* [for me]*."* (Lucy1).

Another powerful story told by Ana [which is the model case in the discussion chapter] revealed the depths of emotional vulnerability. She was caring for a child who was the same age as her daughter:

> *"I had to be very careful….to have a level of openness and involvement with her without her having known how personal it was for me…it was just too close…..am I going to fall apart completely?" (Ana1)*

For Ana she related to this patient as a mother to a daughter, she cared deeply but was determined not to let this cause her patient any difficulty or harm. Ana was left feeling emotionally vulnerable and needed supervision to work through the issues it brought up for her.

These narratives were powerful to hear and although could have led to a closing down emotionally by the ANPs it often led to a commitment to continue to care at a similar level. The self-awareness revealed did, however, offer some degree to protection to these ANPs as they were able to recognise their grief, attachment to patients or connection and allowed themselves to traverse and express their emotional responses.

Despite some positives coming from these experiences there was some anxiety around what happens if the emotional vulnerability cannot be contained. Some acknowledged that they sometimes needed to pull back, take a break or receive supervision so that they did not burn out. Lucy suggested that emotional vulnerability can lead to a loss of control which she feared. She felt that being available was an easier way of being because there was control, as an ANP you could choose when to be available and when not to be but by being vulnerable there was a loss of control :

> *"You're actually more in control of being available than you are when you are vulnerable, you are not in control, you are letting go of control" (Lucy1)*

Despite this potential loss of control others reflected on the positive aspects of being available and vulnerable. Mia acknowledged that you can be *"a bit vulnerable and too available"* but in the interview she suggested this could help patients to feel safe and cared for. She said:

> *"You can be a bit vulnerable and too available for these patients you know but is it a bad thing? I don't think it's a bad thing, it's just if it overruns into your personal life and maybe you don't want that" (Mia1)*

Georgia brought up the issue about how being affected by the consultation and how your feeling as a person impacted her in terms of vulnerability which signified the importance of self-awareness:

> *"Sometimes you're not fine thank-you, umh you know those times when you're vulnerable".*

She then talked of having a medical student sitting in observing her clinic when she was going through a difficult patch in her life and she broke down into tears after a patient, she realised when you're not in a good place yourself that:

> *"it's quite interesting because you realise in between in the gaps when you see patients you do try to restore yourself a little bit and it's difficult to, you know you are a human being and they are not seeing a machine, they are not seeing an automatic machine are they?....It's impossible not to be the person I am" (Georgia1)*

It is clear that vulnerability has many layers from emotional, physical to professional vulnerability. ANPs are clearly impacted by specific patients and experiences (personal and professional) and some view vulnerability as a negative quality with others seeing it as part of being human and what can connect us. The second interview went deeper with these issues.

To end this section an excellent example of vulnerability presented by Georgia brought together many of the aspects of vulnerability:

> *"I am vulnerable because I am a human being…I am vulnerable because I have to manage risk and make decisions minute by minute…I am vulnerable because I have to make the right diagnosis, because I need to choose the*

right treatment, to prescribe the right drug, I am vulnerable because if I screw up I can be sued and I am vulnerable because I am a nurse in a traditionally medical domain. I am vulnerable because I stood on the parapet to be a spokesperson for my professional discipline…I am vulnerable because I am trying to say that what I do is as good as medicine so I am vulnerable on so many levels. My main vulnerability, the one that makes me anxious, is that I am doing the right thing for the right patient at the right time" (Georgia1)

Vulnerability appeared more complex and multi-faceted than availability during the interviews. The ANPs showed insight in recognising the varied facets including physical vulnerability, patient vulnerability and emotional vulnerability. Linked to the discussions were the need for self-awareness and the maintenance of boundaries whilst still coming across as a fellow human. There was recognition of the impact of giving of one self to the patient had the reality that burnt out could occur. The narratives offered showed the depth of care and compassion the ANPs had for their patients and were powerful examples of how vulnerability impacted the participants.

7.4 Key Findings Interview 2:

The aim of the second interviews 18 months later was to clarify that the findings of interview 1 were congruent and to further explore ANP's views of spirituality and spiritual dimensions of consultations. This was key to the hermeneutic methodology chosen as it enabled dialogue to occur in order to complete the hermeneutic circle. All participants consented to the second interview suggesting that these participants were a strong self-selecting cohort willing to share their experiences. It was hoped that the initial interview had sparked some reflection on their practice that might assist the exploration of the phenomena of spirituality as it manifested in their

practice. Additionally, the participants had 18 months between the interviews to further reflect on their practice and to consider if or how spirituality impacted this. During the second interview I explicitly explored with them whether A&V was a useful lens through which to examine spirituality. The format for this session focused more on what had changed for participants, what was new, had matured for them or what surprised me. As discussed previously all participants were sent a copy of the “rule of life” from the Northumbria Community to read prior to the interviews (Appendix 2). This was a requirement as the NHS Research Ethics Committee felt it important that participants saw this to enable them to understand where the concept of A&V came from. I would have preferred not to give a copy of the rule to the participants prior to the interview because of the overt Christian context and concern about biasing the participants. However, in fact only 2 of the participants had read the documents and the impression I gained was that they actually found the “rule” to be helpful. As the others had not read the “rule” before the interview we went through it together during the interview and they were able to discuss their immediate thoughts about its usefulness. They obviously did not have time to deeply reflect but though they were offered the opportunity to contact me after the interview if they had further thoughts, none did.

During the second interviews the ANPs appeared to be more articulate about aspects of their values, beliefs and experiences which brought out some of their deeper thoughts and feelings about spirituality. Reading the summaries from interview one had surprised some of the participants with regard to the narratives and thoughts they had shared. During interview 2 they were able to expand on their thoughts, feelings and experiences regarding spirituality. There was a sense of the interview process being a journey for the ANP personally, professionally and

spiritually which encompassed time for reflection on those consultations and experiences which remained imprinted in the minds and hearts of the participants. The research design, of two in depth interviews with each participant, 18 months apart, appeared to have been an important factor in this journey which enabled the ANPs to reflect on their responses and refine their views over a period of time.

A number of common themes emerged through the analysis which all participants explored in some way during interview 2. These themes were analysed and presented back to the participants in the same way as the first interview summaries were presented back. All participants felt the summaries were accurate (Appendix 8)

After analysis the key themes emerging from the second interview were:

1. Participants thoughts about integrating spirituality into the consultation
2. Participants definitions of availability and thoughts around this in practice
3. Participants definitions of vulnerability and thoughts around this in practice
4. Participants thoughts on Availability and Vulnerability and their relationship to spirituality
5. Participants thoughts on Availability and Vulnerability as a lens for spiritual dimensions of ANP practice

Table 6 offers a comparison of the key themes from interview 1 and interview 2 to show the transition between the interviews.

Table 6 Key Themes from the Findings:

Key Themes Interview 1	Key Themes Interview 2
Defining Spirituality	Spirituality (and thoughts about integrating it into the consultation)
Spirituality and Religion	Availability (Definitions of and thoughts around)
Spirituality in the Consultation and Openness to Spirituality	Vulnerability (Definitions of and thoughts around)
Boundaries and Emotional Connection	Availability and Vulnerability - relationship to Spirituality
Availability and Vulnerability	Availability and Vulnerability as a lens for Spiritual dimensions of ANP practice

7.4.1 Spirituality:

Some of the ANPs had consciously thought about spirituality since our last interview whilst others had not, yet many of their views of spirituality seemed to have developed over the 18 months since the first interview. There were many comments that were the same as in interview 1 but there appeared to be a deeper recognition of the significance of spirituality in their practice.

Some participants still conflated spirituality and religion whilst others defined spirituality far more easily for themselves in terms of innateness and existentialism. The majority of the participants had a much clearer picture of what spirituality meant for them and the differences for them between religion and spirituality.

7.4.1.1. Difficulty in Conceptualising Spirituality:

There was an acknowledgment of the ongoing difficulties in conceptualising spirituality for several participants although all participants appeared to have

developed their ideas, whether by conscious reflection or not, since the first interview. Despite increased clarity for some participants, reflections still recognised spirituality as being complex and challenging to explain. Tara was one of the participants who said that she had consciously reflected on spiritualty after the first interview. She researched some of the definitions of spirituality and tried to separate out spirituality and religion though she still found this difficult. She reflected that:

> *"spirituality…..involves experiences of deep seated sense of meaning and purpose in life, a sense of belonging, a sense of connection of the deeply personal with the universal, acceptance, integration and a sense of wholeness.*"

She then asked an important question:

> *"Is that spirituality or human nature?.....It's just the way we are"*

She continued by reflecting that*:*

> *"hope, meaning and purpose also have religious connotations as well you know, and purpose, belief, hope in that God will come true for them so the words link to religion … I still find it difficult to differentiate between spirituality and religion … spirituality is a huge huge umbrella and means different things for different people….I just find it very difficult, sorry!"* (Tara2).

7.4.1.2 Spirituality and Religion

During interview 2, six of the ANPs felt more confident and clearly differentiated spirituality and religion. Tanya still agreed with her differentiation from interview 1 between spirituality and religion but expanded her thoughts:

"I spent a long time in my life actually exploring what my beliefs and values were and how that fits into what my idea of spirituality is and what religion is and I didn't make those decisions lightly. I put a lot of thought into that really and that's developed over time so I feel comfortable where I am really with my beliefs around spirituality" (Tanya2)

A number of participants had moved on in their thinking about spirituality and religion and felt that a comfortable separation of the two concepts was possible. Despite having a strong faith Ana was still able to see the differences between spirituality and religion:

"I like to separate them…spirituality is about who you are and how you treat others and how you live your life, they [spirituality and religion] *are not the same…I am very much a Christian and could try and fit it* [spirituality] *into religion but it's not the same… you don't have to be religious to be spiritual" (Ana2)*.

Mia linked the two concepts of spirituality and religion:

"Spirituality is religion really….I do link it with religion" (Mia2).

Although she now reflected that spirituality for her brought more of the:

"*meaning of life" (Mia2).*

Tara was very open about her limited consideration of spirituality in her life although her responses revealed significant deliberation on spirituality which could have occurred since agreeing to participate in this study. She still felt that spirituality and religion were possibly the same but during the second interview she said the

literature on spirituality in nursing was limited and that this was unhelpful in helping her understand more fully. For her:

> *"….spirituality and religion, a lot of the things are very closely linked and very difficult to tease apart"* but *"I have actually done a little bit of reading around spirituality and I'm amazed that there appears to not be much in any nursing books that I have here as a whole expanse of nursing books and not one touches on spirituality and I believe if the NMC are saying we should be doing that you know perhaps they are not selling it".*

She made a salient point which she thought explained why nurses in general found it difficult to conceptualise spirituality in that:

> *"they* [the NMC and authors] *say they are different* [religion and spirituality] *and the next step they are actually making big associations between the two" (*Tara2).

Tara reflected on several of her own experiences of caring for patients with strict religious views and said that she found those patients confusing and often frustrating. She talked about a patient with an advanced stage fungating breast cancer who *"believed God would heal her* ". This consultation left her not comprehending how anyone could believe this when the cancer was so advanced that even her family couldn't be in a room with her due to the smell. She acknowledged that this experience had made her more sceptical about spirituality and recognised that she still found it difficult to differentiate spirituality from religion partially because she struggled to separate the two.

7.4.1.3 Conceptualising Spirituality

Polly, Lucy and Jane appeared much clearer about how to conceptualise spirituality for themselves and considered it to be the inner innate part of self. Polly connected spirituality to her ethos in life and what she valued:

> *"I think that spirituality for me is how I choose to live and what's important to me" (*Polly2*).*

She identified that she tried to bring spirituality into the consultation because of how she had chosen to live. In the first interview her focus had been more on what other people believed and how they chose to live, this time she focused more on what spirituality meant to her, she spoke of being much more conscious of integrating spirituality into her consultations.

Lucy had recognised the difficulty of articulating spirituality in interview 1 but suggested it was like a "*fingerprint"* which was unique in each of us. During the second interview she reinforced spirituality being unique and expanded on this as:

> *"your being…you can't escape it being there" (Lucy2).*

She continued to reflect on the difficulty in explaining spirituality:

> *"It's easy to think about it as part of you but to try and take it out and look at it and put it into a category or explain what it is and how it fits is really difficult, very difficult" (Lucy2).*

Lucy and several others had articulated in interview 1 that spirituality is innate and reinforced this in during the second interview:

Lucy said that:

> "*the essence of spirituality and the essence of a person are the same thing to me"* (Lucy2)

Tara and Tanya both agreed with this and whilst not using the word innate they both suggested that "*spirituality is about being human"* (Tanya2) and that it's "*a human need"* (Tara2).

Jane had a fairly clear view of spirituality during interview 1 when she recognised that for her it was an "*inner"* dimension which brought "*balance"*. She further reflected on what spirituality in nursing meant for her and the implications of recognising a spiritual component in the consultation:

> *"being able to connect with them* [patients] *on that level* [depth] *I think is sort of spiritualty in nursing….and I have always accepted there is a sort of spiritual element…it's about a deeper connection that you sometimes experience in a consultation that people are being very open. You are being open to them and allowing them to tell their story, tell you what's happening, tell you what impact it is having and just being able to share that and to perhaps not tell them what to do but to perhaps give them some guidance and to find it's appreciated, returned and welcomed and even acted upon I think and then you feel that something has happened there that isn't run of the mill, that isn't your normal consultation, I think it's really rewarding, when it does happen"*(Jane2)

7.4.1.4 Spirituality and Holism:

Interestingly following interview 1 a number of ANPs chose to consciously embrace spirituality in their practice and equated it to part of their holistic practice. Throughout both interviews the participants often talked about holistic care and for many this was one of the reasons they chose to work in primary care. They all articulated that for them their practice involved treating not just the physical presentation but the whole person. They recognised that their approach to care was bio-psycho-social and whilst some had seen spirituality as part of this others had not considered this. The interview process seemed to help the participants to want to explore spirituality further within the holistic framework and felt that now they had some understanding of it that this would be possible. Several participants linked their willingness to do this to their maturity (in age and as a practitioner). Additionally, in some cases, a personal belief that embracing spirituality was important in practice was expressed

Lucy identified that she had always practiced holistic care but:

> *"never labelled it as spirituality….I think of it now more in terms of spirituality….going through this process* [interviews] *actually opened it up more for me it's made it a bit more of a tangible feel for what it is and why it's there" (Lucy2).*

Georgia already had considered how the "*spiritual dimension"* came to the fore when she treated and cared for patients holistically and said that:

> *"I try to encourage people to give them hope for the future and I suppose a small part of that would be to inspire somebody and to inspire people comes from a spiritual root…and the spiritual bit to me comes to the whole you know*

looks at the whole of the person and almost seeing beyond the physical and psychological…and looking straight into the eyes, that probably sounds a bit weird, but you know you are seeing the soul behind the person" (Georgia2)

Georgia also acknowledged the difficulty the word "*spirituality"* can have for some; she suggested that psychological care is interwoven with the spiritual and asked:

"*do you have to call it that* [spirituality] *or do you have to be more authentic in the care you give and more present, more loving - you don't need to use the word* [spirituality] *if it creates misunderstanding….sometimes words create huge barriers" (Georgia2)*

Adding to this she proposed that possibly the current cultural and political climate might not be open to fully accepting spirituality:

"*I don't think you can sell spirituality in the current climate, maybe in the future, the difficulty is you will have some people who recognise what you are saying and understand it and sign up to it others who you will just put their backs up completely and turn them off"* (Georgia2)

Georgia reflected on the difficulties sharing her thoughts on spirituality with colleagues but how she saw it as being pervasive in her holistic approach to care:

"*I would feel uncomfortable disclosing how I personally use the spiritual domain to relate to my patients especially in a secular practice with no sense of God, or the universe, or anything kind of spiritual. I have to accept my colleagues may not feel the same way about how they consult and don't understand the direction I am coming from but you do the best for your patient in front of you and you have to be your authentic self, don't you? …there*

aren't QOF[7] points for the spiritual dimension and all that happens at a different level…if you watch a video of my consultation you maybe wouldn't see it [spiritual dimension] *depending on what lens you were looking at and the perception of the observer…of course it is colouring the whole thing"* (Georgia2)

For Georgia spirituality was integral to her holistic approach to care. However the difficulties articulating her beliefs regarding this to her colleagues and her concerns that using the term spirituality can *"put people's backs up"* has led to her feeling isolated at times in her beliefs about patient care. Despite this her comments and reflections deeply convey the importance of spirituality in her practice. Her willingness to work at a level that others may not feel comfortable with echoes her maturity and exploration of her own spirituality.

7.4.1.5 Spiritual Self:

As participants explored more about spirituality and holism a number of them explored their own spirituality. During interview 1 Ana had reflected upon her "*spiritual self"* and how she thought of "*God"*. During the second interview she grappled further with several existential questions for herself such as:

"Do I think there is a spirit?, Do I believe in God…I am not sure God really exists but I like to think I have a spiritual dimension to my life…but maybe I am just kidding myself…during the last interview I was trying to think of a definition that didn't include God to enable me to talk about it but I am not sure you can actually do that. I guess it's up to you how you define it. If you're

[7] Quality and Outcome Framework (QOF) – a points system in General Practice which relates to funding

talking about what gives meaning and purpose maybe it doesn't have to include God…maybe spirituality is an added depth, but I'm not sure" (Ana2).

Ana continually acknowledged her own spiritual search for meaning personally and in her work through the interviews. She allowed herself to ruminate on the deeper existential questions and how these were influenced by her own faith experience in addition to her work and life experiences. She wanted to know how to make sense of spirituality for herself.

Whilst reflecting on the "*spiritual self"* others identified that personal and professional maturity appeared to be factors that affect the ability and willingness to engage with spirituality. Lucy suggested that for her:

"age and experience make you more comfortable [with spirituality]" (Lucy2)

Jane also articulated that:

"our ability to connect with people with the spiritual dimension is a feature of maturity of us as practitioner" (Jane2)

All of the ANPs had a wealth of life and work experiences and it seemed that they were willing to weave into the interviews some of these experiences which helped them to reflect upon spirituality. Sometimes this included specific consultations but some of the participants reflected on life experiences. For example Georgia, Polly and Ana all reflected on loss in their personal life and how this influenced their own spirituality whilst Tanya talked of her love of dancing and how this helped her create balance in her life.

Finally, in relationship to the "*spiritual self"* Lucy and Georgia reported that they viewed part or all or themselves as spiritual. Lucy identified how her desire to know

her patients and bring herself into the consultations integrated spirituality for her and helped her make sense of it in her work. She said that:

> *"I want to move beyond a factual consultation….there is that spiritual you that wants to move beyond that and do a little bit more for patients"* (Lucy2).

Whilst Georgia stated:

> *"I am a spiritual being, evolving as I live*" (Georgia2).

The sense of the "*spiritual self"* evolving and responding to personal and professional experiences was vivid and appeared possible through the lived experience of each of the ANP's.

7.4.1.6 Ministry:

Vocation was evident in how all participants talked of their work and their "*hopes"* as a practitioner, but two participants specifically used religious language when talking about spirituality. Both of these participants, Georgia and Ana, returned during interview 2 to the idea that patients often come to see them in a way they would have used a priest or minister in the past. Georgia suggested the consultation was a:

> *"bit like a confessional but I am not a priest or a nun"* (Georgia2).

This was something she discussed in interview 1 where she saw her role akin to that of a "*minister".* There was the acknowledgement that patients might have a faith but feel spiritually lost and come to the ANP with some of their deepest concerns. Ana said that:

> *"there is a strong sense of being used almost like in a priest like capacity and I think that layer of society has been lost……spirituality and nursing are*

closely connected because of the nuns and stuff, very closely connected really…the whole concept of vocation" (Ana2)

7.4.1.7 Integrating Spirituality into Practice:

The earlier discussions in the second interview helped to clarify how the participants now viewed spirituality. The recognition of their own experiences and their choice to offer holistic care was acknowledged as important in their understanding of spirituality in addition to a "*vocational"* attribute of their work. All of the participants were able to consider how they integrated spirituality into their own practice and also to think about it being a "*natural*" and "*meaningful*" interaction which did not need to be forced. Tanya told me that, after the first interview:

"*I think much more about spirituality…I try to allow more time for that to happen* [the consultation to have a spiritual dimension] *…but it feels a bit false for me to think that from today I would go away and do all my consultations thinking 'I am going to be really spiritual about my consultations today' I'll lose those moments that actually become really meaningful…that just naturally happen"* (Tanya2)

Tara and Jane both reflected that that they hadn't realised that some of what they already offered to patients might be a spiritual dimension. Tara recognised that "*perhaps"* she was already providing aspects of spiritual care whilst Jane felt "*enlightened"*. Tara said she:

"realised I knew very little about spirituality…I suddenly realised I spend very little time during a consultation focusing on that area [spirituality]… *perhaps I do touch and not realise it's actually spiritual I don't think I am giving a*

spiritual meaning to the consultation perhaps some of the things I say, or the way I look at a patient, or the encouragement I give them…perhaps I am providing some of that [spiritual dimension] *to the consultation"* (Tara2).

Jane suggested that:

"being able to describe what we are doing, describe what our contribution is and describe the unique features of our care and just remind us every so often of the connections that we can make and the benefit that can bring, I think that's the bit we all like….I never thought of it as spirituality, I never gave it a label, I never really looked at it….it was quite useful and I have to use the word enlightening in terms of spirituality, but it was, it was illuminating and did draw a lot together, a lot of the things I was thinking about and it put it under one sort of umbrella [spirituality]*"* (Jane2).

Georgia also felt more able to recognise that she did integrate spirituality into her practice and she now uses the word *"spiritual"* about her practice although acknowledges that it is only a "*dimension"* of the work of the ANP whose focus is on the assessment, diagnosis and management of undiagnosed and undifferentiated conditions. She said:

"I can think of a spiritual dimension to the consultation because you have made me more aware of it! I use the word spiritual more whereas I would not have thought of it as a separate dimension from what I was doing previously…..at the end of the day it's a dimension of what we do but it's not the purpose of what we do and you need to be clear about that…but you are there for your patients to respond to their agendas and if it comes up I think you should respond as honestly as you can" (Georgia2)

In terms of actual ways the ANPs considered they could integrate spirituality into their care the focus was not necessarily different to how they already practiced. What was different was that they could view this as a way of operationalising spirituality. The common terms they felt connected more to spirituality which were integral to their practice and developing relationships with patients included "*listening", "prescencing", "empathy", "compassion", "humanity" and "care".* As already presented the ANPs wanted patients to feel "*valued", "safe"* and *"respected"* and this together with the care they offered related to their desire to treat patients as *"individuals"* and *"humans".*

7.4.2 Availability.

After talking through "the rule" the participants thoughts and views about availability developed into more "*spiritually focused"* concepts in terms of availability being involved with *"human connection", "love", "hospitality"* and "*opening oneself up more with others*". In interview 1 the focus when talked about availability was more the physical availability of "*being there", "giving time"* and *"being ready*" as well as emotional availability including "*being open*", "*connecting*", truly "*listening"* and creating a safe place for their patients to be honest.

As there was still confusion during the interviews about how spirituality could be tangibly recognised and integrated into practice; some participants pondered whether availability was one way to make this clearer. Some of the terms they used during the second interview fitted with what they had read in the "rule of life" and could have more of a spiritual connotation, these included "*welcoming patients" (Polly2), "being open" (Jane2), "to be available to do whatever…being fully open"*

(Lucy2) "you have to be a channel for helping someone…. you are a channel of love" (Georgia2).

As we discussed the definition of availability from the "rule" participants reflected that they found availability as defined within "the rule" much easier to identify with and relate to in their practice than vulnerability. The majority stated that they could align themselves to the definition of availability from "the rule". Interestingly very few commented on the first aspect of the "rule" which was availability to God. They appeared to align themselves to the concept in relation to hospitality, care and mission.

An aspect of availability discussed during interview 2 could be viewed as professional availability. This was discussed in interview 1 but this time seemed to have a more active focus. There was intentionality and several participants identified this; for example, to be "*available to help those who are vulnerable"* (Tara2). Ana also assented to this but stated that she would only do so *"as long as I am in control"* (Ana2). She continued, though, by suggesting that for her:

> "*spirituality…is about wisdom, something about being wholly available to the person you are with…making them feel valuable, making them feel that at least for that moment in time they mattered most"* (Ana2).

This again revealed intentionality which Georgia identified was important even when it wasn't a "*very attractive"* patient:

> "*at the end of morning when you have had someone dirty and smelly and maybe not a very attractive person who comes in it is easy to slip into making a snap judgement and wanting this person out, but then you have to stop and*

think 'well that's someone in need and I'm here to help them'…… "availability is the one thing we should give our patients because that infers you are responding to their needs" (Georgia2).

Polly and Tanya also articulated their choice to be actively or intentionally available but recognised that that had consequences. There was the suggestion that to be "*truly available"* would "*eradicate professional boundaries":*

"I try to make myself available and yet that can cause some vulnerability in me because of my nature [caring, sensitive]" (Polly2).

"I strive to be open and available all the time it can make you quite vulnerable really….If I was truly available to people, completely and utterly and prepared to take all the vulnerability that came with that I wouldn't be being professional because it would completely eradicate any professional boundaries….where would you stop?" (Tanya2).

Lucy echoed the risk of availability making you vulnerable acknowledging that if you can't:

"section things off [in your mind] *then you make yourself widely available it can be at your detriment* [making you vulnerable]" (Lucy2).

Despite these concerns all participants saw availability as core to their practice, for some this appeared to be innate whilst others, aware of the risks, chose to work this way. They recognised that they wanted to be:

"open to other people, open to helping them, open to listening….we want to be available to give everything we can, to be holistic. We want to understand

the ins and outs of why this person is suffering because we want to able to nurture and improve [their situations]" (Lucy2).

"*welcoming, non-judgemental by making yourself available" (Polly2).*

"available to patients I want to help….. so that they feel they have been supported that day, or they have gained something or they have just stayed alive" (Tanya2).

"*being ready, being open to patients, we are ready to listen ready to help. For availability it is again that sort of impact, that interaction of what's flowing backwards and forwards isn't it and how much I am open to them* [patients]*, tricky one, still not sure where that level should be"* (Jane2).

Both Tara and Georgia also identified that through being available you *"give away something".* For Tara she viewed*:*

"being available to help those who are vulnerable….you are giving away something, you are giving a listening ear, you are giving concern, you are giving empathy, so you are making yourself available through that way to everybody who comes through your door" (Tara2).

Georgia saw availability more in terms of her spirituality:

"you are channel of love….there is a sense that this is a person who has come to me in a time of need and I have to as a spiritual person be there for them, so I understand availability very well and I recognise that it is a sort of mission, a sort of vocation for me" (Georgia).

Georgia and Ana were the only participants to mention the “rule’s” overt definition of *“availability to God”.* It felt comfortable for Georgia but Ana found it raised questions which we explored throughout the interview although she stated that the Northumbria Community’s definition of availability *“was quite similar to how I had seen it” (*Ana2).

Tanya was the only participant who acknowledged that being available could be about meeting your own needs to help others:

> *“you have to recognise that sometimes you are doing it about your own needs and your own requirements”*

She balanced this by saying that she was:

> “*happy to be available to patients at work but that I am not going to take them home with me and I am not gonna do all the things that I would do if I was 100% available*” (Tanya2).

By setting boundaries and acknowledging that at times ANP work could be motivated by meeting her own needs, she showed a level of maturity in her role and use of availability.

7.4.3 Vulnerability:

During interview 1 the findings revolved around trying to define what vulnerability meant, some of components and impact of vulnerability in the consultation and personal reflections. For many the concept initially appeared to be negative with the potential to lead to harm patients or themselves.

The second interview revealed a deeper understanding of the concept and potential shift in how the ANPs viewed vulnerability. Some aspects were seen more positively

than others. For some there were still some reservations about the positive nature of vulnerability.

Jane was struggling with vulnerability as when she thought about it she thought of:

> *"vulnerable adults, people with weakness or who need our help. I don't think I had thought of it other than feeling intimidated perhaps by patients…….I saw almost sort of defencelessness and weakness or being in an inferior position" (Jane2).*

On reflection after reading "the rule" she changed her thinking saying that:

> "*it seems more about openness and willingness to change and to share* [with our patients]" (Jane2).

Tara and Mia had both initially thought of vulnerability in terms of patients being vulnerable. Later they were able to expand their views though Mia wondered if vulnerability as suggested in the rule:

> "*was a bit deep, a bit religious and I don't know whether I won't say I don't agree with it but I just find it a bit difficult"* (Mia2).

Ana recognised she had thought that for her vulnerability could lead to being hurt:

> *"I think I thought of vulnerability as actually opening yourself up and allowing yourself to become hurt."* (Ana2).

However during interview 2 she connected with how the NC descried vulnerability in terms of being teachable and accountable whilst being authentic:

> *"I quite liked this idea of vulnerability being teachable rather than just meaning the ability to lay yourself open to pain if you like and then you can be*

teachable actually by the patient as well that you can learn stuff from them, from their experience rather than your experience" (Ana2)

A number of specific types of vulnerability were expanded upon through the interviews including emotional, patient and professional. Physical vulnerability wasn't brought up during interview 2 although this had appeared in the first interviews.

7.4.3.1 Patient Vulnerability:

Patient vulnerability was more clearly articulated for many of the participants during interview 2. There was a concern that if the ANP was too available and vulnerable it could create "*dependence on you"* (Tanya2). It was recognised that the ANP needed to be aware of this and create a safe place for the patient whilst maintaining appropriate boundaries.

Additionally, participants recognised that patients might not be aware of their own vulnerability especially when thinking about issues of risk and abuse. The ANPs considered part of their role was to recognise this and create a place of safety for their patients. Polly related her response to patient vulnerability as part of her *"spirituality"* and said that:

"*coming to see us can make them* [the patient] *very vulnerable and it is important that is acknowledged and that they need to feel safe…..I think that's part of my approach to spirituality within the consultation"* (Polly2).

Others also talked about patient vulnerability and suggested for example that they are vulnerable because they:

"present with deep emotions, physical, mental and social problems….we may perceive a patient to be vulnerable but they have no realisation of that" (Tara2)

And also because:

"they are vulnerable because they come in here….just expressing how they feel to a complete stranger" (Mia2)

The recognition of patients' vulnerability was clear and as the ANPs considered this they then reflected on their own emotional and professional vulnerabilities.

7.4.3.2 Emotional Vulnerability:

Emotional vulnerability came to the fore when discussing sharing of self. This was significant for most of the ANPs who expanded on this area. Initially the discussion around emotional vulnerability focused on this occurring when ANPs made a choice to share something of themselves within the consultation. This emotional connection appeared to be one way to relate to spirituality in terms of "*human to human"* connection. Polly acknowledged that sometimes sharing with patients left her feeling vulnerable but she still wanted to do this in order to build connection with her patients. She said that:

"sharing personal experiences with patients …can impact the consultation……it's still something I do use" (Polly2).

Polly wasn't sure whether sharing with a patient was a *"good or bad thing" however* Mia was more positive about sharing with a patient; she recognised that by being emotionally vulnerable she could sometimes help patients feel more comfortable:

"*I think we have to do that* [share something of ourselves to help a patient move forward] *not always but in some cases. It probably makes the patient feel a bit more at ease, a bit more comfortable"* (Mia2).

This was echoed by Lucy who suggested:

"in certain circumstances it's good to let them [patients] *know if you have had an experience that has been similar….it can help them in some ways deal with it because they see you as someone who has dealt with it"* (Lucy2).

Conversely emotional vulnerability is not always a choice as aspects of self can be revealed unconsciously for the ANP. Georgia suggested:

"*you are vulnerable in terms of your own life when you're feeling low or depressed or bereaved. You are more vulnerable, then you may show glimpses of yourself to patients more than you would want to"*

She goes on to suggest a need sometimes to protect oneself when dealing with patients who are *"unhappy or wounded",* she says *"there is a sense that reflects back onto you and you do have to protect yourself a little bit* [emotionally]"

However, she reflected a powerful consequence of vulnerability in that:

"inevitably you receive a lot by that interaction and you learn, you develop and you become the person you are by virtue of having fulfilled that role [being there for the patient] *and having met those people which is a great privilege"* (Georgia2).

Jane also reflected on this by recognising that she was an:

"agent of change for patients and what they bring changes us" (Jane2)

The impact of emotional vulnerability was also articulated in terms of it taking energy and the effect it can have personally. Lucy and Polly both recognised the impact of emotional vulnerability:

> *"I do make myself vulnerable in terms of a lot of stress comes back on me"* (Lucy2).

> "*It takes a lot of emotional energy to do that* [share self with patients], *which makes me feel very vulnerable at the end of the day…..emotionally tired"* (Polly2).

Both Lucy and Polly recognised this and were able to put in place boundaries and support to prevent the stress and tiredness from consultations where they had *"given out"* leading to burnout. However, Tanya felt quite strongly during interview 2 that she may have been too available and vulnerable with her patients as she felt she was at the point of "*burnout".* She said:

> *"my stress levels are so high and actually how much emotional and personal damage that does to you as a professional in the long-term?"* (Tanya2)

These experiences of vulnerability are part of the human condition and also part of the role of the ANP. There are not specific to spirituality and at times are detrimental to the ANPs. The need to maintain emotional health especially at times of personal vulnerability was clearly acknowledged yet there was still the desire and recognition that patients come to see the ANP because of their willingness to share of themselves which could be connected with their own sense of spirituality. Using professional judgment to balance when to share and when to protect oneself can be

difficult as the choice to be available can lead to "*vulnerability"* but this may reflect shared humanity which can be deeply spiritual as illustrated by Tanya:

> *"I am quite comfortable about disclosing things about me that put me in a vulnerable position…that actually is about reassuring that person or about allowing that person to truly know I understand where they are at and what their difficulty is which may help them kind of rethink or kind of move forward a little"* (Tanya2*).*

Interestingly though Tanya reported being close to burnout during interview 2; a possible consequence of choosing to become more vulnerable.

7.4.3.3 Professional Vulnerability:

Several of the participants showed insight into professional vulnerability with regard to becoming too involved with patients or raising their expectations:

> *"I think you could let, well you could get more involved in as appropriate, you could lay yourself open to unnecessary hurt. You could raise the patient's expectations too much as to what you can do. I think that's probably a real risk. You know we have all felt very moved by certain patient's situations but actually we can't do anything* about it" (Ana2).

The insights included considering who to share with and how to maintain safety in the relationship:

> *"I think you have to choose very carefully when and what you share about yourself, but that can change depending on the relationship you have with a patient…there is a professional boundary that should not be crossed…sometimes it can cause dependence"* (Polly2).

"we have to just build a little fence around ourselves to a certain extent but we must be prepared to share" (Mia2).

Most of the participants seemed to understand professional vulnerability recognising and acknowledging their own limitations, showing their own human needs and the complexities of managing multiple or difficult pathologies and end of life issues. There was also articulation of the real danger of becoming too involved with patients and how the day to day role of the ANP can lead to *"vulnerability".*

Georgia discussed these day to day professional and personal issues in depth. She added that there was also vulnerability in acknowledging our limitations with patients and that ANPs needed to be self-aware to recognise whether they were "*centred"* enough to be fully available to patients. She said*:*

"*You are kind of vulnerable to the patients in saying you haven't got all of the answers ….you are vulnerable because they are vulnerable because they are seeing you and you might be hungry or thirsty or desperate for a wee or whatever so there's that vulnerability as well as a deeper vulnerability; am I actually centred enough and using the power of grace or wisdom enough to be giving them what they need to hear at this time…….my role is to be there for the patient, to share that experience of illness, and in that, we are a lot more vulnerable"* (Georgia2).

Continuing the theme of professional vulnerability empathy was regarded as important in sharing to show "*human connection".* A shared humanity again can connect to spirituality and can be mediated through how the ANPs use empathy. Lucy suggested:

"a professional who empathises with you and shows some empathy and is upset means they are human and to a degree I think [patients] *appreciate that"* (Lucy2).

The power of vulnerability as a tool within practice to help operationalise spirituality was considered by Georgia. She stated that vulnerability was transformative but needed maturity as an ANP to remain positive for patients. She said that vulnerability was:

"a measure of the maturity of the role….I think being open, vulnerable has the potential to transform practice and take it beyond the consultation to real connection with patients"

She also suggested that being open and using vulnerability consciously helped:

"reconnect with the core values of nursing and allow other aspects of our humanity to influence and guide us" (Georgia2).

Finally, Jane talked about vulnerability, spirituality and "the rule" of life. She related to this by saying:

"I can relate to that [the rule] *almost laying yourself open to what people are saying and about taking from that something".*

She went on to suggest that being vulnerable involved:

*"having someone who is receptive, willing, compassionate…sharing aspects of yourself in terms of companionship, your trust and your empathy" (*Jane2).

By viewing vulnerability in this way she felt able to connect it to her own sense of spirituality and her ethos in practice.

The discussions around vulnerability revealed more complexity than those around availability. The ANPs connected deeply with the need to be aware of their own vulnerabilities and to balance how they *"shared"* of themselves with their patients. All the participants were able to consider the positive and negative aspects of vulnerability and appeared able to reframe the concept through their reflections on how the Northumbria Community defined vulnerability.

7.4 The Relationship between Availability and Vulnerability and Spirituality:

As the discussions moved towards how A&V related to spirituality the discussions became more complex. Most participants felt availability was core to their practice albeit there was recognition that you could be too available leading to vulnerability. Not all participants linked availability to spirituality but some did. Vulnerability, once developed in participant's minds as more than weakness and powerlessness, appeared more complex and potentially risky but it seemed to fit closely with what some participants considered spirituality to encompass. Vulnerability appeared to be the aspect some participants found difficult and could be related to their expressed fear of being too available for patients.

Lucy, Polly, Mia and Tara aligned themselves to the concepts of A&V quite easily and without any significant conflict for themselves:

Lucy believed that:

> *"you can't have one without the other* [A&V]…*if you are truly available then you are bound to be vulnerable"* (Lucy2).

Polly said:

> *"I think they* [A&V] *are important for me….they fit with my spiritual beliefs because of what spirituality means for me" (*Polly2).

Mia stated:

> "*It's how I think it is* [A&V], *it's probably how a lot of people think really….I think it's what we do….it's in your daily life…it fits with how I perceive it…it's part of my moral code "*

However, she also recognised the intentional choice of integrating A&V into her consultation:

> *"but* [integrating A&V is] *not always how I would continue a consultation" (*Mia2).

Tara felt:

> *"they* [A&V] *have importance to help me know more about patients" (*Tara2)

The other four had some powerful insights and interesting reflections. Tanya read the rule:

> *"quite a few times and tried to think about it in my role and I kind of thought it was really quite relevant….they are similar* [to what I believe] *if I think about my own life but I think if I am working with clients I have to rethink a little bit" (Tanya2).*

She went on to reflect about the need of boundaries when using A&V in the full sense of the words in consultations:

"I thought it was interesting to be completely available to people and put yourself in a position where you then become very vulnerable but whether or not that is a really positive thing to aim for and achieve, and we currently try, I don't know whether its beneficial for patients or us. I think I agree with the fact that you need to be available and vulnerable but I do think it needs balancing with rules [boundaries]. *I think it's about trying to ensure that you are clear as a professional that the things you put into your work time and your life have balance….that whatever vulnerability you experience at work you can balance with the rest of your life so you feel emotionally well but that feels a little bit like limits on what you are available for or what you are prepared to give and is that a conflict with the true meaning of availability and vulnerability?"*

Tanya then talked about her own work-life balance, how "*burnt out"* and *"stressed"* she was feeling and how this affected her responses. The interview had helped her to reflect on her current need to protect herself. She admitted feeling a:

" bit of irritation at the rule by bits like if you available to people all the time and you are vulnerable all the time and live by these rules then somehow you're going to be this deep spiritual person which doesn't feel possible to achieve….I attempt to be available to people when I can and I will be vulnerable at times and I equally also know that they are times when I need to protect myself [like now] but *I wouldn't like to go to the extreme which I feel like at the moment where I don't want to be available or vulnerable to anybody…I'd like to think I can bounce back into some balance really and putting it into perspective of this A&V stuff has been helpful to help me think about when it became unhealthy that I was so available and vulnerable it is detrimental to my health"* (Tanya2)

Jane aligned herself with intentional availability but struggled with intentional vulnerability:

> *"To call yourself intentionally vulnerable I guess is just a word. To be intentionally open and take on board what people are saying, to be able to synthesise that with what you are doing and move forward with it and perhaps challenge, yes I can see that, it's just the thought of promoting weakness I suppose, it's just a word but I have problems with the literal meaning…. I am not intentionally vulnerable but you have to be I guess?"* (Jane2)

For Georgia she recognised that for her the concepts were new and quite difficult but she appeared to link ANP vulnerability as a way to connect the spiritual dimension which in turn might be able to reduce patient vulnerability:

> *"It is a new concept* [A&V]*, they are quite difficult concepts. I do think as an NP I definitely have to be available to the patients and accountable to them and if you think at the centre of me is a spark of divinity then I suppose I am making that available to patients through the consultation and the interaction, does that make sense? I think the significance of vulnerability in terms of the NP equals possibly not being centred, fully in the moment, fully responsive and able to meet the patients' needs in terms of spiritual dimensions. She/he may not be tuned into their higher/wiser/more loving self. It's great if the NP is fully self-actualised - but who says the NP has to be wise, loving, spiritually aware? Does this make sense? I think that what the Northumberland Community meant by knowing or understanding scriptures etc, having the right things, knowledge, attitude to offer the patient basically to reduce vulnerability to the patient the NP needs to be centred, aware, present and*

*tuned in to the patient's needs, so lack of spiritual dimension in the NP may make the patient more vulnerable" (*Georgia2).

Ana was one of the few who considered "God" in the interviews possibly because she was reflecting on her faith journey and experiences. She was considering whether A&V without God left them as being ways to offer emotional rather than spiritual support:

"are you just left with emotional support. It struck me it was very like empathy and sympathy? Is there actually spirituality or are we kidding ourselves? I think you need God in there to make it spiritual rather than simply emotional"

However, on reflecting about consultations which appeared to have a spiritual dimension where God wasn't a focus, she added:

*"I think those consultations that have more depth are probably because you are more present, that brings with it A&V concepts" (*Ana2).

Finally Polly offered a helpful way of connecting A&V and spirituality she suggested A&V:

"fit alongside spirituality along with other concepts, not instead of or more important….they move around in terms of importance. Other concepts included *"kindness, care, non-judgement, time, seeing patients as a whole person, prescencing" (*Polly2)

7.4.5 Availability and Vulnerability as a lens for spiritual dimensions of ANP Practice.

After debating the concepts of A&V and considering how they might or might not relate to spirituality the final discussion moved to whether A&V was a suitable lens for spiritual dimensions of practice.

Six of the participants believed that A&V was a useful lens for spiritual dimensions of practice. The other two felt it possibly could be with some adaptations and considerations. All had slightly different emphases and some had concerns about time, boundaries and the impact on themselves and/or their patients.

There was an acknowledgement that they could see A&V as already being evident in their practice. The majority of the participants could connect this now to spirituality. Polly identified that A&V was closely related to spirituality for her and was a useful lens for spirituality:

> *"because of what spirituality means for me. If it's how I live my life then I can't change or adapt that in a consultation because that would mean not being me" (Polly2)*

Lucy felt comfortable with A&V being a lens for spirituality and recognised that A&V is part of ANP practice. She was able to question:

> *"how can you help someone, be open, listen to them without having that availability and we are all vulnerable at some time aren't we? We all put ourselves in the position of vulnerability with dealing with other people. You can't separate availability and vulnerability can you?" (*Lucy2).

Mia felt it was also useful and could be drawn upon as needed. She suggested that A&V:

"are useful, it's there is your mind isn't it to be drawn upon, to be used as an awareness. (Mia2)

Tanya made some interesting reflections about A&V and felt it was useful lens for spirituality. She viewed consultations which had a spiritual element as a "*privilege"* but that it does take time to be *"available and vulnerable".* She said that A&V:

"works as a useful lens for spirituality but I think you don't necessarily do a consultation which is based on that end, you are just privileged that sometimes you get consultations where that connection with that person has been at that kind of place……the consultation can take two ways and it can be either that you're available in a very sort of superficial way that allows us some time to talk through something, to load off and they may go away feeling that's been useful to them in a spiritual way and then you'll get those moments where the connection is just so different and you are in a position where your availability is on a different level and then you are in a much more vulnerable position because sometimes it's about your personal vulnerability either to take on board something which is emotional or traumatic that you are going to carry or that you are disclosing something about yourself which is part of that connection, but I don't think you can see or plan that, I think it just happens and it's not until afterwards when that person has gone and you reflect on that and kind of think that would be fitting into this model of A&V and spirituality".

As Tanya described herself in a place of *"burnout"* she articulated clearly that A&V needed clear boundaries and that there was a need to limit personal vulnerability:

*"you have to be really comfortable with spirituality in yourself and about your limits around vulnerability. If you regularly sort of ensure you are approaching spiritual needs, what does that leave you with and I how do I deal with that? You need clear boundaries to start with" (*Tanya2)

Jane considered how nursing has developed over the centuries and suggested that, although nursing has changed, A&V are still important elements of practice. When considering it as a lens for spirituality she responded *"undoubtedly yes".* She recognised that she had thought:

"an awful lot about what I am doing and it's made me very aware when I am consulting…of how open I am, even if in how I'm welcoming them [patients]…*it's made me think much more about being open….trying to look at it* [the consultation] *from the perspective of being open, of sharing, of creating contact and then possibly of changing what you do" (*Jane2).

Ana also agreed A&V was a useful lens but there could be:

"some slight differences in emphasis i.e. being fully present and that they [A&V] *could be applied without an overt awareness or thought that they were spiritual concepts…..Maybe that's* [A&V] *something that now we have talked about will be in my mind" (*Ana2)

Tara and Georgia also both leaned towards the concepts being a useful lens but with less concreteness:

"it would be difficult to say yes or no because every patient is different and every patient's spiritual needs are different….I think they [A&V] have importance to help me know more about patients and their beliefs…. [A&V

might help me see] *where they* [patients] *are coming from and also where they want to go and want to see their life to be, what they get fulfilment out of*" (Tara2).

Georgia felt availability was definitely useful as a lens but that:

> *"vulnerability is more difficult but then as we were talking, it hadn't come to me at first, but I think that empathy is where vulnerability really kind of makes sense to me and then 'yes; it would be a useful lens"* (Georgia2).

A&V appeared to connect with many aspects of what the participants viewed as spirituality. The majority felt it was a useful lens for operationalising spirituality whilst others believed it could be with a slight change of emphasis or re-framing. There were cautions identified when over use of A&V could cause harm to the patient or the practitioner. However, the participants seemed to say that these could be limited through self-awareness and self-reflection in practice.

After the second interview and once transcription was complete I again sent the participants summaries of the interview (Appendix 8). All participants reflected that the summaries were a true picture of what they had said.

7.5 Reflexive Summary:

The findings of the interviews were incredibly powerful for me and showed such diversity and depth that I found it hard to decide what to include and what not to. The journey with the participants through the hermeneutic circle enabled such richness to develop as the time for reflection, discussion, development and collation of thoughts, feelings and experiences continued. This allowed for a fusion of horizons to occur which is ongoing as I continue to reflect and develop my own thoughts and ideas.

Obviously some repetition occurred during the interviews but there were many aspects which had developed, matured and solidified for the participants.

Definitions and understanding of spirituality were primary discussion areas. Interview 1 revealed more confusion about defining spirituality and the participants identified more connection between the concepts of spirituality and religion. However a number of participants revealed a depth to their understanding of spirituality and were able to either separate out aspects of spirituality from religion or reflect upon the commonalities of the two concepts. Initial deep descriptions which connected with my own thoughts included spirituality being "*innate", "human", "my way of life", "essence", "fingerprint" and* being *"everywhere".* There was recognition for some that they already integrated spirituality into care but often when dealing with existential issues for example palliative care. During interview 2 almost all of the participants had thought about spirituality in their lives, and in their practice. One participant appeared to feel more comfortable linking spirituality and religion. Several participants not only had reflected but had also read some of the literature around spirituality to challenge and refine their views. Spirituality in interview 2 still acknowledged it being "*human", "innate", "essence", "fingerprint", "unique"* and being *"always there"* however focused more on overtly on *"hope", "meaning and purpose", "connection" and "belonging".* At this point I could see a close fusion of horizons which reflected where I was situated at that time with my own definition of spirituality. There was recognition of spirituality having *"subjectivity"* and being a *"huge, huge umbrella term".* In the second interview it appeared that the experience of undertaking interview one, and maybe the very act of volunteering to participate, had heightened their awareness of spirituality in their lives and their practice. This study did not set out to change practice, nor did it set out to measure ways of changing

practice; however, this observation may be of significance. On reflection when I thought about what participants might say about spirituality I did not really predict anything, my feeling was that some would have considered what this meant as they volunteered to be interviewed. In previous experience of running an event for ANPs on spirituality and having a lot of hostility expressed I wondered whether this might come through in the interviews. However, all of the participants were fully engaged in the interviews and seemed to find the process helped them understand for themselves what spirituality meant for them personally and professionally. The ongoing dialogue through the hermeneutic circle appeared to aid this process with one participant acknowledging the reason she volunteered was to have the opportunity to talk to another about spirituality.

Following on from the discussions around spirituality in interview 1 all of the participants reflected on boundaries within practice and how these related to spirituality. There was recognition for all that there were professional boundaries as laid out in the code of conduct (NMC 2015) however other boundaries were "*moveable"* and "*not fixed"* allowing the ANPs to draw closer to patients emotionally or pull back depending on feedback, observation of the relationship and patient need. All participants chose to work as an ANP to be able to offer full care to their patients and they chose to care and connect to their patients as "*human to human"* rather than an *"automaton".* Their practice necessitated balance, self-reflection, self-awareness and recognition that "*burnout"* could occur if they didn't maintain the right balance as professionals. In interview 2 there was less emphasis on boundaries and more on providing holistic care and how that connected to spirituality. Within these discussions there was a connection made to "therapeutic optimism" and how ANPs could hold "*hope"* for their patients as well as a recognition that they wanted to be

"fully present" and "centred" when consulting with patients to ensure that patients felt *"safe", "valued"* and *"cared"* for. Holistic care was where the ANPs felt spirituality found its natural home and although they didn't feel this should be "*forced"* within a consultation there was acknowledgement that it "*coloured the whole thing".*

I didn't expect many of the ANPs to have considered spirituality in the consultation in depth. Partly because I recognised that often as ANPs we focus on the "presenting problem" and not missing any "red flags". I thought that some participants might talk about holistic practice and connecting with their patients at a deeper level rather than aligning this to spirituality. I had hoped, though, that this was where they might be more aware of spiritual dimensions and I was pleased that this was expressed overtly by a number of participants. Although I brought up the subjects of boundaries and holistic care I was surprised at the amount of discussion around boundaries and spirituality compared to that of holistic practice. These discussions provided some salient information about how to *"balance"* the needs of the patient and the desire to be *"holistic"* and show *"deep care and compassion"* with professional responsibilities and care for oneself.

The study was always going to have a lot of discussion about availability and vulnerability as this was the lens for the study. It was important to have a baseline understanding of what the participants understood by these two terms before they read the Rule of Life. The ANPs all responded positively to what availability meant and concurred that this was important within their practice. Their saw it as "*being there", "being present", "being open", being ready", "listening"* and providing a *"safe place to disclose"* as well as providing the time to be seen by the ANP in a consultation. However, they viewed vulnerability fairly negatively and recognised it could mean being at *"risk",* being *"defenceless", "weak"* or *"hurt".* A few were able to

see some positive value of vulnerability in that it could be a place where patients can "*connect"* with them, find "*hope"* and be "*welcomed".* Several ANPs suggested that they felt they could be in *"control"* of availability but not vulnerability and that being too available could lead to vulnerability for themselves.

As interview 2 approached I worried that giving the participants the "Rule of Life" as laid out by the Northumbria Community would possibly add confusion about defining A&V as the Rule is from a Christian view point. I thought that many of the ANPs would relate easily to their understanding of availability but that vulnerability would again be seen more negatively. I had hoped that some might think about vulnerability in terms of sharing something of themselves to help the patient move forward as I have seen this in my own practice. Most of the participants had not read the Rule whilst others had actively done some reading around the Northumbria Community and spirituality which impacted their responses. What I found was that many had been able to extrapolate the meaning of the concepts away from that offered by the Northumbria Community. There was in depth debate about the concepts of A&V and, although there were some negative connotations, in general the participants viewed A&V as a useful lens for spirituality.

In Interview 2 the participants viewed availability in more depth and breadth. There was a recognition that they could show they were available to their patient by their *"welcome",* by showing patients that they *"valued" them as "individuals"* and that they were there to *"respond to their need".* Within availability a number reflected on their use of sharing something of themselves within the consultation, this was illustrated by several narratives. They expressed that availability was a choice and that they could offer *"care", "empathy", "love", "support", "concern"* and *"help"* to their patients.

With vulnerability there was also a more positive view from the participants, though *"risk*" and "*dependency"* for patients and the possibility of "*burnout"* for the ANPs were clearly articulated. The views of vulnerability after reading the "rule" encompassed the choice to be *"open", "willing to share",* to be *"self-aware", "reflective*", open to challenge and teachable. There was acknowledgement that many of these ANPs were mature and experienced in their work and that this often led to a degree of *"comfort"* working with their own vulnerability and that of patients. One participant felt that being vulnerable could be "*transformative"* for both patients and participants whilst another saw her role as a "*companion"* to her patients which enabled "*deep connection*" to occur.

Finally, in interview 2 availability and vulnerability were considered as a lens not just as a way of understanding spirituality but as a possible way to integrate spirituality into practice. The majority of participants viewed this as possible with most of the participants seeing it as integral to spirituality. One participant Mia agreed it was useful but didn't see it as how she would always want to consult. Jane struggled with the concept of being intentionally vulnerable as the rule describes it but decided it was just a word.

I was surprised and pleased that A&V could be considered as a lens to operationalise spirituality and I agree that in order to connect to ANP practice it does need adaptation and contextualisation. Overall I was astounded by the abundance of data which viewed spirituality so positively and saw it as integral to ANP practice. I expected far more negativity and criticism. However the lack of negativity might be due to the fact the participants were self-selected volunteers. It could also be that the length of time we engaged in dialogue enabled them to really consider and explore what spirituality meant for them and their practice. It appeared that the experience of

talking to me in the first interview and having the time to think and observe their own practice between interviews had influenced the way they practiced and thought about their practice. This was apparent through analysis and is a clear justification for having separated out the two sets of data. Fundamentally, I believe I was faithful to hermeneutic phenomenology. The findings revealed the lived experience of these ANPs and the dialogue that occurred between us ensured the hermeneutic circle was continuous and, at the end of the process, complete. However as identified in chapter 5 the process will never be at an “end” point as it will continue to evolve. The ability to dialogue during and between interviews allowed a “fusion of horizons” to also occur which has strengthened this study and also my own thoughts around spirituality in ANP practice in Primary Care. The discussion chapter will consider these key findings and present a conceptual understanding and framework for operationalising spirituality, developed from these findings.

"*We are not human beings having a spiritual experience; we are spiritual beings having a human experience" Teilhard de Chardin*

Chapter 8 Discussion:

8.1 Introduction:

This chapter critically evaluates key findings and contextualises them in relation to spirituality, A&V and ANP practice. This study has enabled a unique exploration of spiritual dimensions of ANP practice in Primary Care in the UK and the findings offer significant insight into the way that spirituality is viewed and manifested in day to day ANP practice, rather than general nursing practice. This discussion presents interpretation of the findings which are presented as an amalgamation of participant findings. Individual participant thoughts and reflections (especially Ana and Georgia's) are utilised to illustrate specific sections or points and may appear to have more coverage than other participants.

The key contribution to knowledge this research provides falls into two areas; firstly a conceptual understanding of spirituality attempts to offer a way of seeing how spirituality is manifested in ANP practice. Second a framework for operationalising spirituality through a re-conceptualisation of A&V is proposed as a vehicle to guide the ANP in practice. The rationale for the conceptual understanding and A&V framework are critically discussed.

The aim of this study has been met through the in-depth interviews and analysis of the data. The aim was:

To carry out a Hermeneutic Enquiry of the Spiritual Dimensions of Advanced Nurse Practitioner Consultations in Primary Care through the Lens of “Availability and Vulnerability”.

Within this chapter the three objectives of the study are explored. The objectives of the study were:

1) To undertake a phenomenological enquiry of the spiritual dimensions of - Advanced Nurse Practitioner consultations
2) To develop a shared understanding of the phenomena of spirituality through the lens of “Availability and Vulnerability”
3) To develop a conceptual understanding of spirituality for ANP practice.

The methodology utilised enabled each of the participants to go deeper with self-revelation and also with their understanding of spirituality and spiritual dimensions of practice. By introducing the concepts of spirituality and A&V the participants were invited along a journey of self-discovery within the hermeneutic circle. Including the concepts of A&V in the process enabled the development of a new heuristic model for understanding spirituality in ANP practice. This represents the beginning of a new understanding of the place of spirituality in ANP practice as unique from either the broad roles generally occupied by nurses or the more prescribed role of the GP. Discourse around the elements of this model has led to a conceptual understanding and framework for practice. Exploring A&V seems to have enabled the concept of

spirituality to be further understood and expressed by the participants. The conceptual understanding models this in action.

This chapter is divided into three sections:

- The Conceptual Understanding with a Model Case
- Critical Discussion of Elements of the Conceptual Understanding of Spirituality
- Availability and Vulnerability- A Framework for Operationalising Spirituality for ANPs in Primary Care

8.2 Conceptual Understanding:

Chapter 7 presented the hermeneutic analysis of the interviews which was intentionally written sequentially, interview 1 followed by interview 2. After immersion in the findings and analysis of the data, in addition to ongoing dialogue with the participants leading to a fusion of horizons, a conceptual understanding has emerged. In order to give structure to the conceptual understanding part of the discipline included in Walker and Avant's (2005) staged model for concept analysis was utilised. Their framework asks the researcher to identify all the possible aspects of the concept; this has been achieved to an extent through the analysis of the data. The conceptual understanding enabled by this framework can help in the exploration of a concept that may be seen as vague or nebulous (Rhodes 2012); spirituality is such a concept.

There were many inferences throughout the interviews that spirituality, despite being poorly understood initially by some of the participants, was innate to each of us.

Participants described spirituality in many ways but fundamentally the connection with what makes us truly human appeared to correlate with how spirituality was understood. Significant dimensions were often discussed by the participants as they began to conceptualise the aspects of spirituality that made sense for them. Utilising the lens of A&V appeared to clarify their thoughts around spirituality and helped many of them reframe initial confusion around how to integrate spirituality into their own practice; it also aided description of where the limits and boundaries of spiritual practice might be located.

In attempting to draw out the conceptual underpinnings of spirituality from the data presented by the participants four areas emerged that underpinned their conceptualisation of spirituality. These included the *context* of relationship with patients and clinical practice and the *emotional engagement* and impact embracing spirituality in practice can have. The concepts of *A&V* when reframed by the participants were viewed and described as a helpful way of understanding spirituality and became the final two areas within the conceptual understanding.

Figure 2 is an attempt to represent this conceptualisation as an emergent understanding. Each area is an aspect of spirituality evident in the data, although diagrammatically represented this is not a cyclical or linear process. It is a dynamic process which is interconnected and interrelated where spirituality can connect to everyday practice. All four areas are integrated within spirituality for ANPs and do not connect to each other in a linear fashion, they often overlap and interlink; this is a reflection of reality. The conceptual understanding is presented simplistically as a heuristic tool for clarity. However, the reality is not so simple.

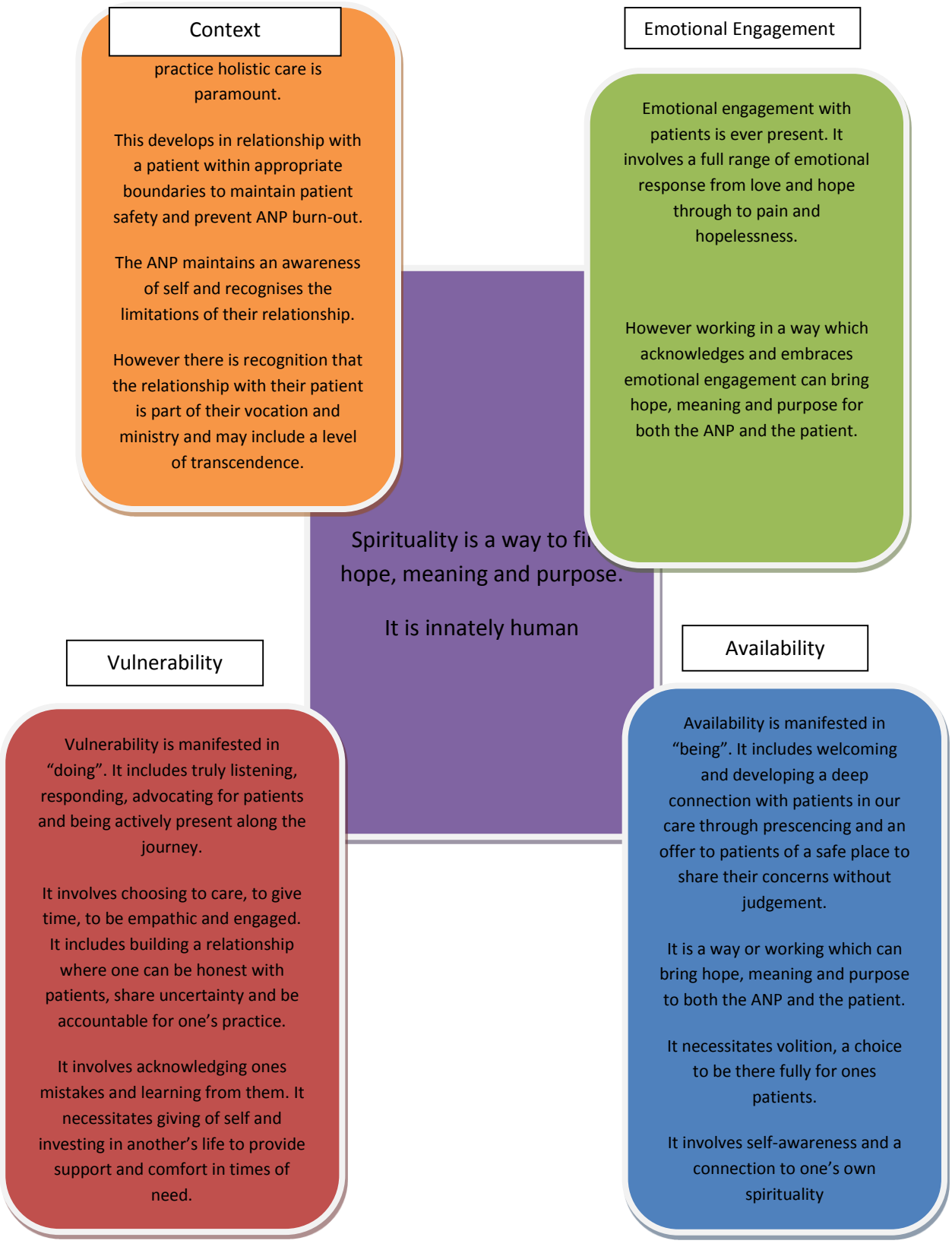

Figure 2: Conceptual Understanding of Spirituality in the ANP Consultations

Walker and Avant (2005) suggest that a model case could be utilised to illustrate all elements of a concept. Looking at the many narratives offered by the participants, the one offered by Ana of her relationship with Olivia reflects all of the critical attributes of the conceptual understanding of spirituality in ANP practice. This narrative offers a view of how spirituality in ANP practice can be demonstrated. The *context* of Ana's desire to provide holistic care was mediated through her *availability and vulnerability* which is manifested in what she does and how she is. There was significant *emotional engagement* with Olivia who she cared for very deeply.

8.2.1 Olivia's Story (Model Case Study):

For me this story connects deeply with spirituality and humanness and it struck me as a beautiful and powerful example of spirituality in practice revealing the availability and vulnerability of the ANP and the human connection which impacted both the ANP and patient profoundly. Ana related the story of "Olivia" (name changed to protect her identity) to me.

Olivia was a 15 year old girl when she began to see Ana after being diagnosed with Anorexia. Olivia was the same age as Ana's own daughter which immediately caused Ana to consider how she would feel if this was her own daughter:

> *"I had to be kind of aware of that and keep that just you know because you respond as a clinician but you are also respond as a mother"*.

For Ana this brought about a connection based on empathy and care which developed over the next few years and became more emotionally complex for both

Ana and Olivia when Olivia's mum died suddenly. It was clear that Ana felt deeply as she said:

> "*I feel myself getting emotional about it as I talk, so excuse me, but she's only 16 and her mum died* (tearful). *She is the same age as my daughter you see and that was really difficult…..I just thought this is too terrible for words. I know people die all the time but it was just too close you know and then I thought 'how am I going to see her again, I am going to fall apart completely' I was worried about how I would react and of course how she would feel and how I would deal with all of that and I remember the woman who I see for supervision she said 'well can you carry on seeing her?' and I said 'well how can I not'. You know I couldn't not see her obviously even if it was difficult for me to see her so I did and it was difficult".*

Ana acknowledged clearly her care for Olivia and her shock and sadness that she had lost her mum, she also acknowledged that she felt a level of responsibility for her which she reflected on after Olivia eventually went on to University and received support from there:

> *"I actually feel quite relieved that she is getting that support there now because while ever she wasn't doing that although I knew she was no longer my responsibility in that sense, you can't just let that go can you and I still see her in the holidays and e-mail her occasionally but there feels like there is a slight distance coming there now which I feel is actually quite appropriate".*

Although a clear human connection was present which involved deep care, empathy and compassion with Ana walking alongside Olivia it was rarely verbally acknowledged until towards the end of their consultations together as Ana felt

strongly that she needed to maintain her professional boundary although she acknowledged how much Olivia meant to her:

> *"I had to be very very careful in this to - I don't know how you can explain it - to have a level of openness and involvement but without her having known I guess how personal it was or without us ever acknowledging that in a way because I think she knew that I had children her age. She never mentioned it and obviously I never mentioned it until the very last time I saw her when she went to Oxford and she asked me about my children which was interesting really and I could talk about it then briefly but it wouldn't have been appropriate to have talked about it at any other time but there was that awareness that she was so I don't know, it's how you can be of help and value to a person in that position and I think when I was thinking about this for this actually as well what you have got to be very careful of is that the consultation doesn't in any way become about you. That would be the risk wouldn't it that in being open and I am talking more generally here than just with Olivia in being open you mustn't ever cross that line where it becomes too much about me and not about them anymore"*

Ana and Olivia navigated through not just living with and addressing an eating disorder with all its complexities but also dealing with bereavement and continued to have a healthy ANP and patient relationship where there was a deep connection but where Ana ensured a professional boundary was in place despite many conflicting emotions around the desire to mother this girl. Connection gave Olivia a sense of stability and consistency for a number of years before she went to University and it is clear that this meant a lot to her as she still contacts Ana occasionally when she

comes home for holidays. Her relationship with Ana appears to have been hugely significant.

Olivia often reflected to Ana about her existential angst and search for meaning and purpose in her life especially after losing her mum. Her need to explore this was the focus of many of their consultations and she eventually made the decision to go to University to study. Her journey with anorexia and loss at such an early age provoked many of the questions about life and revealed a spiritual need to Ana which she was able to allow space for.

Olivia's story illustrates the integration of spirituality in Ana's practice. Throughout the interviews Ana had spoken about her belief that spirituality is innate and part of being human. In her relationship with Olivia she could not be anything but "human" whilst recognising the boundaries of practice so the consultations remained about Olivia and not Ana. Ana was able to be self-reflective throughout her relationship with Olivia and acknowledged the deep emotional repercussions that occurred because she chose to be available and vulnerable with Olivia.

Ana made a choice to offer Olivia a welcoming safe place where she could be truly herself and share her struggles with anorexia and also the loss of her mother. She built a relationship with Ana based on trust and respect. Ana held Olivia throughout her struggles deeply prescencing whilst offering Olivia care and concern. Ana also mentioned in her interviews her work being about "*ministry"* and with Olivia this was evident in her practice.

There were many occasions when Olivia lost hope, meaning and purpose and Ana was also challenged personally in these areas. Yet even though Ana was offered the

opportunity to stop seeing Olivia she continued to hold hope for her and chose to continue seeing her until she left University.

The consultations with Olivia lasted over several years and had a deep impact on Ana which at times was incredibly difficult to manage. Through supervision and taking care of her own needs she was able to traverse these difficulties and maintain a holistic approach to care based on human connection, and deep care and compassion. Through this model case the conceptual understanding of spirituality can be further understood through its relationship to availability, vulnerability, context and emotional engagement. This case fundamentally shows the innateness of spirituality mediated through a relationship of "*human to human"* connection. The outcome for Olivia was that she regained hope, meaning and purpose and for Anna holding out hope for Olivia and seeing her recovery gave her a sense of meaning and purpose personally and professionally.

8.3 Critical Discussion of the Conceptual Understanding

In order to explain the conceptual understanding further it is necessary to critically discuss how the conceptual understanding developed from the findings. As the analysis progressed it became apparent that spirituality within ANP practice integrated specific attributes of practice. Firstly, the context for spirituality to be operationalised appeared to include not just the consultation and aspects of relationships with patients but also the unique way ANPs journey with their patients, often over many years. This long term relationship seemed to enable holistic care to be practiced in a way which recognised the implicit and explicit elements of a patient's journey through ill health and wellbeing which over time touched on deep emotional reactions including hope and hopelessness. However, it was also evident

that spiritual dimensions could and did also occur during short, one off consultations and not just those where a longer term relationship had developed. Secondly emotional engagement with patients was paramount for a spiritual dimension of practice to be present. This involved recognising within oneself the scope of emotional responses working with patients evoked and not just patients' emotional responses. In order to connect spiritually with a patient the ANPs chose to engage emotionally on a human to human level. Spirituality has been described as a point of deep connection which enables a place of safety to be created where a patient can express issues related to meaning (Pesut & Reimer-Kirkham 2009). This connection appeared to be the epitome of spiritual interaction for the ANPs and their patients which time and again the participants illustrated through narratives. Thirdly and fourthly A&V appeared to be helpful mediators for spirituality to be operationalised in practice. The concepts created much discussion and debate but for the majority of the participants they represented a way in which they could integrate spirituality.

This next section will discuss aspects of the findings including defining spirituality and the four elements of the conceptual understanding: context, emotional engagement and availability and vulnerability.

8.3.1 Key Elements of the Conceptual Understanding:

8.3.1.1 Spirituality

Defining spirituality was the starting point for all the ANPs interviewed and necessitated deeper exploration. Some of the participants initially appeared to be at a loss as to how to define spirituality, reflecting a common experience of nurses (McSherry & Jamieson 2013). Trying to define spirituality is a constant theme throughout the literature (Miner-Williams 2005, McSherry 2006a and Reinert &

Koenig 2013) so it was not surprising that some of the ANPs struggled to define what it was. Burkhardt (2007) suggested that spirituality is like the wind, it can be sensed and felt but cannot be tied down. The participants were able to acknowledge spirituality in their practice and articulated this through experience rather than concrete scientific descriptors. Over the time of the study a clearer conceptualisation of spirituality evolved for many of the participants. I felt that this clarity might be related to the time they took to think about spirituality in their lives and practice, and the experience of the two in depth interviews spaced 18 months apart. Through this they had time to reflect, articulate and discuss their ideas. This reflects Koenig's (2009) suggestion that we each need to define spirituality for ourselves and that it is personal to each of us. Some participants had researched the concept further after the first interview and had consciously begun to think about spirituality in their consultations. Being more self-aware and understanding one's own spirituality is a key facilitator for operationalising spirituality (Stranahan 2001, Ellis et al 2002, McSherry 2006a, King 2011). It appeared that, as the participants began to have conceptual clarity about spirituality for themselves, they connected with an integrated sense of meaning and purpose more fully in their professional and personal lives. Merton (1993) suggested that having a greater understanding of spirituality, personally and professionally, could give purpose and meaning on one's own life.

The participants in this study all wrestled with the complexities of defining spirituality but added to the richness of current definitions with some of their understandings. When defining spirituality many used terms such as *"the essence of a person", "being human" "inner self" "something that gives life meaning and purpose" "your being"* which have humanistic qualities. One of the powerful definitions verbalised

was by Lucy in that "*spirituality is like a fingerprint"*. This relates well to the uniqueness and individuality of spirituality identified in the literature (Narayanasamy 2006) and appeared to help Lucy to understand spirituality for herself in a much more significant way. She explained that recognising spirituality as "*your being* [means] *you can't escape it being there*" and that she wanted to connect with the "*essence"* of her patients to offer "*holistic care".*

The complexities of defining spirituality are well recognised (see chapter 2) however the plethora of definitions could offer richness and diversity (King 2011). Allowing for diversity and contradiction is important when it is suggested that spirituality is both unique and universal (Miner-Williams 2005, Narayanasamy 2006 & Tanyi 2002). It appeared for the ANPs that presenting a narrow definition of spirituality was unhelpful as this could lead to a danger of alienating many ANPs from operationalising it in practice. Allowing time to determine a personal definition of spirituality through the interview process appeared to lead to spirituality being acknowledged and operationalised by the participants. The discussions I had with each participant included some of the debates and theory surrounding spirituality which helped the ANPs to understand the complexity and nuances described by King (2011). Nolan (2011) recognised the heuristic value spirituality gives when talking about human experiences and this was reflected as the participants talked through their thoughts and experiences of spirituality.

There were some clear challenges related to defining spirituality which were presented in chapter 7. The nebulousness of spirituality was a challenge which some ANPs struggled with, Georgia suggesting that "*it's woolly"* whilst Tanya suggested

"you can't put your finger on it". How to define a concept which has different meanings for each person was a subject of reflection and discussion. Some participants viewed this as a positive attribute which enabled the ANP to see spirituality as individual and unique to each patient.

A further challenge is operationalising something that is unique to each person. It necessitated attentiveness to each individual patient and recognition that what gives hope, meaning and person to one person may not be the same for another. This did seem to resonate with their ANP practice as they related their desire to provide individualised holistic care as a way to operationalise spirituality (Shuler & Davis 1993, Hubbell et al 2006, Helming 2009, Chrash et al 2011).

To some extent an association to religion combined with some confusion between religion and spirituality was expected; some participants recognised that this could be a potential challenge in practice. This was supported by the findings in the ANP literature (Treloar 2000, Stranahan 2001, Hubbell et al 2006, Helming et al 2009 and Carron et al 2011). Several participants recognised that some patients viewed spirituality as their religious beliefs and this sometimes impacted the consultation adversely. The experience with the patient with the fungating breast carcinoma who believed God would heal her was one example which Tara shared with me as she felt at a loss to explore this in a therapeutic way since the patient was hostile to anything she suggested. This had left Tara frustrated and with a belief that religious beliefs could be destructive from her perspective. This challenged Tara's own belief systems and on reflection had coloured her view of spirituality and its relationship to religion. However, through further discussion she was able to begin to separate the

two and during her second interview was able to see the difference and viewed spirituality more positively.

Initially several other ANPs also confused spirituality and religion. However, in the main as they talked about spirituality during the second interview they realised that religion and spirituality could be distinguished from each other and attempts should be made to define each separately even though this was difficult. Tanyi (2002) suggested seeing spirituality and religion as distinct to aid clarity. Lucy suggested that:

> *"I like to separate them…spirituality is about who you are and how you treat others and how you live your life, they* [spirituality and religion] *are not the same…I am very much a Christian and could try and fit it* [spirituality] into *religion but it's not the same… you don't have to be religious to be spiritual"* (Lucy2).

It was important to note that despite the majority of the ANPs thinking a separation of spirituality and religion was important they realised this might be unhelpful for some patients. Patients with a strong faith felt comfortable connecting this to their spirituality as Ana, Tanya and Jane identified. However, all the participants recognised that individualised holistic care was fundamental to spirituality. This meant that those with religious beliefs and values were acknowledged and respected equally to those patients whose spirituality was not faith based.

Interestingly, several participants who identified themselves as having a strong faith defined themselves as "*spiritual"* but not "*religious".* They defined clearly a difference between the two and chose to align themselves to a broad definition of "*spiritual".* Lucy described herself as a Christian but she recognised there was something more

to spirituality for her whilst Jane reflected that she had *"a strong faith"* but that "*spirituality is different".* Ana described her *"spiritual self"* but reflected that she kept trying to exclude "*God"* from the discourse to enable spirituality to be easily talked about; she came to the recognition that this wasn't possible for her and she was rethinking how her "*spiritual self"* and "*God"* connected. Pesut and Reimer-Kirkham (2009) suggested that secularising spirituality was an attempt to find common ground in the ongoing debates. For some of the participants this clearly helped them but the interviews revealed how hard it could be to differentiate spirituality and religion with one participant still choosing to link the two. King (2011) suggested there was no need to separate the two out completely with Clarke (2009) reminding us of the need to consider the rich heritage brought to nursing from religion.

It was illuminating for me that there was little overt negativity or antagonism around spirituality, although this may be due to the self-selected sample, apart from the two examples of "*spirits"* and "*spiritualism*" initially confused with spiritualty and which were seen as harmful to patients. It was surprising for me to find that "*spirits"* and "*spiritualism"* were included in the definition of spirituality by several participants because I personally did not view these as spirituality. For both Mia and Tara who talked of these it had led them to an avoidance of operationalising spirituality because they saw these aspects as negative. In the second interviews these words were excluded for those participants from their concepts of spirituality and they related them specifically to religious activity. Doing this appeared to enable them to see spirituality in a more positive light.

As all of the participants began to think about spirituality over time they were able to articulate more distinctly what spirituality meant for them. We tend to leak thoughts and feelings in the terminology we use and this has been evident throughout the interviews. In the initial interviews it was clear that some of the ANPs had not previously perceived spirituality as an aspect of their practice. However, as they verbalised their own ethos and values at work this connected to spirituality profoundly. Clarke (2013) reflected that spirituality is part of one's being and that beliefs and values held are carried into each interaction. Viewing spirituality as part of the essence of being human and being innate resonated for most of the participants. As they considered their values it was clear that they wanted to ensure these were mirrored in their interactions and work as ANPs. The innateness of spirituality was reflected through the ongoing discussions about their own ethos and values which often reflected glimpses of their own innate spirituality and as they reflected on patients they had worked with through narratives this innateness was further explored.

8.3.1.2 Spirituality Innately Human:

Despite some of the participants initially being clearly confused about spirituality others seemed to have clearly conceptualised it for themselves in terms of "*innateness"* and "*being human".* Tanyi (2002) acknowledged the difficulty with the subjective-ness of defining spirituality but agreed it was inherently *"being human*". Acknowledging the innateness of spirituality was an important area to focus on because it allowed ANPs to work in a way that was open to spirituality being different for each person; being fluid but still valid. There didn't appear to be a need in the participants to have spirituality pinned down to one thing. I wondered if some of this was due to working in a field where uncertainty was prevalent in that each day they

didn't know what was coming through the door and each presentation of a disease might be expressed in different ways for different patients. The suggestion of spirituality being like a "*fingerprint"* allowed for variation and uniqueness. However, in some ways it made addressing spirituality harder for the ANPs I interviewed. It meant the ANPs needed to be flexible in their approach to explore with their patient what was important to them within the limitations of time. As Treloar (2001) and Heming et al (2009) suggested it meant being open to hearing the patient's story and being present, offering empathy and accepting patients where they were.

Extrapolating the concept of spirituality being innately human has been a powerfully illuminating journey for me. Spirituality is a concept which I have grappled with personally for many years and the sense of it being something innate in each of us from the data was comforting and encouraging for me as this accords with my own reflections of practice as discussed in chapter 3. There was no conflict for me in the fusion of horizons about spirituality being innate whereas the discussions about *"spirits"* and "*spiritualism"* had caused me significant struggle. Of course when a topic is close to your heart you hope that others may view it in a similar way; yet I was open to having my own thoughts and ideas challenged and refined. What was remarkable for me was the journey for the participants some of who had never considered the meaning of spirituality personally or professionally. Lucy identified that "*going through this process* [interviews] *actually opened it* [spirituality] *up more for me it's made it a bit more of a tangible feel for what it is and why it's there" (Lucy2).* Whilst Jane had chosen to participate so she could explore spirituality. It was a privilege to witness the development of her views over the two interviews and the process again partially reflected my own journey. There appeared to be a continuum from where the ANPs began in interview 1 and where they ended later in

interview 2 in relation to their conceptualisation of spirituality. As discussed above the early data showed some of the linkage to religion and confusion about what religion and spirituality are. Later it was more clearly related to the essence of self, being innately human and carrying the core values of care. This enabled what the ANPs felt was a therapeutic interaction to occur, providing deep meaning and purpose for the ANPs and hopefully for their patients, too. For these participants relating spiritual dimensions to practice appeared to include a collective view of *"humanness*" being core. They related this to their ANP professional role but also to what was innate in each of them and how this translated into their consultations.

The recognition of spirituality being innate is supported in the nursing literature (Burkardt 2001; McSherry 2006b; Burkardt 2007;Pesut 2008). What was also interesting in the data was the reflection of the participants' desire to be "*human*", to be "*present"* and *"engaged*" fully with their patients which could be viewed as an embodiment of spirituality, echoing Helming et al's (2009) findings. The majority of the participants stated that this was a significant part of the reason they worked as an ANP because they could relate to their patients as a "*human"* and connect with them throughout their journey through illness or distress. This desire to connect as a human was powerful for some with Ana reflecting a concern that ANPs would become "*automatons"* if this was lost. Connecting with patients in this way often allowed for an understanding of the meaning systems of patients and allowed a safe space to develop where issues of hope, meaning and purpose could be explored (Pesut & Kirkham 2009).

8.3.1.3 Hope, Meaning and Purpose:

The general consensus discussed in chapter 2 suggested that hope, meaning and purpose were some of the key attributes linked to spirituality; see for example (Coyle 2002; White 2006; Cook et al 2009; Gordon et al 2011). There was a sense that meaning and purpose were the vehicles for providing hope which enabled patients to cope with illness (Coyle 2002); with spirituality connecting deeply to the search to find meaning (Clarke 2006b). Often hope, meaning and purpose are lost during times of illness and crisis. However, the ANP could hold hope for patients when they felt they had lost these and help patients explore and discover the key attributes of hope, meaning and purpose (Rogers et al 2013; Rogers & Wattis 2015). The ANP's strongly reflected this throughout their interviews even where they were not consciously referencing this as spirituality. These attributes are also ways in which some of the ANPs conceptualised spirituality. Many of the participants explored spirituality being about connections, relationships, contentment, balance, significance, values, beliefs and hopes. This led on to some to the participants being able to articulate that these are the areas that give hope, meaning and purpose. Ana recognised that spirituality was about "*something that gives life meaning and purpose"* whilst Georgia identified that part of the ANP role was to *"try to encourage people to give them hope for the future".* Practising holistically seemed to offer an opportunity to work with patients to bolster hope even when the diagnosis was terminal; for example, that their symptoms could be managed or they could stay at home with their family. Equally those struggling with depression or other illnesses which caused hopelessness could be encouraged by the knowledge that others have found hope amidst great distress and suffering. The ANPs in this study appeared to work as agents for change illustrating what may be seen as *"therapeutic optimism*"

for patients that things can be different, that they can find hope and meaning (Hemingway et al 2013; Rogers et al 2013). Puchalski (2001) asserted that many patients when facing illness and crisis considered hope, meaning and purpose. By listening to patients when they asked questions such as why me, what does this mean and “how do I deal with this the ANP’s in this study were able to explore these areas. These types of questions are common existential questions patients may ask and can be avenues to explore spirituality with patients (Rogers & Wattis 2015).

The findings from this study therefore suggest that spirituality in ANP consultations is innately human and is a way of helping patients to find hope, meaning and purpose.

The following sub sections explore the context, emotional engagement and availability and vulnerability as they relate to the innateness of spirituality within ANP practice.

8.3.2 Context

Clarke (2013) asserted that spirituality was always contextual. Coyle (2002) related this closely to an individual’s life experience. When exploring the connection between spirituality and the role of the ANP a number of contextual issues were identified as important by the participants. These included the relationship between the ANP and their patients, holistic care, boundaries, burn-out and ministry. Although the term transcendence was not overtly discussed, all the ANPs talked of it in the sense of going beyond themselves to care for their patients. Several ANPs also considered their own life experiences, especially those of loss and bereavement, and used them when appropriate to “*get alongside*” their patients. Stranahan (2001)

found that personal experiences and crisis often led ANPs to being more open about spirituality which seemed to be the case with these participants.

8.3.2.1Relationship:

In distress, patients often need "*human connection*", to know they are heard and to feel as though they are cared for (Stevens Barnum, 2011). In order for this to occur relationship is fundamental and was a significant focus of many of the participants' "*hopes"* for their practice. They considered that their patients needed to feel "*safe"* and to "*trust"* them and that this could occur by the ANP connecting with them *"human to human*". O'Brien (2008) identified that relationships between patients and practitioners demand authenticity. However, the recognition of the professional aspect of the relationship was important to ensure the patients' needs were of foremost importance as Jane and others reflected. Mia recognised the patient was not your "*friend"* but you would want them to be cared for as you would a "*family"* member. How the ANP connected with a patient when they met and fostered a healthy relationship based on care and compassion appeared to be how participants recognised a "*spiritual dimension"* had occurred in their practice reflecting Helming et al's (2009) findings. Gordon et al (2011) proposed that spirituality was fundamentally relational and several examples shared by the ANPs focused on the importance and depth of some relationships with patients which had influenced them. Ana and Olivia was a good example where they had developed a strong rapport based on trust and openness which allowed Olivia to share her struggles fully with Ana. Ana was able to be empathic, compassionate and supportive though she maintained the boundary needed to hold the relationship safely. Other participants reflected on a sense of shared humanity occurring when they could offer empathy and journey alongside their patients whilst balancing this with appropriate boundaries. All the participants

felt that human connection was paramount in order to build a healthy relationship. This has been recognised as the basis for spiritual care to occur (NHS Education for Scotland 2009). The participants reported that patients often shared life events and experiences which were intensely private and life-changing with Jane and Polly reflecting that it was a privilege to hear this, resonating with the findings of Chrash et al (2011). The ability of the ANP to build a relationship based on trust where the patient could feel safe, listened to and valued significantly affected whether the consultation could develop into a positive and healing experience for the patient. Milligan (2011) identified patients feeling a sense of shared humanity as a facilitator for spirituality within clinical practice. O'Brien (2008) asserted that shared humanity in relationship needed to be authentic with a possibility for mutuality including the sharing of self. Common experiences of life can be a basis for spiritual care. However, the participants were clear that there were events that could be shared as they were seen as helpful to the patient whilst a pouring out of their own struggles in life would not be seen as helpful. A good example was when Ana was caring for a patient whose child had a rare genetic disorder which her niece had died from. She felt that she could empathise fully with her patient by sharing this. However, she recognised that she was only able to do this as it had been many years since her niece had died and she had processed her grief to a point where she could talk about this without her own emotions tangling the relationship. She witnessed her patient being freed further to be honest with her about her distress and pain as she began to face her child's illness. In general, there was a real opportunity, with a degree of self-awareness of what and when to share with a patient, to deepen the relationship in a way which enabled a patient to address issues of spirituality. By the nature of a relationship it must be two-way. However, nursing has often distanced

itself from this in the guise of “professionalism”. There is a balance which must be maintained between authenticity and working within the NMC code of conduct (2015). The focus should be always the patient. Clarke (2013) suggested that authenticity in relationships developed from our embodiment of our values, our own spirituality. She acknowledged that patients respond to honest connection but the priority always needs to be on the patient.

The relationship Ana had with Olivia demonstrated more fully the significance of relationship and shared humanity. There was a clear bond between them which was based on Olivia feeling safe, held and cared for and Ana holding hope. The relationship affected both Ana and Olivia deeply leading to intense emotional responses which were able to be contained within appropriate boundaries. There was a sense in journeying with Olivia for Ana for a period of time in order to help her find a place of meaning and purpose again, a renewed sense of hope for the future which she had lost. Ana recognised that her relationship with Olivia had a spiritual dimension which developed over several years during times of immense hopelessness and despair for Olivia. She described the relationship as “*a set apart moment”* which despite being intense and having significant emotional impact on Ana germinated into a profoundly spiritual and rich experience in hindsight.

Initially physical context in the sense of what the patient brought to the consultation was obviously important. However, how the ANP responded to their patient was fundamental in how the ANP and patient relationship developed. The ensuing relationship appeared to be the seed for spirituality to be recognised and responded to. In addition to the examples of Ana’s practice, participants talked of how patients presenting with terminal illness easily engaged with the existential questions

reflecting the findings of Puchalski (2001). They could easily relate spirituality to this. They also highlighted patients struggling with mental health problems who had lost hope and how part of their role was to hold hope, be therapeutically optimistic and engender a belief that things could get better (Rogers et al 2013). The many simple examples of practice participants gave about day to day interactions, where they were developing relationships with patients and journeying with them, revealed spiritual dimensions clearly linked to the relationship and not the specific presentation. The authenticity and ability to presence quickly in a relationship, the compassionate approach demonstrated in their deep care for the patients they saw, the human interplay with a degree of mutuality and acknowledgement of self and limitations, all appear to display significant attributes of spirituality.

Physical context (i.e. presentation) is worth consideration. It will never be as simple as being able to say that in consultation A I would be more likely to integrate spirituality than in consultation B. As some participants acknowledged, it wasn't just the terminal patient who they would engage with spiritually but it could be the patient with multiple attendances for minor illness or the one off consultation. What appeared to be much more significant was the relationship the ANP built with their patient, irrespective of the presentation. The ANP building a relationship with whatever the patient brought and being aware and open to spirituality as part of their holistic approach could therefore operate across a range of contexts.

8.3.2.2 Holistic Care

The quest to provide a high standard of holistic care to patients was evident in all of the interviews and was part of the contextual understanding of spirituality. Each ANP spoke of their desire to provide the best possible care to their patients and a desire

to be fully present and to listen to patients throughout the consultations. Treloar 2000, Hubbell et al 2006, Helming et al 2009 and Tanyi 2009 recognised that prescencing and listening were core to ANP's operationalising spirituality. Spirituality as an aspect of holistic care has been well documented (Greasley et al 2001; Hubbell et al 2006; Chrash et al 201; Nardi & Rooda 2011; Montgomery-Dossey & Keegan (2013).

A number of altruistic and often deeply philosophical ideologies presented by participants around holistic care linked substantially with the discussions on spirituality. Statements like being willing to "*explore any avenue*" to help patients move forward connected with the premise of spiritual care moving in "*whatever direction is needed"* (NHS Scotland 2009). Being willing to listen to patients' concerns and consider not just the presenting problem appeared to be the way all the participants ideally liked to practice. Each ANP talked about being clinically competent and providing evidence based care to assess, diagnose and manage the plethora of presentations that occur in practice. The desire to do this in a holistic way supporting patients' spirituality was also evident, though perhaps at times an unconscious part of the consultation.

Several of the ANPs had a concrete understanding of holistic care which integrated spirituality and applied this to their practice. They viewed their patients as fully human and wanted to connect with them in a way that recognised this. Seeing patients in this way has been described as a tenet of holism (White 2006). Others who wrestled with spirituality in terms of what it was and how to integrate it into their practice, were able to talk about holistic care which included "*prescencing", "compassion"* and *"empathy",* similar aspects to those who labelled them in terms of spirituality. Holistic care appeared to be one a prominent aspect of the discussion

linking closely (and at times fully) with spirituality. Lucy acknowledged that she always strove to practice holistically and she recognised that she now thought *"more in terms of spirituality….going through this process* [interviews] *actually opened it up more for me it's made it a bit more of a tangible feel for what it is and why it's there" (Lucy2)* with Georgia stating that the "*spiritual dimension"* comes to the fore when you treat and care for patients holistically and you *"try to encourage people to give them hope for the future and I suppose a small part of that would be to inspire somebody and to inspire people comes from a spiritual root" (Georgia2).*

Despite the participants being able to see how spirituality connected to their concepts of holistic care there were obvious tensions for them in terms of the realities of practice in primary care where they often saw 30-35 patients per day at 10 minute intervals. Georgia recognised that it could cause tension and have a negative impact on practicing holistically when:

> "*you have got somebody who comes in, you know the patient who comes in and their burst in tears before you even before they have sat down and you have only got a ten minute consultation and you have got maybe fourteen patients to see and you are already running late and you have to be available and you have to deal with the presenting problem at the time and make the patient feel a tiny bit better so they can go out there maybe with a little bit of hope or having felt understood and listened to but then I have got to be equally available to the next fourteen patients who are coming to see me and I have got to keep myself functioning well*".

She clearly was self-aware in recognising that she wanted to give the patient in despair or distress time to feel listened to and understood but that she had patients

waiting and needed to keep to time and complete the surgery giving equally to all the other patients. She also recognised the impact on herself and the need for her to keep functioning and emotionally well. Sometimes the demands of constantly trying to work holistically and give the best care possible had a powerful impact on the ANPs and it was evident that there was a risk of burn-out for them. Tanya at the time of the second interview reflected that she was close to that place.

Within the consultation there was also some tension between how to integrate the bio-medical aspects of care with the spiritual aspects of holistic care. At the end of the interview process all the ANPs could see the value and importance of spirituality within their practice. However, working through how to operationalise this in the midst of medical assessment and time constraints was and will continue to be an ongoing journey.

Interestingly the choice to work in an area which gives more autonomy for the practitioner appeared to provide a vehicle where holistic care is integrated to include spirituality. The ANPs chose to give time, to listen, to care and be present to their patients holistically. By doing this they provided a platform for patients to be able to talk about their concerns and anxieties and for the ANP to journey with them. The ANPs all displayed great maturity and a willingness to reflect and be aware of their own practice, life experiences and how these impacted on their work. This depth of maturity was evident as they openly wrestled with spirituality during our interviews. This appeared to lead to inner and outer transformation with regard to spirituality reflecting the findings of King (2011). Clarke (2007) proposed that many nurses will not be confident talking about spirituality with their patients because of limited life experiences and immaturity however in this study several participants acknowledged that their own maturity with age and experience enabled them to be comfortable to

connect spiritually with patients. All of the participants reflected self-awareness and maturity throughout our discussions. Stevens Barnum (2011) suggested that personal maturity will help practitioners to successfully integrate spirituality into practice however willingness and a desire to do this are needed which the participants showed. The ANPs interviewed had a wealth of nursing experience and expertise and many shared life experiences with me which had influenced their choice to become an ANP. This level of maturity appeared to be a factor in enabling them to engage fully with holistic care and hopefully to consciously integrate spirituality within this.

In order to "*keep functioning well"* and offer holistic care as a practitioner and remain centred upon patient need a relationship within healthy boundaries must be maintained.

8.3.2.3 Boundaries:

When integrating spirituality into care the issue of boundaries was significant. The ANPs had an unwritten moveable line which was contextual and relational where they made professional judgments regarding the risk taken in when to *"cross"* this line and when to "*pull back".* This line being moveable relied on the ANP being self-aware and responding to the needs of the patient whilst practising within their code of conduct. Many reflected that boundaries were not black and white but rather *"grey".* There was a sense that the experience and maturity of the ANPs might have helped them to feel comfortable negotiating the line in practice as they felt confident in their self-awareness and competent to "*pull back"* if necessary.

There was some expected discussion around the awareness of not imposing beliefs and views onto a patient. Two participants raised the issue of a nurse who had been

suspended for praying with a patient. Tara reflected that she *"felt sorry for the nurse*" but recognised she had overstepped a professional boundary. Ana retold an instance when a patient asked her to pray with her and how uncomfortable she felt despite having a faith; this led her to recognise this was a boundary she would not cross. When boundaries connected with religious practice the participants appeared clear on their stance which was to respect others beliefs but not enter into proselytising or praying with patients, there were no expressed tensions with this stance. Post et al (2000) suggested that patients often pressure clinicians to blur boundaries between religious practice and clinical care. This was clearly identified as unhelpful by the ANPs and falls outside the Nursing Code of Conduct (NMC 2015). This is a significant difference from the US ANP literature which reported that some ANPs believed that praying with a patient was part of their role in addressing spirituality (Stranahan 2001; Hubbell et al 2006). None of the participants in this study talked about this as a way they would operationalise spirituality. There are obvious cultural differences between the USA and the UK. Clarity for the ANPs interviewed with regards to boundaries and spirituality were less absolute that that of religion (i.e. not proselytising). Spirituality was seen more as integral to the holistic approach to care and how the ANPs chose to practice and connect with their patients which involved some flexing of boundaries. The boundaries involved with spirituality were still seen as being consistent with other aspects of care, falling into the code of conduct but necessitated some degree of discernment, for example the ANP may share some aspect of themselves with the patient to establish a human connection.

Boundaries within the ANP and patient relationship were significant with participants discussing the impact it could have on themselves and their patients if boundaries

were not held to some degree. Mia, Lucy and Tanya discussed emotional involvement with patients that was stronger than usual. However, this was not seen as necessarily having negative repercussions or overstepping a professional boundary. The example of Olivia is a good illustration of the need to hold a boundary but also of the emotional impact caring for patients can have on the ANP. It was necessary (and probably vital) for Ana to maintain her professional boundaries with Olivia. At times she felt such anguish for what Olivia was going through she could have overstepped these in order to 'rescue' or 'mother' her. However, Ana was self-aware enough to recognise that this would not be helpful in the context of the professional relationship and sought to explore her feelings through supervision. She needed to be present with Olivia, to listen and empathise throughout this incredibly painful journey of loss, despair and hopelessness. By maintaining this boundary, she was able to support Olivia to find hope, meaning and purpose for herself in the midst of adversity.

The findings regarding boundaries were extensive and multifaceted. One particular contextual factor that I identified was the ongoing tension for participants between their own "*hopes and dreams*" as an ANP and their practice within the professional code of conduct as a nurse. For Ana as an ANP she wanted to support and care for Olivia giving her a safe place to talk through her concerns with Ana present as a safe person for Olivia. The tension of herself as a mother was in conflict with her professional responsibilities. She needed to work this through in supervision to be able to offer Olivia the care she needed without it becoming a maternal relationship. Ana wanted to be holistic in her care to Olivia but she needed to keep in mind a clear boundary. This desire to care holistically whilst maintaining boundaries was reflected by the other participants. All the ANPs had chosen advanced practice as a new

direction in their work which gave them more autonomy and increased their levels of accountability and responsibility. This was more pronounced as they worked in isolation at times and the need for supervision and support for themselves was vital to talk through boundary issues. Ana's supervisor challenged whether she was in danger of crossing a professional boundary and whether it was appropriate for her to continue to work with Olivia. Ana reflected and said "*how can I not"* as for her the relationship they had developed and her desire to be present for Olivia was stronger than the emotional conflict she felt. She used the supervision process to prevent herself becoming burnt out and to allow her space to reflect and become more aware of the dynamics of her relationship with Olivia and her own emotions. The strength of the relationship was a powerful determinant for Ana continuing to work with Olivia despite the emotional challenge.

The NMC (2015) stated that nurses need to have clear professional boundaries at all times with the patients in their care and that the nurse must maintain objectivity. All the participants assented to this yet recognised that there can be a deep connection made with patients as part of the human interaction which occurs within the consultation. In an earlier Code of Conduct the NMC (2012) accepted this and acknowledged that "*intimacy"* may occur due to the depth of sharing a patient makes with information which is often private and sensitive. The participants all reflected on how they managed this and the challenges which could occur when you "*cared"* for a patient. Tanya gave the example of witnessing a patient she cared about being knocked down and how she grieved for that patient. She was aware of the connection that she had with this patient who she had cared for over a number of years. He was a homeless man with multiple health and social problems and Tanya had chosen to consistently care for him often seeing him two to three times each

week due to the complexity of his illnesses. They related to each other often through humour and Tanya reflected that she had a "*soft spot*" for him and held hope that his life could improve. She was able to support him within professional boundaries and had a strong relationship; the loss of this relationship through tragic circumstances had an immense emotional impact. Despite this Tanya still wanted to connect with her patients as she supported them often through very difficult circumstances. Building relationships with patients over many years in primary care could challenge the sense of a boundary line which might have been perceived as static and tangible. However, maintaining the objectivity and focus on the patient could ensure that professional boundaries were maintained.

All of the participants reflected fluidity of boundaries, being flexible but with a clear point which would not be overstepped. At times this was positive as it led to an increased depth of relationship with patients where the ANP felt they connected and helped the patient move forward. At other times the blurring of boundaries led to over dependence from the patient and a sense that the ANP had given too much. This could at times have led to burn-out or pulling back from a patient. Working through the conversation of spirituality and boundaries over the period of time of the research enabled significant self-reflection and an opportunity to explore the context of boundaries. The tensions for boundaries were in maintaining the balance between being too distant or too close and being too detached or being over-involved.

8.3.2.4 Burn-out:

Burn-out was included within the domain of context as it directly affected the ability of the ANP to practice holistically and to be available and vulnerable. White (2006) suggested that operationalising spirituality has an emotional cost. Several

participants recognised that when they worked holistically and gave of themselves to patients it could be emotionally costly and if this was not recognised it could lead to burn-out. Burn-out is not uncommon amongst health professionals who often put their heart into caring (Wright 2005). He goes on to describe burn-out as a spiritual crisis which impacts the professional's meaning and purpose and leads to the struggle to work. Wright (2005) suggested that burn-out does not have objective criteria and can affect individuals differently. Burn-out can and does occur for ANPs. It may be partially connected contextually with boundary issues, relationships and providing truly holistic care (White 2006). Giving too much of self or being constantly available and present to patients could become draining and unsustainable. Several participants recognised that burn-out might be prevented by recognising when boundaries were challenged, by being self-aware about one's own limitations in addition to one's own needs and engaging in supervision.

For some of the participants there was clear self-awareness of the impact their work [which included spiritual dimensions of practice] was having on them. In these situations they chose to *"take a step back*" or as allegorically said by Georgia chose not to take on a patients "*emotional vomit*". Georgia appeared to imply with this term that ANPs were vulnerable to taking on other people's emotional distress and that this could impact the practitioner's wellbeing adversely leading to burn-out. However, this could be seen as conflicting with her "hope" as an ANP that patients would feel able to share their inner struggles [their spiritual need] with her. My interpretation of the point she was making is that when the ANP takes on all of the patients' distress this may lead to them becoming overwhelmed and possible burn-out

The tension between connecting with a patient to meet their health care needs and keeping a degree of emotional distance to remain objective was seen as important in maintaining emotional wellbeing. The tension verbalised between when and how much to "*give"* of oneself was dependent on so many factors and as Georgia again eloquently identified "*they are not seeing an automatic machine are they?....It's impossible not to be the person I am".* There is a need to be congruent in the ANP and patient relationship whilst recognising the limits of one's role and the possible impact intense altruistic relationships can have.

Each ANP appeared to have different points when they recognised that "*burn-out"* was on the horizon. Wright (2005) suggested it was unusual for burn-out to occur out of the blue and for many it is a gradual process over years. Some could identify a particular case which affected them deeply for example when Polly was involved in supporting a family in the death of a child and felt she had become too involved or when Georgia's mum had died and she felt emotionally vulnerable. These events led to Polly and Georgia feeling vulnerable and recognising that they needed support. They also accepted that how they felt affected their ability to give fully of themselves to their patients. At these times they utilised coping strategies to prevent burn-out; Polly sought supervision whilst Georgia took time off work and also went on a retreat to give her time to process her grief. They both were aware of their vulnerability and used coping strategies they had to help themselves prevent burn-out although the vulnerability was still present. After breaking down in tears after a consultation when a medical student was sitting in with her Georgia reflected on how demanding her work was and how when personally vulnerable the emotional impact can be significant. What was difficult for Georgia wasn't seeing the patients but the added demand of having a medical student sitting in observing her consultations all day.

She reflected that "*"it's quite interesting because you realise in between in the gaps when you see patients you do try to restore yourself a little bit"* and that having someone in to watch meant she didn't have the moments between seeing patients to help her "*restore*". She recognised she was vulnerable after her mum died and had taken time off work to grieve. She had felt able to return to work despite still recognising some vulnerability and had been managing to see patients. The difficulty for her occurred when the medical student was allocated to observe her consultations which meant she couldn't take a moment to reflect and "*restore"* between patients. This seemingly small addition to her work of allowing someone to observe whilst she was still vulnerable was the difference between her coping and being able to give to her patients and not coping.

For Tanya burn-out was a direct consequence of the ongoing demands of her work and her willingness to be available and vulnerable in her consultations. She was in a very difficult place during our second interview. I was conscious of this and as a fellow ANP I struggled with my desire to support her personally versus my role as a researcher. Tanya was self-aware enough to recognise her struggles and after the research interview we were able to talk. I offered her peer support as a fellow ANP rather than the researcher. She decided that she needed some time off work for recovery and subsequently took sick leave. During the interview she recognised that she needed to "*protect"* herself at the moment within consultations but fortunately she did find that the:

> "*A&V stuff has been helpful to help me think about when it became unhealthy that I was so available and vulnerable it is detrimental to my health myself* [like now] *but I wouldn't like to go to the extreme which I feel like at the moment where I don't want to be available or vulnerable to anybody…I'd like to think I*

can bounce back into some balance really and putting it into perspective of this".

Despite being in a place where she felt she had given so much of herself to patients and been so available and vulnerable that it had led her to burn-out she still wanted to be available and vulnerable to her patients but in a healthier way. A tentative finding from several of the participants' narratives could be that context is important in burn-out. It can occur as an ANP operationalises spirituality in their practice, when they feel the boundaries are being compromised, when an emotional connection occurs which impacts them personally or when they give too much of themselves to their practice.

It seemed that one of the ways to be holistic yet not become burnt-out was to be fully aware of the boundaries within the consultation, to continue to reflect on one's practice and to be self-aware. There was clearly a degree of tension for the ANPs as they reflected on the need for boundaries to be flexible and not static and to be able to work in a way which matched their ethos and values as clinicians. The framework developed for practice (Figure 3) could at first glance appear to advocate leading the ANP to a place where they could burn-out by being available and vulnerable. However, this is not the case; it is about the balance of A&V which includes self-awareness and self-reflection as an ANP to care for others whilst caring for oneself.

The next section was viewed as important as some of the participants reflected that their ethos and values for practice could be described as vocational and even as "*ministry"* which connected to their own spirituality.

8.3.2.5 Vocation and Ministry

Entering nursing is often seen as a vocation. Young and Koopson (2011) suggested nursing is a "spiritual longing" to help heal others with Helming et al (2009) proposing that nurses may enter the profession to carry out "spiritual work". This may be true for some nurses but many would not recognise their work in this way. All of the ANPs reflected on the importance of their work as a vocation with two suggesting this had similarities to those in "*ministry*", even seeing their work in this way. Each participant had chosen to develop their careers to practice in a truly autonomous role where they accepted responsibility and accountability not just for patient care but also for their work in assessment, diagnosis and management. They all spoke about a desire to provide total care for their patients beyond the bounds of traditional nursing practice and for them the role of the ANP provided a vehicle for this aspiration. During the final interview I talked to the participants about their hopes and dreams as an ANP. They talked of providing the "*best possible care"* for their patients, *"to make a difference", "to build relationship"* and also to provide more than just *"physical care".* Being available fully to their patients was one way they were able to do this*.* As the participants talked of their work as vocational, they talked about it in terms of service where at times they made sacrifices emotionally to offer the best care possible. Some also related their vocation overtly to availability for example Georgia: *"I understand availability very well and I recognise that it is a sort of mission, a sort of vocation for me" (Georgia2).*

Choice was important. The ANPs had chosen their roles as a vocation and they made daily choices to be emotionally and physically available to their patients which at times had a significant impact on them. The risk of being "*too available*" was recognised but they often still chose to give of themselves, carefully flexing

professional boundaries but not hiding behind professional distance. They wanted to be truly present because of their personal beliefs surrounding their perceptions of holistic care. O'Brien (2008) asserted that holistic care was the focus of vocation and that if nurses became too concerned with hiding behind the veil of professionalism spiritual care would be diminished. She suggested that there was a choice to provide service to patients which was mediated by "*agape"* love (see section 8.3.3.1) (O'Brien 2008).

Historically nursing practice was considered a "*ministry"* although this has lessened over the centuries (Robinson et al 2003; Stevens Barnum 2011). Primary care appears to be an area where ANPs have the ability to "*minister"* to the patients within their practice population by building relationships which spans many years and includes connections not just to the patient but also their family. Georgia and Ana both overtly related to their work in similar terms. Georgia reflected about society and the changes that have led to a more individualistic society. She stated that; *"People tell me all sorts of things in the privacy of the consultation….I suspect in times by gone people would have gone to their priest"*. She reflected on the changes in her own practice and how more patients would come to her with deeper concerns linked with their feeling of meaning and purpose in life. With this shift she suggested that there was a strong "*overlap between the ministry and nursing but you wouldn't say that to a patient, you wouldn't advertise that to a patient but of course there is because you are listening to a suffering human being and you are offering them help, support and healing….that's what a minister does"*. This reflects O'Brien's (2008) concept of ministry in nursing focused on service to the patient.

One particular extreme conceptualisation of vocation which was not talked about or recognised by any of the other ANPs was shared with me by Georgia possibly

because she saw me as someone who would not take offence or be alarmed. She talked about her work in terms of her being a "*spiritual healer*". Georgia said that she had considered this concept very deeply after years of nursing experience, the loss of her mother and her own existential journey. She said that *"I am comfortable in my own skin as a spiritual healer"*. Her insights and thoughts caused me to reflect on the appropriateness of seeing the ANP role in terms of being a "*spiritual healer*" and connected to "*ministry*" which had also been mentioned by Ana. Patients do come to ANPs and share incredibly deeply, possibly due to the way society is now constructed leading many people to feel isolated, lacking community cohesion and deep connection with others (King 2011). Spirituality has been viewed as an avenue which could help to address some of these issues and ANPs may be in the most appropriate place to do this (White 2006). However, given the difficulties with understanding spirituality, the confusion about the term, how to integrate it into practice and the resistance from some who view spirituality as a religious concept and fear proselytization it would appear unwise to use terms like "*spiritual healer*" in ANP practice. The term "*spiritual healer"* is too nebulous and loaded with connotations and it would not necessarily be of help to patients or ANPs in their exploration of spirituality.

The concept of ANP work as being akin to "*ministry*" may resonate more easily with some ANPs. Ana picked up the theme of ministry in her work "*there is a strong sense of being used almost like in a priest like capacity and I think that layer of society has been lost*". Although other participants did not explore ministry as Georgia and Ana did, many identified with the changes in society and the fact that patients often shared far more than their medical concerns and their role was more than addressing the physical presentation. Within primary care the data shows many

patients attended because they could come and talk about whatever was concerning them and in many ways this was positive. Olivia valued seeing Ana over the years and shared her deepest concerns. In the past she might have gone to see a '*priest*' to talk about her anorexia and subsequently the loss of her mum but she did connect to Ana and felt safe enough to work through many difficult experiences, emotions and the turmoil of her existential struggle. Without asking Olivia only Ana's reflections are able to be taken into account but this seems to be a relationship where Ana "ministered" to Olivia in the true sense of the word transcending the normal bounds of the ANP role and function.

It is possible from the findings that when the ANPs do articulate and reflect contextually on spirituality in practice that this connects with a vocational vision of their role. It also revealed aspects of transcendence where the ANPs wanted to go "beyond" themselves to offer the best possible care to their patients.

8.3.2.6 Transcendence:

Within the literature transcendence often has a prominent place when conceptualising spirituality (Coyle 2002; Pesut et al 2008). Interestingly none of the ANPs specifically mentioned this term, possibly because they did not view spirituality in this way and possibly because it is not a term used in their vocabulary. Context is much more than just the ANP role, the environment worked in and the patients that are seen. It involves holistic approaches to care, vocation and the fundamental ANP and patient relationship. Within these aspects of context transcendence finds its place. Although not overt, transcendence was evident in how the ANPs described some of what occurred during their consultations.

Transcendence is defined as “existence or experience beyond the normal or physical level” (Oxford Dictionary 2014 Para 1). Chrash et al (2011) viewed this in terms of relationship with God or the divine however transcendence can also be viewed as giving of self and connection to others which resonated with the experiences of the ANPs. White (2006) described this as horizontal transcendence as opposed to vertical transcendence to God. All of the participants articulated how they went ‘beyond themselves’ to help patients, build relationship and to offer compassionate approaches to care. A further interpretation of transcendence, as described by Clarke (2013) suggested that nurses can help patients transcend their situations through the ethos of practice which offers strength and optimism to patients as illustrated in the model case.

8.3.2.7 Context Summary:

The context for spirituality to be active within the ANP consultation was not just the physical context or the presentation of the patient. It was evidenced by the ANPs commitment to holistic care and also their vocation (or for some their ministry). It also was premised on the findings related to the ANP and patient relationship and the desire to give of oneself to provide holistic care. To work in this way there was an evident need and ability for the ANPs to be self-aware and to be able to balance the tensions and boundaries that occurred during their consultations. Some acknowledged that there was an emotional cost which could occur leading to burn-out. However, strategies to prevent this were also discussed, for example the use of supervision and maintaining a healthy work and life balance.

It is clearly not just the ANP who experiences the gamut of emotions though this is what was discovered during the interviews. The impact and expression of emotions

affected the patient as well as the ANP and seemed to be fully connected to the spiritual dimension of practice. These are explored in the next sub section.

8.3.3 Emotional Engagement

As with the other sub sections emotional engagement overlaps and interlinks with the other sub sections. It does not just include emotional responses from patients or the ANPs. Neither are emotions just connected with spirituality. What appeared to be evident in the findings was that some strong emotions seemed to connect to spirituality for some of the participants. This sub section is not a comprehensive overview of all aspects of emotional engagement or emotions but an illustration of why this sub section is significant for spirituality.

The ANPs in this study engaged emotionally with their patients across a wide range of emotions for patients and ANPs. Some of the stronger emotions formed an important part of the conceptual understanding of spirituality because they often facilitated or were responses to the ANP and patient relationship and/or the patient's current presentation. If spirituality is universal and innate it follows that emotional engagement is a significant part of the human condition and needs to be considered within the spiritual dimension of practice. The ANPs all reflected on how their work included emotional engagement with patients. They also talked of the personal emotional repercussions of "*giving of themselves"* as an ANP. The data is intricately interlaced with the depth of emotions which are experienced by patients and ANPs alike. Narratives included Polly's experience of supporting a family through the loss of a child not only reflected grief, despair and hopelessness but also Polly's sense of utter helplessness as she experienced similar emotions to the family. Tanya also reflected on these emotions when she witnessed a patient who she cared for deeply

being knocked down in front of her. Hopelessness and despair in their patients appeared to facilitate a consideration of spirituality for the ANP as they explored what led to these emotions and how they could be worked through to a place where grief gave way to hope.

Other participants reflected on holding hope for their patients throughout their interactions when patients presented with mental health problems, chronic illness or terminal diagnoses when hope appeared to be lost by the patients. This was often a long process which included a range of emotions. Jane brought up several examples of patients she was caring for with depression and how she saw her role as being able to assure them that recovery was possible and that their symptoms would improve. Lucy identified how she supported elderly patients dealing with complex medical problems and how she would hold hope that their symptoms could be controlled so their quality of life was better. The ANPs were often agents for change for hope in their practice and carried therapeutic optimism when their patients felt hopeless. Hemingway et al (2013) and Rogers et al (2013) reported that therapeutic optimism is an important factor in the development of hope and meaning for patients. Bland (2002) recognised that the need to maintain a sense of hope for patients and believing that they can recover has been widely discussed in the literature; this is an important spiritual resource when patients feel all hope has gone.

Ana's relationship with Olivia was another helpful example of therapeutic optimism which caused Ana great pain at times although this led to a sense of hope as Olivia began to rebuild her life. Spiritual Care was said to begin with encouraging human contact in a compassionate relationship (NHS Education for Scotland 2009). It would

therefore follow that emotional engagement is necessary in order to develop a compassionate relationship.

A range of life's emotions were evident in the data with three *"emotional"* components standing out in terms of their relationship to spirituality; love, soul-ache and dis-ease. All of these specific components were suggested by Georgia who appeared to have spent many years considering her own spirituality, spirituality in practice and the ANP role. They were also illustrated by other participants in the narratives and experiences they shared with me.

8.3.3.1 Love:

The data revealed many elements of *Agape* love which is seen as being "*unconditional"* based upon compassionate care for another and is fundamental to holistic care (Gordon et al 2011; Clarke 2013). *Agape* is a Greek term (similar to the Hebrew *Chesed* – loving-kindness) denoting practical love, not something health care practitioners should be fearful of or run away from (Robinson et al 2003, Gordon et al 2011 and Clarke 2013). It isn't *Eros* love which is romantic and sexual; *Agape* love is the basis of how we relate human to human (Clarke 2013). Mia and Lucy talked of wanting to care for their patients as they would their family, Tara wanted to "*give patients what they deserve*" and Jane and Tanya talked of "*relationship"* being key in their practice. Within these conversations what was apparent was their desire to offer holistic, compassionate care connecting to their patients with empathy and presence.

Spirituality is entwined with love and relationship (Young & Koopson 2011). Helming (2009) suggested that many ANPs entered into nursing owing to a sense of love and care for others. They felt called to compassion in alleviating human suffering which

she termed "*spiritual work"* (Helming 2009). The ANPs all recognised that a motivation for their work was a desire to care, to support and help their patients altruistically.

Love is a term usually not prominent in the nursing literature but when the data was analysed it could be viewed as the basis of these ANPs practice even when not specifically defined as love. Georgia brought love to the fore when she described that in her work "*you are channel of love….there is a sense that this is a person who has come to me in a time of need and I have to as a spiritual person be there for them"* (Georgia1). She went on to identify that within her practice she wanted to bring in "*a dimension of love and of healing*". This was a powerful expression that what someone needed when they were in distress. They needed another person present who cared, offered compassion, supported them and comforted them. The participants all wanted to be present for their patients, to listen, to care and support them. These can all be seen as aspects of love (in the sense of agape or chesed). Stevens Barnum (2011) recognised that we have one "*medicine"* free to offer all our patients which is "*love".*

8.*3.3.2 Soul Ache and Dis-ease:*

"Soul-Ache" was also an emotional component which appeared profoundly philosophical and connected to spirituality. "*Soul-Ache"* was described by Georgia during the interviews as a way of seeing the internal struggles patients experienced which could be existential and were not seen by focusing on the "*physical".* I was struck by Georgia's use of the term as she suggested that it gave a window into understanding patients and enabled her to consider spirituality in her practice. As she recognised "*soul-ache"* in her patients she felt it helped her to be holistic,

embrace spirituality and give the best possible care. Throughout the interviews she reflected on many things she had experienced in her life and work which had led her to "*coin"* this term. She had developed her career by consistently reflecting on her work and the experiences and the needs of her patients. She was a pioneer of ANP practice having been one of the first in the region and since the death of her mother and other personal trials she had been contemplating spirituality. Before we met she had been on a retreat with a nurse with an interest in spirituality and during this time she had begun to further consider the existential struggle of life. She recognised that in her experience many patients came to see her to talk about their life concerns and to be listened to. She said that many times she had worked with patients in despair who felt hopeless. Their illness or circumstance led them to a place where they wrestled with the questions often associated with existential angst. She then expanded this to offer her philosophical view of spirituality which culminated in linking it with a new way of looking at spirituality which was exceedingly powerful using the term *"soul-ache"* to describe the existential struggle faced in life. She suggested that many people had this and wanted to talk about their life concerns and be listened to. With patients she suggested having this awareness of their potential *"soul ache"* in her mind helped her to provide truly holistic care. She said *"I have coined my own term, soul ache". S*he used this term when presentations were much deeper than the physical and included *"life concerns".* She reflected that she wouldn't say to a patient you have "*soul ache*" but she suggested that it helped her as a practitioner to connect with spirituality and to see the "*whole of the person and almost seeing beyond the physical and psychological…and looking straight into the eyes, that probably sounds a bit weird, but you know you are seeing the soul behind the person"* (Georgia 1). The term "*soul ache"* is an interesting concept which

appears to be similar with the concept spiritual distress used by the North American Nursing Diagnosis Association (NANDA 2001). NANDA (2001) suggested that "spiritual distress" is when something occurs which pervades the whole person impacting them on every level. Kliewer and Saultz (2006) used a term "*dis-ease"* rather than "*spiritual distress"* and connected this to a lack of peace, or comfort. They suggested it relates to emotional, spiritual and relational aspects of a patient's life. This term was also presented by Georgia but described as a milder form of "*soul-ache"* analogous to the relationship between physical discomfort and an actual ache. She appeared at times to use the terms interchangeably however "*dis-ease"* may be viewed as a more generic term whilst "*soul-ache*" could relate specifically to spirituality. Georgia talks about "*dis-ease"* in terms of "*all is well in their world"* and that terming it in this way helps her to recognise that she needs to address more than just the physical presentation. She viewed her role as being aware of these two conditions and although not sharing this with her patients she would attempt to address these within the care she offered to patients.

8.3.3.3 Summary:

It is clear that emotional engagement occurred for all of the participants and their descriptions of this at times were profound. The participants wanted to work with patients in a way which brought connection and which also acknowledged their humanness. Although only three examples are given in this section, they were the ones which struck a deep chord with spirituality. Acknowledging and embracing emotional engagement often appeared to enhance consultations and give the ANPs a sense of meaning and purpose in their work. The way they chose to work

holistically and authentically often helped patients regain hope, meaning and purpose in their own lives. The findings suggest that "*love"* in the agape sense could be a driver for the ANPs actions, and recognising "*soul ache"* or *"dis-ease"* in their patients may be a trigger for thinking about spiritual care.

The next two sub sections focus on A&V and how these concepts connect with spirituality. The section on availability is much shorter because the participants all aligned themselves with this concept easily. The concept of vulnerability created far more dialogue, discussion and controversy.

8.3.4 Availability and Vulnerability:

8.3.4.1 Availability:

The concept of availability resonated easily for the participants as they reflected on their practice. The definitions of availability given by the participants initially aligned to the dictionary definition of availability of being "free, present or ready" (Oxford Dictionary Online accessed 2014). They all expressed that their role was to be "*available"* to see patients on a day to day basis with whatever presentation the patient brought. Their training had equipped them to be comfortable seeing a wide range of presenting conditions and each participant wanted to be present to their patients and to offer holistic care. As the ANPs explored the concept in relationship to spirituality it became more expansive. They reflected more on the depth of relationship that could develop with patients which was mediated by the ANP's presence and willingness to truly listen and empathise with their patients. The desire to practice compassionately and create a safe place for patients to express their concerns without judgement was important for all of the practitioners. The

participants used self-awareness and reflection in deciding when and how available to be with their patients. There was recognition of the need to preserve (flexible) boundaries and that the goal was to empower patients and support them through holistic care, not to create dependency.

The ANPs interviewed saw around 25 patients per day, their case load being similar to that of a GP. They had 10-15 minutes per patient and in that time made an assessment and diagnosis before discussing management with their patients. An important part of their practice was to offer patients time to be heard, resonating with the findings of Treloar (2001), Ellis et al (2004), Holmes (2006), Hubbell et al (2006) and Heming et al (2009). One study showed that ANPs had more "*time"* to listen to patients compared with GPs (Venning et al 2000). However, in this study the ANPs reported similar amounts of time with each patient as their GP colleagues but chose to work in a slightly different way. They all wanted to work holistically bringing together the best of medicine and nursing which has been suggested to be a benefit of the ANP role (Walker et al 2007). Some of the participants recognised that working within a biomedical model could leave patients feeling unheard and uncared for, a view echoed by other clinicians (Royal College of Psychiatry 2015). They consciously ensured that they married their medical skills with their nursing skills to offer their patients something more than traditionally offered by the GP. Part of this seemed to be the way that they were available to their patients physically and emotionally. Jane suggested this could be because ANPs are more emotionally connected to their patients than GPs, she suggested that she was more "*open and friendly"* to her patients than the GPs whom she described as more "*formal".*

Availability was found to have several meanings to the ANPs in terms of physical availability and emotional availability. This could lead to tensions for ANPs which were explored in more depth during the second interview where a number of the participants acknowledged the impact of emotional availability on themselves. Availability for the ANPs included offering patients the opportunity to be welcomed, heard, valued, cared for and attended to within the holistic approach to care and linked directly to how the practitioners experienced spiritualty similar to other reports of ANPs (Treloar 2001; Hubbell et al 2006; Helming et al 2009; Carron 2011). The choice to be available was based for the ANPs on their vocation as an ANP. The ANPs believed that a key aspect of their role was to offer more time to patients and offer the "*full package of care".*

8.3.4.2 Physical Availability:

Physical availability could be seen as the "*bread and butter"* of ANP practice in that they were physically offering patients an appointment to consult with them each day. The ANPs acknowledged that they were available to their patients by their physical presence for example Georgia stated that: *"I am available -because I am available to my patients on a day to day basis, I am available to them at their time of need" (Georgia2).* All of the ANPs had chosen to work in this role desiring to be present to offer their patients something different, but complimentary to the traditional GP appointment. For each participant being physically available was foundational. When we later talked about their aspirations, all the ANPs recognised that patients need "time". However external time pressures were recognised as being in tension with availability and one participant described how even under time pressure she would try to make the patient feel understood and listened to and support them to find "*a*

little bit of hope". Availability was something all participants felt comfortable with and experienced as part of their daily work.

However, ANPs viewed availability as more than just being physically available by offering an appointment. They talked about specific ways of showing patients that they were available to them by the way they welcomed them and offered hospitality in the form of being open, listening, offering care and making them feel valued. Nouwen (1973) suggested that recognising work as service in this way was an important aspect of hospitality and welcome.

These insights broadened out the dimension of availability. A number of the participants throughout the interviews talked more about welcoming patients. They identified that the first moment they made contact with a patient was a chance to begin to build a connection, a relationship of trust where patients felt safe and heard. Welcome appeared to show "*I am available and here for you*" (Jane1). It was a simple but powerful act that had repercussions for the ongoing relationship between the ANP and the patient. In that moment the ANP was able to connect with many of the facets of spirituality including "*shared humanity"* and that ability to connect was an important aspect of availability. The welcome offered by the participants could be viewed as hospitality. The participants used words like *"welcoming", "open", "ready", "accessible" "focused on you"* as they talked about availability. They reflected that they wanted their patients to feel "*comfortable"* and "*safe"* and this was possible through their welcome and choice to be present to their patients. The concept of hospitality was explored by Nouwen (1973: 65) who stated that "hospitality is a fundamental attitude towards our fellow human beings" and that it had the power to help professionals "retain their humanity" in their work. This was important to each of the participants. They were willing to "*be human"* in their relationships with patients.

Ways of maintaining availability after the initial welcome were identified as "*listening", "prescencing"* and "*focusing"* on patients which could be viewed as a physical or emotional availability. All of the ANPs viewed a positive outcome for the patient being that they would feel that they had been heard, that they could trust the ANP and ideally that they could leave with some hope. This might be for a cure, or that their symptoms could be managed, or simply that someone understood how life was for them and would journey with them. Stevens Barnum (2011) suggested that physically being with patients and trying to understand what was happening for them and how it was affecting them was crucial to building relationship and integrating spirituality into care. Sherwood (2000) suggested that prescencing is an integral aspect of operationalising spirituality. Simply being with patients can help them to explore the many unanswerable questions about their illness and life. She continued by describing prescencing as "one of the highest forms of human interaction". The ANPs recognised that by choosing to be present, open, ready and focused on the person in front of them they were able to offer a level of availability that helped their patients and this was connected to spirituality for some though others felt this was just "good nursing care". Ana illustrated availability well as she stated that for "*that moment in time"* she was there fully for her patients and wanted them to know she was available to them totally to hear their story and value what they brought.

8.3.4.3 Emotional Availability:

Being available is important in spirituality and helps to build relationship (Helming et al 2009; Young & Koopson 2011). Being available can facilitate trust where patients feel able to share at a deeper level. Most ANPs recognised the need for patients to trust them to hold whatever they brought to the consultation with care and compassion. The ANPs often made a choice in how and when they connected to the

patient through being emotional available; they recognised that this choice impacted on how much patients shared with them. For example, when they were exhausted, over-stretched or dealing with significant personal issues, participants recognised they were less emotionally available to their patients and didn't always connect with a patient beyond addressing their presenting problem. In these circumstances patients may not have felt able to share their deeper concerns. The participants clearly recognised this and showed their maturity in how and when they became emotionally available. They recognised that being emotionally available could have significant impact on them personally and professionally. Jane felt that it was a "*privilege"* when patients shared of themselves with her whilst Georgia recognised that taking on others "*emotional* vomit" could adversely affect the ANP's emotional health. The ability to maintain self-awareness and maintain boundaries, especially when they felt vulnerable, appeared to enable practitioners to continue to be emotionally available in the majority of consultations. Sometimes supervision helped with this process.

The avenues to emotional availability appeared to be connecting with the patient, being compassionate, empathic and offering hope. Being compassionate to their patients was consistent throughout the research with the ANPs regularly holding the best interests of their patients to the fore and working to connect on a level where the patient felt safe enough to be honest and open about their presentation and concerns. The avenues to emotional availability support hope, meaning and purpose for patients and for ANPs in their vocation.

Several of the ANPs mentioned a special connection when patients shared very personal, significant experiences. The practitioners honoured and valued how much courage it took for patients to share at that level. ANPs could be affected deeply by

the consultation and availability could be a mediator for a spiritual meaning to be found within the consultation.

8.3.4.4 Vocational availability:

Entering nursing may be seen as a vocation or, as Young and Koopson (2011) suggested, a "spiritual longing" to help heal others. All of the ANPs reflected on the importance of availability to their sense of vocation. They each chose to develop their careers to practice in a truly autonomous role where they accepted responsibility and accountability not just for patient care but also for their work in assessment, diagnosis and management. They all spoke about a desire to provide total care for their patients beyond the bounds of traditional nursing practice and for them the role of the ANP provided a vehicle for this aspiration. During the final interview I talked to the participants about their hopes and dreams as an ANP, They talked of providing the "*best possible care"* for their patients, *"to make a difference", "to build relationship"* and also to provide more than just *"physical care".* In order to do this, they chose to be available fully to their patients. They viewed their work as vocational and as a service where at times they made sacrifices emotionally to offer the best care possible. Some also related their vocation overtly to availability for example Georgia: *"I understand availability very well and I recognise that it is a sort of mission, a sort of vocation for me" (Georgia2).*

Choice was important. The ANPs had chosen their roles as a vocation and they made daily choices to be emotionally and physically available to their patients which at times had a significant impact on them. The risk of being "*too available*" was recognised but they often still chose to give of themselves, carefully flexing professional boundaries but not hiding behind professional "distance". They wanted

to truly be present because of their personal beliefs surrounding their perceptions of holistic care. O'Brien (2008) asserted that holistic care was the focus of vocation and that if nurses became too concerned with hiding behind the veil of professionalism that spiritual care would be diminished. She suggested that there is a choice to provide service to patients which is mediated by agape love (O'Brien 2008).

Recognition of choice seemed to provide some level of safety and enabled the ANP to "*pull back*" if they felt it was necessary. The recognition that it was a conscious choice helped practitioners to form an optimal connection with the patient. A number of the participants reflected on times when they felt they had been "*too involved"* with a patient and needed to "*pull back",* others reflected on when they had personal stressors such as recent loss. The ANPs acknowledged that, though their desire was to be there for the patient, sometimes they also chose to protect themselves by being less emotionally available because being emotionally available meant as Tara said *"giving something away"* and could take its toll. I took this to mean that at times the participants needed to maintain distance in order to be emotionally safe themselves.

In summary it was recognised that as an ANP there was a desire to help patients in any way possible reflected by Jane who said she would "*explore any avenue possible that would help*" but it was important for this not to spill over into their personal life. It appeared that moveable "*boundaries"* and at times the choice to be less physically and emotionally available could be intuitive and protective. Availability might depend on the signs being given by patients and the recognition of what Jane called "f*lowing backwards and forwards"* within the consultation. There doesn't seem to be a level of how emotionally available the ANPs should be but it was clear that all

the ANPs had seen the positive and negative impact of emotional availability for patients and themselves.

Availability resonated fully for the participants but necessitated the self-awareness and reflectiveness of the ANP to prevent "*burn-out"* in the practitioners and "*dependency"* in their patients. In general availability was viewed positively and connected to the ANPs vocation to their work and desire to provide truly holistic care. Knowing oneself and being able to connect to one's own spirituality appeared to have a connection to how available the ANP was willing to be. King (2011) asserted that self-knowledge was needed in order to truly care compassionately. She suggested that, as people explored who they were and found themselves, they could abandon themselves in the care of others. Each of the participants appeared to have gone through this process of "finding" themselves as they sought to understand their own spirituality and how they could operationalise spirituality in practice. This process led them to explore some of their own vulnerabilities.

8.3.5 Vulnerability

Vulnerability was something that participants found more contentious. Initially it was perceived as "*weakness"* and "*being hurt"*. As practitioners their experience of vulnerability was associated with risk, "*losing control"* and not being "*safe".* In these days of "risk assessment" and "risk management" that was not a comfortable "place" to be. The participants recognised that patients became vulnerable as soon as they shared with the ANP and that the ANP had to "*hold"* that vulnerability safely with "*the greatest respect and confidence*". Though the aspects above are important this section mainly draws upon aspects of vulnerability as connected to spirituality in ANP practice.

Vulnerability was described in several ways including physical, patient, professional and emotional vulnerability. The participants at times felt physically vulnerable and at times had been verbally or physically threatened in their professional context. They saw that patients could be vulnerable because they either chose to share in depth about themselves or were at risk because they were in danger of being exploited. In order to navigate through these vulnerabilities and risks the ANPs recognised that self-awareness and recognition of their limitations as practitioners was needed.

8.3.5.1 Physical Vulnerability:

Physical vulnerability was one of the first aspects of vulnerability to be explored. Some profound illustrations were given for example when Mia was attacked by a patient with a knife. The impact of physical vulnerability could leave profound anxiety around vulnerability but interestingly for Mia this did not prevent her from wanting to still connect deeply with her patients. Others identified events where they felt they had been vulnerable but they still also wanted to continue to give to their patients.

The connection to physical vulnerability was expected but despite being attacked by a patient with a knife Mia still wanted to be fully present to her patients. She told me it was her "*role in life and medicine".* This altruistic view was something that came through the interviews in general. Choosing to be present for their patients involved an element of risk-taking. However, this didn't mean they were blasé about risk as boundaries and the environment they practised in enabled risk to be managed.

The view of vulnerability in terms of physical threat was only briefly discussed by the participants. They all seemed to take the concept further when relating it to spirituality as the interviews progressed. However, acknowledgement of patient vulnerability occurred prior to the shift of focus to vulnerability and spirituality.

8.3.5.2 Patient Vulnerability:

There was clear understanding that patients were vulnerable because they placed their trust in the ANPs and shared often very private information. Sometimes the ANP had to "hold" this information as patients didn't always recognise that they were vulnerable through their sharing. The participants recognised that their role was to be an advocate for those patients to ensure their best interests were paramount. Making the consultation a safe place was an important consideration for many and the acknowledgement of patients' vulnerability and the need to create a safe environment where they were "*held"* and understood was clear. Some did relate this to their concept of spirituality (for example patients with "soul-ache" and /or "dis-ease"). The gift of time, listening and being present in addition to creating a safe place enabled a deeper connection to occur but also led to the ANP showing a degree of professional vulnerability.

8.3.5.3 Professional Vulnerability:

Professional vulnerability was an important factor for the ANPs which included how they managed boundaries, how they recognised their own limitations and recognised they did not have all the answers and knowing that being authentic meant sometimes sharing uncertainty with patients and being open to challenge. They also recognised the need to learn and develop their capacity to manage vulnerability through their work and relationships. The participants revealed their own humanity in how they talked about patients that had affected them deeply and how they managed the complexities of multiple or difficult presentations, pathologies and end of life issues. They also spoke of the danger of becoming too involved with patients.

Georgia explored vulnerability in the context of the ANP not having all the answers and need to acknowledge this even when patients were coming with a perceived need, hoping for answers. At times the ANP felt unable to give fully because of their own vulnerabilities which might be related to life issues or simply the fact that they were too busy. Georgia questioned, at these times, whether she was "a*ctually centred enough and using the power of grace of wisdom enough to be giving them what they need to hear at this time"*. She recognised mutual vulnerability as an ANP balancing her needs with the patients'. During the interviews I experienced challenge and enlightenment about availability and vulnerability as many of the interviewees were themselves so perceptive, so open and so vulnerable. Several participants consistently shared their humanness, struggles and desire to address their patients' needs.

8.3.5.4Self-Awareness:

According to Tacey (2009) self-awareness provides the necessary insights needed to maintain healthy boundaries and emotional health. All of the participants were able to be reflexive to varying levels and were clear that being self-aware professionally and personally was necessary to maintain patient safety and professional integrity. Reflection appeared to assist the process of self-awareness and to develop understanding and meaning in practice as previously found by Sherwood (2000).

A number of considerations were shared around vulnerability and its expression. These included when to share verbally or emotionally, what was the benefit to the patient of sharing, could it lead to patient dependence, was it professional and what impact would it have on the practitioner. Sometimes it appeared appropriate to

share the ANP's personal experience with a particular patient but the ANP needed to feel comfortable in doing this. An example of this was when Ana shared about her niece having the same condition as a patient's daughter. Williams (2001) suggested sharing our own life experiences with patients might be profoundly helpful for some patients. However, the choice of what to share needed to be made wisely with the patient's best interests at heart. Jane concluded that vulnerability was having "*openness and willingness to change and to share* [with patients]". She linked this to spirituality and human connection. Ballat and Campling (2011) asserted that human connection demanded self-awareness and took us to the heart of relationships where things can be messy, difficult and painful. Sharing of self could leave the ANP feeling vulnerable and concerned about whether they had crossed a boundary, it could also be emotionally difficult and painful as it was for Ana when she "*gave of herself*" emotionally to Olivia. There was a tension between how much could be shared and how far professional boundaries could be flexed without being broken. For a number of the ANPs this appeared to be an intuitive decision. There were patients that they felt they connected with and felt comfortable enough to share with whilst with others they immediately pulled back. For example, Tara shared about a patient who was asking her about her family life and she felt uncomfortable and changed the subject back to the presenting problem and Jane was invited to the pub by her patient and had to clarify her role was a professional role and this wasn't appropriate. These participants clearly recognised there were boundaries they would not want to cross sometimes because of the professional code of conduct and other times because they felt vulnerable themselves. Ana said "*well you could get more involved than is appropriate, you could lay yourself open to unnecessary hurt. You could raise the patients' expectations too much as to what you can do. I think there's*

a real risk". There was a recognition that sharing too much might lead to becoming too involved with the patient which could lead to hurt on both sides. Being aware of these tensions but also continuing to practice authentically and at times being actively vulnerable was associated with emotional vulnerability.

Sherwood (2000) suggested that relationships between nurses and patients were reciprocal and that this was significant in patient healing and wellbeing. In order to fully connect with another there needed to be a willingness to connect with *"shared humanity"* which did at times take courage and also a willingness to be emotionally vulnerable.

8.3.5.5 Emotional Vulnerability:

Brown (2010) suggested that emotional vulnerability was about being willing to "*be seen*" authentically, to accept that it could be risky and uncertain but that it was powerful and had significant impact on relationships. All of the ANPs appeared willing to be emotionally vulnerable and were able to reflect on when they had shared something of themselves with their patients. White (2006) recognised that spirituality had an emotional cost and if offering truly holistic care the practitioner must be prepared to realise this could be positive or negative. There was a sense from the findings that giving of oneself in the relationship with the patient increased connection, trust and safety. The patient could see the ANP as human and authentic and not just *"an automatic machine"* or *"automaton".* There was an awareness for Jane that sharing of oneself as a person may be what "*makes them* [patients] *come back"* and Georgia suggested that emotional vulnerability is *"a measure of the maturity of the role….I think being open, vulnerable has the potential to transform practice and take it beyond the consultation to real connection with patients".* Young

and Koopson (2011) saw a deeply spiritual dimension when the practitioner was willing to share something of their own life experience. Georgia proposed that being open and using vulnerability consciously could help ANPs *"reconnect with the core values of nursing and allow other aspects of our humanity to influence and guide us"*. Nouwen (1972) stated that it was impossible to help another person without becoming involved and willing to truly understand their situation. It could be risky, it could be painful but it also revealed the depth of human connection and spirituality which could help patients to find hope.

Despite emotional vulnerability being a way of relating to a patient as human and authentic there was clear evidence that this took energy from the ANP (see section on boundaries and burn-out). The desire to be real and human in consultations could lead to excessive personal vulnerability, stress and burn-out. Several participants recognised that at the end of a day of consulting they felt "*emotionally tired"*. The examples of Tanya with burn-out and Ana with Olivia demonstrate the emotional price that ANPs sometimes paid because of their willingness to be authentically present and vulnerable in their relationships with patients

Returning to the model case presented at the commencement of this chapter, Olivia's story reveals the huge impact of emotional vulnerability for Ana. She knew that she "*had to be very careful….to have a level of openness and involvement with her without her having known how personal it was for me…it was just too close…..am I going to fall apart completely?" (Ana1).* She was able to truly connect with Olivia and support her through not just her eating disorder but the loss of her mum. Ana knew she cared deeply for Olivia and had an attachment to her so she

continued to seek supervision to support her through the process to maintain healthy boundaries. The emotional impact for Ana was profound and, although it had happened many years ago, Ana still felt deep emotion when talking about it with me. Again Ana, on reflection, would not want to have not cared in the way that she did or not to have worked with Olivia yet she continued to reflect on the impact it had. Olivia was also in a very vulnerable position addressing an eating disorder then losing her mum. It appears that Ana was a consistent supporter in her life, someone she could share her inner struggles with and be heard. Their relationship appears to have offered hope for Olivia and eventually that hope was also present for Ana when Olivia went to university and seemed to be doing well. At times Ana wondered how she could keep her emotions in check when seeing Olivia and how she could continue to work with her when she felt such strong feelings which seem to include love for her. She empathised deeply and also put herself metaphorically in the position of a mum for Olivia. Despite maintaining professional boundaries she wanted Olivia to know she was safe in this relationship, that Ana would be there for her and would walk the path with her through difficult terrain. This left Ana at times distressed and emotionally exhausted, vulnerable but determined to continue the care she was giving. It is a story of sacrifice by Ana who gave of herself and became very vulnerable by choice because she believed Olivia had a future and could find hope again after the death. It is a story of human connection and deep spirituality which encompasses all of the elements of the conceptual understanding and which led to hope, meaning and purpose for the ANP as well as for Olivia amidst some very difficult emotions throughout the journey.

Both of Tanya and Ana's examples are powerful but what continues to strike me is the human connection and willingness of the ANP to be present over a number of

years to patients in turmoil and pain. The ANPs not only gave of themselves but invested in their patients and chose to be fully present and fully engaged showing empathy and care. Neither would have done anything different despite the emotional impact. The strength of vulnerability here speaks powerfully of the willingness to be with patients in the depth of pain and uncertainty and to journey with people without knowing the outcome. White (2006) suggested that being willing to share uncertainty in relationship with patients could push professional boundaries into the place where we were no longer “practitioner experts” but fellow human beings. The journeys Ana and Tanya shared with me were a good illustration of this and showed how owning our vulnerability as well as recognising it in our patients could positively impact consultations which was consistent with the findings of Girling (2009). Many of the relationships the ANPs talked about revealed a spiritual depth mediated through their emotional vulnerability. Vulnerability has been described as an aspect of spiritual prescencing which affected the building of trust with patients (Sherwood 2000). This was evident in the stories shared. As the ANPs began to accept their own vulnerability they appeared more likely to recognise and respect this in others confirming the findings of Young and Koopson (2011) that this could lead to stronger relationships with patients

Summing up vulnerability for the ANPs in the findings, Georgia eloquently said:

> *“I am vulnerable because I am a human being…I am vulnerable because I have to manage risk and make decisions minute by minute…I am vulnerable because I have to make the right diagnosis, because I need to choose the right treatment, to prescribe the right drug, I am vulnerable because if I screw up I can be sued and I am vulnerable because I am a nurse in a traditionally medical domain. I am vulnerable because I stood on the parapet to be a*

spokesperson for my professional discipline…I am vulnerable because I am trying to say that what I do is as good as medicine so I am vulnerable on so many levels. My main vulnerability, the one that makes me anxious, is that I am doing the right thing for the right patient at the right time" (Georgia1).

Brown (2010) wrote about vulnerability suggesting it was the birthplace of joy, love and gratitude and that being vulnerable enabled us to truly connect with another which is what we as humans are hardwired to do. Her extensive research on vulnerability viewed it not as a weakness but as a courageous act. The ANPs in my research continually showed courage in their turning up each day, being willing to be present and to give of themselves to their patients. Brown (2010) also suggested vulnerability without boundaries was not vulnerability. Vulnerability needs boundaries and the ANPs worked with this daily when considering how much to give of themselves, how much they should share, how to connect deeply without losing themselves or burning out. Having boundaries connected with Rolheiser's (2004) view of not becoming a "*doormat"* by becoming so vulnerable and going to the extreme of letting every aspect of our lives hang out. He suggested true vulnerability was held within the strength of being able to be present to another without the false props we often use to bolster our egos. Our need to be distant from our patient or not to share could be hidden behind a cloak of professional standards. The participants in this study confirmed the findings of Herrick & Mann (1998) that being able to maintain boundaries but be fully present could lead to extraordinary freedom and connection with others and engender hope in them.

8.3.6 Availability and Vulnerability as a Lens for Spirituality:

Throughout the interviews it was evident that availability and vulnerability enabled the ANPs to understand and articulate aspects of their practice which could be

viewed as having a spiritual dimension. Viewing spirituality through the lens of A&V provided an accessible path to addressing spirituality in primary care. As the ANPs reflected on and articulated the meaning of A&V it appeared to bring together many aspects of their practice which gave meaning and purpose to their work. Links to the concept of spirituality were found throughout the interpretations ANPs made for themselves about A&V. Being available was the easier concept for the ANPs to embrace and accept in practice with minimal change to the emphasis of the NC. Vulnerability was more complex to embrace and fully accept initially as it was associated with *"weakness"* or "*being hurt".* When viewed through the dimension of vulnerability as presented by the NC it appeared to resonate and make more sense for application to practice. All of the ANPs in the study felt A&V could be a useful lens for understanding and operationalising spirituality. Six felt this was definitely a useful lens with the other two agreeing it could be with some changes to the emphasis which have been added to the framework (Figure 3). Availability is fundamental to ANP practice but it demands authenticity and vulnerability which at times can be painful. A&V are primarily concerned with being human and being willing to connect with others authentically; all of the practitioners assented to this and many viewed this as what led to a spiritual dimension occurring in practice.

8.4 Framework for Operationalising Spirituality into ANP Practice through the Concepts of "Availability and Vulnerability":

Through analysis of the data and the discussion of the findings I believe that the reframing of the aspects of A&V can offer a realistic and helpful framework to guide ANPs who wish to understand where spirituality might be evident in their practice and to find ways of managing and developing their skills whilst also maintaining their

resilience and protecting themselves from the harm that they face in crossing boundaries and becoming burned out. Figure 3 identifies this framework and will be explained throughout this section.

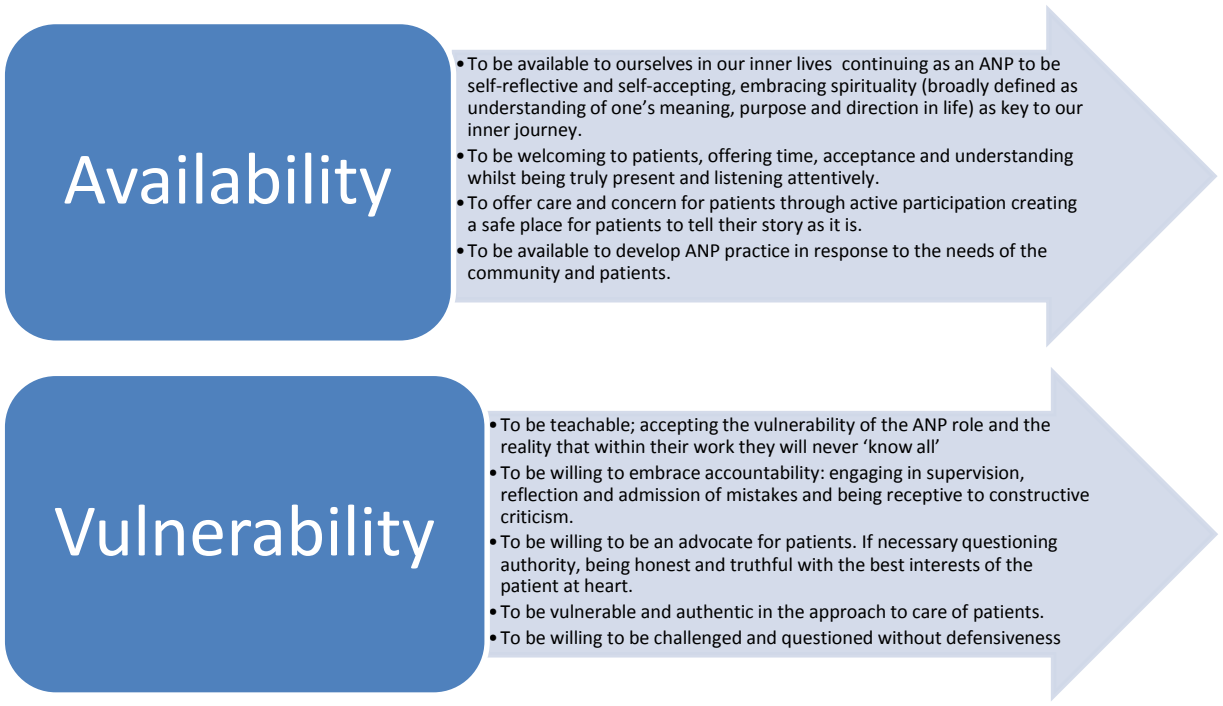

Figure 3: Availability and Vulnerability: A Framework for Spirituality:

8.4.1 Availability Re-framed:

The four aspects of availability defined by the NC could be adapted for ANPs who consider spirituality to be important in their practice. Extrapolating key principles could potentially enhance the consultation and ensure that spirituality is integrated into day to day care. The NC's concept of availability is clearly rooted in Christian understanding (Appendix 2).

In order to be useful within an ANP consultation I propose an adaptation to make the NC conceptualisation of availability accessible for all ANPs irrespective of faith belief. There is a precedent for this in the example of how mindfulness has been adapted

from Buddhism to be integrated into healthcare as a recognised treatment option (Williams & Penman 2011). I believe that this could also be done with A&V and in response to the findings of this study attempt to do so as follows.

8.4.1.1 Availability to "Ourselves":

It appears that to practice availability one must be aware of one's inner life and the places from where values and beliefs emanate. This is important whether or not one has a faith. It was evident that the participants in this study viewed their work as vocational and consistently gave of themselves sometimes to the point of burn-out. Being conscious of one's inner journey personally and professionally enabled these ANPs to be able to practice holistically whilst being aware of their own needs. Self-reflection, self-acceptance, self-care and supervision are vital for healthy relationships needed in the helping professions and were evident in the participant interviews. Self-acceptance is important before we can truly accept others as they are (Vanier 2004a). Being comfortable with self, being at home in one's skin is a foundational starting point for authentically working with patients as an ANP. Vanier (2004a: 23) states that "People reach maturity as they find the freedom to be themselves, and to claim, accept and love their own personal story, with all its brokenness and beauty". By consistently reflecting on one's journey the authentic self becomes an agent for increased compassion and honest relationships through true self-acceptance.

The first aspect of availability has been reframed as:

"First to be available to ourselves in our inner lives continuing as an ANP to be self-reflective and self-accepting, embracing spirituality (broadly defined as

understanding of one's meaning, purpose and direction in life) as key to our inner journey."

8.4.1.2 Availability to Others through Welcome:

The ANPs studied viewed the consultation as a place where patients could be listened to and understood by their welcome, acceptance and prescencing. ANPs in Primary Care on average see 25-30 patients per day and time with each patient is necessarily limited. The way the consultation begins and how the patient is welcomed often impacts the whole consultation. By introducing themselves to their patients and offering patients time to talk about their presentation and anxieties is akin to offering hospitality and welcome. Hospitality is defined as a friendly and open reception (Thompson 1995). By consciously welcoming each patient and by being open and willing to be available to our patients and to truly listen, the ground is laid for a mutual exchange based on equality and acceptance. There is no need to justify attendance when one feels welcomed, heard and accepted. Key to welcoming a patient is to truly listen. Nouwen (1996) links listening to welcoming and acceptance. He suggests that true listening isn't about just letting someone speak but paying full attention to what they are saying, what they are not saying and who they are. Expanding upon this he says "the beauty of listening is that those who are listened to start feeling accepted, start taking their words more seriously and discovering their true selves. Listening is a form of spiritual hospitality…" (Nouwen 1996: 85).

The second aspect of availability has been reframed as:

"Being welcoming to patients; offering time, acceptance and understanding whilst being truly present and listening attentively."

8.4.1.3 Availability to Others through Caring:

Care and concern were the primary focus of the ANPs work and appeared to be a core ethos. To care for another is to commit to give of yourself, in doing so one can welcome a patient's story, creating a safe place where patients, free to be themselves, can tell it like it is. According to Nouwen this is the highest form of hospitality (Nouwen 1973). To be able to do this ANP need to have an understanding of their own inner journey and also their areas of experience and expertise. Many ANPs when starting out seeing patients rigidly hold to a medical model of history taking which includes specific questions and approaches. As an ANP matures they are often aware of how the consultation becomes more meaningful for patients when they feel listened to (Balint 1964). To do this, though, the ANP needs to open themselves up to letting the patient lead the consultation and to give time to hear the patient's story.

The third aspect of availability has been reframed as:

"To offer care and concern for patients through active participation creating a safe place for patients to tell their story as it is."

8.4.1.4 To be Available in Response to the Needs of Patients and the Community:

For many ANPs their work is one of vocation, to respond to the needs of those in their care. The participants interviewed had moved into advanced practice with a desire to enhance their skills to care for patients in a different way embracing nursing and medicine. Some saw their work in terms of a "*ministry*" and others as a vocation. Over time many of the ANPs worked in specialist areas of practice (e.g. depression clinics, women's health clinics, minor surgery, teenager clinics) when they saw the

needs of patients beyond what is normally offered in the surgery. The ANPs responded daily to the needs of their patients and were aware of ongoing needs within the community they practiced in. They were willing to develop, to be flexible and responsive.

The final reframing of availability for the ANP has become:

“To be available to develop ANP practice in response to the needs of the community and patients.”

8.4.1.5 Availability Summary:

The findings of this study suggest that availability is a powerful mediator for spirituality in ANP practice. It recognises the synergistic relationship that exists between the practitioner and the patient and is a powerful vehicle for building authentic relationships. It necessitates ANPs working in a way which consistently reflects not just on patient need but also their own needs and limitations. It involves making a choice to be welcoming, to listen and to presence attentively with each patient creating a place of safety where they feel accepted and valued as a fellow human. It can help ANPs to understand spirituality and operationalise it within a primary care consultation. Figure 4 summarises the reframing of availability.

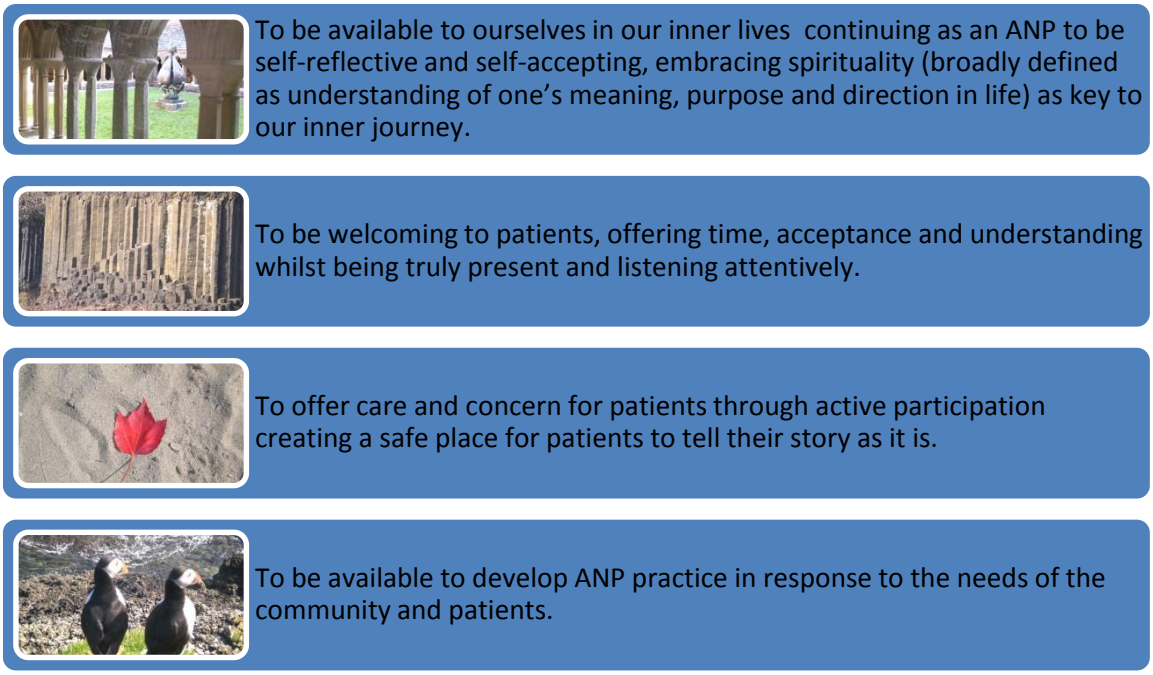

Figure 4: Availability:

8.4.2 Vulnerability Re-framed:

For vulnerability to be utilised as a lens for spirituality it needed further work and a change of emphasis from the participants' initial views. This mainly included a moving away from *"weakness*" and "*defencelessness*" towards some of the ideas of the NC. The aspects which resonated for the participants included the idea of embracing vulnerability by being teachable. As the ANPs talked about their work they talked about the wide variety of presentations which constantly challenged them to ensure they were kept up to date about clinical issues which is expected when working at such an advanced level. More significant for me were the reflections made by several participants on their learning from their patients and how they saw their work as a privilege. The ANPs appeared willing to learn from their relationships, their interactions and the responses of the patient to them. The aspects of vulnerability defined by the NC are reflected in their Rule (Appendix 2).

8.4.2.1 Embracing Vulnerability by being Teachable:

As discussed being teachable can translate for the ANP as being willing to learn, to adapt and to gain new knowledge all of which are important for the ANP especially in Primary Care. As the ANP works in a generic way the knowledge needed to manage patients presenting to the surgery is very wide in its scope. No ANP will ever have arrived in terms of knowing all that could ever be needed. What all ANPs use in practice is their knowledge, their experience, their skill and discernment. They use their consultation skills to ascertain why the patient has presented and look for signs and symptoms, red flags and worrying features of illness in terms of detecting illness and presentations which may point to serious illness, impact or death. They make decisions with their patients in light of the evidence presented and signs detected to formulate a diagnosis and a plan even if the diagnosis is not known. They then use the formulation to decide on a way forward which may include further tests, investigations or referral to another for diagnosis. On most occasions time and support are given to patients and follow up appointments allow the ANP and patient more time to develop trust, to see if the illness or presentation improves or to work through the formulation to a place where either the patient is restored to health or is enabled to live with the illness, manage their symptoms and sometimes accept that death will be the outcome. Within many complex and challenging situations the ANP will not have the necessary knowledge of all conditions and life experiences. They may seek another clinician with more experience for guidance or a specialist in secondary care. Often the ANP will take time to study a condition, sometimes through more education and training sometimes through supervision and reflection. In order to do this the ANP must be willing to be teachable, to accept their on-going need for education, training, supervision and reflection in order to provide a service

where patients feel safe, supported and able to know they will be listened to and treated with understanding and respect.

The first aspect of vulnerability for the ANP has been reframed as:

“To be teachable; accepting the vulnerability of the ANP role and the reality that within their work they will never ‘know all’”.

8.4.2.2 Willingness to be Accountable to Others:

Accountability is part of the nurse’s code of conduct and is a way of ensuring practice is safe and transparent (NMC 2015). Patients need to feel safe and to trust their ANP. In light of the reality of ANPs not knowing everything, patients can actually value the truth. Statements of honesty can actually improve the ANP and patient relationship: “I’m not sure what is going on here but let’s try this and see how things go”, “I’m going to ask a colleague to see you as I don’t have much experience in this condition”, “What do you think is going on here?” or “I’m going to arrange some investigations and let’s see what they show”. These sorts of admissions actually make the ANP accountable to the patient and often engender healthy relationships. Additionally admitting mistakes as an ANP helps us to recognise our own limitations and recognise the need for further training, education and the support of other colleagues. Miller (2014: 1) quotes Thomas Merton (1983) who reminds us that “the only mistake is one you don’t learn from….”

The second aspect of vulnerability has been reframed as:

“To be willing to embrace accountability; engaging in supervision, reflection and admission of mistakes and being receptive to constructive criticism. To be willing to share uncertainty with patients and act in a way which is open, honest and transparent working within their limitations.”

8.4.2.3 Being willing to be Vulnerable by Advocating for Patients:

Embracing the heretical imperative as part of the vulnerability vow created some confusion for the ANPs who viewed it as complicated. This was not specifically unpacked in relation to the heretical imperative but it did come to the fore in terms of the ANPs being willing to speak up for those who may not have a voice (to be an advocate), to speak the truth even if it meant challenging their colleagues or the systems they worked within. Unsurprisingly the ANPs could relate to the vulnerability which comes from being an advocate. They articulated strongly a desire to meet their patients’ needs and often, through advocacy, patients could see that they were valued and although not explicit in the interviews it appeared this could give patients a stronger sense of meaning. In order to advocate not only do ANPs needs to consider challenging colleagues but the wider systems including the political arena and the culture of individualism.

The third aspect of vulnerability has been reframed as:

“Being willing to be an advocate for patients. If necessary questioning authority, being honest and truthful with the best interests of the patient at heart”.

8.4.2.4 Vulnerability and Authenticity:

An aspect of vulnerability includes in being willing to receive constructive criticism to develop personally and professionally which necessitates maturity and resilience so as not to lose confidence. The goal for the ANP with this aspect of vulnerability is to put building relationship with the patient before reputation. Though professionally of course reputation is of importance the goal here is not to just put value as a professional above the relationship with the patient. Relationship based upon care for patients is another mainstay of ANP practice. The translations for the final two reframed aspects of vulnerability are:

"To be vulnerable and authentic in the approach to care of patients"

And

"To be willing to be challenged and questioned without defensiveness."

8.4.2.5 Vulnerability Summary:

Some aspects of vulnerability at first glance will be viewed as expected aspects of ANP practice and may not be seen as a lens for operationalising spirituality. However deeper consideration of the connection to spirituality is seen through the practitioner's choice to be authentic in their relationship with their patients based partly on the premise of common humanity but also partly on the way the ANP chooses to practice. It reminds ANPs that they are vulnerable because they have chosen to practice in a domain historically run by doctors where they are tasked with seeing everything and anything that comes through their door. It reminds them that they have limitations which they can vocalise to their patients. They need to recognise that they need to be willing to be teachable and accountable for their own

practice and by accepting they are fallible and human they can then connect with their patients who are fallible and human. Figure 5 summarises the reframing of vulnerability.

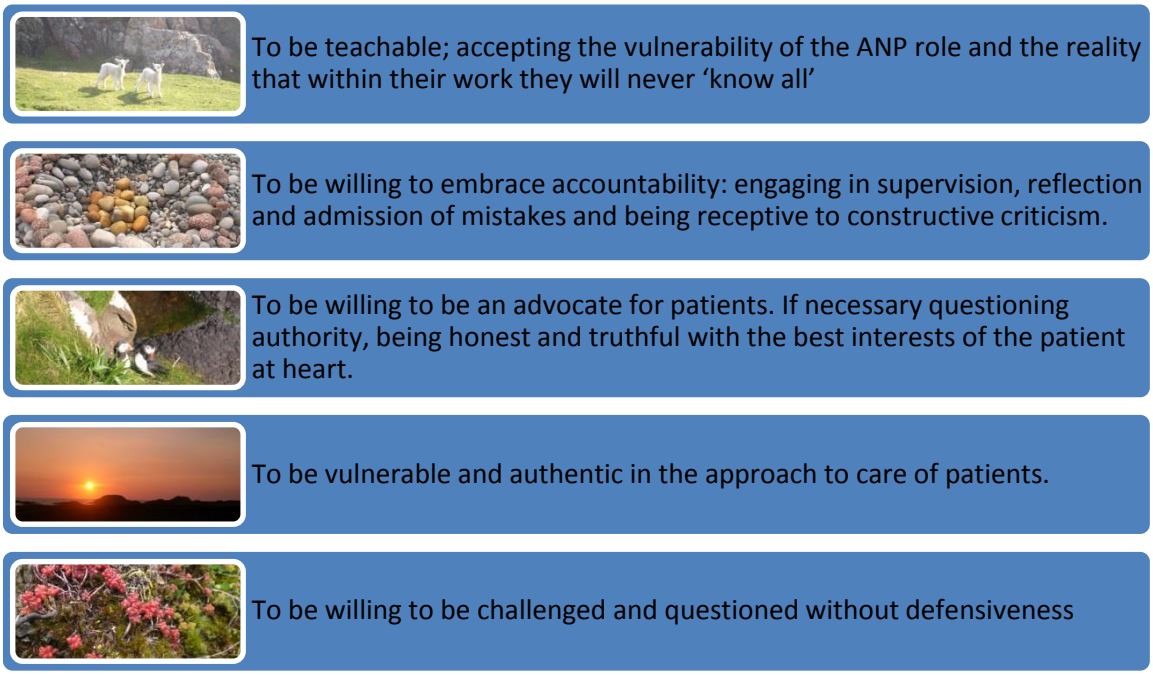

Figure 5: Vulnerability:

8.4.3 Summary:

Reframing A&V as a framework for ANP practice can be seen as a trellis for embracing spirituality within the consultation. It could have a major impact on the ANP and the patient if these concepts were integrated into holistic care. They would support practice in a way which is freeing and adaptable, recognising the patients' and the ANPs' spirituality. Reframing these concepts in professional terms may give ANPs in the UK a framework in which to operationalise spirituality in their practice.

"Spirituality is innately human and is influenced by context and emotional engagement. It can be operationalised through availability and vulnerability"

Melanie Rogers

Chapter 9 Conclusion, Contribution to Knowledge and Recommendations for Future Research

This final chapter concludes this study with a summary of the originality of this study, the contribution to knowledge and the new theories which have been developed. It recognises that there are innate limitations to the findings. However, the hermeneutic methodology chosen (and followed meticulously) allows for a deeper understanding of the concept of spirituality to be offered. The ANP participants were able to explore spirituality in a way which they had not done prior to the study. Utilising a hermeneutic phenomenological methodology has enabled a greater understanding of spirituality to occur. There is no definitive answer to what spirituality is or how to operationalise it in practice. Our understandings change and respond to the experiences we have and are dynamic. However, this study has attempted to explore the richness of potential meanings of spirituality in ANP consultations. The participants' understandings and descriptions of spirituality unfolded over the 18 month engagement and will continue to do so.

This study has explored spirituality in Advanced Nurse Practitioner Consultations in Primary Care through the Lens of Availability and Vulnerability.

9.1 Conclusion and Contribution to Knowledge:

This study offers an exploration of how spirituality has been articulated by 8 experienced ANPs working in a Primary Care setting in the UK. The context for this study is different from the USA where the majority of the current empirical research has been carried out, and different from the research that has been undertaken in other areas of nursing practice. This is the first study to be undertaken in the UK and as such the findings provide original new knowledge and an important contribution to understanding spiritual dimensions of ANP practice in Primary Care. Further the development of a conceptual understanding of spirituality in ANP practice and a framework for operationalising spirituality through the lens of Availability and Vulnerability provides a contemporary and practical theory for understanding and integrating spirituality into practice.

This study required prolonged engagement with the participants to enable the hermeneutic circle to be completed in addition to the fusion of horizons. I came into the study with my own pre-understanding about spirituality and I wondered whether other ANPs had similar views and whether A&V could be a useful lens for operationalising spirituality. I consistently challenged and re-thought my own position in relation to the interviews and the findings of this study to the place where a tight fusion of horizons has occurred for me. Many aspects of my own pre-understandings have been refined and changed. I now see spirituality more than just as an essence of being and connected to hope, meaning and purpose. I see it as a dynamic process which involves context, emotional engagement and a merging of availability and vulnerability into practice. These help it to become more evident in ANP practice. I see it as being influenced by the multi-faceted ANP and patient journey

which evokes deep connection to the ANP's vocation and desire to be there for their patients. I see that vocation may be a helpful articulation of the context in which spirituality might sit for some participants. This enables the ANPs to practice in a way which fits with their personal ethos, beliefs and values about their work.

I have also come to view spirituality fundamentally stemming from a love for our patients. Love in the *agape* sense can act as a motivator for ANPs' practice as the ANP seeks to offer the highest standard of care and support to their patients. This connected closely to the comprehensive discussions regarding boundaries and how ANPs keep a "*human to human"* connection whilst working within professional boundaries. It also connected with the ANPs recognising patients who had lost hope, were experiencing soul-ache or dis-ease and wanting to help them through these difficult periods. The fall out though of potentially "*loving*" too much and "*giving*" too much of self to help a patient was illustrated by some of the participants talking about "*burn-out"* which was specifically evident in Tanya's life at the time of the second interview. Being willing to work in a way which integrates spirituality into practice and is responsive to patient need necessitates self-awareness and self-reflection and awareness of boundaries for the ANPs. Burn-out may be seen as a potential consequence of engaging in spiritual dimensions of practice without adequate support.

A&V clearly appears to be a useful lens for operationalising spirituality. The A&V views expressed by the participants, fused with my own horizons and translated into a framework for operationalising spirituality, offers an achievable model for developing and understanding spiritual care in ANP practice in the UK. It may also help to both recognise and manage boundaries, and recognise and avoid personal

safety risks such as burn-out. Integrating spirituality through A&V also has the ability to enrich practice for both patients and ANPs and can enhance holistic care.

This study has enabled thick and deep descriptions to be presented in the hermeneutic tradition to help better understand spirituality from the ANP perspective. The strength of the study involved the prolonged engagement with the participants and the shared understandings which developed through dialogue during and after the interviews. As with all hermeneutic studies this is not fixed. The understandings I have at this moment are at this moment and may change with further analysis and experience. This may be viewed as a limitation however I view this as a strength as it is possible for the data and analysis to yield more and more rich understanding.

Without data from patients this study cannot show the importance of spirituality from their point of view. However, the ANPs alluded to this through their witness in practice and the narratives they shared. One can only propose that care which puts the patient at the centre and is willing to explore individual needs, including aspects of meaning, hope and purpose is positive when carried out with respect and sensitivity. From the data it is clear that the ANPs also benefitted from integrating spirituality into their care approach despite the potential for negative personal impact if A&V are not managed with careful boundaries.

The data, hermeneutic circle and fusion of horizons have enabled a conceptual understanding of spirituality to be presented. This understanding roots spirituality as a way of finding hope, meaning and purpose and as innately human. It is operationalised in a number of ways illustrated by context, emotional engagement, availability and vulnerability. It is not linear or cyclical but fluid and adaptable. It may help ANPs further understand and think about spirituality in their own practice.

A new framework for spirituality has been proposed from this study. The framework for operationalising spirituality has been developed specifically through the presentations of the concepts of A&V brought to the participants in the interviews. A&V for the majority of the participants appeared to be a useful lens for understanding and operationalising spirituality. The framework is not intended to be prescriptive but offers a trellis or model through which ANPs can consider their own practice, their approach to the consultation and how they can begin to operationalise spirituality.

This study is the first of its type exploring spirituality and how it relates to the role of ANPs in the UK. It is also the first hermeneutic enquiry in this field internationally. It is hoped that it may spur on further research in this area and begin dialogue between ANPs about spirituality. As with my ANP participants I believe our approach to care is altruistic, always focusing on offering the highest standard of care to our patients whilst valuing them as individuals with unique and sometimes complex needs. Ensuring that spirituality is understood, explored and integrated into care is one way of providing truly holistic care. It will not only benefit the patient but also the ANP as they also reflect on their own needs and values in life and practice. For me spirituality is not just another practice it is a philosophy which is integral to my own life. My own experiences and preconceptions flow through this study but hopefully are authentic enough to have accepted challenge and change in response to the dialogue with participants, analysis of the data and engagement with the literature. My hope is that this study brings together a fusion of horizons which offers new understandings of spirituality in ANP practice to the nursing profession.

A final finding is methodological in that I did not set out to influence their practice but the methodological process of the hermeneutic circle meant that the participants had the opportunity to reflect on and observe their own practice through the lens of spirituality between interviews and this influenced the way they thought about, articulated and perhaps practiced spiritual care. I engaged them as more than just disembodied research subjects. By the process of sharing their transcripts with them and undertaking the second interview they were closer to collaborators, observing and reporting back on their own practice. I make no claims that I have changed their practice through the hermeneutic circle, nevertheless I note this finding as it relates to these particular ANPs in this study.

Overall this study offers an exploration of how spirituality or spiritual care is practiced by ANPs in a primary care UK context - much of this context is different from the US where the majority of the current empirical research has been carried out and it offers new knowledge and is an important addition to understanding of spiritual dimensions of practice as viewed by the participants. The contribution to knowledge of this study is original and provides a new conceptual understanding of the spiritual dimensions of ANP practice in addition to a framework for operationalising spirituality in practice.

The findings from this study therefore suggest that spirituality is innately human and is influenced by context and emotional engagement. It can be operationalised through availability and vulnerability and is a way of helping patients to find hope, meaning and purpose when this is challenged by illness or disability.

9.2 Study Limitations:

A number of explicit limitations are recognisable due to the methodology chosen and these were explored in chapter 5. The important limitations to conclude with are as follows:

- Prior to conducting the study I had not undertaken hermeneutic phenomenological research. I therefore learnt on the job and although all attempts were made to follow the hermeneutic approach it is possible that I may have misunderstood the minutiae of the methodology.

- This was a small, qualitative study with 8 participants who were of a similar demographic. All bar one of the participants was Caucasian from a western Christian heritage. As participants were from a Christian background it is possible that this impacts the findings however this study is transferable to other populations because of its focus on spirituality.

- The participants were self-selected volunteers. This could have meant that they already had an interest in spirituality and also limited the study possibly to those with a positive view of spirituality. Other ANPs who did not volunteer possibly do not view spirituality in this light.

- The study was influenced by my personal and professional experience which although reflexively explored can create bias and also may have led to me selecting data for analysis which fitted with my own preconceptions.

- Availability and Vulnerability were chosen as a lens for this study and thus led to a framework for operationalising practice being developed. If this had not been the lens these concepts may not have been identified as helpful or explored by the participants

9.3 Recommendations for Future Research:

It is hoped that more researchers will consider investigating spirituality within ANP practice as this is currently unchartered territory and is a rich source of experience, understanding and practice. There are many approaches that can be used to explore spirituality and its place within healthcare. Additionally, more studies are needed looking at spirituality in other disciplines and roles. Ultimately, the patients and carers voices need to be heard to ascertain the value of spirituality and spiritually competent practice from their point of view.

Some potential options for future research are:

- Further studies with ANPs in Primary Care nationally and internationally embracing different methodological approaches and numbers of participants.

- Similar hermeneutic enquiries following this study's methodology would provide additional thick descriptions of spirituality.

- Studies exploring the relevance of the conceptual understanding and framework for operationalising spirituality are important to refine and explore the relevance and usefulness of the concepts and framework in practice.

- Studies in other disciplines exploring spirituality through the lens of A&V would be interesting and could help validate the framework developed during this study.

- More studies are needed with patients and carers specifically in primary care where the data exploring spirituality is limited.

9.4 Final Personal Reflections:

This study has been a labour of love in many ways. Spirituality has been part of my life and work for many years and is integral to who I am today. The subject was chosen as a topic for study because I wanted to understand more about spirituality and explore whether this was an important aspect of ANP practice. I felt that it was a subject which had been in the main ignored in ANP practice and warranted investigation.

I started the study naïvely having not heard of hermeneutic phenomenology and not undertaken any individual research study since my degree in 1994. I had much to learn about the methodology and the research process as well as spirituality from a wider perspective. I began with huge enthusiasm and excitement which was marginally knocked during the REC process and when other colleagues criticised the choice of subject saying "*are you starting a prayer group then*" or "*when are you bringing your guitar to work*" to "*how dare you bring this subject into the university, you are proselytising".* These experiences only knocked me temporarily as I met other colleagues who encouraged, affirmed and supported me as well as having supervisors who were consistently for me. I met others through work that shared

similar interests in spirituality and then began to network with spirituality groups nationally and internationally and was continually inspired by those seeking to understand more about spirituality and integrate it into care. These connections spurred me on.

Then half way into the study I had a severe depression which took away every aspect of my hope, meaning and purpose. I saw no way through, no light, no prospect of things getting easier. That place lasted for almost 2 years and has had a profound effect on my life, my spirituality and my practice. I picked up the study again mid-way through my illness and as I continued to analyse and data, read the literature and reflect on spirituality some sparks of hope returned. With support from family, friends, colleagues and supervisors I have completed this study which has aided a sense of meaning and purpose in my life. Spirituality has helped me rebuild my life and consistently reminds me of how I can help my patients in my own practice to find hope when facing illness, crisis and pain.

"Spirituality is innately human and is influenced by context and emotional engagement. It can be operationalised through availability and vulnerability"

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Appendices:

Appendix 1 Spiritual Assessment Tools:

FICA – TAKING A SPIRITUAL HISTORY

The acronym FICA can help structure questions in taking a spiritual history by Healthcare Professionals.

F—Faith and Belief

“Do you consider yourself spiritual or religious?” or “Do you have spiritual beliefs that help you cope with stress?” IF the patient responds “No,” the physician might ask, “What gives your life meaning?” Sometimes patients respond with answers such as family, career, or nature.

I—Importance

“What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?”

C—Community

“Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?” Communities such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

A—Address in Care

“How would you like me, your healthcare provider, to address these issues in your healthcare?”

Adapted from Puchalski & Romer (2000)

The HOPE Questions for a Formal Spiritual Assessment in a Medical Interview

H: Sources of hope, meaning, comfort, strength, peace, love and connection

O: Organized religion

P: Personal spirituality and practices

E: Effects on medical care and end-of-life issues

Examples of Questions for the HOPE Approach to Spiritual Assessment

H: Sources of hope, meaning, comfort, strength, peace, love and connection

We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?

What are your sources of hope, strength, comfort and peace?

What do you hold on to during difficult times?

What sustains you and keeps you going?

For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?

If the answer is "Yes," go on to O and P questions.

If the answer is "No," consider asking: Was it ever? If the answer is "Yes," ask: What changed?

O: Organized religion

Do you consider yourself part of an organized religion?

How important is this to you?

What aspects of your religion are helpful and not so helpful to you?

Are you part of a religious or spiritual community? Does it help you? How?

P: Personal spirituality/practices

Do you have personal spiritual beliefs that are independent of organized religion? What are they?

Do you believe in God? What kind of relationship do you have with God?

What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)

E: Effects on medical care and end-of-life issues

Adapted from: Anandarajah G & Hight E (2001)

Appendix 2 Rule and Information Booklet on Availability and Vulnerability:

Summary of the Rule of the Northumbria Community

A Way for Living

We are called to be AVAILABLE to God and to others:

1. Firstly to be available to God in the cell of our own heart when we can be turned towards Him, and seek His face;
2. Then to be available to others in a call to exercise hospitality, recognising that in welcoming others we honour and welcome the Christ Himself;
3. Then to be available to others through participation in His care and concern for them, by praying and interceding for their situations in the power of the Holy Spirit;
4. Then to be available for participation in mission of various kinds according to the calling and initiatives of the Spirit.

We are called to ***intentional, deliberate*** VULNERABILITY:

1. We embrace the vulnerability of being teachable expressed in: a discipline of prayer; in exposure to Scripture; a willingness to be accountable to others in ordering our ways and our heart in order to effect change.
2. We embrace the responsibility of taking the heretical imperative by speaking out when necessary or asking awkward questions that will often upset the status quo; by making relationships the priority, and not reputation.
3. We embrace the challenge to live as church without walls, living openly amongst unbelievers and other believers in a way that the life of God in ours can be seen, challenged or questioned. This will involve us building friendships outside our Christian ghettos or club- mentality, not with ulterior evangelistic motives, but because we genuinely care.

http://www.northumbriacommunity.org/who-we-are/our-rule-of-life/ accessed 12/2/14

Northumbria Community Rule of Life:

'The Rule we embrace and keep will be that of AVAILABILITY and VULNERABILITY.'

We are called to be AVAILABLE to God and to others:

Firstly to be available to God in the cell of our own heart when we can be turned towards Him, and seek His face; then to be available to others in a call to exercise hospitality, recognising that in welcoming others we honour and welcome the Christ Himself; then to be available to others through participation in His care and concern for them, by praying and interceding for their situations in the power of the Holy Spirit; then to be available for participation in mission of various kinds according to the calling and initiatives of the Spirit.

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We embrace the vulnerability of being teachable expressed in: a discipline of prayer; in exposure to Scripture; a willingness to be accountable to others in ordering our ways and our heart in order to effect change.
We embrace the responsibility of taking the heretical imperative: by speaking out when necessary or asking awkward questions that will often upset the status quo; by making relationships the priority, and not reputation.
We embrace the challenge to live as church without walls, living openly amongst unbelievers and other believers in a way that the life of God in ours can be seen, challenged or questioned. This will involve us building friendships outside our Christian ghettos or club-mentality, not with ulterior evangelistic motives, but because we genuinely care.

Information Booklet about the Northumbria Community:

What is the Northumbria Community?

The Northumbria Community is an ecumenical network community of approximately 3000 people worldwide, with Anglican, Roman Catholic and Baptist founders and leadership. It was founded in the 1970s' and its purposes are the resourcing and renewal of the church and missional community to the unchurched. The community has never sought to be a church in its own right and has always encouraged its members to be involved with their local denominational church. As part of its accountability the Community has Visitors from the C of E (John Pritchard), Baptist Union (Ernie Walley), and Roman Catholic Diocese of Newcastle (Ambrose).

The Community has found inspiration from many sources including the Desert Fathers, the Celtic Saints, and various streams of monasticism as well as from people such as Dietrich Bonhoeffer, Thomas Merton, Jean Vanier, and Henri Nouwen. It has used this inspiration to build a missional community that is concerned with spiritual formation of the ordinary people of God rather than something that is pseudo-Celtic or wholly monastic.

The Mother House of the Community, currently at Hetton Hall, has a number of functions, these include: teaching, retreat, and administration, as well as being a model of Community ethos. The Mother House is not only being 'home' to the Community, it also welcomes a significant number of non-Community clergy and laity from all over the world who take part in the teaching programme or use the house for guided retreat or as a base for extended study.

The missional aspect of the Community is predominantly seen through each of its members 'living the life' in the places of their influence, 'whether they be great or small'. Having said this, the Community also engages in specific missional activities through local churches and beyond, and uses the arts, storytelling, creativity, dance, and pilgrimage to engage people with the story of God. As part of this there is a commitment to try to provide liturgies that voice today's human experience, in all of its shades, before God, and in them for people to encounter the Gospel.

Web Link: http://www.northumbriacommunity.org/

NORTHUMBRIA COMMUNITY

Hetton Hall, Chatton, Northumberland,

NE66 5SD

tel: 01289 388235 fax: 01289 388235

email: office@northumbriacommunity.org
website: www.northumbriacommunity.org

Summary of the Rule of the Northumbria Community - A Way for Living

We are called to be **AVAILABLE** to God and to others:

Firstly to be available to God in the **cell** of our own heart when we can be turned towards Him, and seek His face; then to be available to others in a call to exercise **hospitality**, recognising that in welcoming others we honour and welcome the Christ Himself; then to be available to others through participation in His care and concern for them, by praying and **interceding** for their situations in the power of the Holy Spirit; then to be available for participation in **mission** of various kinds according to the calling and initiatives of the Spirit.

We are called to intentional, deliberate **VULNERABILITY**:

We embrace the vulnerability of being **teachable** expressed in:
a discipline of prayer;
in exposure to Scripture;
a willingness to be accountable to others.

A Rule of life is absolutely essential to any monastic expression. It says this is 'who we are, this is our story' and reminds us of those things God has put on our hearts, and calls us back to the story that God has written as foundational.

The idea of a Rule of life developed in the monastic communities of Christianity, and indeed, monasteries and convents today still function under a Rule. St. Benedict wrote the most famous Rule in the early years of monasticism. Monastic stability is to be accountable to a Rule of life as a framework for freedom, not as a set of rules that restrict or deny life, but as a way of living out our vocation alone and together. It is rooted in Scripture, pointing always to Christ; and to use the words of St Benedict, it is 'simply a handbook to make the very radical demands of the gospel a practical reality in daily life'.

The history of the Northumbria Community is one of responding to a call we believe to be from God: a call to risky living, exploring ‘a new monasticism’ and our Rule developed out of this life already being lived – a written response to the many people who were asking - **what is central to your hopes & dreams, what are the values & emphases that reflect the character & ethos of your way for living?**

> ‘For us, the life came before the Rule. We were living, hoping and dreaming these things before they were ever written down. So, we must focus not on the Rule, but on the things God has put on our heart. The Rule serves to remind us of these things, serves as a check, and calls us back to see if our dreams are still there. ‘It has more to do with a spiritual vision of community life, with roots continually to be rediscovered, than with a legislation document’ as ‘The Taize Story’ says in discussing their own community rule.’ Andy Raine

2. WHY DO WE NEED A RULE OF LIFE?

The purpose of a Rule is to lay down working guidelines for the inner life and also provide a structure for the balanced ordering of our roles, responsibilities & relationships. This is why a Rule of life is not only relevant to the monastic tradition. The principles can be used by anyone who is concerned about how they live their lives and provides markers and guidelines, inspired by the Spirit, to help them on their journey towards God.

It becomes for us 'an exterior framework for an interior journey': a kind of scaffolding to use to build the spiritual structure of our individual life with God. It gives creative boundaries and spiritual disciplines while still leaving plenty of room for growth, development and flexibility. It gives us something to hold on to as we journey in our search for God, and when we are blown off course, it provides a safe haven to come back to. It is a means of perception, a way of seeing so that we can attempt to handle our lives and relationships wisely.

> An illustration of the purpose of a Rule of life is to think of an analogy with a pair of glasses (spectacles). We don't merely look *at* a pair of glasses however expensive or original they are. The reason why we don't look at them is that the whole purpose of having a pair of glasses is to look *through* their lenses to what we see in everyday life. It would be utter foolishness if all we did was to look at the glasses rather than look through them to what they revealed to us

A Rule is meant to be a spur to growth. It can be likened to a stake used to hold up a plant. By providing structure and support to the plant, it enables the plant to grow quickly and healthily. In a similar way, a Rule of life provides structure and support not only to our prayer life, but to every aspect of life, enabling us to grow into the persons God wants us to be. Because of this, a Rule works best when it challenges us. It can't be so easy that we are not stretched but neither can it be so demanding that we have difficulty even meeting its minimum standards. Otherwise it is likely to discourage us, and therefore defeats its own purpose. A Rule is not a tool to make us feel good or feel bad -- it's a tool to help our individual growth in spiritual maturity. If it becomes hard to follow, becomes a burden or causes you feelings of guilt, then give it up - it is not for you.

Our Rule expresses a spirituality that is grounded, coming out of the hard won experience and chaos of those who have faced some of the hard questions. *How do I live with myself? How do I live with others? How do I relate to the world around me? How do I find time and space for God?*

Paradoxically the Rule will send us in two directions – inward into the heart of God and on the outward journey of service in the world. Cultivating these spiritual disciplines will create the freedom to love, and enable the spiritual life to become visible. This will in turn create the space where God's love and grace can reach us, heal us, direct us and free us to be the persons we truly are.

Appendix 3:

©Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist

Paper 12 reviewed via CASP:

Carron R & Cumbie S (2011) Development of a Conceptual Nursing Model for the Implementation of Spiritual Care in Adult Primary Healthcare Settings by Nurse Practitioners. *Journal of the American Academy of Nurse Practitioners* (23) 552-560

Screening Questions:

1. Was there a clear statement of the aims of the research?
Yes Can't tell No

To develop a conceptual nursing model for the implementation of spiritual care in adult primary care by nurse practitioners with an emphasis on older adults

2. Is a qualitative methodology appropriate?
Yes Can't tell No

A grounded theory and phenomenological approach have been chosen to explore spiritual care perceptions of the chosen participants

Is it worth continuing? **Yes**

3. Was the research design appropriate to address the aims of the research?
Yes Can't tell No

S/A for author justification

4. Was the recruitment strategy appropriate to the aims of the research
Yes **Can't Tell** No

Although purposive sampling was identified the researchers have not explained how the participants were chosen. There were four groups of individuals chosen (14 participants): Adult Primary Care Patients, Family Nurse Practitioners, Community Spiritual Leaders/Educators and Benedictine Nuns. No rationale was given for the final four groups and no explanation of what a Spiritual Leader/Educator was given.

5. Was the data collected in a way that addressed the research issue?

Yes Can't Tell No

Data collection occurred through interviews of 30-90 minutes duration. It was unclear whether this was face to face or not. It is unclear whether these were individual interviews of focus groups or whether any structure was utilised.

6. Has the relationship between researcher and participants been adequately considered?

Yes **Can't Tell** No

It is unclear whether the researchers fully examined their own role, potential bias or influence and influence during formulation of the research questions or data collection. They state they knew many of the participants but did not state in what context.

7. Have ethical Issues been taken into consideration?
Yes Can't Tell No

Ethics was gained through the University of Wyoming via an Institutional Review Board. Little else has been written about ethical considerations.

8. Was the data analysis sufficiently rigorous?
Yes **Can't Tell** No

Data analysis occurred via content theme analysis (Van Manen) and a systematic coding procedure. Neither of which are expanded upon. Constant comparative analysis occurred to ensure the findings were grounded in the participant interviews. Data analysis was halted when data saturation was achieved.

9. Is there a clear statement of findings?
Yes Can't Tell No

Findings are concisely reported due to the journal structure however they do include a number of verbatim quotes from participants. There is some discussions of the findings for and against the researchers arguments. The findings presented do not fully meet the original aim of the research.

10. How valuable is the research?

The research has limited value due to the participants included in the study and the bias of insider research and analytical bias. The study does show a desire from those interviewed to integrate spiritual care interventions into practice. Many unjustified assumptions are made throughout the papers which are not supported.

This area is poorly researched to the findings do add qualitative data.

Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist Accessed 31.05.

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Appendix 4:

Table of Reviewed Articles in Date Order:

	Citation:	Where from:	No of Participants and Response Rate	Aim	Methodology	Findings
1	Treloar L (2000) Integration of Spirituality into Health Care Practice by Nurse Practitioners. Journal of the American Academy of Nurse Practitioners, 12 (7) 280-285.	Arizona, USA	N/A	To describe the role the NP can and should take with patients and families in integrating spirituality into health care practice	Discussion Paper	She recommends NPs take leadership in integrating spirituality in their care.
2	Maddox M (2001) Teaching Spirituality to Nurse Practitioner Students: The Importance of the Interconnection of Mind, Body and Spirit. Journal of the American Academy of Nurse Practitioners 13 (3) 134-139	USA	N/A	To describe the Authors experience in locating and implementing a spiritual assessment tools for NP students	Discussion paper	Spiritual assessment is an important component of a comprehensive health assessment
3	Stranahan S (2001) Spiritual Perception, Attitudes about Spiritual Care, and Spiritual Care Practices among Nurse Practitioners. Western Journal of Nursing Research 23 (1) 90-104	Indiana USA	Two hundred and sixty-nine questionnaires were sent; 102 were returned and used for data analysis, representing a response rate of 40%.	To examine the relationships among spiritual perception, attitudes about spiritual care and spiritual care practices in NPs	Quantitative non-experimental cross-sectional survey design. Questionnaires were sent to all nurse practitioners licensed by the state of Indiana.	Twenty-three (22%) respondents had received no training or education in spiritual care. Seventeen (17%) indicated spiritual care was integrated in their baccalaureate or basic nursing curricula. Twenty-seven (30%) of the 90 respondents with a master's degree or higher believed spiritual care was Integrated throughout their graduate curricula. Eighteen (18%) of respondents had received specific course work in spiritual care either as undergraduate or graduate nursing students. Nine (9%) had received continuing education 4in spiritual care. Even though 79 respondents (77%) had received some education in spiritual care, 53 of the 92 respondents who answered the

						question (58%) felt their education was inadequate or somewhat inadequate to prepare them to provide spiritual care. Thirty-six (39%), on the other hand, believed their education was somewhat adequate. Four (4%) indicated that their education in spiritual care was excellent.
4	Ellis M, Campbell J, Detwiller-Breidenbach A & Hubbard D (2002) What do Family Physicians think about Spirituality in Clinical Practice? The Journal of Family Practice 51 (3) 249-254	Columbia, USA	13 Family Physicians	To describe the context in which physicians address patients' spiritual concerns.	Qualitative study using semi-structured interviews	Those addressing spiritual issues do so because of the primacy of spirituality in their lives and because of the scientific evidence associating spirituality and health. Five themes were identified as being: the appropriateness of physicians in addressing spiritual concerns; situations in which physicians focus on spiritual issues; how physicians address spiritual issues and finally the barriers and facilitators to spiritual assessment.
5	Monroe M, Bynum D, Susi B, Phifer N, Schultz L, Franco M, Maclean C, Cykert S & Garrett J (2003) Primary Care Physician Preference regarding Spiritual Behaviour in Medical Practice. Archive Internal Medicine 163 2751-2756	Carolina, USA	476 physicians responded (62% response rate)	To determine the willingness of internists and family physicians to be involved with varying degrees of spiritual behaviours in varied clinical settings.	Quantitative- multi-centre, cross-sectional, non-randomised study	Most primary care physicians would not initiate any involvement with patients' spirituality except with dying patients. Less than 1/3 of respondents felt they should routinely ask about patient's spiritual/religious beliefs. 14.2% prayed silently for their patients, 5.9% agreed they should pray with a patient but 55.6% would pray with a patient at their request this was higher than internists. 31.4% primary care physicians had had training in addressing spiritual issues as appose to 15.4% internists. Primary care physicians were more likely to want to be aware of

						patients beliefs than internists
6	Murray S, Kendall M, Boyd K, Worth A & Benton T (2003) General Practitioners and their Possible Role in Providing Spiritual Care- A Qualitative Study. British Journal of General Practice **53**, 957-959.	UK	40 GPs caring for patients with terminal illness	To identify patients' holistic needs and the GPs role in providing spiritual care	Qualitative- telephone interviews	The GPs conceptualised their patients' spiritual needs as greater than their religious needs- this included meaning and purpose of life. Most of the GPs had a high awareness of the potential spiritual needs of their patients but lacked time and appropriate strategies to include these in their consultations
7	Ellis M & Campbell J (2004) Patient's Views about Discussing Spiritual Issues with Primary Care Physicians. Southern Medical Journal 97 (12) 1158-1163	Columbia, USA	10 Chronically or terminally ill patients	To explore patients' views about discussing spiritual issues with primary care physicians	Qualitative semi structured interviews	Patients need to feel honoured and respected by their physicians to risk discussing spiritual issues. Barriers to discussing spiritual health were also identified as physicians' time, continuity of clinician, biomedical approaches and patient friendly offices. Some respondents wanted their physician to initiate a spiritual discussion and felt it should be easier with those with chronic/terminal illnesses
8	Holmes S, Rabow M & Dibble S (2006) Screening the Soul: Communication regarding Spiritual Concerns among Primary care Physicians and Seriously Ill Patients approaching the End of Life. American Journal of Hospice and Palliative Medicine 23 (1) 25-33	California, USA	Questionnaires were given out in out-patients. 65 patients returned their questionnaires (90% response rate) and to primary care physicians – 67 returned their questionnaires (87% response rate)	To explore the spiritual concerns of seriously ill patients and the spiritual care practices of primary care physicians	Quantitative	71 % of patients and 68% of physicians described themselves as spiritual. 60% patients did not want to have a spiritual discussion with their physician. Only 12% had been asked about the importance of spirituality, 15% asked about religion and 14% offered a referral to clergy. 75% of patients prayed about their health and 70% did not want a physician to pray with them but 54% wanted them to pray for them on their own. 62% felt it was not the physician's job to ask about spirituality, 31% felt they didn't have time and 17% felt their physician would not want to discuss it. The physicians

						revealed that 68% felt it was important to address spiritual concerns but 64% had never asked a seriously ill patient if they would like to see a chaplain. 82% did not ask about spiritual concerns because of time, 37% didn't feel competent and 21% did not feel it was part of their job
9	Hubbell S, Woodard E, Barksdale-Brown D & Parker J (2006) Spiritual Care Practices of Nurse Practitioners in Federally Designated Nonmetropolitan Areas of North Carolina. Journal of the American Academy of Nurse Practitioners, vol. 18, no. 8, pp. 379.	North Carolina, USA	101 questionnaires were sent out and 65 returned (65% return rate)	To explore if NPs integrated spiritual care into practice	Quantitative A non-experimental cross sectional descriptive design using a self-report questionnaire	Although NPs felt spiritual care was important in practice 73% did not routinely provide it. 54% NPs would refer patients to clergy, 46% encouraged patients to pray and 39% talked to patients about religious/spiritual matters
10	Helming M A (2009) Integrating Spirituality into Nurse Practitioner Practice: The Importance of Finding the Time. Journal for Nurse Practitioners (8) 598-605.	USA	N/A	Review of Literature around medical schools integrating spirituality into practice and practical suggestions for NPs to add spirituality care into their practice	Discussion paper	She recommends finding time to provide spiritual care and that NP education should teach spirituality.
11	Tanyi R, McKenzie M, Chapek C (2009) How Family Practice Physicians, Nurse Practitioners and Physician Assistants Incorporate Spiritual Care in Practice. Journal of the American Academy of Nurse Practitioners (21) 690-697	USA	3 Physicians, five Nurse Practitioners and two Physician Assistants	To investigate how primary care family practice providers incorporate spirituality into their practice in spite of documented barriers.	Qualitative, Phenomenological approach.	Spiritual needs can be addressed with patients despite documented barriers.
12	Carron R & Cumbie S (2011) Development of a Conceptual Nursing Model for the Implementation of Spiritual Care in Adult Primary Healthcare Settings by Nurse Practitioners. Journal of the American	USA	14 (5 adult patients, 3 family NPs, 4 community spiritual leaders/educators and 2 Benedictine nuns)	To gain an understanding of spiritual care perceptions by adults and the role of the NP in response to these identified needs so that we could propose a conceptual nursing model for the implementation	Qualitative, descriptive with grounded theory and phenomenological approaches.	That as the NP and patient relationship develops there is often scope to explore spirituality with the patient. Additionally the conceptual model suggests within the NP/patient relationship there is a "spirit" relationship which is reciprocal.

	Academy of Nurse Practitioners (23) 552-560			of spiritual care in adult primary healthcare settings.		
13	Vermandere M, De Lepeleire J, Smeets S, Hannes K,Van Mechelen W, Warmenhoven F, Van Rijswijk E & Aertgeerts B (2011) Spirituality in General Practice: A Qualitative Evidence Synthesis. British Journal of General Practice Nov 2001, 749-760	Belgium	No participants, 7 studies included.	To investigate the literature surrounding GP views on their role in spiritual care including barriers and facilitators for assessing spiritual needs	Qualitative Evidence Synthesis	Most GPs see their role including assessment of spiritual needs despite recognised barriers but they experience discomfort and fears around introducing the topic.

Appendix 5 Invitation to Participate

Letter of Invitation: UNIVERSITY OF HUDDERSFIELD (Headed Paper)

A Hermeneutic Enquiry of the Spiritual Dimensions of Advanced Nurse Practitioner Consultations in Primary Care through the Lens of Availability and Vulnerability.

Melanie Rogers

Dear

Information Sheet:

Invitation to Take Part in Research.

I would like to invite you to take part in a study looking at spiritual dimensions of Advanced Nurse Practitioner (ANP) consultations. Before deciding whether you would like to take part please read about why the research is being done and what it would involve for you. Please read the information carefully and talk to others including fellow Yorkshire Nurse Practitioner Forum members, colleagues, and myself if you wish.

Part 1 tells you why the study is being done and
Part 2 gives you more detail about the conduct of the study.

Do feel free to contact me if there is anything unclear or if you would like more information. Take time to decide whether you would like to take part.

Part 1:

What is the research about?

The purpose of this study is to ascertain whether you feel that there may be a spiritual dimension in some ANP consultations with patients in primary care. I would like to discover whether this may occur because you choose to be "Available and Vulnerable" with your patients. The history of this concept of "Availability and Vulnerability" will be explained via an information booklet provided prior to the second interview being carried out. The research is being carried out to meet the requirements of a PhD study and the findings will be disseminated in the PhD report, journal articles and conference presentations.

Little has been written about the spiritual dimensions of ANP consultations however we often see our role as offering a "holistic" approach to care. Many of the patients we see present with complex medical and mental health problems which inevitably results in more regular contact and the development of a relationship with patients, and sometimes their families, over extended periods of time. On many occasions I have noticed that there is often a sense of hopelessness in these patients and sometimes existential issues have been raised. This sometimes occurs after self-disclosure by the patient about something which is impacting on their life physically or emotionally. It is not surprising that during times of suffering that patients may seek to find meaning in their existence or release from their distress. I am interested to discover whether you have had similar experiences within your ANP practice and whether this is dependent upon the relationship developed with your patient, your own openness to allow patients to "open" up on a deeper level or whether being

consciously more “available and vulnerable” with patients possibly sharing aspects of your own life may enable more “spiritual dimensions” to be evident within the consultation.

Why have I been invited?

You have been asked to join the study because you are an experienced ANP and I am keen to discover your views and beliefs about what may happen within a consultation when a “spiritual dimension” occurs with a patient. As a practicing ANP you see patients every day, many of whom have complex medical needs which may cause them distress. These patients often view you as someone they can talk to and there may be opportunities when you share something of yourself (by being vulnerable) to help the patient move forward. In order to capture what may be occurring in these “spiritual dimensions” I would like to interview 8-10 participants. You are invited to meet with me for **3 face to face interviews** lasting approximately **45 minutes** each over a **1 year period**.

Do I have to take part?

It is up to you to decide whether you want to take part in this study. Once you have read through this information sheet and if you are happy to take part in this study I ask you to sign and return the consent form in the stamped addressed envelope provided. If you have any queries and would like me to describe the study in more detail feel free to contact me by phone or email (details at the end of this leaflet). The consent form is needed to show that you have agreed to take part. You are however free to withdraw at any time without giving a reason.

What will happen if take part?

Once I have received your consent form I will send you a letter containing details of all the arrangements. You will be given a copy of your signed consent form to keep.

I will be asking you to choose a suitable date for the first interview which will take place between September and December 2009 at a venue of your choice. A second interview will be carried out between February and May 2010. A final interview will occur between August and November 2010. I will have a series of questions to ask you and we will also have some time to discuss your thoughts, experiences and values. The second and third interviews will include some time to share my initial analysis of the information you have shared with me.

With your consent the interview will be audio-taped, transcribed and any information that identifies you will be removed before analysis. No names will be used in the thesis and the tape will be destroyed after the thesis has been written. I may wish to use some direct quotes you have used during the interview within the thesis.

Expense Payments

There should be no cost incurred by you for taking part in the study however it will cost you some time. Unfortunately there is no reimbursement for participation in this study.

What are the possible risks in taking part?

I anticipate there will be no risks involved by participating in this study. However we will be discussing your thoughts, feelings, beliefs and values surrounding spirituality within the consultation. This may cause you to consider your own spirituality and you may wish to talk further about this. A list of local counsellors and spiritual directors will be made available should you wish to do this.

What are the possible benefits in taking part?

All the data collated will be useful in understanding what occurs within the ANP consultation when an interaction occurs where the ANP is available and vulnerable.

What if there is a problem?

Any complaint you may have about the way you have been dealt with during the study will be addressed. The detailed information on this is given in **Part 2** of this leaflet.

What should I do if I am interested in taking part?

Please read all of the information in **Part 2** before deciding to take part and signing the consent form.

Part 2
What if there is a problem in taking part?

If you have any concerns about any aspect of this study you should ask to speak to the researcher: Melanie Rogers who will do her best to answer your questions.

Contact Details:
Melanie Rogers
Room 3/04- Harold Wilson Building
University of Huddersfield
Queensgate
Huddersfield
HD 1 3DH

Telephone: 01484 471090 or 0783 3605744
Email: m.rogers@hud.ac.uk

Do feel free to discuss the project with anyone independent of the study. If you are unhappy and wish to complain formally you can do so through my supervisor Dr Annie Topping, Professor of Health & Social Care and Director, Centre for Health & Social Care Research, School of Human and Health Sciences, University of Huddersfield,Queensgate,Huddersfield, HD1 3DH. Email- A.E Topping@hud.ac.uk, Telephone- 01484 473974.

Will my taking part in the study be kept confidential?

Yes, because I will follow the best ethical and legal practice and all information about you will be handled in confidence. All information that is collected about you for this research will be kept strictly confidential and will be held in compliance with the Data Protection Act. Data from your interview will be collected by me and I will give you a pseudonym so that you cannot be identified. The tapes will be all kept in a locked cabinet at the University of Huddersfield. The data collected from all the interviews will be transcribed by an administrative assistant who will have no details about you. The data will then be analysed and used in the thesis. We have a duty of confidentiality to you as a research participant and I will do my best to meet this duty.

What will happen to the study results?

The study results will be written up in a PhD thesis and several journal articles to enable the information to be read by other ANPs and interested parties. You will not be identified in any written materials. I will send you a summary of the results of my analysis and any journal articles if you would like to read them.

Who is funding the study?

This PhD has been fully supported by the University of Huddersfield.

Who has reviewed this study?

The University of Huddersfield's Human and Health Sciences School Research and Ethics Panel has reviewed this study and have agreed that it meets the ethical requirements of qualitative research.

Thank-you very much for reading this information.

Follow Up letter:

Dear

I have now finished my initial analysis from our interview earlier this year and hope to see you again in January/February for our second interview. I have enclosed a short summary of my initial analysis of our interview and would be grateful if you could read through this prior to our interview and hi-light any areas you would like to discuss further or elaborate on.

Having completed 8 interviews the analysis has showed approximately 12 themes which you have all brought up during the interviews. I have therefore summarised your comments into these themes. The summaries include a brief overview of verbatim comments you made.

An important aspect of my research is to develop a shared understanding between us and I would be grateful if there are any areas which you feel have misinterpreted that you could hi-light these and we can then clarify these when we meet again.

Our next interview will focus on "Availability and Vulnerability" within your consultations. I have enclosed a leaflet from a Christian monastic community in Northumbria which describes these concepts from a Christian view point. It is important to be aware that this study is not intending to look at the Christian origins of these concepts and that there is no desire to influence our interviews with a religious view point. The aim of the research is to consider whether "Availability and Vulnerability" is a useful lens which ANPs can consider when thinking about spiritual dimensions of the consultations. The use of these terms by me has been adapted from the Northumbria Community use of these concepts in their "rule of life" to consider what these would mean within a consultation and how they may be related to spirituality.

I am looking forward to seeing you again and want to thank-you for your ongoing participation with this study. If you have any specific questions please do not hesitate to contact me.

Best Wishes Melanie

Appendix 6 Consent Form:

A Hermeneutic Enquiry of the Spiritual Dimensions of Advanced Nurse Practitioner Consultations in Primary Care.

Melanie Rogers

Interview consent form

I have been fully informed of the nature and aims of this research and consent to taking part in it.	
I understand that I have the right to withdraw from the interview at any time without giving any reason, and a right to withdraw my data if I wish.	
I give my permission/do not give my permission for my interview to be tape recorded.	
I give permission to be quoted (by use of pseudonym).	
I understand that the tape will be kept in secure conditions at the University of Huddersfield.	
I understand that no person other than the transcriber and the interviewer will have access to the recording.	
I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.	

Name of participant

Signature

Date

Name of researcher

Signature

Date

Two copies of this consent from should be completed: One copy to be retained by the participant and one copy to be retained by the researcher

Appendix 7 Topic Guide:

Interviews will take place in a convenient location for the interviewees. It is anticipated that 8 Advanced Nurse Practitioners will be the maximum number to participate in this study. The interviews will be audio-taped.

The first interviews will open with general information about the purpose of the interview and time will be given to establish a rapport. Confidentiality from the researcher, data storage, sharing of data will be discussed further.

1) Initial background- discussion of current role, years qualified and any areas of specialist practice will be ascertained.

2) What made you decide to become an ANP? What influenced your decision?

3) Discuss your views about the differences in ANP consultations with patients who may present with serious medical problems, complex presentations and mental health problems as appose to minor illness. How do you view the relationship you develop with these patients? Is it different to those consultations with minor presentations? What happens over a period of time when you see these patients regularly?

4) What do you see as the most important aspects of the ANP consultation? Does this differ to the role of others nurse in primary care?

5) What do feel is important in a holistic assessment of your patient?

6) Does spirituality have any importance in your approach to your patients? Does your consultation include acknowledgement of patient's spirituality?

7) Is there a difference in your mind between spirituality and religion?

8) Do you make an emotional connection with your patients or do you keep a "professional distance"? How much of yourself do you share with patients who you may be seeing regularly?

9) What do the words availability and vulnerability mean to you? Is this something important in a consultation?

10) Have you ever felt that you have become more involved in a patient's life than you should have done as a professional? Can you tell me a little about that experience?

Second Interview:

Summary of previous interview and initial findings. Feedback of current progression of research.

Opening conversation with discussion about the concept availability and vulnerability (A&V) as expressed by the Northumbria Community.

1) You have now read the information I sent you from the Northumbria Community about A&V, how does this correlate to your understanding of these terms?

2) Do you feel this concept has any relationship to what we have discussed about “spiritual dimensions” within ANP consultation?

3) Are there any areas which would make you feel uncomfortable about consciously observing for, and participating in “spiritual dimensions” of care?

4) Do you see A&V as a useful lens to address “spiritual dimensions”?

5) Does integrating A&V include an acceptance of the role spirituality may have in a consultation?

6) Have you thought further since reading this information about the role or spirituality in your life and work?

7) What do you feel the safeguards should be when a “spiritual dimension” is apparent in a consultation?

Thank-you for your time and support throughout this research

Appendix 8 Participant Summaries:

Appendix 8.1 Interview 1 Summaries:

Appendix 8.1.1 Ana 1 Summary:

Themes:

1) Consultation Variants- simple consultations can also be complex

2) Important aspects of relationship and consultation- listening, wholeheartedness, time, being present without being emotional, knowing when to share and when not to. Giving the pt what they need, how you broach things, the patient agenda, time limits.

3) Changes over time- you get to know someone very well over time

4) Holistic practice-balancing pt agenda and not missing life threatening conditions, physical/emotional/well-being.

5) Boundaries and emotional connections-not sure where line is (if touch it pull back a little), self- knowledge important, professional relationship. Talked about a pt who after you had to shut the door for ½ hour to cry. With Olivia just so painful

6) View of Spirituality and openness to inclusion within the consultation- a set apart moment in time....wholeheartedly give yourself in a way to another person. Younger pts who struggle with life questions and lack of purpose. It sometimes comes up when talking about life and death issues.

7) Differences between Spirituality and Religion- probably linked. Spirituality- people who have a depth of understanding by the way they express things and is how you live. Something that gives life meaning and purpose is close- but I don't really know if I can define it. Religion can be very dogmatic, a set of rules

8) Availability- seeing pts over time, taking simple consultations a little further, unrealistic to give all pts what they need (balance their needs against others). You can be available without being vulnerable but making yourself available could lead you to becoming vulnerable-you may not realise what you're getting into. Period of time concentrating on the pt

9)Vulnerability- Personal empathy for pts, blinking back the tears with Olivia- having to careful about level of openness, felt out of depth- could only respond as one human being to another, making yourself vulnerable then there is that potential you will be hurt by this consultation (lot of comments relate to Olivia). Story 5 made you more careful- the pt who you sent the card to

Being A&V gives our work meaning

9) Personal beliefs- Used to be a Christian (I kind of lost my basic faith but I wouldn't say God doesn't exist)

10) Ethos- not crossing the line where it becomes more about you than pt. Empathy and care comes through the interview

11) Stories used- “Olivia”- relates spirituality to experience with her, patient who asked you to pray with her- felt quite uncomfortable, muslim pt who want to break fast- bit of a privilege, pt with similar illness to niece, pt attacked by child, pt with sore throat but friends killed in car crash, old lady send a card.

Appendix 8.1.2 Georgia 1 Summary:

Themes:

1) Consultation Variants- we are in danger of being formulaic

2) Important aspects of relationship and consultation- interaction between the ANP and pt. They need to be listened to, validated and understood. They need to trust you. ANP develops because of consultation. To have global comprehensive view. Prescencing, allow them to talk, help lighten their burden. Safely manage pt. The whole crux is a therapeutic relationship

3) Changes over time- getting to know pt and families

4) Holistic practice-treating the person (Osler/Adams/Hippocrates). Wright- you should always make the pt feel better. Being totally in the moment, connecting at a deep level

5) Boundaries and emotional connections- not putting your views onto pts, not presuming to force own view onto others. Important to keep a certain distance, protect yourself- keep sane and balanced- a real tension. Shared humanity- we are all struggling and going through fundamentally the same problems in life and death. Taking care with issues of transference- you need to be professional. With emotional connections: those are moments that stay with you for life, they inspire you as a human and a nurse, gifts from the pts to you. You can’t always protect yourself- you are guided by pts cues on what is appropriate and what is not. If you’re human you’re going to give a little bit of yourself

6) View of Spirituality and openness to inclusion within the consultation- always interested in a wider sense of spirituality. “Soul ache”, pts tell us lots which in the past they may have told to their priest. It’s how I interpret things. Another dimension which makes us truly human. We are spiritual beings in a physical body. You bring it in indirectly by how you consult as a human- it’s part of who I am. Uncovering the purpose of being here. The nurse is changed by the encounter...when 2 humans come together and connect. I am comfortable in my own skin as a spiritual healer. Overlap of ministers and nurses. Dis-ease

7) Differences between Spirituality and Religion- spirituality is more diffuse, more broad, it’s harder to define. A suspicion or intuition that we are more than matter. Religion set of guidance and principles which you can adopt and adhere to, may be dogma and doctrine. Spirituality- it isn’t the church it’s those little intuitions, flashes of understanding, moments of inspiration that make you think there is more to life that meets the eye (Scott Peck)

8) Availability and vulnerability- I am available to my pts on a day to day basis, in their time of need. I am available to my medical colleagues, to my nursing colleagues, to my students. Difficulties in availability when pts breaks down and you only have 10 mins “you have to be available” but equally to next 14 pts. Vulnerable when personal things going on in your life and it’s still raw (restoring yourself in between pts), you are human, not a machine. Vulnerable because I am human, because I manage risks/decisions, because I can sued,

because I am a nurse in a medical domain. My main vulnerability is that I am doing the right things for the right patient at the right time

9) Personal beliefs- Catholic upbringing- mystery

10) Ethos- we are all healers

11)Stories used- Yes, pt who complained, personal story- losses and reasons why went into nursing, consultation with a priest, consultation with a mystic, holding a pts hand

Appendix 8.1.3 Tanya1 Summary:

Themes:

1 Consultation Variants-some pt seen daily as chaotic lives, rare to have minor presentations

2 Important aspects of relationship and consultation- getting to know pts leads to more depth and quality and being more frank and honest. Giving time to build trust

3 Changes over time-trust....surviving each day and coming to terms with the trauma that's happened

4 Holistic practice- the relationship with your pt, taking in all aspects of their lives

5 Boundaries and emotional connections-sometimes you have to be really conscious about putting in boundaries as pts may over familiarise with you or see you as their friend. Some pts do ask you about your life- sometimes it feels comfortable and sometimes not. Pts often die young- dealing with personal grief. It can be very hard. Switch from professional role to parental role with some pts

6 View of Spirituality and openness to inclusion within the consultation- spirituality quite broad and about things like connection, being something about you as a person, my views/beliefs. For pts sometimes about culture but also about who they are/where they have been/where they are at that moment in time. Spirituality-their being, being human, their relationships, life and death and about religious kind of connotations. Most spiritual moment talking about something as fundamental as life and death. Connect better with thinking my consultations are spiritually based (life/death consultations)

7 Differences between Spirituality and Religion-you can't quite put your finger on it. Spirituality-you meet someone and you sort of connect with them that feels different that makes you feel perhaps comforted or complete. Spirituality is about life it's bigger than faith. I don't connect religion with spirituality- its woolly isn't it- not the easiest thing to implement as its about your personal perceptions of it. Religion- I guess a set of rules, following a model of life and beliefs/guidance that you value.

8 Availability- if I was truly available to somebody I would have a professional relationship with somebody who could have an element of trust and could actually disclose things in a very safe way

9 Vulnerability- upset by pts death when at the funeral no-one was there. When relationship changes to you being more parental or personally attached. Feeling vulnerable when

something happens with a pt and you feel comfortable (discuss when shared something)- you are potentially crossing boundaries (there has to be trust). In context of your pts about losing some element of privacy and control

10 Personal beliefs- I choose not to be religious- what I feel personally is more spirituality just the amazement of the fact that we are alive.....to be on the earth, the way it works, the way life is.

11 Ethos-to provide holistic care to marginalised pts, to connect

12 Stories used- 1) alcoholic pt who step in front of a truck, pt who asked about dancing

Appendix 8.1.4 Tara 1 Summary:

Themes:

1) Consultation Variants- getting to know pts better when seeing them more often

2) Important aspects of relationship and consultation- giving the whole care package, giving time for them to disclose, to talk. Sometimes easy to relate to pts and sometimes you have to work really hard to build a relationship. To give a professional service- a confidential personal caring service as good as if not better than the GP. To show concern

3) Changes over time- pts may divulge with time when they feel comfortable

4) Holistic practice-understanding the pts concerns, their worries and beliefs. Identifying the problem the pt really wants to deal with. It's never ending

5) Boundaries and emotional connections- I always analyse what I should and shouldn't say on feedback from pt. If sharing anything personal- is it ethical, does it help that pt. Sometimes we cross boundaries depending on the feedback we get and there are so many influences- we need to tailor how we react or relate to pts- it's very complicated at times. Pts have asked for phone numbers/to meet etc- that's a no no.

6) View of Spirituality and openness to inclusion within the consultation- spirits. Learning about spiritual needs in a multi-cultural area is really interesting. Story of pt who felt god would heal her- very difficult but open to others beliefs. Story of nurse who prayed for a pt- it was inappropriate but I felt quite sorry for her because she thought she was doing the best for her pt

7)Differences between Spirituality and Religion- think there is a difference but don't know what it is. Spirituality- beliefs and needs, spiritual needs. Spiritual- not human, the spirits of the dead, spirits of relatives coming back to see them. Religion would be belief in their God

8)Availability and vulnerability- Availability I am ready to listen, to be there for you. Vulnerability someone's at risk from others or to themselves (bullying, physical, mental, social). ANP vulnerability when being asked personal questions but once opened self-up to share with a pt (I must have felt comfortable with that pt to have divulged)

9)Personal beliefs- I don't believe in God or any type of gods. Beliefs related to what is right and wrong

10) Ethos ? to show concern, to care, to listen

11)Stories used- Yes pt with mesothelioma and one with fungating breast

Appendix 8.1.5 Polly 1 Summary:

Themes:

1) Consultation Variants- different level of time and support for pts with more serious illness

2) Important aspects of relationship and consultation- time and support, allowing pts to talk, offering appt to come back, trust, safe place. How the ANP comes across to pt and how they feel in their company. The environment, the relationship

3) Changes over time- you tend to become more involved in different aspects of their life rather than just what they present with. You find out what's going on in their life and how it affects their illness

4) Holistic practice- understanding what's going on for the pt. Understanding relationships, psychosocial and work also what they believe is very important

5) Boundaries and emotional connections- there is a professional boundary that needs to be kept but it's not about having to keep a distance. Line can blur because you are someone the pt trusts- you may share superficial info with pts but nothing of significance. Pts sharing what is important to them can create a connection

6) View of Spirituality and openness to inclusion within the consultation- everything that a person believes in, their way of life, what's important to them, how they want to live their life and how they want to impact on others. Spirituality has importance in approach to pts but not necessarily evident- will ask pts what's important to them

7) Differences between Spirituality and Religion- spirituality is how a person likes to live their life and doesn't have to be linked to religion. People can choose not to be practicing but they still have their beliefs and values there still spiritual beings

8) Availability and vulnerability- availability being there when you are needed. Vulnerability how ANP keeps emotionally self also being in a place where you can be vulnerable to what's going on around you. Also it's a safety word- so not being safe perhaps as an ANP not being professional. If in consult and I felt vulnerable I don't think I would be providing anything for that pt- it would be better for me to withdraw if that was the case

9)Personal beliefs- how I live my life

10)Ethos- holistic care, giving time, value different needs

11)Stories used- Yes, pt with insomnia who had been suicidal, pt involved with as a HV, pt who others felt were dependent on her

Appendix 8.1.6 Lucy 1 Summary:

Themes:

1) Consultation Variants- initial approach the same but management may be different

2) Important aspects of relationship and consultation- empathy, trust, therapeutic relationship, being open and honest with pts, having time for them. Important to get the information, to make them feel comfortable, getting the right story being gentle, adaptable and flexible

3) Changes over time- building more of a therapeutic relationship, they develop confidence and trust in you. You take a real interest in who they are and how it's impacting them and their families/lifestyle

4) Holistic practice- connecting with others, building a rapport, being on the same page, for them to trust you, being aware of yourself- where you're coming from

5) Boundaries and emotional connections- I always wanted to be a nurse, to do things for everybody, to make them feel better- it can be a bit to my detriment in that you can get over involved then you need to learn to step back. The boundary goes up and down it depends on the situation, I don't think you can draw a line- I like to think I look after them as I'd want to be looked after as if it was my dad or mother. You need to remind people it's a professional thing. There is no shame in showing people you care but it can be difficult. You don't always step back and can carry a bit of that with you and that can be upsetting. I have taken things home- I don't think you can escape that- it's being human. Nothing wrong with showing you care

6) View of Spirituality and openness to inclusion within the consultation- I've always thought about it, always tried to connect and understand where pts are coming from, how they are feeling/coping. Spirituality is about the essence of a person. Important to understand your own spirituality. It's everywhere really so I can't see you can separate it from how you deal with pts. Spirituality is my inner being, my force, my essence, where I am coming from. How people tick

7) Differences between Spirituality and Religion- Spirituality about your essence, your make up, about being who you are. I don't think spirituality is that connected to religion but for some people it is all about religion and their spiritual self in terms of a higher plane

8) Availability and vulnerability- Availability being there, being open, being accessible because you are available to someone else's needs, being open and ready for something so that you are not quite as vulnerable- you are more in control when your available than when you are vulnerable. Vulnerability- maybe letting pts have some information about you (superficial). Being quite raw and open, letting down all the barriers and being vulnerable to someone else- probably beyond where they should be making self vulnerable to harm

9)Personal beliefs- my spirituality is really the way I care and the way I understand and the way I benefit from whatever I do. Brought up C of E

10)Ethos- my ethos in life is this and that's my spiritual self because it's who I am and my life force

11)Stories used- Yes pt who gave a book, asylum seekers, pt from Romania, Pt with reyes

Appendix 8.1.7 Mia 1 Summary:

Themes:

1) Consultation Variants- complexity means pts look for a clinician they can confide in and who is continuous

2) Important aspects of relationship and consultation- empathy, listening, understanding, pts opening up to you showing their "true colours". Being on the same level. Helping pts understand their situation, what's going on in life and how that impacts them

3) Changes over time- better rapport with more complex presentations, the relationship changes if becomes more "personal" over time. We may do more for the pt as we are more involved. They trust me more and think my judgement is sound

4) Holistic practice- deeper relationships with those who show "true colours", looking at person as a whole including their family and life situation. Drawing the problem out

5) Boundaries and emotional connections- may not be professional to get involved with patients but "that's just how I am", you need to feel at ease with your pt as well as they with you. There is a line you shouldn't cross but doing this job it's not easy to not cross the line but the relationship stays within the consultation. There are times I need to wind it up and keep a boundary. If someone's ill and needs your help you should be there for them and it's not just 10 minutes. It's sometimes hard not to get involved- I find that quite difficult. I have a couple of women who I cry with- they are aware of their prognosis and I can't do anything about that. I do care about them- it could be my family. People need support, help, a friend and I like to think I can do that but maybe it's a bit all encompassing maybe we can't really

6) View of Spirituality and openness to inclusion within the consultation- is it religion or something else? We are all the same but people's morals and beliefs are different. The way you've been brought up, how you live your life. Spiritualism. Talking with a pt who cried- there was a spiritual dimension. Whatever you believe in- some might be right or wrong. I'm not going to be judgemental with pts. We should fit their consultations into their beliefs

7) Differences between Spirituality and Religion- So close but not exactly the same, they must be interlinked. Spiritualism believing in the afterlife.

8) Availability and vulnerability- that can conjure up a bit of a problem can't it? Sometimes caring too much and becoming too involved, you can be a bit vulnerable and too easily available for these pts you know but is that a bad thing? Just it if it over runs into your personal life. Someone who relies on you too much. Personal ANP vulnerability- you can't handle a pt, the violent pt- you've got to be guarded

9)Personal beliefs- not very religious but believes in God, went to church when younger. I have my beliefs and morals- it's in your background

10)Ethos- to care, to be there for pts

11)Stories used- Yes, pt with shoulder pain who thought she had cancer, violent pt

Appendix 8.1.8 Jane 1 Summary:

Themes:

1) Consultation Variants- not discussed

2) Important aspects of relationship and consultation- Trust, time, therapeutic use of self- a reciprocal. Being an advocate relationship focus must be on pt, to put pt at ease, let them tell their story- don't interrupt

3) Changes over time- build a rapport and relationship, builds trust, they feel more comfortable with us, they believe we know what we're doing, it builds warmth and familiarity

4) Holistic practice- how we respond to pts- listening, warmth, support, empathy, honesty, negotiation. Having an interest in them as a person rather than their disease. How problems are impacting their lives

5) Boundaries and emotional connections- . Tricky line as some pts have known me for years- superficial reciprocity is fine (ie pts asking about your children) but not deeper ie this happened to me- that level of disclosure is unhelpful in this sort of relationship- I would pull back from that. As ANP bit friendly and more open than GPs- I tend to be more amiable/friendly. Boundary is maintaining persona that they trust- I am not their friend but a professional they can call upon and I can try and help them. There is a power balance and a need to keep some detachment.....we are trained to keep a distance but I am not comfortable with that degree of detachment- I liked the thought of bringing yourself into the relationship but there are private issues that should be kept -private. Connections- when pts disclose abuse- it's a privilege that they have told me- I think at that time you have touched something in them, something really important, something very deep- it doesn't happen often but it's very rewarding to help them move forward, find happiness and some safety and security again. Story of shaken child and emotional involvement- I was acting in a personally supportive way rather than a professional supportive way

6) View of Spirituality and openness to inclusion within the consultation- if pt presenting often I would ask them about what was happening in their life. May be able to provide something in consultation which may improve their quality of life, help with their internal focus/drive/aspiration. Often underlying dissatisfaction and unhappiness- the onus is on the ANP to help get to the bottom of that. Pts with low mood would make you consider spirituality, exploring why their life is out of balance or if something is lacking- that's a sort of spirituality. Spirituality is something not related to the material, the physical, something from inside- whether a spirit or a soul or whatever it is that needs nurturing. It's about happiness, balance, inner contentment with where you are and who you are. Loss of collective nature of community leading to isolation impacting spirituality

7) Differences between Spirituality and Religion- 2 types Spirituality that comes from a strong faith and Spirituality within relationship (emotional wellbeing).

8) Availability and vulnerability- Availability- in professional sense that you are here and have made yourself ready for pts. I'm available, I'm here, I'm focused on you, I'm going to give you the best that I can in this therapeutic relationship. Vulnerability- I rarely feel intimidated by people but it has happened, sometimes to give something we don't want to give makes us feel vulnerable. Pts have varying levels of vulnerability from risk to coercion (taking wrong messages)

9) Personal beliefs- ?

10) Ethos- connection, community, to be available to pts who are isolated. For pts to have positive outcomes in terms of therapeutic – are they feeling better?

11) Stories used- Yes 1) abused pts, 2) pt seen for anti-psychotic whose daughter was moving away, 3) grandchild- shaking injury

Appendix 8.2 Participant Summaries 2:

Appendix 8.2.1 Lucy 2 Summary:

Themes:

View of summary 1

accurate "I can see reading back it is me"

Views of concepts of A&V from NC and personal view of definitions

"similar in many ways. They are quite similar in many ways….because it's about putting themselves out there, open to other people, sometimes putting themselves where you can get the vulnerability bit in a situation where you are vulnerable"

"you can't have one without the other" (A&V)

Views of Availability

"Putting yourself out there to be available to do whatever…open to other people….open to helping them, open to listening

"If you're not the kind of personality that finds it easy to section things off then you make yourself widely available open always to everything….it can at times be to your detriment" "we don't like talking about (vulnerability), we might like talking about availability because we want to be available, we want to give everything we can- be holistic. We want to understand the ins and outs of why this person is suffering with a problem and how it affects them….because we want to be able to nurture and improve….I think we are quite happy to look at availability….I think availability comes very easy to us (talks about Florence Nightingale and the essence of nursing- caring)

Views of Vulnerability

"if you are to be truly available then you are bound to be vulnerable…..you are opening yourself up maybe more than some people would like to"

“There are people who can put their life into a box…I can’t. I try to but I probably open myself up too far. I do make myself vulnerable in terms of having a lot of stress comes back on me”

“I think because we try to be professionals we are wanting to help others and solve things for them and we don’t want them to see that we are too human at times, we don’t like to be seen as vulnerable”

If ANPs open up too much “it might cause a bit of chaos for pts….you need to draw a line…..(not get too choked up if you upset) “because someone has to keep things together” however “ a professional who empathises with you and shows some empathy and is upset means they are human and to a degree I think (pts) appreciate that…..you want to be the responsible one”

“in certain circumstances it’s good to let them (pts) know if you have had an experience that has been similar without you know making it over the top….if they think sometimes you have had a similar experience it can help them in some ways to deal with it because they see you as someone who has dealt with it”

Usefulness as a lens for ANPs?

?yes

In personal experience those ANPs who “want to be able to do more and more for their patients….to improve the outcome…have to be open otherwise you wouldn’t build that rapport with your pt…..you have to get to know more about who they are as a person but you also bring into it who you are as a person”

“I think people who want to be NPs often want to move beyond…a factual consultation” There is “that spiritual you that wants to move a little beyond that and do a little bit more for people”

How can you help someone, be open, listen to them without having that **availability** and we are all **vulnerable** at some time aren’t we, we all put ourselves in a position of **vulnerabilit**y with dealing with other people. **You can’t separate the 2 (A&V) can you?**

Does A&V correlate with ANP view of spiritual dimensions of consultation?

“It can do- yes”

Boundaries and own practice

“think on your feet but you have got to be open and adaptable”

“age and experience makes you feel more confident to deal with things, to remain calm in a situation. If somebody is expecting something that I don’t feel capable of giving…I’d have the draw the line”

“they come in the training”

“we have accountability. most people can find their level can’t they of when they think they have overstepped the mark”

Use of similar words by ANPs

Empathy, understanding, therapeutic outcome

Thoughts/feelings about integrating spirituality into consultations

age and experience make you feel more comfortable...."

"I don't think you can escape it (spirituality) being there in the first place"

Thoughts around Spirituality

"..the essence of spirituality and essence of a person are the same thing to me"

"you don't have to be religious to be spiritual"

"it's always been there but I never labelled it as spirituality...I looked at it more as holistic care...I have thought of it more in terms of spirituality" (now)

"I'm more self aware

"a lot of this comes as you mature...you develop and experience different things, your views change, you become more open minded...you try to get the bigger picture...it comes through your life....the development of spirituality"

"going through this process and the day (spirituality in health day) actually opened it up, it made me more conscious of what it was....a bit more of a tangible feel for what it is and why it's there"

"its your being...to try and take it outside and analyse it, that is difficult...it's easy to think about it and know its part of you but to try and take it out and look at it and put it in a category or explain what it is and how it fits is really difficult, very difficult"

"I am very much a Christian (though talks of faith internally, doesn't go to church but prays at times to myself)...and you could try and fit it (spirituality) into that kind of religion but I like to separate them... it's just about who you are and how you treat others and how you live your life really so I don't like to think about them as the same"

Hopes and Dreams

as an ANP "to be able to provide a good service to people. be reliable, who can make the outcome for the patient the best it can be... you can't have perfects...but really the best I can do is help people to live a meaningful and well life"

"Developing others.. passing on values"

Values and Empathies as an ANP

"the right attitude..be understanding and non-judgemental and to really care what happens to people and to listen"

Stories Used

Elderly pt who gave a book- "I think he just identified with me….it was a heartfelt thing"

Appendix 8.2.2 Polly 2 Summary:

Themes:

View of summary 1

"I felt it was a fair summary of the discussion as I could remember it"

Views of concepts of A&V from NC and personal view of definitions

Talks about concepts in terms of pt continuity

"I really liked the way that the Northumbria Community works in that it wasn't necessarily demanding that you follow a particular religious group but it seemed to me about how you lived your life and how you were with others....which is what I believe anyway and you show your spirituality in how you live your day to day life and within that the availability and vulnerability follows that ethos"

A&V- "I think are important for me....they fit with my spiritual beliefs...it feels like a holistic part of my work as an NP.. because of how I choose to live my life"

"They fit with spirituality alongside other concepts, not instead of, or more important ....they probably move around in terms of importance" Other concepts expressed "kindness, care..non judgement, taking time to sit back and see them as a whole person

Views of Availability

"welcoming, being non judgmental and making yourself available"

"I try to make myself available and yet that can cause some vulnerability in me because of my nature"

Views of Vulnerability

"I was surprised about what I said about sharing personal experiences with pts (in first interview) and how that can impact on the consultation-I don't know if that's a good or bad thing....its still something I do use...things from previous consultations. or from my own life and I do feel that occasionally, not often that it might be appropriate to share with those patients to help them understand or cope with the situation they are in"

Shared analogy she uses with depressed patients of life as a chest of drawers and one day finding you squeeze anything else in- "to help them try and understand that they are not going mad..that they are not unusual"

" I am aware I am quite a shy person anyway so I do what I need to do to make people feel comfortable, especially in a consultation....I feel it takes a lot of emotional energy to do that which makes me feel very vulnerable at the end of the day...emotionally tired and (I) need to find somewhere where its almost safe for me not to have to think about other people first all the time"

"I think if you share any of yourself then it has the potential to make you vulnerable in that relationship and I think on the whole you judge when and who it is safe to do that with and so I wouldn't choose to do that with everyone"

Would not share of self “with patients where they don’t make you feel at ease”

Reading rule has made her consider more “the vulnerability of the patient. Coming to see us can make them very vulnerable and it is important that that is acknowledged and that they need to feel safe...I think that’s part of my approach, my spirituality within the consultation”

Usefulness as a lens for ANPs?

“on reflection it could be. I think my big fear would we have time to do that but yes I think to some degree you know you are already doing that internally when you are thinking about what you’ve seen in your consultations”

Does A&V correlate with ANP view of spiritual dimensions of consultation?

“I think it has to for me.....because of what spirituality means for me. If it’s how I live my life then I can’t change or adapt that in a consultation because that would mean not being me”

Boundaries and own practice

“I wouldn’t want to share anything intimately personal or anything when I thought the patient might be able to come back and say ‘well she said this’...I think you have to choose very carefully when and what you share but that can change.....it depends on the relationship that you have with that person”

“there is a professional boundary and that shouldn’t be crossed and the other thing is you need to be careful not to create a dependence on you or what is perceived as a dependence”

Then talks of other clinicians view of dependence when actually it is about continuity for pts and them not having to go over the issues again and again- interesting dependence vs continuity

Use of similar words by ANPs

Understanding, support ,listening

Thoughts/feelings about integrating spirituality into consultations

Thinks about it on “general reflection at the end of the mornings surgery or a patient that is particularly worrying me”

“I think that spirituality for me is how I choose to live my life and what’s important to me that then is followed through consultations and patient care so for me I have to make them match, make them meet through reflection...I probably haven’t though ‘well what I am thinking spiritually”

Safeguards around integrating sp into consultations “no different in any consultation, the patient needs to feel safe”

“some patients just want to come and be told what’s the matter with them, what they have to do about it and that’s the end of it”

Thoughts around Spirituality

“I think that spirituality for me is how I choose to live my life and what’s important to me”

Consciously tries to embrace spiritual dimensions in consultations because of how she has chosen to live –“I would say that yes”

Hopes and Dreams as an ANP

“surviving each day (joke), providing good quality care for patients, enjoy/ get some benefit from ongoing development/learning an a NP”

Values and Empathies as an ANP

“give time, let them speak, listen to what they have to say and listen to what they think as well” “I feel strongly that we should be empowering them (pts) to think and feel for themselves without being told what to do, to take charge of their own health”

“to keep the patient as the focus because that’s important”

Stories Used

Chest of drawers

Girl who was raped and didn’t come back- is it because she didn’t feel safe or external factors- lot of self-reflection from ANP about could she have done more

Appendix 8.2.3 Mia 2 Summary:

Themes:

View of summary 1

“I think this is me when I have read it...I think you have got me summed up”

Views of concepts of A&V from NC and personal view of definitions

“It’s how I think it is .It’s probably how a lot of people think really...I think it’s what we do”

“I know it’s there in your daily life....it fits with how I perceive it”

Views of Availability

“I would agree with that” (NC definition)

“availability I can agree with that”

Views of Vulnerability

“I don’t know about vulnerability...a little deeper than I would have thought” (NC definition)

“I think more of the patient’s vulnerability which is not necessarily the same thing is it?.. I think they are all very vulnerable when they come here...just expressing how they feel to a complete stranger, its not an easy thing is it and I don’t know it’s a hard one but I don’t think its that deep”

Q about sharing something of yourself in order to help another move forward- “Yes I’d go with that yes...I think we have to do that, not always but in some cases. I probably makes the patient a bit more at ease, a bit more comfortable, that we are actually human and we do have the same problems and sometimes it just helps”

Talked about 2 levels of vulnerability- NP after attack and pt vulnerability- “it would fit more into where I am”

“it’s the vulnerability area that I don’t know whether I agree with but I don’t know it is a bit deep, it is a bit religious isn’t it and I don’t know whether I won’t say I don’t agree with it but I just find it a bit difficult”

Usefulness as a lens for ANPs?

“they are fairly useful-it makes me sound like a bit of a crackpot really...its there in your mind isn’t it to be drawn on but I don’t think you should push that issue with pts and it’s not something they talk about is it really, its just what you glean from the consultation” more to use as “an awareness” not overt

Does A&V correlate with ANP view of spiritual dimensions of consultation?

“it does in my mind...its how I see it but not always how I would continue a consultation”

“ it’s part of my upbringing, I just think it’s important, it’s part of my moral code if you like- does that sound silly?” Boundaries and own practice “there are always safeguards in consultations...I don’t think you should push your views onto any patients and I certainly wouldn’t do that”

“we have to just build a little fence around ourselves to a certain extent don’t we but be prepared to share if it’s coming out that way- does that sound right”

Use of similar words by ANPs

“Empathy is a big one isn’t it”

Thoughts/feelings about integrating spirituality into consultations

it comes from the patient- “it comes from them and then you know it can be opened up if you like but it’s just there-I don’t always use it. I’m crackers”

More conscious of it now “particularly in the few days after we had that last interview I started to think about it but then life goes on and it’s just nothing changes really” (meaning she feels the same way about spirituality relating it to her moral/religious framework)

“it will come up won’t it and you know we can look at areas

Thoughts around Spirituality

“Spirituality is Christianity, is religion really”

“I find it quite difficult to discuss really”

“i do link it with religion, I do link it with moral code but not to the extent where I would enforce anything like that on a pt. It’s just borne in mind isn’t it, the christian life”

“I don’t go to church every week...but it’s there, it’s always been there”

“it’s the way I am...I haven’t looked at it in a different way or anything”

“I’m just aware...I link spirituality with religion”

“what we have taught to us as children and grown up with is not necessarily the same...I probably agree with you now because I think spirituality like you say is more meaning of life and things rather than- I know it goes hand in hand but there is a little stand alone bit isn’t there”

“part of our make-up...the way we are brought up”

“I’m not going around reading a bible or anything I just know it’s there, it’s just my life, it’s hard to explain really but it’s how you act and how you conduct yourself isn’t it”

Hopes and Dreams as an ANP

“just that I do a good job and you know I am respected for that really”

“to be useful in practice...looking after the patient in all aspects, sorting out the problems, being a point of contact..who will listen and show empathy”

To feel that pts “have benefitted from it (the consultation) then that’s enough for me yes”

Values and Empathies as an ANP

“it boils down to moral values and moral code....I think its just being, having empathy and caring about people....I want to care for people and I want to given them a better life in some way”

“treat them as your family”

Stories Used

Talks of young girls getting pregnant requesting a termination as a spiritual issue

Appendix 8.2.4 Tanya 2 Summary:

Themes:

View of summary 1

“the summary of it and the interpretation of it was pretty accurate and correct”

“It was an interesting thing for me personally to read back...around some of ways that I responded to things

Views of concepts of A&V from NC and personal view of definitions

"I read it quite a few times and tried to think about in my kind of role and I kind of thought it was really quite relevant really in the sense that I work with such vulnerable people"

Talking about rule of life-

"thought it was interesting that to be completely **available** to people and out yourself in a position where you then become very **vulnerable** but whether or not that is a really positive thing to aim for achieve and we currently try- I don't know whether that's really beneficial for patients or for us"

"nice concept to think that you are always available to others and that you can accept vulnerability- is that a conflict of actually having some life rules for yourself to protect you as a professional and to protect people?"

"I think I agree with the fact that you need to be available and vulnerable but I do think that needs balancing with the rules and I think that's kind of its difficulty isn't it. I think its about trying to kind of ensure that what you are clear about as a professional is that the things that you put into your work time and your life allows you to have that balance that whatever vulnerability you experience at work you can off balance within the rest of your work or life so you can feel emotionally well but that then feels a little bit like your kind of limits on what you are available for or what you are prepared to give and is that a conflict with the true meaning of being **available and vulnerable**?"

"they are similar if I was thinking about my own life but I think I am working with clients then I have to rethink a little bit"

"it makes me feel a bit irritable (reading rule)....I attempt to be available to people when I can and I will be vulnerable at times and I equally also know that they are times when to protect myself...I value those key very connective deep moments with people when actually it's very meaningful but I get a bit irritated (by the implication of the rule) by bits like if you are available to people all the time and you are vulnerable all the time and live by these rules then somehow your going to be this really deep spiritual person which doesn't feel possible to achieve"

Reflecting on recent stresses at work and feeling burnt out "putting it into perspective of this a&v stuff has been quite useful to think about stuff around life rules and actually where does it become unhealthy that you are so available and so vulnerable that starts to be really detrimental to your health and well being and I think I would like to keep hold of some of that for the next few months as some changes are happening. I'd like to think that I wouldn't kind of go to the extreme which I feel like at the moment where I don't want to be available or vulnerable to anybody at the moment so I'd like to kind of think I can bounce back into some balance again really"

Views of Availability

Work place "we are kind of pretty much there every day for people to come in and utilise us as a sounding off board or as an emotional kind of environment to feel protected and safe...because of that you do very much strive to be open and available all the time which does in turn make you quite vulnerable really"

“if this was about being truly available to people completely and utterly and you were prepared to take all the vulnerability that came with that for me that wouldn’t be about being professional because you would completely eradicate any of the professional boundaries....where would you stop?”

“bit of conflict, I think about availability in that you have to recognise that sometimes you are doing it about your own needs and your own requirements and not just purely out of wanting to be, wanting other people to gain something from it and I think that’s a little bit about being professions.....I am more than happy to be available to people at work and support them emotionally.... but I am not going to take them home with me and I am not gonna do all those things that I would do if I was 100% completely available”

For her “if I am available to people in order to help, I guess to make someone feel that have been supported that day or they have gained something or they have just stayed alive...my interpretation of availability isn’t necessarily the same as the person who is sat in front of me”

“I guess it’s about (time)....but “I’m not sure it is about time....I might have been available within the relationship of time and I might have listened to that person and may have been able to help them resolve some things but I wouldn’t necessarily come away and feel like I have really given that person something extra of me that would fit in my concept of A&V and spirituality whereas I can have a brief minute when they are leaving but actually the quality of that interaction is much more about me putting myself in that **vulnerable** position really”

“I don’t think I would sit and say that every time we are available to somebody that that is necessarily is on spiritual level because it doesn’t always feel like that”

Views of Vulnerability

After 1st interview “reflected about just how vulnerable a profession you are when you are working with people who are at the end of stage of life early in their lives.....it was interesting to think about (the boundaries) we do put in place to protect ourselves and how much it does actually make you kind of **vulnerable or available** really”

“.....I felt that the more available you become then the more vulnerable you become do you actually then lose track of that stuff around rules of life really and do you then make people dependent on you? When you are not there what gap does that leave for them (the pt) and how vulnerable does that make them as a pt then equally the more vulnerable you become as a practitioner and I guess this feels quite relevant for me at the moment because my stress levels are so high is that actually how much emotional and personal damage that does to you as a professional in the long term”

“I think sometimes I am quite comfortable about disclosing things about me that put me in a vulnerable position within that relationship that actually is about reassuring that person or about kind of allowing that person to truly know that I understand where they are at and what their difficult is which may help them to kind of rethink or kind of move forward a little bit....sometimes it can’t feel comfortable and that can be because of the individual”

“the thing around vulnerability that the more approachable you are the more people actually become dependent on you and it doesn’t always the become helpful for either of you”

Usefulness as a lens for ANPs?

"yes I would but I am gonna say that I only think about it actually in my consultations where we really have the time to sit there to be **available and vulnerable**, I can't say that for all of my consultations"

"it works as a useful lens for spirituality but I think you don't necessarily do a consultation which is based on that end, you are just privileged that sometimes you get consultations where that connection with that person has been at that kind of place.....that consultation can take 2 ways and it can be either that you are available in a very sort of superficial way that allows us some time to be able to talk through something, to off load and then they may go away feelings thats been useful to them in a spiritual way and then you will get those moments where that connection is just so very different and you are in a position where your availability is on a different level and then you are in a much more vulnerable position because sometimes it's about your personal vulnerability either to take on board something from them which is emotional or traumatic that you are going to carry or that you are disclosing something about yourself which is part of that connection but I don't think you can see or plan that. I think it just happens and often it's not until afterwards when that person has gone and your reflect on that and kind of think that would be fitting into this model of A&V and spirituality"

Does A&V correlate with ANP view of spiritual dimensions of consultation?

"It's about depth of the consultation I think or about the interaction of the consultation"

Boundaries and own practice

"it is really difficult sometimes to have those boundaries and those things when your working with people who are very emotionally attached to you because they see you on a more regular basis"

"I can come to work and put boundaries in place and think of good life rules that allow people to feel emotionally and physically well but I work with people who are never going to achieve what my concepts of those life rules are and in some cases by doing some of those life rules actually puts them in danger and vulnerable (ie np life rules may impacts pts street safety ie she doesn't believe in harming others but some of her pts do but doesn't put that view on pts).....some of the clients I work with have life rules that don't fit in with my concept of life rules-it's quite complex really"

"I think availability comes with some boundaries really or some consequences or restrictions really"

"you have to be really kind of comfortable with it (spirituality) in your self about your limits around vulnerability. If you regularly sort or ensure that your approaching peoples spiritual needs, what does that leave you with and how do I deal with that and I guess there is an element of ensuring that whatever you kind of put yourself into that vulnerable situation is that because you know your boundaries, that you recognise that within the consultation and you can manage that afterwards and that would be around clinical supervision and having clear boundaries to start with"

Use of similar words by ANPs

Listening and understanding

Thoughts/feelings about integrating spirituality into consultations

"Within my consultations I have done that much more (think about spirituality) and I think I feel much more kind of think I have been much more able when patients come in and talked about what they believe is their concept of spirituality which often for a lot of my clients seems to be linked with their religious beliefs. I think I have been able to kind of receive or be more aware of that really. I don't think I ignored people before but maybe I didn't always kind of connect into the importance of how it affected some of the things we talked about in the consultation. I have certainly tried to allow more time for that to happen"

"I just make a presumption that my clients when they talk about religion that is what they mean by spirituality whereas I know clearly what my views are on that that are very separate and why wouldn't I assume that other people haven't done that or think about it differently...I shouldn't assume they are linked together for everybody- that does make it harder though, how do you gain that from patients and should we and how would we?"

"It's not always predictable when we are going to have those moments (spiritual) and it feels a bit false to me to think that from today I would go away and do all my consultations thinking 'I am going to be really spiritual about my consultations today' and for me to lose then I think, I'd lose those moments that actually become really meaningful within your relationship with a patient because it naturally just happens and I am not sure I would want to do that really"

Thoughts around Spirituality

"I think it was interesting my response about my beliefs and differences around spirituality and religion....that is what I believe but maybe it doesn't capture the whole depth of it" (1st interview)

"I guess if you think about spirituality as being about being a human and about human contact and about protecting and supporting then ...about my life and morals"

"I spent a long time in my life actually exploring what my beliefs and values were and how that fit into what my idea of spirituality is and what religion is and I didn't make those decisions lightly, I put a lot of thought into that really and that's developed over time so I feel comfortable where I am really with my beliefs around that (spirituality)"

When talking about listening to patients and friends in need "it's just about being a human being isn't it?, its about having manners, its about being courteous...just being a good person...when I think about spirituality I do think it's much more a depth thing really otherwise I could just say 'well you know I am just this amazing spiritual person that's just there for everyone on tap and I know that's not true because. I sit there and I might listen to somebody for 10 minutes some says and I am listening to you and really connecting with you and other days I am listening because I am there but I actually really tired and stressed and I am really thinking about other things and I am not really spiritually connecting to you am I?"

Hopes and Dreams as an ANP

“to maintain what I have now...element of having a relationship with patients that isn’t about..ticking a box or being practical”

“it’s great to competent at my job, it’s great to help someone physically and to make people feel better”

“to be in a position where I am healthy and open enough (to allow patients to cry/be vulnerable)... to be well and emotionally balanced “

Values and Empathies as an ANP

“to maintain some professional standards.to work professionally...to work in a way that breaks down lots of barriers for people (ie letting them call her by her first name)..as long as I maintain professional standards”

Stories Used

Talks about film “Another Year” where a couple try to be completely available and let very vulnerable people into their home- the people they give to never really change and become more depressed and the reason the couple are doing it is to feel better about themselves- it’s a bit like A&V it sometimes helps people but sometimes doesn’t

Talks of spirituality being big for asylum seekers (linked to their religion) and then for the homeless spirituality being around life/death them wanting to end their lives or not coping with life

Appendix 8.2.5 Tara 2 Summary:

Themes:

View of summary 1

“I think it was actually fascinating that I had said all those things in the hour and it was really interesting for me to see some of the things I had brought up...there was nothing in the summary I disagreed with, on reflection I realised I had said all those things”

Views of concepts of A&V from NC and personal view of definitions

“I think they have importance to help me know more about patients and their beliefs and where they are coming from and also where they want to go and want to see their life to be, what they get fulfilment out of

“I think vulnerability (correlates for her) then gives defs of vulnerability and availability for her

Views of Availability

“I think availability- my understanding of it is people are available to help those who are vulnerable. Patients needs to show availability to actually help themselves”

“I mean you know by having a consultation you are giving something away, you are giving a listening ear, you are giving concern, you are giving empathy so you are making yourself available through that way to everybody who comes through the door you are showing some availability”

Views of Vulnerability

"I think all of us have certain aspects of vulnerability and I think in that there is good and bad. I think patients are vulnerable the minute they take on the role of being a patient as are their relatives. I think as nurses we are also vulnerable because we are dealing with patients who present with deep emotions, physical, mental and social problems so I think all of us have to cope with vulnerability...I think being vulnerable there are positives about that as well"

"I think vulnerability is definitely important because we may perceive a patient to be vulnerable and they have no realisation that that's actually a fact" talked of pts more at risk of sexual abuse and they not being aware of that

" from my last interview I remember talking about when I felt able to give a part of my experiences which I thought would help the patient and when I knew my boundary for sharing those perhaps because that made me feel vulnerable or perhaps professionally I thought it was wrong so yes it would be you know it is important that we do share and give" In response to whether deliberate vulnerability is relevant in the consultation"

"we are very vulnerable as well as the patients and relatives and anybody we come into contact with you know, you can be made to feel vulnerable"

Usefulness as a lens for ANPs?

"I think it would be difficult to say yes or no because every patient is different and every patients' spiritual beliefs are different"

"I think they have importance to help me know more about patients and their beliefs and where they are coming from and also where they want to go and want to see their life to be, what they get fulfilment out of"

Does A&V correlate with ANP view of spiritual dimensions of consultation?

"Yes- but I still find it difficult to differentiate between spirituality and religion"

Boundaries and own practice

" be aware to be professional at all times and if someone has spiritual or religious beliefs not to persuade them to change like the nurse you mentioned who prayed for the patient"

"I think it is very difficult looking at spiritual and religious side of the consultation to make sure that we never ever put our own opinions on things"

Talked about pt from last interview with fungating breast who believed God would heal her - that would be very difficult to not want to challenge (MR) "you know I suppose I did and the chances are you are not going to get better"

Use of similar words by ANPs

Empathy, care, listening (not love- "love is above that")

Thoughts/feelings about integrating spirituality into consultations

“I realised I know very little about spirituality and about different peoples religions and ....I suddenly realised that I perhaps spend very little of time during a consultation focusing on that area (spirituality)”

“..perhaps I do touch on it and not realise it’s actually spiritual...I do believe perhaps using that as an excuse there is a huge time commitment in looking at that part of the consultation- sadly”

“I think it does need time for 2 things- one from the patients perspective to enable them to feel comfortable and to express their beliefs and feelings and also from their point of view to have a better understanding of that patients’ beliefs and that would help looking at the whole health belief problems of that patient”

“it’s got to be patient led you know possibly the questions we ask you know abut their life, what do you want the end result to be and what would you hope for to happen in the next few weeks- maybe ‘I want to be physically well, I want to be cared for again or loved again”

“I think we work more to a medical model and it is very difficult to get into those areas (spirituality)...perhaps it may be more beneficial...in psychiatry or drug use....in a longer consultation”

“I think it is very difficult looking at spiritual and religious side of the consultation to make sure that we never ever put our own opinions on things”

“I probably spend less time on spirituality than perhaps I should”

“sometimes during a consultation you actually don’t realise a lot of what you do is instinct, give on instinct and you know perhaps during a consultation although I don’t think I am giving a spiritual meaning to the consultation perhaps some of the things that I say or the way that I look at the patient or the encouragement that I give them...perhaps I am providing some of that (spiritual dimensions) in the consultation”

Thoughts around Spirituality

“I have actually done a little bit of reading around spirituality and I’m amazed that there appears to not be much in any nursing books that I have here as whole expanse of nursing books and not one of them touches on spirituality....so I do believe if the NMC are saying we should be doing that you know perhaps there are not selling it”

“....it’s a time thing and perhaps spirituality means so many different things to so many people”

“but I still find it difficult to differentiate between spirituality and religion- a lot of the things are very very closely linked, I just find it quite difficult to tease both of them out”

“I think spirituality is a huge huge umbrella as religion is as well and I think spirituality for different people means different things. I think religion as well for different groups means different things and I just find it all very difficult- sorry”

“Hope, meaning and purpose also has religious connotations as well you know and purpose, belief, hope in that you know the God will come true for them so in that respect those 3 words can also be linked to religion as well”

“you can have Christian values you know and life values related to your beliefs in religion”

“huge, huge area...a lot is about spiritual beliefs, what has gone on in the past, what happens to our souls when we die and things like that- some of those things I don’t think are helpful to bring into a 15 minute consultation”

“I think it (the word spirituality) is unhelpful because a lot of the sort of definitions.... come under over things as well....(gives me a definition) “what is spirituality-‘involves experiences of deep seated sense of meaning and purpose in life. A sense of belonging. A sense of connection of the deeply personal with the universal, acceptance, integration and a sense of wholeness’. Is that spirituality? Is acceptance spirituality or is it just part of human nature?....I know very little about spirituality but I would probably say it’s just part of human life, it’s just part of the way we are- we want to be accepted, most of want to be loved, at times most of us feel unaccepted in areas whether that be socially or at work or in difficult times”

“a lot of it (spirituality) goes into ..the afterlife and the dead and the spirits...a lot said it’s different from religion and then the next says it’s very similar to religion-it’s a very difficult subject”

“there’s another thing about spiritual health care’ to feel safe and secure’- well that’s a human need isn’t it?, ‘to be treated with dignity and respect- well that’s what we want out of nursing care isn’t it or nursing care for our friends. ‘To feel that they belong, are valued and trusted’. Well again is that spirituality or is that just a human need? ‘To have the chance to make sense of their life including illness and loss and permission, support to develop their relationship with God whether absolute’”

“I know they say they are different (religion and spirituality) and the next step they are actually making big associations between the two”

Hopes and Dreams as an ANP

“that I give every patient the care they deserve. My hope is that I never make a mistake again in care. I know I will make mistakes but nothing that will cause real harm to that patient or their family.

Values and Empathies as an ANP

“I suppose my values that I have been brought up with historically you know to give care to people, not to cause hurt, to be a good listener. Perhaps to show empathy, care and perhaps a need to want the patient to respect me in a way and hope that they feel they are getting good care. That’s why I became a nurse, not working in tescos!”

Stories Used

No

Appendix 8.2.6 Jane 2 Summary

Themes:

View of summary 1

"I read through them and it seems all there-I can't see anything I would want to add to that"

"I suppose the trickiest one was the boundaries and emotional connections bit really but what you wrote down was a fair representation of what I have said. I suppose it just made me think a bit more about where I draw a boundary in a consultation"

Views of concepts of A&V from NC and personal view of definitions

"availability yes....vulnerability I was struggling with....(see defs)

"the heart of how the nursing is different for us compared to how it used to be and that is an area that's really interesting but that element still of nursing and maybe vulnerability and availability are the ones we take with us?"

"to call yourself intentionally vulnerable I guess is just a word. To be intentionally open and take on board what people are saying. To be able to synthesise that with what you are doing and move forward with it and perhaps challenge, yes, I can see that. It's just the thought of almost promoting weakness I suppose. It's just a word, it's just a word and describes perspectively that I can understand but I just have problems with the literal meaning of it. Availability yes you can see entirely how that applies to nursing, vulnerable, I am not intentionally vulnerable- you have to be I guess"

Views of Availability

"Availability-being ready, being open to people, to patients, I think I recognise that"

Views of Vulnerability

"Vulnerability I was struggling with because when we think about vulnerability, of vulnerable adults we think of people with a weakness, or who need our help. I don't think I ever thought of it other than feeling intimidated perhaps by patients as vulnerability applying to me and that seemed to be what the rule of life was saying and when I thought about it again I guess there is an element of we are agents of change for our patients and also what they bring us changes what we do so I guess that would be where I see it (vulnerability) sitting....not that what we do changes our views entirely but what they bring into the consultation we sought of synthesise with what we know and take that forward and perhaps alter how we consult in the future"

Being in the same practice for 20 years- "yes it does open you up really and opens up parts you wouldn't normally give to people other than family"

When talking of not sharing of self- "I don't want to sound like I'm cold and detached and I don't interact of I don't have compassion or I don't meet on that level with people but that's why they come to see me and I guess some part if what I do share in terms of who I am rather than what I have done or what I have experiences makes them keep coming back and choosing us as clinicians"

When looking up vulnerability- "I saw almost sort of defencelessness or weak or in a sort of inferior position. It seemed to be more about openness really than vulnerability (from the rule??) and I know this word is creating a block in me really but it seemed to be more about openness and willingness to change and to share and to perhaps alter what we think or how

me behave as a result of those interactions...I am looking at it (vulnerability) very literally...I couldn't come up with a better word for it really. Willingness to be accountable then?"

Talking about NC definition of intentional vulnerability- "yes I can relate to that, I can relate to that almost laying yourself open to what people are saying and about taking from that something that's possibly going to help people in the future or that changes the way you think or look at people, I can see that and I do think it's just the word...I think the perspective is very good but I struggle with the word"

"when I first read it I thought 'my God I will make myself weak in front of these people. Surely they will want to see me as being professional and able and confident' and it seemed the whole antithesis of everything that I had thought I should be but I can see that it is just a word and the meaning it conveys in terms of spirituality is different to the meaning it conveys in terms of you know the vulnerable adult perspective"

Usefulness as a lens for ANPs?

"Undoubtedly yes-it's made me think an awful lot about what I am doing and it's made me very aware of when I am consulting. how open am I just even in how I'm welcoming them. Have I got a bit blasé about it all? Am I sitting here as they come to the door or when I first started I would walk down and fetch them. just to try and create an open and start of the relationship. so I think it's made me think much more about being open, about not letting the little bits that they are dropping in the smoke screen stuff. Not letting that pass by and at least giving them the opportunity to talk about things they want to rather that you know trying to run to time or who is coming next. The vulnerability has been confusing me all weekend really (talks about trying to find another work and it make her think of weakness)...but trying to look at it from that perspective of being open, of sharing, of creating contact and then possibly of that changing what you do and what they do afterwards I think is really interesting...I just need to work my way around the word"

Does A&V correlate with ANP view of spiritual dimensions of consultation?

"Availability yes- we are here, we are open, we are ready to listen, ready to help. For availability it is again that sort of impact, that interaction of what's flowing backwards and forwards isn't it and how much I am open to them, tricky one, still not sure where that level should be"

Boundaries and own practice

"I still find it hard and I still find it's a moveable feast. I tend to renegotiate according to a situation, the problem and the person...a lot of patients know me and have grown up with me....they probably know more about me or I disclose a bit more than I would do to others so it's a bit of a dilemma for me really and one that I do still struggle with at times...They come to me as a professional because they think I can help them and I think I need to retain some, a little bit of detachment to be able to be able to fulfil that role and I think the times I have got into problems is when I have overstepped it" (eg from last interview of grandchild)...."I had perhaps been a bit too friendly and a bit too familiar with them and I had to draw back and it was very uncomfortable.....I mixed up the personal and professional...I really felt very strongly that I had and I'd had always had a very strong view of my professional identity and I got it completely blurred there but does it make me vulnerable...again I just keep coming

back to vulnerability as being a weakness and I don't particularly feel weak in a consultation other than I suppose its hopeless when you feel that you just don't know what is going on, those are difficult moments but I still struggle with vulnerability and I tried looking it up to see if I could find another word I would be more comfortable with but I can't"

"you do share aspects of yourself in terms of your companionship, your trust, your empathy...but if we are talking about sharing personal experiences perhaps experience of illness I am not sure that it always does help. I think sometimes that clouds things rather....I am not sure that sharing any of my personal story would help them and I think that does take it out too far out of a professional relationship for me"

"shared history certainly does (change the consultation) and sort of emotional attachment or connections certainly change consultations...the centre of it still you have got to get those clinical decisions right where you can"

"trying to be all of those things and explore all those avenues (the complex of social etc) I seem to be creating odd dependents on me or on services...we all have within clinical practice 2-3 people who almost seem dependent on us and that's hard because then we have lost our way a little bit because what we are trying to be is an advocate and trying to empower them rather than them relying on us to make decisions for them...it's difficult to disentangle from without creating resentment or pain"

Use of similar words by ANPs

Humanity, openness, willingness, compassion, trust

Thoughts/feelings about integrating spirituality into consultations

"yes being able to connect with them on that level and I think that is sort of spirituality I see in nursing."

In response are there specific times that a spiritual dimension occurs- "yes specific time I think" then talks about simple consults where someone comes for the pill and that's what they get, then other consults where pts may not get what they come for "maybe a conflict if we don't give exactly what they expect and that takes on another dimension. A lot of social stuff comes our way, a lot of mental health problems... and sometimes just the chronic disease .create more of a feel of connecting with people. you learn a little bit more about how their problems are impacting their life, what their life is, what their expectations are, what their aspirations are, when they become a social being with an illness. there are the most satisfying. The most difficult too...trying to find a balance between professional taking the objective view of what it is happening and a person taking a subjective view of how it is impacting their life (?spirituality)

"I think I have always accepted there is a sort of spiritual element. I have never used anything to actually focus down what it is. there's always benefit to us and the patients in being able to describe what we are doing, describe what our contribution is and describe the unique features of our care and just remind us every so often about the connections that we can make and the benefit they can bring as that's the bit I think we all like"

"I don't know...I never thought of it as spirituality, I never gave it a label, I never really looked at it- I do reflect and I do keep reflective journals and I do think about consultations but I

never really put it into that domain as such but it was quite useful and I hat to use the word 'enlightening' in terms of spirituality but it was, it was illuminating and it did actually draw together a lot of the things you do without thinking about it and it put it under one sort of umbrella" Was aware of it happening without giving it "a particular label"

Thoughts around Spirituality

"I thought there is this sort of faith spirituality" relating back to previous defs she gave 1) faith and 2) "relationships and trust"

"..just being able to connect with people, to be able to comfort or reassure, or explain or to be an agent of change for them, just trying to reach something that perhaps they are not giving to other people that would be the view sort of spirituality"

"I think it's always been there...I do have a strong faith but I see this as different....I have always been quite clear about where the 2 things are (previous 2 defs of spirituality)"

Has always seen religion and spirituality as separate- "it has never occurred to me (*to conflate the 2*)"

If patients ask her if she believes in God "I don't lie to them, don't say I have no opinion on it. I would tell them my views and ask them theirs and that might lead t some comfort perhaps to them if that's what they were looking for but I don't do more than that really" (end of life issues/bad diagnoses)

Reflection via email "I was reflecting later about the perspective we discussed and thought our ability to connect with people and the spiritual dimension as a feature of maturity of us as practitioners"

"it's about a sort of deeper connection that sometimes you experience in a consultation that people are being very open. You are being open to them and allowing them to tell their story, tell you what's happening, tell you what impact it is having and just being able to share that and to connect with them to perhaps not tell them what to do but to perhaps give them some guidance and to find it is appreciated, returned and welcomed and even acted upon I think and then you feel that something has happened there that isn't run of the mill, that isn't your normal consultation. I think it's really, really rewarding when it does happen...I think it's what's keep us hooked really on the thought that a tiny difference (has been made)"

"it's the relationship be it of the therapeutic that is really challenging, the best bit"

Hopes and Dreams as an ANP

"professionally it is just to be I suppose the best clinician you can be, through the relationship—I would want to explore any avenue that I thought would help or change whatever I needed to if I thought it would be of great benefit (to the pt)"

"I would want to do it until I retire as its enjoyable, I think its rewarding and I think it does have benefit.I think the whole role of a NP has benefit and I think just being a good front line clinician raises the profile of our profession"

Values and Empathies as an ANP

"a nursing ethos...I think I'm still a nurse but I struggle sometimes to identify what the nursing contribution is and I think when you back to the ethos of nursing in terms of caring and compassion, of looking after the whole person, of taking on board social, emotional factors I think that's really important. Its not necessary in every consultation. Some people want just want a repeat of this or I need the pill or whatever, and you can do that in a professional way and a friendly way but that's what they want but I think for a lot of the problems that we have in primary care, all of the other are really important. All of the being the good nurse is still really important and they are ones that have the most value and the complex stuff, yes so what was the other bit of it?"

"I think the values that we would normally ascribe to nursing I think are first comfort, care, personal values I suppose honesty, treating people fairly, having respect. I think all of those are really important when you are dealing with patients who are ill or are disempowered and needing your help I think they are really important so I guess that would take the sort of personal values, the professional ethos and put it together with the sort of hybrid role of a fairly sort of clinical, traditionally medical core of skills and I think that's the only way that I can work. Does that answer all of it or is there still a bit missing?"

Stories Used

Talks of using examples for pts with depression- taking them forward 2-3 months to how they will be with treatment etc.

"But I think I sometimes struggle when I feel I am being manipulated to actually maintain that perspective and to keep on being open and to keep on being willing to take on board and to trust what people are saying when I feel that I am being manipulated by people to their own ends and I suppose the only one I can think of as being recent has been a lady with undoubtedly had anxiety and depression at the beginning but has come to enjoy the attention from family not working having to time to herself, being able to say yes or no to pretty much whatever she wanted to the point of manipulating by taking a few tablets, just enough, so her husband would take her to hospital and I am really struggling to get to the bottom of that and to keep this open, trusting persona going really. They are very hard and they do challenge your own values because you want to keep on being supportive and you keep on wanting to believe but there is always that undercurrent that you are manipulating me now and your family to your own ends. A big bit of me hopes in a way that i'ts internal distress. I don't want to believe she's intentionally doing it, again she's somebody I have known quite a long time and I have never seen this behaviour from her in the past so I am hoping its some internal distress but I feel that I am being used as part of a broader plan and again that is taking some disentangling from me but then that's when all of this becomes very very difficult. I don't have an answer for that"

Appendix 8.2.7 Georgia 2 Summary:

Themes:

View of summary 1

"It seems very fair, yes it seems a good description of what you know I can remember"

Views of concepts of A&V from NC and personal view of definitions

it is a new concept-I think these are kind of everyday words but are used in a completely different meaning here"

"these are quite difficult concepts really. I mean I think as the NP I definitely have to be available to the patients and accountable to them and if you think at the centre of me is a spark of divinity then I suppose I am making that available to the patients through the consultation and the interaction with them...does that make sense?"

From email after the interview-

"just had important thought after you left- don't know if you can include in-but pondering meaning of vulnerability on way to ballet.... as you do.. and I think real significance of vulnerable in terms of the NP = possibly not being centred/fully in the moment/fully responsive and able meet pt needs/in terms spiritual dimension s/he may not be tuned in to their higher/wiser/more loving self= ie great if the NP is "fully self actualised" but who says the NP has to be wise/loving/spiritually aware?? does this make sense? I think that what the community meant by knowing/understanding the scriptures etc... ie having the right things/knowledge/attitude to offer the pt. basically to reduce vulnerability to the pt the NP needs to be centred/aware/present and tuned in to pt needs. so lack of spiritual dimension in the NP may make the pt more vulnerable

Views of Availability

"I think I understand the concept about being available to God and others- that makes a lot of sense to me and I can recognise that in a sense you are 'God this is going to sound really high and mighty' but you are a channel for love aren't you and for grace....and at the end of the morning when you have someone dirty and smelly and maybe not a very attractive person who comes in it's easy to slip into making a snap judgement and wanting this person out but then you have to stop and think 'well that's somebody in need and I am here to help them...you have to be a channel for helping somebody....people who don't like the S word would say that is absolutely not what you are supposed to do, you are just there to respond to their maybe psychological need but primarily their physical need and do the job and get them out but actually you know there is a sense of this is a person who has come to me in a time of need and I have to maybe you know if I am spiritual person I have to be there for them. so I understand available very well and I recognise that is a sort of mission, a sort of vocation for me"

Views of Vulnerability

The word vulnerability umh I don't understand as well. I can see it terms of a monastic community where you have the whole ethos of having a discipline of prayer and scripture and community life but I don't understand it in this context so much"

"I can understand it in that I can use some of the spiritual discipline and religious background I may have had in my life to be useful for the patient but that's all, I am not clear with that"

"...I'm still grappling with vulnerability. I suppose if it means to be intentional and deliberately vulnerable then certainly one thing you could you know you are kind of vulnerable to the patients is saying that you haven't got all the answers and you know you are kind of

empowering them(like the young man)..to think for themselves and certainly you know wanting to be accountable to them but you know if a monastic life is very different because they are saying 'this is who we are and this is our story' and that's firm whereas when a patient comes to see me he has no idea if I have any spiritual, religious allegiance and that's entirely right and I have to be open to everybody"

"I think you are vulnerable by terms of being a human being. trying to do your best for the patient in front of you but you won't end up (always) doing what's right, you know there is a possibility of doing harm and that's because in a short consultation you can never get to really know what is going on. You are hearing the words that people are saying and sometimes you can't connect to the hidden agendas...."

"you are vulnerable because they are vulnerable because they are seeing you and you might be hungry or thirsty or desperate for a wee or whatever so there's that vulnerability, as well as a deeper vulnerability is am I actually centred enough and using the power of grace or wisdom enough t be giving them what they need to hear at this time?"

"you are vulnerable in terms on your own life when your feeling low or depressed or bereaved you are more vulnerable then you may show glimpses of yourself to patients more than you would want to"

When talking about empathy and the close relationship it creates with patients "that means you are vulnerable because if that person you are so close to is unhappy or wounded in whatever sense then there is a sense that reflects back onto you and you do have to protect yourself a little bit and also that that patient is there to give you something back because although you are the one who is supposed to be giving inevitably you receive a lot by that interaction and you learn, you develop and you become the person you are by virtue of having fulfilled that role and having met those people which is a great privilege so you are very vulnerable by that degree of empathy"

Saying that nurses are more vulnerable than Drs "the whole focus (of nurses) is to be there for the patient and share that experience of the illness which is very different from the focus of medicine which is to affect a cure so in that sense we are a lot more vulnerable"

"I think as you go through life it maybe isn't just the fact that I am getting older now but you know life events say like when you have been bereaved that makes you vulnerable or if you have got a threat of illness in the family that would make you vulnerable again and inevitably as you get older you come in contact with more you know things like people dying and people being ill and that's going to change how you view life as well so you're going to be more vulnerable because when you are younger you tend to think that you will live forever and that things only happen to other people don't you so that's going to change you but some people then might react by being actually more protective and defensive and not letting themselves think about things like that and others will want to use that as an opportunity to grow and move on so again people will react differently but for me, as for me, that increased vulnerability to use your word has actually probably made me more open to those aspects in patients and in consultations."

Usefulness as a lens for ANPs?

"definitely availability. I would say vulnerability is difficult because you know that it's in the context of the community with is say in terms of your discipline of prayer, your exposure to the scriptures and so on and you know NPs come from a wide background probably intellectual, psychological and spiritually so that's gonna make them more vulnerable if you like. At least in a religious community you have got that core of belief that unites everybody whereas we are going to be a very disparate group so I am not sure how useful (vulnerability) is in this context (The NC)

Later in interview recognition that empathy and vulnerability go hand in hand and then thinks "yes it would (be a useful lens), it just made me realise that as we were talking, it hadn't come to me at first but I think that empathy is where vulnerability really kind of makes sense to me in the way I understand it"

"it's a big question, I don't know. It's very difficult because you are trying to bridge two worlds (nursing and medicine)...make no mistake medicine is a very reductionist scientific world" then talks about someone who says ;it's about the attitude that you have when you have got the patient in front of you that makes the difference (not doing the QOF points etc!)

"I don't know if it would be helpful to start to say that NPs are more vulnerable because of their empathy, You might get a backlash from that I don't know. Availability certainly. I think availability because you know that's the one thing that we should give to our patients because that infers you are responding to their needs"

Does A&V correlate with ANP view of spiritual dimensions of consultation?

Availability yes but questions around vulnerability

Boundaries and own practice

Re: young man worried about mortality. "I was careful not to give my views really"

"I think it's a bit like a confessional isn't it what goes on between the nurse and the patient in the consultation is confidential to both"

talks of a fine line when giving poem to cheer up lady vs "on a more serious note where you think a quote or a line in a poem or something that would influence what you said to a patient or could be used to support them. there is a fine line"

"you have got to be very careful that you don't impose your world view on the patient, that you give them space to explore their feelings and thoughts in a safe environment with somebody they can trust...you have to be very clear about not kind of preaching or giving your own world view if it's not sought or not relevant...I am not the priest or a nun I am a NP"

Talked of psychotic pt who thought he was possessed "now I certainly wasn't going to go down the spiritual dimension with him. there are times when it is not appropriate one bit. The intention is to be authentic to who you are but also being open to the needs of the patient"

Use of similar words by ANPs

Empathy

Thoughts/feelings about integrating spirituality into consultations

“some of the questions you asked me reverberated in my mind subsequently when seeing patients. I can think of in the context of a spiritual dimension to the consultation because you have made me more aware of it”

After 1st interview in consultations uses the word “spiritual more whereas I would not have thought of it as a separate dimension from what I was doing previously”

“at the end of the day it is a dimension of what we do but it’s not the purpose of what we do and I think you need to be clear about that. I have a friend who is a psychiatrist and if I talk to her about anything like this you can see her hackles rising and thinking ‘ooh are you having any supervision, you know any clinical supervision and by what right are you talking about these things?’ but you are there for your patients to respond to their agendas and if it comes up I think you should respond as honestly as you can”

..I guess I might feel uncomfortable if I disclosed how I personally use the spiritual domain to relate to my patients (can feel vulnerable as an NP) especially if I work in a secular practice where there is no sense of God or the Universe or anything kind of spiritual. I have to accept that some of my colleagues might feel that that is not the way they consult or would want to consult and don’t really understand the direction that I am coming from so I might feel uncomfortable (with colleagues) if I disclosed how I feel but usually you do the best that you can for the pt in front of you and you have to be authentic to yourself, don’t you”

Talking about if you audit a consultation you can audit BP checked, treatment started, referral made etc but “there are no QOF points for a spiritual dimension and that all happens at a different level, a different subtle level...if you watch the consultation on a video you maybe wouldn’t see it depending of what lens you were looking at and the perception of the observer....of course it is colouring the whole thing”

“don’t start making tick boxes about how you address spiritual dimensions of it because nursing has been made so reductionist....it’s how you do things not what you do....the only way you can encourage it is by your teaching about how you consult. but you may have to use different words so that those people feel happy about it because if you start talking about an outpouring of love and grace in a relationship they will look at you as though you are nuts”

Thoughts around Spirituality

Again talking about giving a poem/quote to a pt...”you are trying to encourage people and give them hope for the future and I suppose a small part of that would be to inspire somebody and to inspire people seems to come more from a spiritual route.....if you are going to inspire people to turn their lives around or to make healthier choices then I think that’s where the spiritual dimension comes in for me”

“it’s more in my mind....I’m trying to tease out is this a spiritual bit compared to a psychological bit but actually in practice I don’t think you can separate them. I think they are interwoven. You can use different language to look at a different or the same phenomenon in fact. It’s just a different aspect of the same phenomenon and using different words”

“I think the spiritual bit to me comes to the whole you know looks at the whole of that person and almost seeing beyond the physical and psychological which can be a bit reductionist, if

you are looking at the kind of life of that person that that person emanates and looking straight into the eyes-that probably sounds really weird but you know seeing the soul behind the person"

"it's probably always been there but become more conscious...as I journey through life and you know weighing up these things myself"

Talks about conversation with friend who said her wanting to heal people was firmly in the "spiritual dimension" and she wonders "do you actually have to call it that or do you have to be more authentic in the care you give and more present, more living- you don't need to use those words if it creates a misunderstanding (spiritual dimension)"

"I think we are all spiritual beings whether we think we are or not, we all have that dimension but I think it's the words that people use that are important because sometimes words create huge barriers and you will have people swearing blind they do not have a spiritual bone in their body....yet actually through their demeanour they can be very spiritual and then you have very religious people who purport to being very spiritual and yet they behave in a really terrible way...so words can be very misleading"

"your ethos on life that you do keep very much to yourself unless your having this kind of conversation"

"you are evolving as you live"

"it probably was always there because it's part of who I am and it changes as you mature and grow older"

"I don't think you can sell it (spirituality) in the current climate, maybe in the future, although there is a huge revival of interest in things spiritual and the difficulty is that you will have some people who recognise what you are saying and understand it and sign up to it and others who you will just put their backs up completely and turn them off"

Hopes and Dreams as an ANP

"it would be a kind of dimension of love and of healing and wanting wholeness and wellbeing for them and that you should be motivated by an outpouring of love if you like but that sounds completely fruity loops and if you said that to a lot of people they would take me off to the nearest nutty farm....."

Values and Empathies as an ANP

my values are to be a safe practitioner, to do no harm or as little harm as possible to the person in front of me. To recognise their vulnerability because they have come to see me in their time of need and maybe a time of heightened anxiety, fear or grief so they have a high level of vulnerability so it's important that I do the right things with them"

Stories Used

1)Young man terrified of dying- "what he didn't like was the fact we were all mortal beings and we are gonna die one day...I kind of had more courage to question him a little bit about that and maybe more courage to say well you know maybe it's good that your having those anxieties because in a way that means you are a searching human being about the meaning

of life and obviously I don't have a magic wand to be able to tell you what the meaning of life is but to search is the meaning of the human dimension in all of us and we struggle with our own mortality and that maybe this is an opportunity for you to kind of find out more about the spiritual dimension of life you know so I wasn't trying to lead him and give him my answers but just reflect back what was going on inside of him. He was in some sense searching for a deeper meaning...I didn't feel I was kind of veering onto a religious dimension or anything like that because there was clearly no religion being discussed....

2) talked about a priest who came to see her who had spiritual issues "I felt she was talking to the wrong person....she needed a spiritual director and not an NP" (clear divide here!)

3) "very spiritual person" came to see her "and again I felt that you know it wasn't my role to help her with those issues but if she talked about them to me I could be open and honest and listen intently but it wasn't my role to be her spiritual director either really- you have to be fairly sure of your ground"

4) patient came to see her and she happened to have a print out of a poem and she gave it to the patient..."I was telling one of the doctors at work and they thought it was a bit weird and I should stick to giving prescriptions!. I guess I might feel uncomfortable if I disclosed how I personally use the spiritual domain to relate to my patients (can feel vulnerable as an NP) especially if I work in a secular practice where there is no sense of God or the Universe or anything kind of spiritual..."

Thinks giving the poem "wasn't the best decision to be honest" It was given to an old lady who was feeling quite low and vulnerable at the time and I thought it might cheer her up..it was a spur of the moment thing

5) story from last interview about man she held hands with..."on one level absolutely nothing happened yes you just held hands, big deal, but on another level everything happened because you were so completely connected at that deep level so it depends whether you are looking. You might not see anything at all, you might see that it colours the whole thing"

Appendix 8.2.8 Ana2 Summary:

Themes:

View of summary 1

"there was one little bit at first I couldn't think what on earth it referred to but I remembered now, I couldn't think what the patient was but I thought it summarised it very succinctly, yes"

About the interview- "it was completely exhausting. I think doing it in the middle of work and then having to go straight back I found it very draining to do....I was quite surprised maybe at my own responses...how it really kind of goes quite deep doesn't it. I think it was because of the emotional content because of some of the patients I talked about...(in practice) we get very little debrief about that kind of thing so when we do it all comes out"

Views of concepts of A&V from NC and personal view of definitions

“it was reading the stuff about A&V and it does come from a very Christian context but part of me did think if you take God out of those concepts are you just left with emotional support and it struck me it was very like empathy and sympathy...the only thought I have had is what’s the real difference between emotional and spiritual and if the person doesn’t have a religious belief and I know in many ways you are trying to move away from that, is there actually spiritual or are we kidding ourselves? That was really what I thought that you need a God in there or God concept to make it spiritual rather than simply an emotional concept”

“I need to think a bit more about where God sits in all of this...”

Views of Availability

“I notice under availability one of the things they put was availability to God which of course raised up all these things that we have just talked about”

“yes I suppose that was quite similar to how I had seen it (availability) “

“being open and available to a patient, as long as I am control of that .....”

Views of Vulnerability

“vulnerability I think they referred to teachability didn’t they which I mean I can see that but it wasn’t quite how I thought of it. I think I thought of vulnerability as actually opening yourself up and allowing yourself to be hurt”

“I thought can we offer hospitality in the practice to patients and actually we can and that’s a nice way of thinking about it because sometimes we just regard it as lets just get them out of the door as quick as possible and that’s not very hospitable is it but you can kind of extend that ethos a bit, I just thought that could maybe add something to the consultation...I quite liked the idea of vulnerability being teachable rather than just meaning the ability to lay yourself open t6o pain if you like and then you can be teachable actually by the patient. that you can learn stuff from them, from their experience rather than your experience...kind of listening to them”

Usefulness as a lens for ANPs?

“more or less but some slight differences in emphasis”

“I suppose Ihaven’t really grasped what it means to look at it through that (a lens)...maybe if you sat back a consultation ..and look and analyse and think ‘oh you know’ maybe a particular consultation that strikes you and if you could look back and think ‘well actually that was, was I looking through that kind of lens’. It might be worth doing”

“I’m sure it probably is...maybe that’s something that now we have talked about it will be in mind”

“maybe you can apply these concepts without having an overt awareness of thought that they were spiritual concepts”

“I think they would be useful lens (other things may also fit)...and they may be included within A&V ..as they are broad concepts really when you think about it...being fully present which is included within those terms anyway is the only other phrase I might use”

Does A&V correlate with ANP view of spiritual dimensions of consultation?

"it must have really although there could be other ways as well that I haven't thought of..these are the terms used here and there could well be other things you might say 'well yes that as well' but I think those consultations that have more depth probably because your more present, you are in the moment which you don't always do and can't always do. It's not always appropriate but then that brings with it that A&V concepts"

Boundaries and own practice

"I think within both concepts I think you have to have some sort of boundary or you just become useless to people you have to have an ability I think to be available to also to stand back because if you get too involved you know you just become a mess really won't you, you can't live everybody's pain for them it's just too much and actually it wouldn't be appropriate and it wouldn't be helpful for them if you did that. It wouldn't help you and it wouldn't help them so it's know where that line is isn't it"

If being A&V "you could get more involved in and you could lay yourself open to unnecessary hurt. You could raise a patients expectations too much as to what you can do. I thin that's probably a real risk"

"I do think some patients use us almost like a priest don't they nowadays"

(in response to story 1)there are "somethings we can't do for our patient, that is not within our remit here to do that...but there is a strong sense of almost being used in a priest like capacity and I think because of the loss of that layer of society I do think people do use us like that. People feel guilty about stuff don't they and they quite often bring that guilt to us...there is almost this feeling nowadays that you should not feel guilt and I don't agree with that. I think it's probably quite good to feel guilty if you have done something wrong...how you balance that with actually just supporting somebody in a non judgemental capacity I am not sure"

Talks about TOPs- in the past I would have been "strict down the line, I don't believe in it blah de blah. I think you soften as you get older and realise life isn't black and white...I think I can honestly stand back and say 'well I won't stand in judgment and say it's wrong' but I wouldn't have to sign the form. We all know it is abortion on demand and I don't want to actively be involved in that because I think 'well I do draw the line the nearer we get to that' but then you get the girls after termination ridden with guilt and that's really hard to deal with....you can't just lift that guilt can you?

Feel uncomfortable if "I cross a boundary where I am not in control of that anymore then it becomes personally difficult"

Use of similar words by ANPs

Empathy, presence

(love "that's very emotional there may be 1-2 patients I genuinely do love but god we are going to get into a whole new mind field if you start unpacking that...you can be available to a patient you don't particularly love or like to be frank)

Thoughts/feelings about integrating spirituality into consultations

“I guess there is potential for that isn’t there?.....I think people do come far more generally to general practice with spiritual and social issues, a lot of which we can’t change and I think for our own sanity we have to recognise what we can change and what we can’t otherwise we just burn ourselves out”

“Patients will come won’t they and you will have 10mins with them and they will say ‘oh I feel so much better seeing you’ and I think wow, that’s amazing what did I do? “ then talks about Ballant and the “concept of actually being with a Dr acts as a medication...the magic of being with a Dr that makes people feel better ?? relating this to a spiritual dimension

From MPS How Far is too Far article...they talked about empathy and sympathy and “it just made me think that there were certain similarities here and they were saying sympathy wasn’t a particularly helpful emotion but sometimes it’s unavoidable but it was more that you got so involved that actually you were the one..who becomes useless then because you are in floods of tears you are of no use but equally to show some slight emotion that you are not just a robot I think can be of some help to patients”

(so a level of vulnerability may help the pt move forward- “a level can”

“I think you know within yourself when you are crossing a line...when it’s beginning to become more about you than them...so being self aware (is impt)..you’ve probably got to make a few mistakes- we are only human. as you got through your life in this kind of role you develop those skills really I would hope”

Thoughts around Spirituality

“I wonder- do I think there is a spirit? Do I? If I believed in God would I say I did but because I am not sure if I do I am not sure if I am kidding myself....I don’t have any specific religious faith and I am not really sure if God exists and all the rest of it but I do like to think I have a spiritual dimension to my life and that I see that in other people but maybe I am just kidding myself, I could say that quite easily if I believed in God that wouldn’t be a problem”

Last interview..”I think I was trying to find a definition that didn’t include God to in a way enable me to talk about it but I am not sure you can actually do that. I guess it’s up to you how you define it isn’t it. If you are talking about gives life meaning and purpose then maybe it doesn’t have to include God but is that actually spirituality”

Then asks about is there a def of spirituality and does it include God and I said some do/don’t...”So when does that just stop becoming just you know the things that matter to you emotionally in your life?”

“Thinking about it the night before (my thoughts) kind of consolidated slightly last night into some sort of you know words but yes emotion I guess on one level but I don’t regard myself as an overly emotional person...maybe spirituality is an added depth but I am just not sure”

“it’s really hard to keep spirituality an religion separate”

Thinking about the student nurse “it wasn’t emotion as such, it was genuine care, it was being wholly available for her patients...and in a not very self conscious way”

“I seem to be drawn to people who often have an overt religious belief although some people with an overt religious belief drive me up the wall.....There are other people who have a depth of emotion and wisdom and stuff like that who I don’t think have any religious belief-maybe I should ask them?”

“it’s not just niceness...wisdom, something about being wholly available to the person you are with” talks of a GP who “has the ability to make that person just feel valuable”..... then “making the other person feel that at least for that moment in time they mattered most” (egs of “an external expression of (spirituality)”

“I’ve always had a slight awareness”

“spirituality and nursing you know are closely connected...because of nuns and stuff, very closely connected really...the whole concept of vocation, yes”

Hopes and Dreams as an ANP

“to be the best clinician I can be and I think that embraces not just the physical aspects of it but other aspects of the consultation”

“to have a more strategic role, working in a higher level that just seems impossible to do...to keep one foot in that grass roots stuff because actually apart from anything that’s where you get a lot of the positive feedback from patients...to know you are making a positive difference to peoples lives on a day to day basis”

Values and Empathies as an ANP

“integrity, honesty, truthfulness, good practice of course, going that slight extra mile-not always because you would burn yourself out...to be inquisitive, maybe curious (about pt presentations not just what they present with)

Stories Used

1) patient who had seen the GP as mother had had an affair with the daughters boyfriend and the mother came to the GP “clearly wanting absolution. I remember feeling quite strongly that it wasn’t the GPs place to give or not give absolution but it was like the person couldn’t move on until they were told that”

2) story of student nurse who exuded “what I would have said was spirituality. I mean she would have and she went the extra mile for all her patients and she was calm and kind and she was more than the average nurse...at this point I had quite a faith and I can remember being astonished that she didn’t have. I thought how can she do that and not be a christian....she almost seemed to have a spirituality about her care...I remember the aura she had about her that made her patients feel better and made everyone around her feel better...maybe she had these concepts (A&V) without an overt religious thing...she had a calmness, a centred ness, never seems flustered or troubled...and I have met people like that since and often it turns out they do have a faith”

3) GP “who is sort of wise with her dealings with patients and I don’t think she has a religious belief but I think she has a big understanding of people’s spiritual and religious

beliefs...maybe I am mixing up being a really nice person with somebody who has got spirituality”

4) “I would love Olivia because you respond as a clinician but also you respond as a mother.. I actually feel quite relieved that she is getting that support there now because while ever she wasn’t doing that although I knew she was no longer my responsibility in that sense, you can’t just let that go can you and I still see her in the holidays and e-mail her occasionally but there feels like there is a slight distance coming there now which I feel is actually quite appropriate, yes. What you don’t want I think is your patients to become so dependent upon you but its terribly flattering when they do”

Appendix 8.3 Responses from Participants re: Summaries:

-That's an excellent transcript of our conversation- covers a lot can’t think of anything to add!

- Wow you have been busy! I really can’t add anything else to the discussion.
I wish you every success with your work. As always I admire you so much. You are a shining beacon to us all

- Thanks for the summary, I don’t have any corrections and think it is accurate. Gosh I do talk a lot. Well done for transcribing it all.

-This looks fine I can remember saying most of these things it is interesting reading back what was said and digesting it.

- Well done on getting so far! It must be very satisfying. I have read through your notes and would agree this is a fair representation of our interview. I have no further thoughts specifically about the concepts of availability and vulnerability as a lens for viewing the spiritual dimension of ANP
consultations. I have considered it many times in practice, reflecting on how open I have been within consultations. I still think the ability to reflect on this is a measure of the maturity of the role, when we have incorporated the new skills demanded by the advanced role, I think we are able to reconnect with the core values of nursing and allow other aspects of our humanity to influence and guide us. I think being open, "vulnerable" has the potential to transform practice, to take it beyond the consultation to real connection with our patients.

- This looks good - it was interesting to read back over it. A patient I have been seeing recently came to mind in the context of availability and vulnerability and, I realised, as an illustration of not letting the consultation become about yourself. This poor girl (well, woman really, aged 38) had just lost her first baby at 2 days old. She came to me for a dressing on her CS scar which wasn't healing. I found seeing her incredibly traumatic and found I was shaking and near to tears - which I held back, and tried to acknowledge her terrible loss without making her feel she had to open up and talk if she didn't want to. I ended up seeing her quite a lot over a period of a few weeks - it was a good illustration of
how a very simple nursing task (a dressing) could in reality be almost a front for what I think was a much more complex interaction - sometimes she would open up and talk a bit, others not, but I think she felt safe as she had the physical "excuse" of the dressing to come along (anyone else I would

have discharged to self-care long ago). Anyway, I thought about arranging her post-natal with a particular GP who she had seen shortly after the birth. This GP told me how she herself had found
it all very difficult and had cried with the patient, as she had several friends who had lost babies. This made me wonder if I had been a bit too detached in my own attitude. However, the patient actually cancelled the post-natal as she couldn't face seeing this GP and all the emotion it engendered in her.

For me, I guess I had to be vulnerable and available without the luxury of letting go emotionally. Not sure if that has anything to do with spirituality or if it's just being professional! There are, I think, many nuances to this tale, too complex to express in an email, but I hope you will get the gist of what I am saying.

- Yes this sounds like the ramblings of a slightly unhinged person so I suspect that's about right. Hope it's going Ok

Appendix 9 Data Analysis (Worked Examples):

9.1 Polly Example:

9.1.1 The Whole Text

For the first example during interview 1 Polly discussed holistic practice.

Firstly the whole text of data was initially examined for understanding (to ascertain the fundamental meaning).

Section of Polly's first interview:

P1: I think allowing the patient to talk which is sometimes quite difficult when you have got very busy clinics but it is allowing the patients to talk to you and give them time and offer them the opportunity to come back so the support is there so they don't have to tell you everything on the first time but you can allow them to get to know you a bit as well so that they can feel confident they can trust you.

MR: and when you say that to get to know you a little bit, what do you mean by that?

P1: I think they have to feel like I am not going to not believe them, not keep their secret safe, if not help them directly but be able to support them so they feel they have got somewhere safe to come and that's not always possible and I am sure that works for different people find that in different people so they have to make that decision.

MR: I ask how would you know that you are a safe person or they can load that level of trust?

P1: Again I think that's something that comes with time and my approach to them and how they feel in my company.

MR: Do you think there are other areas of importance so there is listening, allowing the patient to feel safe and to be heard? Are those the key areas

P1: I think they are the key areas. I think there are other aspects like the environment when they come into the room, like how does it feel for them. I do feel different people want different experiences and they get that in different places.

MR: and what kind of important about holistic assessment patients because we use that term a lot as nurse practitioners?

P1: I think we have got to look at what's going on in all aspects of their life if we truly want to know what it feels like for that patient to experience in, the situation they are in, its not easy because its not quick to do. It does rely a lot on the patient wanting to share with us. I do think it gives you a better picture of what's happening to them.

MR: In terms of …..?

P1: How they can experience their own situation so it might be a straightforward diagnosis but what's going on for them in their life will affect how they experience it.

MR: So kind of thinking about psycho-social, historic relationships,

P1: Relationships, psycho-social, work has a big impact on a lot of things, support they have got outside here.

MR: So its about kind of the diagnosis maybe and how its affecting them. Is there anything else that you view as holistic?

P1: Outside the psycho-social ??? (tape goes funny). What they believe in is very important

MR: As in?

P1: Again it's across the board sort of family beliefs, religious beliefs, right through, it's the things that they value and make these things important for them or not important.

In this section of the interview Polly was focusing on holistic approaches to care. She was able to identify for her that listening to the patient's story and them feeling heard was fundamental to the relationship between them and holistic care. She describes how she builds relationships with her patients and the importance of holistic assessment and compassionate approaches to care.

9.1.2 Sentence Investigation

Secondly every sentence was then investigated to expose its meaning for understanding of spirituality. Themes emerged at this point which led to a detailed understanding of the phenomena. These themes challenged my previous understanding and allowed ongoing challenge of the themes.

As an example the three sentences below show the themes that emerged these were colour coded:

"what's going on in all aspects of life if we truly want to know what it feels like for that patient.....it's not easy because it's not quick to do...it relies on the patient wanting to share with us"

Understanding "relationships, psychosocial, work have a big impact on a lot of things"

"what they believe is very important... family beliefs, religious beliefs. It's the things they value that make things important for them or not"

Themes: Holistic care, empathy, patients sharing, bio-psycho-social aspects, personal beliefs and values

9.1.3 Relationship to the Whole

Thirdly every sentence was then related to the meaning of the whole text and the meaning the whole text was then expanded.

This was recorded in a table with overarching themes from the whole interview. These included:

Addressing patient needs/patient centred	Listening/understanding and empathy	The relationship
How you consult	ANP personal growth	trust
Managing time/giving time	Professional service	Prescencing
Giving of self	Environment-physical and personal	

9.1.4 Shared Understanding:

Finally passages that represented shared understanding between the participants and myself were identified giving insight into spiritual dimensions of consultations and spirituality.

The summary of the whole interview was sent to Polly with a brief summary about holistic care which Polly felt was a true reflection of what she was saying:

Holistic practice- understanding what's going on for the pt. Understanding relationships, psychosocial and work also what they believe is very important

9.2 Georgia Example:

9.2.1 The Whole Text:

The second worked example during interview 1 with Georgia was when she talked about what availability and vulnerability meant to her.

Firstly the whole text of data was initially examined for understanding (to ascertain the fundamental meaning).

MR Yes I wanted to talk a bit more about availability and vulnerability and I have obviously given you some information from a Christian community from a Northumbrian community and part of the PhD is not about having Christian influence to what we are discussing and although this is obviously from a religious viewpoint its more the words 'availability' and 'vulnerability' that I want to look at and there might be some relationships to some things that are not going to be ???? discussed so first thing I wanted to ask was we mentioned availability and vulnerability at the last interview now you have had chance to read what the Northumbrian community say themselves about that, does it correlate to your understanding of these terms or is it a completely different concept.

G1: It is a new concept. You see I think these are kind of words that are kind of everyday words but are used in a completely different meaning here. I think I understand the concept about being available to God and others. That makes a lot of sense to me and I can recognise that and in a sense you know you are God this is going to sound really high minded, but you are a channel for love aren't you and for grace and I think you have to kind of I know that a few years ago I kind of consciously you know when you are really tired and it's the end of the morning and you have got somebody who is smelly and dirty and maybe not a very kind of attractive person who comes in and then you know its very easy to slip into making a snap judgement and wanting to get that person out but then you have to stop yourself and think 'well you know that person is somebody in need and I am here to help them' and you have to be a channel for that kind of helping somebody and that you know again people who don't like the 'S' word would say that that is absolutely not what you are supposed to do, you are just there to respond to their maybe psychological need but

primarily physical need end of and do the prof and get them out but actually you know there is a sense of 'this is a person who has come to me in a time of need and I have to maybe you know if I am a spiritual person I have to be there for them in that dimension so I understand the term 'available' very well and I recognise that and yes it is a sort of mission and it is a sort of vocation for me and I know a lot of people would say that's not for them so I recognise that. The word 'vulnerability' umh I don't understand as well. Umh I can see that in terms of a monastic community where you are having that whole ethos of having the discipline of prayer and scripture and community life umh I don't understand it in the context of this so much.

MR: Okay

G1: I understand it in that I can use some of the spiritual discipline and religious background that I may have had in my life to be useful for the patient but that's all. I am not as clear with that.

MR: So obviously the concept 'availability' and 'vulnerability' within this are from religious Christian ethos. What would it mean to you say within your practice or has it a meaning for you within practice aside from the spiritual, religious expression that the Northumbrian community have.

G1: It's a difficult question isn't it. These are quite difficult concepts really. I mean I think as the nurse practitioner I definitely have to be available to the patients and accountable to them and if you think that at the centre of me there is a spark of divinity then I suppose I am making that available to the patients through the consultation and the interaction with them, is that what you were meaning? Does that make sense?

In this section Georgia talked about the different context for A&V. She resonated with the concept of availability as this connected with her values. She reflected on the difficulty in practice to be available sometimes and the need to recognise those in need. She talked of others views of spirituality and how they may see the physical care as a priority. She was able to recognise availability as a vocation and mission for herself as a spiritual person. She struggled more with vulnerability in applying it to the context of practice.

9.2.2 Sentence Investigation:

Secondly every sentence was then investigated to expose its meaning for understanding of spirituality. Themes emerged at this point which led to a detailed understanding of the phenomena. These themes challenged my previous understanding and allowed ongoing challenge of the themes.

As an example the sentence below shows the themes that emerged these were colour coded:

"I think I understand the concept about being available to God and others- that makes a lot of sense to me and I can recognise that in a sense you are 'God this is going to sound really high and minded' but you are a channel for love aren't you and for grace....and at the end of the morning when you have someone dirty and smelly and maybe not a very attractive person who comes in it's easy to slip into making a snap judgement and wanting this person out but then you have to stop and think 'well that's somebody in need and I am here to help them...you have to be a channel for helping somebody....people who don't like the S word would say that is absolutely not what you are supposed to do, you are just there to respond to their maybe psychological need but primarily their physical need and do the job and get them out but actually you know there is a sense of this is a person who has come to me in a

time of need and I have to maybe you know if I am spiritual person I have to be there for them, so I understand available very well and I recognise that is a sort of mission, a sort of vocation for me"

Themes: Love, grace, patient need, judgment, physical needs, prescencing, vocation

9.2.3 Relationship to the Whole:

Thirdly every sentence was then related to the meaning of the whole text and the meaning the whole text was then expanded.

This was recorded in a table with overarching themes from the whole interview. These included:

Availability and Vulnerability	What drives us- deep self-awareness, acknowledgment of being needs driven	True Availability- Definitions of availability A
Creating a safe/welcoming environment A	(Possible loss of if become vulnerable) Boundary A	Acknowledgement of transcendence A Essence of caring- Florence
Professional Availability (self out of it, standing back, theory) A	Patients openness A	Opening of self (Christian.....)A

Awareness of other and other concepts of what availability means (connecting)	Validation of another	Time and vulnerability a minute can mean more)
Definitions	Humanness	(intangibility of spirituality is coming out throughout

9.2.4 Shared Understanding:

Finally passages that represented shared understanding between the participants and myself were identified giving insight into spiritual dimensions of consultations and spirituality.

The summary of the whole interview was sent to Georgia with a brief summary about holistic care which Georgia felt was a true reflection of what she was saying:

Availability and vulnerability- I am available to my patients on a day to day basis, in their time of need. I am available to my medical colleagues, to my nursing colleagues, to my students. Difficulties in availability when patients breaks down and you only have 10 minutes "you have to be available" but equally to next 14 pts. Vulnerable when personal things going on in your life and it's still raw (restoring yourself in between patients, you are human, not a machine. Vulnerable because I am human, because I manage risks/decisions, because I can sued, because I am a nurse in a medical domain. My main vulnerability is that I am doing the right things for the right patient at the right time

She also added via email after the interview-

“I just had important thought after you left- don't know if you can include in-but pondering meaning of vulnerability on way to ballet.... as you do.. and I think real significance of vulnerable in terms of the NP = possibly not being centred/fully in the moment/fully responsive and able meet patient needs/in terms spiritual dimension s/he may not be tuned in to their higher/wiser/more loving self= i.e. great if the NP is "fully self actualised" but who says the NP has to be wise/loving/spiritually aware?? does this make sense? I think that what the community meant by knowing/understanding the scriptures etc... i.e. having the right things/knowledge/attitude to offer the pt. basically to reduce vulnerability to the patient the NP needs to be centred/aware/present and tuned in to patient needs. so lack of spiritual dimension in the NP may make the patient more vulnerable