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**An exploration of mental health nurses' understanding of the spiritual
needs of service users**

Ruth Brown

**A thesis submitted to the University of Huddersfield in partial
fulfilment of the requirements for the degree of Professional
Doctorate**

The University of Huddersfield

September 2017

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Dedications

I would like to dedicate this work to my late mum Sylvia who sadly died during my course and to my wonderful husband Paul. The following words say far more than I ever could.

'You were my strength when I was weak; you were my voice when I couldn't speak,

You were my eyes when I couldn't see, you saw the best there was in me.

Lifted me up when I couldn't reach, you gave me faith 'coz you believed

I'm everything I am

Because you loved me'

(Dianne Warren)

Acknowledgements

I would like to say a very special thank you to Dr Joanna Brooks, Professor John Wattis and Dr Kathleen Chirema for all their dedicated hard work in supporting me through this process. I was so lucky to have you all as my supervisors.

Thank you also to the participants of my study for your time and your honesty. This couldn't have been achieved without you.

Abstract

Background

Over recent decades there has been increasing interest in the importance of spirituality and its impact on the well-being of mental health service users. Nurses have a professional obligation to care for patients holistically and this includes assessing and caring for spiritual needs. However, there is little research regarding the specific issues faced by many mental health nurses. The aim of this study was to explore mental health nurses' understanding of the spiritual needs of service users and how they reported responding to these needs.

Methods

This qualitative study used semi-structured interviews as the method of data collection. Seventeen participants took part which included ten female and seven male participants across a wide range of working-age brackets. The data were subsequently transcribed and analysed thematically using Template Analysis (King, 2012).

Findings

Four key themes were identified from the data in relation to personal and professional influences on understanding spirituality and caring for spiritual need; different approaches to nursing spiritually; and 'fear and anxiety' which permeated participants' talk on the research topic in many ways. The findings presented show the complex influences that affected participants' reported understandings and subsequent responses.

Conclusion and recommendations

Mental health nurses experienced anxieties around misinterpreting spiritual need as mental disorder, particularly in service users who experience psychosis and other complex mental health issues. Strategies for engaging with mental health service users who express spiritual and religious beliefs could therefore be a focus for future research. This thesis adds to the wider body of knowledge and may usefully contribute to the development of future practice and policy guidelines so that mental health nurses are better able to confidently and competently understand and respond to spiritual need in service users.

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Chapter 1: Introduction

1.1 Thesis structure

This thesis is presented in six chapters. Some aspects of the study will be written in the first person to emphasis the reflexive nature of my work and to contextualise my position as a mental health nurse researcher (Chirema, 2008). This introductory chapter first outlines the aims of this study and the structure of the thesis. It provides some personal narrative explaining my own history in mental health nursing, how I became interested in spiritual issues and how, as a nursing educator, I became aware of these issues in relation to nurse education, which led me to choose this area for my professional doctorate studies. Chapter 2 provides a review of the relevant literature. I reflect upon the many definitions of spirituality used in the healthcare setting and review literature which has addressed spirituality and spiritual care in relation to nursing, with a focus on the mental health arena. I then consider spirituality and care for spiritual need in relation to relevant policy and practice guidelines, and nurse education. Chapter 3 describes and justifies the methods used in this qualitative study, and provides detailed information about the study setting and the process of data analysis. In chapter 4, I present my findings. Four themes emerged in my analysis of the data: Role of spirituality from personal perspective; Influences on professional understandings of spirituality; Nursing spirituality; Fear and anxiety. This final theme (Fear and anxiety) was an integrative theme, and I explain how this permeated many aspects of my participants' reflections on the research topic. In chapter 5, I discuss my findings in relation to existing knowledge and consider how the work presented in this thesis adds to this body of work. Finally, in chapter 6, I highlight the key findings of my work and their implications for practice, education and further research.

1.2 Introduction to the research topic

This professional doctorate thesis explores mental health nurses' understanding of spiritual needs of service users. Recent decades have shown a significant increase in literature recognising the importance of spirituality and how caring for a person's spiritual needs can have a positive impact on their mental well-being (Narayanasamy, 1999; Persut et al., 2007; McSherry & Jamieson, 2011). Nurses have a professional obligation to care for patients holistically and it is part of the nurse's role to assess a

person's spiritual needs and address them accordingly (McSherry, 2011; NMC, 2014). However, there is a paucity of research regarding the specific issues faced by many mental health nurses. The aim of this study was to explore mental health nurses' understanding of the spiritual needs of service users, using appropriate qualitative methods so as to facilitate an in-depth understanding of the mental health nurse perspective. The overarching research question was therefore 'How do mental health nurses understand and care for the spiritual needs of service users?'

1.3 Personal engagement with the subject

The following section will make my own position in the research explicit, especially with regards to my personal view on spirituality. Although this was not a question I asked of the participants in this study, many chose to disclose and describe very personal accounts of their beliefs. What I actually asked the participants was what they understood about spiritual needs of service users and nearly all of them responded with comments like "spirituality is for me...." or "I was brought up as a" and then gave an account of their religious and/or spiritual beliefs before applying their understanding to service users. Many of them said their introduction to religion and spirituality was from childhood and that they were born into families who followed a particular religion. My experiences were very similar in that my introduction to religion and spirituality was from a very young age and my early influences were typically from my parents. My mother was a Christian and regularly took me to Church and involved me in varied church activities. My father was what he described as an atheist and there were many family discussions around their differing beliefs and as a result I was exposed to personal accounts of religion and spirituality.

As I grew up my views on Christianity, atheism and spirituality evolved and changed and I still retain a lively interest in all expressions of spirituality and a conviction that attention to spiritual issues is central to holistic care. Transcendence and a person's sense of hope, meaning and purpose are core to what I would consider to be spirituality itself, all of which I discuss further in chapter 2. Yet because of my background, which exposed me to many forms of spiritual expression, I appreciate that some people find the guidance, companionship and ritual practices only found in mainstream religions

helpful. However, I also understand that there are a wide variety of experiences of the spiritual and the transcendental and I seek to accept them all in a non-judgemental way. My professional experiences as a mental health nurse are discussed later in this chapter. My personal openness to wide and varied spiritual expression and needs has fuelled my interest in how mental health nurses address these issues. I have been involved in various teaching initiatives in this area. Even before I started this study, some of my friends, aware of my interests, have discussed how personal spiritual and professional perspectives can be reconciled. I have at times found this difficult and after listening to the participants in this study I am aware I am not alone with this. My openness to different expressions of spirituality and spiritual need appeared to facilitate my participants discussing how they approach these issues in their practice without fear of being judged.

In the discussion chapter, I reflect on how I perceive my personal perspective on spirituality to have influenced my research, particularly when interviewing and interpreting subsequent findings.

1.4 Professional engagement with the subject

I am currently a senior lecturer and field leader in mental health nursing at a university. My clinical background included nearly twenty years of working in various mental health services with the most recent in an adult acute inpatient ward. As a mental health nurse part of my role was to assess the various mental health needs of the service users in my care. During my assessments I encountered many service users from diverse backgrounds who expressed spiritual needs. Some of those needs were related to religious practices which were often relatively straightforward to address. However, there were others which were more challenging and I often found myself wondering if the support I offered was effective.

In my working life, it was my perception that if a service user expressed what I considered a spiritual need, it was often viewed by nurses and other health professionals as a symptom of their illness and not as a way of supporting themselves. It concerned me that when a service user expressed these needs, often medication and

other mental health interventions were used and viewed as successful if the person stopped their religious or spiritual expression. Whilst I acknowledge that indeed this may be relapse signature for some people who become fixated with religiosity, I do not believe this is true of all cases.

To provide some context, I describe below three examples encountered in my own professional practice - I have changed aspects that may identify an individual to protect their anonymity however the situation is factual and based on my experience as a nurse.

1.4.1 Dianne

Dianne was a woman in her late fifties who had a diagnosis of schizophrenia which for the main part of her life was well managed and she lived a full life. She lived at home alone but was a member of the Christian Science community and regularly attended worship with them and was greatly involved in the church's activities. Following bereavement and other life stresses, Dianne became unwell and began to experience some florid symptoms of her illness which resulted in her admission to a mental health acute ward. Dianne had agreed that she was ill enough to remain in hospital, however she was reluctant to agree with some of the medical recommendations that were offered. She was happy to participate with some of the talking therapies and other supportive interventions but refused to accept any medication. She said that she did not believe in medicines and that the power of prayer would heal her with support from her friends at church. This belief was 'normal' for her and other Christian Scientists and this had not changed as a result of her relapse.

During the discussions about her care there was a lot of pressure on the consultant psychiatrist and mental health nurse key worker to pressure her into accepting a form of treatment that went against her spiritual and religious beliefs because of the hospital protocols regarding length of admission. As a result Dianne in turn received a lot of pressure from mental health services to accept medication and at one point was assessed under the Mental Health Act. If the section had been applied this would have

enabled the possible enforcement of medication against her will. Dianne did not meet the criteria for Mental Health Act application. Therefore, after long multi-disciplinary discussions regarding how to approach her care, the decision was made to respect her beliefs and use interventions other than anti-psychotic medicine.

As part of the team that was responsible for caring for Dianne I was party to the heated discussions around her care and how much consideration would be appropriate given her beliefs. It was only because of the forward thinking and strength of conviction of her allocated consultant psychiatrist that Dianne was not further pressured into accepting medication she did not want.

In this particular instance after a few days Dianne capitulated and requested medication which supported her recovery. However, because of this 'change of heart' it is unclear how long the respect of her beliefs would have continued with the increasing pressure on inpatient beds and other resources.

1.4.2 Abdul

Abdul was a middle aged man of Asian descent who was referred to mental health services following a visit to his GP. In part of his assessment Abdul described pain in his spirit and stated that God felt he was unworthy which caused the pain. He said this pain was killing him and he couldn't sleep or eat. He said his spirit was sick and needed healing.

The initial assessment concluded that Abdul was psychotic and recommended the appropriate treatment for psychosis. Abdul was also admitted to hospital and was detained under the Mental Health Act as a risk to self because of suicidal ideation. During the period of detention for assessment it became apparent that his expression of pain to his spirit was in fact a description of depression and what a mental health nurse would identify as feelings of hopelessness, helplessness, isolation and loss. The assessment concluded that it was appropriate for Abdul to be detained under the Mental

Health Act. However some of the treatment that had been initially recommended was adjusted to suit the new identified needs

It is fair to say that all treatment, particularly in mental health, may be adjusted according to the changing needs of the service user. However, it is equally fair to acknowledge that in circumstances like this, the treatment recommended may also depend on the understanding of the practitioner. In the above scenarios the assessing practitioners included mental health nurses.

1.4.3 Danny

Danny was a man in his early twenties who was in touch with mental health services following a diagnosis of schizophrenia. He had been discharged from hospital where he had had a protracted stay due to his lack of adherence to recommended interventions including a Mental Health Act detention. Danny was in his own words 'an outdoor sort' and needed to 'feel part of the world'. Unfortunately, due to the conditions placed on him throughout his admission he was unable to engage with outdoors as much as he would normally. Following his discharge he was supported by the community mental health team who subsequently transferred him to assertive outreach as they were finding it difficult to locate Danny in some of the remote places he preferred to be in. This included living for the most part in a tipi in the hills above a small local town. This was considered part of his mental illness by the collective mental health team. However, as part of the culture of this little town, this type of need was not considered unusual and was fairly well accepted. Danny needed to be close to nature to feel valued and part of the world but to mainstream middle class health professionals it was considered reasonable to conclude these needs were indeed symptoms of his psychosis. At no point was this considered to be a spiritual need as Danny had stated in his initial assessment that he was not religious.

As my career progressed, these and other experiences caused me to think more deeply about spirituality and what spiritual need is. As a practising mental health nurse I was concerned that my assessment in some areas of care was very subjective. In a

profession where evidence-based approaches are highly valued and expected I felt this element of care was questionable and wondered if the same people would receive different care depending on the assessing mental health nurse.

Some of the evidence based practice approaches are taught in university as part of pre- and post-registration nursing courses. For the last ten years I have worked in university as a senior lecturer and field leader in mental health nursing. Part of my role, other than teaching, is developing new modules and curricula for pre and post registration mental health nurses. As a nurse educator, I have noticed that although spirituality is included in the curriculum, it is often addressed as part of something else, for example holistic care, person-centred care or compassion. I have also noticed the reluctance of many of my academic colleagues to directly 'teach' this aspect of the curriculum and how it is often addressed as self-directed study as opposed to face-to-face sessions.

1.4 Chapter Conclusion

Nurses have a professional obligation to support spiritual needs (see Chapter 2) and as a nurse researcher I would like to contribute to the body of knowledge that supports other mental health nurses in providing best practice care for service users. This thesis describes and presents my study, undertaken as part of a professional doctorate, which set out to provide an in-depth understanding of how mental health nurses understand spirituality and respond to spiritual need in service users.

Chapter 2: Literature Review

2.1 Introduction

As outlined in Chapter 1, the aim of this study is to explore mental health nurses' understanding of spiritual needs of service users. This chapter builds upon an earlier journal article I wrote, published in 2011 (Elliott, 2011, see Appendix 1) which focused on the issues faced by mental health nurses and examined literature regarding spiritual beliefs and assessments by mental health nurses. Given the specific focus of this research, my primary focus will be on the literature pertaining to mental health nursing. However, I will also, where relevant, draw on additional literature from other (social science) fields, to show how pertinent issues have been understood in this broader context.

The initial part of my review of the literature will reflect upon the many definitions of spirituality used in the social and healthcare settings and the confusion regarding the relationship of spirituality to religion. Specific issues and research about application in the mental health field will then be considered and the Royal College of Nursing's (RCN) seminal study in this area undertaken in 2010 will be discussed. The standards set for education and professional practice in this area set by the Nursing and Midwifery Council (NMC) will be reviewed. The policies and directives issued by the Department of Health (DH) will be considered in more detail. The advice published by organisations like the Mental Health Foundation and the nurses' professional organisation the Royal College of Nurses (RCN) will be reviewed. The limitations of these documents and the consequent difficulty in agreeing standards, policies, directives and advice related to practice will be reviewed in the light of academic discussion in this area. I will also discuss different views on who is responsible for addressing the spiritual needs of service users. How far is it the responsibility of mental health nurses, should it be shared with other members of the multidisciplinary team and how far is it a specialist function for chaplains or other clergy? Mental health nurse education will be examined to explore how nurses learn their 'craft' (including spiritual care) at undergraduate level and/or as part of their continued professional development (CPD). I will analyse what evidence there is that ensures this aspect of care is addressed at an educational level and who is responsible for its facilitation. The final part of the chapter will consider

spiritual care provision in relation to mental health nurses and analyse how or even if they currently address this aspect of care and whether they are currently meeting the recommendations from relevant professional bodies and the DH. The conclusion will summarise the main points of the review and highlight the need for further research in this area.

2.2 Definitions of spirituality in healthcare

The lack of a clear and agreed definition of spirituality is the first issue to be addressed in seeking to understand how mental health nurses care for the spiritual needs of service users. Confusion about what spirituality is does not only affect healthcare. Bregman (2014), addresses what she calls *The Ecology of Spirituality* from a variety of perspectives: psychological, religious, and sociological. She also considers three particular areas of application: healthcare, the workplace and recreation. She cites the example of occupational therapy in healthcare where Unruh et al. (2002) conducted a survey of definitions in use in their own discipline and identified a total of 92. This review will therefore begin by exploring critically a number of definitions of spirituality used in a social and healthcare contexts before moving on to further contextualise its meaning within the realm of mental health nursing specifically.

I will begin by reflecting on the, sometimes difficult, relationship in the literature between the terms (and concepts of) spirituality and religion. Whilst there is no doubt that, for some, religion is an integral part of their spirituality, for others it is crucially important to be clear that spirituality and religion are not synonymous terms (Post and Wade, 2009). If they were, this would (incorrectly) suggest that only those who are religious or believe in God can be spiritual. Most understandings of the term religion suggest an affiliation with an organised institution which recognises a theological doctrine whereas those who identify as 'spiritual' may be disengaged from any particular religion (Sperry and Shafranske, 2005). A person may be religious, religious and spiritual, just spiritual or none of these.

Much of the existing literature reviewed for this study suggested a strong association between religion and spirituality which is shown in many of the definitions and descriptions. Corrigan et al (2003) note that the terms spirituality and religion are often used interchangeably but similarly argue that they are increasingly recognised as distinct but overlapping concepts. Swinton and Pattinson (2010) argue for a “thin, vague and useful understanding of spirituality”. This approach enables the practitioner to start with broad enquiry and follow where the patient leads. However, for research purposes this vagueness and broadness makes it hard to distinguish spirituality and spiritual well-being from existential issues and psychological well-being. This issue is addressed in detail by Koenig and colleagues in chapter two of the *Handbook of Religion and Health* (2012). Despite the authors’ explicit efforts to be comprehensive and to include more research on non-Western religion in the second edition of the *Handbook*, the perspective remains predominantly Christian. Humphrey (2015) notes that spirituality as a concept is often Christianised and may not be necessarily applicable in secular or other contexts. If many of the ideas and ‘grand narratives’ of spirituality in the academic literature are limited to particular religious understandings and perspectives, this will, in turn, perpetuate the link between them and resultant findings and narratives in the field (Humphrey, 2015).

Often however the term spirituality is not used as a generic term entirely devoid of religion but is rather utilised as a term to encapsulate both religious and non-religious personal beliefs (Koenig, 2010). It has been suggested that spirituality considered in its own right is a modern secular understanding (e.g. Crossley and Slater, 2005; Westerink, 2012; Huss, 2014). It has been argued that understandings of spirituality as an individual concept are influenced by the increasing secular community and the separation from traditional religious affiliations (Huss, 2014). Bregman (2006) suggested that in contemporary usages the word spirituality is often understood as a universal term applying to both ‘believers and non-believers’. However, Humphrey (2015) indicated that spirituality pre-dates organised religions, and that these are in fact rooted in universal ancient pagan beliefs that everything that exists is spiritual. Pagan culture may be found in prehistoric sites all over the world and Humphrey asserted that this provided evidence that mainstream religious practices were developed from pagan beliefs in spirit and the human ability to live in a transcendent state, beyond everyday experience.

Bregman (2006) noted that despite what she described as a growing differentiation between religion and spirituality, the 'umbilical cord' between the two remained intact because of the difficulties in defining spirituality in the absence of religion.

When attempting to define spirituality, many academics start with the origin of the word 'spirituality' which is derived from a Latin word, '*Spiritus*'. This refers to the essential life force which drives people and has influence of over all aspects of a person's life including relationships, behaviour and health (Baldacchino et al, 2001; Barker, 2001; Swinton, 2001; Tanyi, 2002; Koenig, 2007). Although this ancient definition still has resonance for contemporary understandings of spirituality there have been many attempts to define it further in order to encapsulate what spirituality is and as a result there are numerous 'definitions' used in healthcare.

The following definition offered as an example is fairly simplistic:

"Spirituality is a personal search for meaning and purpose in life, which may or may not be related to religion"

(Tanyi, 2002, P. 690)

Whilst this is a fairly succinct definition and may provide a baseline for discussion, it does not fully encapsulate the complexity of the concept in relation to mental health nursing. Gaskamp et al (2006, p8) defined spirituality as;

"The experiences and expressions of one's spirit in a unique and continuing process that reflects faith in God or a Supreme Being".

This definition is somewhat circular. Although it emphasises the concept of God or some other supreme being, it makes no specific mention of religion, nor does it allow for spirituality without the concept of God (or a supreme being). This allows for people who have a belief or affinity with God or another deity, but do not follow a particular religion. Nonetheless, the definition suggests that spirituality is inextricably linked with faith. It

also includes the word 'unique', indicating the individuality of a person's understanding or relationship with the spiritual aspect of themselves.

Narayanasamy (1991 p3) presents spirituality as a more complex concept, describing it as;

“A quality that goes beyond religious affiliation that strives for inspirations, reverence, awe, meaning and purpose even in those who do not believe in any god”

This definition similarly recognises that although spirituality and religion may be synonymous for some, others may find spirituality meaningful in the absence of religion. The notion of 'striving' indicates that people who feel spiritual need to work at it in order to 'better' understand and enhance their spirituality and hints at transcendence to another level of self.

The next definition incorporates some of the previous ideas but includes the word 'intrinsic' as well as 'transcendence'. This proposes that all people have a fundamental need to discover the spiritual aspect, which is to be revered, both inside and outside of self and suggests that this is needed to live a fulfilled life.

“The intrinsic human capacity for self-transcendence in which the self is embedded in something greater than the self, including the sacred and which motivates the search for connectedness, meaning and purpose and contribution”

(Benson et al., 2003, p.205)

This definition also introduces the concept of connectedness, signifying that a person cannot exist without a sense of belonging, meaning or purpose. Like Narayanasamy, Benson and colleagues suggest a need to 'work' at being spiritual by using the word 'search'. They also imply that it is recognition of the capacity for self-transcendence which motivates the spiritual quest.

Rather than providing a definition of spirituality, other authors consider the essence or essential qualities of spirituality. Many (e.g. Tanyi, 2002; Koenig, 2010; McSherry, 2010) consider these to include meaning, purpose, belief, faith, a connectedness to the sacred (however expressed), inner peace and strength and, for some, a belief or faith in a higher power or God.

Ellison (1983, pp. 331-2) provides a detailed description of the essence of spirit.

“It is the spirit of human beings which enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning which transcends us, to wonder about our origins and our identities, to require mortality and equity. It is the spirit which synthesizes the total personality and provides an integrative force. It affects and is affected by our physical state, feelings, thoughts and relationships. If we are spiritually healthy we will feel generally alive, purposeful and fulfilled, but only to the extent that we are psychologically healthy as well.”

In some ways this approach is superior to an exacting definition as it allows the person to consider what the essence is of spirituality. It suggests spirituality should not be defined, but known, and known not purely at the cognitive level but also at the interpersonal (heart) level. Swinton (2014) identified two forms of knowledge, nomothetic and ideographic, which have relevance in contemporary approaches to healthcare. Nomothetic knowledge is exemplified by modern scientific knowledge obtained through quantitative research like randomised controlled trials and experiments. It is knowledge which is accepted as factual and true. It can be replicated, and is falsifiable and generalisable. Ideographic knowledge is a second way of knowing which can be described as the ‘heart’ level. This type of meaningful knowledge cannot be replicated because it is unique to that person at that time and in that place and that person will not experience the same event in the same way more than once. However, ideographic knowledge is nevertheless real and significant and the concept of spirituality and what it means to an individual could be classified as ideographic.

Humphrey (2008; p107) expressed this differently:

“We can only come to know this web of existence through cultivating a seventh sense, since the web of existence is sutured together by spiritual forces beyond secular and scientific modes of knowing.”

She went on to suggest that future professions within social sciences will need to ‘journey’ between the worlds of ‘knowing’ and deconstruct the ‘antinomies’ between science and scholarship (nomothetic) and spirituality and selfhood (ideographic) to truly ‘know’.

The approaches to defining spirituality discussed here are a few amongst many, but demonstrate the complexities of defining and understanding this concept including differentiating it from religion.

It is unsurprising then that nurses may run into difficulties trying to understand spirituality (on both a personal level and in relation to others), and trying to translate that understanding into provision of spiritual care.

2.3 Spirituality in context- transcendence

Many of the previously described definitions and descriptions indicated an almost inextricable association between religion and spirituality which for some included a belief in God or higher power. In contrast, some contemporary definitions proposed spirituality may be viewed as separate to religion with the notion of transcendence being the point of distinction. The Oxford English Dictionary (2017) defines transcendence as “beyond or above the range of normal or physical human experience”. It could be argued that religious prayer may enable a person to achieve transcendence. Pargament (2009) considered the psychology of religion which described spirituality as dynamic and said that spirituality is a sense of unity, meaning, connectedness and transcendence to the highest of human potential. However, as previously discussed a person may also observe the doctrine of religious practice including prayer and not be spiritual. It is the introduction of spirituality as a separate concept which would enable a religious or secular person to transcend. King (2014) talked about transcendence as

being pivotal to spiritual connection but suggested that spirituality may be attributed to all aspects of human life. However, King also grounded transcendent practices in a person's will to live, and their sense of hope, meaning and purpose. For some a secular sense of transcendence may be found in connection with earthly things like family, career, hobby or other activity like sport, art and music.

Therefore, for the purpose of this study and because of the close association between them, I recognise that the terms religion and spirituality may be used together. What is key for me in relation to my own understanding of spirituality (as distinct from religion) is that spirituality includes (and involves) the aforementioned notion of transcendence. This is not of course to say that religion may not include spiritual or transcendental elements – but my own personal understanding is that spiritual practice will always be deeply involved with transcendence whereas religion may not necessarily. It is important to emphasise that there are many understandings of spirituality which I have evidenced in the definitions above but following my exploration of spirituality this is my personal understanding. This was not shared with the participants prior to the interviews as I had no wish to impose my own definition or beliefs on others but I feel it is important to offer clarity of my position to appropriately contextualise the work.

In the following section I will move on to suggest why it is important that spirituality is considered in the provision of health and social care, with a particular focus on the provision of mental health care.

2.4 Spirituality, health and social care and mental health nursing

Healthcare and specifically mental health care have been traditionally linked with spirituality. Barker (2001) highlighted the historical context in relation to the role of Celtic monks. Over a thousand years ago they cared for people who suffered emotional trauma and vulnerability, which contemporary nurses now recognise as mental ill health. Ross (2016) identified that many strategies used by psychotherapists and other healthcare professionals were spiritual in origin. For example, mindfulness or meditation which is extensively used in counselling has Buddhist origins (Hanh, 2011). Moreover,

most care disciplines including social work, psychotherapy and occupational therapy have religious roots which historically were linked with concepts of spirituality (Barker, 2006).

Narayanasamy (2001) also described nursing as having 'roots in spirituality' but suggested the relationship between these two concepts started to decline in the early 19th century with developments in medicine and an increased emphasis on physical care. Narayanasamy (2001) identified a turning point in the early 1980's when interest in the traditional association of nursing with spirituality revived and acknowledgement of the importance of spiritual care began to increase. In their reflection on current interest in spirituality in nursing, Rogers and Wattis (2014) reflected on modern-day wider societal and cultural pressures, suggesting that materialist lifestyles have an adverse effect on a person's ability to find hope, meaning and purpose: the core aspects of both spirituality and mental well-being. Gilbert (2008) explored issues with social workers' own religious or spiritual ideals and suggested a conflict with professional principles. For example, some religions have strong views regarding homosexuality, divorce, abortion and female equality which may be in opposition to non-judgmental values of social work, psychology and other care giving professions. Whilst individual care givers may be able to superficially overcome their secular, religious or spiritual beliefs, the therapeutic relationship with their client may be restricted by their own values. This is evidenced in other studies which identified reluctance of care givers in addressing spiritual needs (Belcham, 2004).

The Mental Health Foundation (2004) report *The Impact of Spirituality upon Mental Health* specifically focused on the spiritual needs of people in mental health services. According to this review, aspects of spirituality can have a positive effect not only on mental but also on physical aspects of health (for example, traditions associated with spiritual or religious ritual which encourage hope, love, acceptance and forgiveness serve neural pathways affecting the endocrine and immune systems). Yet, literature shows that the restrictive attitudes towards homosexuality, divorce etc are generally associated with religious practices and doctrine whilst more liberal and inclusive attitudes are more commonly associated with secularised spirituality (Ross, 2016).

Greasley et al (2000) reviewed articles written in the 1990's and called for spirituality to be 'reinstated' as central to nursing indicating that historically spirituality had greater emphasis. Whilst the context was 'nursing' generally as opposed to mental health nursing specifically, Greasley and colleagues stressed the significance of spirituality for people who needed comfort and support particularly during times of crisis which would include mental ill health. Corrigan et al (2003) invited service users who were diagnosed with serious mental health issues to complete a self-report on religiousness and spirituality. Their results indicated that spirituality and religiousness were positively associated with psychological and mental well-being with a reduction of symptoms associated with serious mental ill health.

Koenig (2010) examined a selection of research which considered the relationship between spirituality and mental health with a focus on anxiety and depression as well as substance misuse. Koenig's view was that spirituality is distinct from other notions such as values, morals and humanist behaviour. He defined spirituality as a connection to the sacred which he described as transcendent. In his examination of the research literature, Koenig concluded that spirituality can often offer comfort alongside hope, meaning and purpose in the context of mental health issues. The absence or loss of spirituality (and/or religion) places the person at a higher risk of mental ill health or suicidality (Koenig, 2010). However, he cautioned that there are occasions when spiritual feelings may become entangled with mental and emotional issues (discussed in relation to alcohol and drug issues below), further complicating the concept for both service user and caregiver. Serious mental illness often runs hand in hand with diminished capacity, Mental Health Act applications, and psychotic phenomena which may distort the expression of spiritual need (Barker, 2004). As a result, mental health nurses may fear misinterpreting spiritual needs of the service users and confusing them with symptoms of mental illness which may cause a reluctance to provide spiritual care (McBrien, 2006; Barker 2004; Swinton, 2010).

Spirituality has been recognised as an integral part of the mental health healing process for people who also have alcohol or substance misuse issues. Cook's (2004) definition

of spirituality originally came from an analysis of definitions used in the field of alcoholism and addiction:

“Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective experience of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately “inner”, immanent and personal within the self and others, and/or as a relationship with that which is wholly “other”, transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with meaning and purpose in life, truth and values.”

(Cook, 2004 p10)

The values held by Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) in the ‘12 steps recovery programme’ directly access spiritual belief and practices and encourage the service user to ‘give themselves over’ to a ‘higher power’. This higher power is not specified and therefore open to interpretation by the person but generally this is seen as spiritual transcendence (Koenig, 2010). A questionnaire based on these values concluded that people who engage with the 12-step programme had fewer relapses and sustained their recovery (McLaughlin, 2004). Koenig (2010) agreed with this conclusion but warned that there were circumstances where spirituality and religion might compound the issues faced by people who misused alcohol or other substances. A person who already had strong spiritual beliefs might feel shame and guilt as a result of their perceived weakness, reject the principles offered by the 12-step programme and paradoxically turn towards alcohol or drugs for solace. Because of the issues with medication which people who misuse alcohol or substances face, AA and NA use spirituality as their main approach to helping the person recover with a high level of success (Koslander and Arvidsson, 2007). Koenig, (2010) stated this was because spiritual beliefs and practices helped people make sense of mental and emotional crisis and provided a framework for a person’s life.

It follows from this that mental health nurses need to have the skills and professional competencies to effectively and safely include spirituality in their nursing practice. The

regulatory body for nurses is the NMC and its Standards for Competence (2014) stated that nurses must:

“Carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement”

NMC (2014; p7)

Understanding an individual's spirituality is essential in assessing and providing spiritual care to a diverse patient population (Barker, 2001). However, it has been reported there is hesitancy and unease amongst mental health nurses when it comes to talking to people about their spiritual needs (Watkins, 2008). This type of hesitancy is also reflected in the difficulties social care colleagues experience and their reluctance to address a client's spiritual needs (Johnston and Mayers, 2004; Crossley and Slater (2005). Belcham (2004) conducted a qualitative study about spirituality in occupational therapy which recognised spirituality and religion as having a positive impact on health and occupation which is essential to holistic practice. Whilst religion seemed to be relatively straightforward for Occupational Therapists (OT's) to address they reported finding incorporating spirituality outside of religion difficult.

Understandings of spirituality are related to culture and religion. The concept of spirituality is becoming more diverse with varying cultural practices and within that each person has their own perception and emphasis in understanding spirituality. Statistics produced by the Office of National Statistics (ONS) (2011) census showed that the United Kingdom has a more diverse community than any other country in Europe. This contributes to a richness of spiritual understanding but additionally means that mental health nurses will need to cater for and address the spiritual needs of patients from varied cultural and religious backgrounds. With the emphasis on evidence based practices, care approaches like the ones used in social sciences are more often than not secular and studies have shown that care givers are often less likely to be involved

in organised religious practices (Schulte et al, 2002). Whilst this does not necessarily mean that a secular care giver would reject a client's spiritual or religious experience, it may mean that they find this more difficult to address or prioritise.

Nurses often feel unprepared or uncomfortable in supporting spiritual need and either neglect to respond to this need or refer to another professional (Elliott, 2011). Narayanasamy and Owens (2001) conducted a critical incident study to describe what nurses considered to be spiritual needs and explored how nurses responded to what they felt the spiritual needs of patients were and the interventions used. Their findings suggested there was confusion about both the concept of spirituality and the nurse's role. In a Swedish study looking at patients' perceptions of how spirituality was addressed specifically in mental health care, Koslander and Arvidsson (2006) found that nurses were reported to avoid addressing any spiritual need, leaving patients to turn to other resources for support including other service users, health professionals other than nurses, and religious leaders such as a Priest or Imam. Whilst patients wanted to discuss spirituality and spiritual need (and felt they recovered from mental ill health quicker when nurses addressed their spiritual care), patients felt it was the responsibility of nurses to broach the topic of addressing spiritual needs. Although patients in Koslander and Arvidsson's study felt nurses neglected their spiritual needs, the nurses may have been using empowering person-centred approaches to care. Professional person-centred approaches empower clients to identify their own care needs, which may include religious or spiritual, and how those needs may be met (Sharp and Nash, 2017).

Koslander and Arvidsson (2006) concluded that nurses should work to develop an awareness of how they could address the spiritual needs of service users and ensure good spiritual care was integrated into treatment where spiritual beliefs or practices were significant to a service user. Corrigan et al (2003) also reported that mental health professionals often failed to inquire about service users' beliefs or spiritual needs. One of the reasons for this hesitancy may be nurses needing to position themselves within a care system which associates professional credibility with a particular type of scientific approach often favoured by professions like medicine and psychology (Gilbert, 2008). The nebulous characteristics of spirituality make traditional quantitative approaches to

scientific study of the concept difficult. The scientific emphasis of their profession may be a barrier to addressing what Zinnbauer et al (1997 p.549) described as the “fuzzy concept of spirituality”. Carpenter (2002) who studied mental health recovery and the implications for social work, criticised the dominance of scientific based professions like medicine and psychology in mental health services, and said that elements of holism including spirituality are often neglected because of the focus on psychiatric symptoms. He suggested that scientific approaches alone cannot support the whole person and other approaches should be explored as well.

McSherry and Jamieson (2010) stated that whilst spirituality was fundamental to good nursing care, it was not the responsibility of the nurse alone to provide it. Nonetheless, the nurse should be at least sensitive to the person’s needs and supportive, if necessary, in accessing a more appropriate person or service (Corrigan et al; 2003). Narayanasamy and Owen (2001) found that some nurses perceived spiritual care as the role of a chaplain or other religious leader and referred the service user to them. Whilst this placed responsibility for spiritual care elsewhere, arguably they were facilitating spiritual care as opposed to neglecting it. In line with other work discussed here, they found spirituality to have a positive effect on patients. They also importantly found that nurses could – and did - derive satisfaction from the experience of giving spiritual care. Johnston and Mayers (2005) reviewed how occupational therapists (OTs) acknowledge, assess and meet spiritual needs. They suggested that the concept of spirituality could be relatively easily addressed by OT’s because of their approaches in how they support a person’s perspective on hope, meaning and purpose. Nonetheless, they reported that OT’s found supporting spirituality difficult and that many felt addressing spiritual needs was not part of their role. Helminiak (2008) identified similar feelings amongst psychologists, Sheridan and Hemert, (2014) also highlighted difficulties in social work and described the relationship between social work, religion and spirituality as often tenuous because of the general perception that social workers are predominantly secular. This is despite social work’s professional values which advocate individualised client empowerment and person centeredness.

As was the case in Koslander and Arvidsson’s (2006) study (described above) Greasley et al (2001) concluded in their work that service users perceived a failure on

the part of mental health professionals, including nurses, to adequately address spiritual elements of care. They suggested that this might be a symptom of the medicalisation of care where more quantifiable aspects of care have more emphasis and perceived value. Greasley et al (2001) argued that nurses are caught up with the mechanics of nursing and have moved away from interpersonal care which is associated with concepts like love, compassion and spirituality. Nurses cannot, or find it difficult to, marry the scientific aspect of nursing with the more artistic and nebulous concept of spirit. With developments in psychotropic medication, nurses are increasingly reliant on this approach which has caused a reduction of spiritual care (Koslander & Arvidsson, 2006). Swinton (2001) discussed the reluctance in research and education to address spirituality in mental health care including nursing and suggested it was because of the lack of professional credibility around it which may result in spirituality not being treated as a significant aspect of holistic care. Gilbert (2008) studied spirituality in social work groups. She identified that the key change to the shift from concepts like love etc (as described by Greasley) was in the professionalisation of social care which seemed to create the conflict between historical spiritual values and new professional principles. As a result, the 'fuzzier' concepts of spiritual care had given way to more quantifiable 'treatments'. Helminiak (2008) also identified this as a problem. He conducted a critical appraisal on '*confounding the divine and the spiritual: challenges to a psychology of spirituality*' and described the ambiguity surrounding spirituality from the standpoint of psychology. He went on to question whether a scientific approach to addressing the spiritual dimensions of a person was possible and if psychology, as a profession, had the competence to study spirituality at all.

Mental health nurses differ in their views regarding spirituality and find the concept difficult to define in a meaningful way particularly in relation to its application in caring for service users. In her case study research which sought to promote incorporation of spiritual beliefs into inpatient crisis psychiatric care, McLaughlin (2004) concluded that a workable definition of spirituality was elusive for many mental health nurses. As a result, individual spiritual needs were often overlooked and much needed to be undertaken to improve the quality of care delivered to people with mental health needs. Narayanasamy and Owens (2001) perceived a lack of clarity when trying to define spirituality, describing it as elusive, and suggested further problems arose when

spirituality was equated with religion. Corrigan et al (2003) suggested there are no consistent findings which suggest spirituality is more beneficial than religiousness and that both may have positive effects on health for people who experience mental disorder. They suggest that it is the social inclusion and empowerment offered through association with a particular religious institution which is often beneficial to service users and argue that it is this that is often lacking in mental health services. Sharp and Nash (2017) considered the professional skills essential to ensure this type of care is facilitated and discussed empowerment, compassion, empathy and genuineness. Most other care professions, including scientific focused professions, could also lay claim to these qualities, suggesting that such professions (and indeed individuals) with a secular focus may have the required skills to address spiritual and religious needs if needed.

Some of the values discussed could be viewed as humanistic. However, Egan and DeLaat (1997) warned against labelling holistic values under the term humanist because, according to them, many humanists reject the concept of God or supreme entity which many people who define themselves as spiritual accept. They preferred a person-centred philosophy because this approach embraces and respects individuals' beliefs and practices including religious, spiritual and cultural. Sharp and Nash, (2017) wrote about spiritual team work in the context of end of life care in psychotherapy but their approach drew parallels with other care teams and contexts. They emphasised that a patient or client is 'first' in a therapeutic relationship and should take a central role in their own care. Similarly, literature showing these principles are embraced by other professions like social work, psychology, OT and nursing and ensure that a patient or client is personally valued as someone who is worthy, self-determining and individual.

2.5 RCN Survey

In 2010, the Royal College of Nursing (RCN) conducted a large-scale survey which included British nurses from all disciplines, asking them about their perceptions of spirituality and spiritual care (McSherry and Jamieson, 2011). While the survey recognised the difficulties in defining spirituality the following definition was used to contextualise the work:

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

Murray and Zentner (1989, p. 259)

The survey received over 4,000 responses from RCN members, making it one of the largest studies of its kind, and the responses from nurses were unprecedented. Findings revealed that, despite nurses recognising spirituality as a fundamental aspect of nursing care, many of the respondents felt that they in turn needed support and education to enable them to feel confident in providing it. Although it was not specified in which field of nursing respondents worked, the main body of participants seemed to be from the field of adult nursing and there was no specific mention of mental health nursing. Each field of nursing has its own unique challenges and whilst this survey provided valuable insights into how nurses understand spirituality generally, it does not accurately reflect the issues specific to each individual field of nursing.

2.6 Guidance available to mental health nurses in relation to spiritual elements of care

Having established that both service users and professionals see spirituality as important in the context of mental health nursing, but also that incorporating spirituality into mental health nursing appears problematic, this section will review the different sources of guidance that might help mental health nurses make sense of this area. Many nurses find spirituality a difficult concept to address (Swinton, 2001), so what guidance and training is available in this respect? There are a variety of sources: the NMC which sets standards, policies and directives from the Department of Health (DH) and its agencies, advice from generic mental health organisations like the Mental Health Foundation and the (Sainsbury) Centre for Mental Health and advice from the nurses' own professional body, the RCN.

The NMC Standards for Competence (2014) referred to above required nurses to be competent in systematic assessment, including spiritual factors. Disappointingly, the NMC Code (2016) makes no specific mention of this area though it can be assumed to be included under the general rubric of 'prioritising people'.

It is recognised by the DH that over recent years NHS services, including mental health, have experienced radical changes and challenges, and mental health services have been developed with some services disbanded or reconfigured (DH, 2014). Over twenty years ago, the 'Working in Partnership' document (DH, 1994) provided a formal review of mental health services. Since this time there have been a range of additional policy and guidance documents issued by the Department. Recommended approaches to mental health care emphasise recovery and holism (of which spirituality is a component), and aim to help individuals create their own 'normal' and feel valued within society (DH, 2004). However, there is seldom any mention in such documentation of spirituality as a key aspect of care needs. The National Service Framework for Mental Health (NSF) (1999) cited research published by the Mental Health Foundation (1997) that discussed the importance of addressing spiritual issues, but did not in itself cover spirituality in any great depth. The Mental Health Policy Implementation Guide (2003) further built upon the NSF but both were superseded by further documentation released in 2009 (DH, *New Horizons*) and 2011 (DH, *No Health without Mental Health*), neither of which made explicit mention of spirituality. *New Horizons* (DH (2009) demanded quality care at the highest standards with 'personalised care' as its pivotal point. However, although it acknowledged the potential impact of wider social and financial aspects on mental health, this document focused on the practicalities of treatment and did not capture the essence of recovery and what 'recovery' might mean to the individual who had been mentally ill. In an equality statement which forms part of the *No Health without Mental Health* (2011) document, the following characteristics were noted as a basis for non-discrimination (based on the Equality Act, 2010): age, race, religion or belief, sex, sexual orientation, disability, marital or civil partnership, pregnancy or maternity, or gender reassignment status. Spirituality was not mentioned. This might be because spirituality, unlike religion and religious practice, is hard to define, categorise and measure.

The National Institute for Mental Health, England (NIMHE) was established in 2001 to coordinate research, disseminate information, facilitate training and develop services. In 2003, NIMHE and the Mental Health Foundation (a longstanding Mental Health Charity) (MHF) began a two-year partnership which looked at spirituality in relation to mental health and in 2006 the MHF published a commissioned review of the literature: *The Impact of Spirituality on Mental Health*, discussed in more detail later.

Spirituality and spiritual care in mental health were addressed in the DH document *10 Essential shared capabilities: A Framework for the Whole of the Mental Health Workforce* (DH, 2004), where spirituality was specifically mentioned under the heading of 'Diversity'. However, although this document was intended to ensure a comprehensive and inclusive approach to training for mental health practitioners, it provided little specific guidance as to how spirituality should be incorporated either into training or into practice. Then, as part of a wholesale review of services in England, the *Chief Nursing Officer's review of mental health services* (CNO, 2006) (Recommendation 10) directed mental health nurses to act in response to the spiritual or religious needs of individual service users. Although the document suggested that dealing with spiritual needs was significant to recovery and highlighted educational needs in relation to spirituality in its recommendations, there was again little guidance provided on how to address spiritual needs. Whilst terms such as 'holism' and 'recovery' can be found, other language in the CNO review ('treatments' and 'interventions') suggested a more disease-based, less holistic approach. Mental health nurses were directed to assess spirituality within their initial assessments, but this seemed to be at the level of establishing an individual's religion and related needs only.

A critique of policy was provided by McSherry and Jamieson (2011), who considered spirituality as part of the contemporary political context. They also referred to the drivers which caused government to identify spirituality as integral to mental health care. Whilst they contended that spirituality was indeed very important in terms of care, they criticised governmental initiatives and suggested that the apparent concern regarding spiritual support for service users was tokenistic and raised false expectations. They argued the reference to spiritual care was included merely to serve a political agenda

with little consideration as to how its application affected patients or the nurses who were expected to provide such care.

It appears from the existing literature that there is a need for better education and guidance for mental health nurses which is key to providing and improving spiritual care. Government policy is tokenistic (McSherry & Jamieson, 2011) and the NMC only makes a passing reference to spiritual assessment and provides no specific guidance on how nurses can confidently facilitate spiritual care. However, the RCN (2011) published a 'Pocket guide to spirituality in nursing care' following its survey (RCN 2010) which has at least attempted to provide something constructive for nurses to work with. However, this is for nurses generally and is not mental health specific. In terms of making spirituality part of the nurse training curriculum, the responsibility in providing education remains with Higher Education Institutions (HEI's) which act under guidance from the NMC and respond to government directives. However, with half of nurse training taking place on placements in clinical areas, qualified nurse mentors are equally responsible for providing appropriate education concerning spiritually competent practice to students and junior colleagues. Current methods of teaching encourage students to reflect, share and place emphasis on compassion and empathy, and this could facilitate openness towards spirituality (Chirema, 2008). However, the lack of clarity and guidance from the governing bodies result in pre- and post-registration courses often failing to deal with spirituality adequately (McSherry and Jamieson, 2010). Barker (2001) has called for nurses to rethink their role as 'carers' and adopt a 'caring' approach with guidance from the service user and not rely on formal education alone. One of the consistent issues raised in the broader literature was the perception that there was a lack of education around spirituality in the health and social care professions. Crossley and Slater (2005) conducted a qualitative study which explored clinical psychologists' experience of addressing spiritual beliefs in therapy and said the lack of engagement with spirituality in therapy was because the participants had never thought about or discussed the concept which was notably absent in their clinical training courses. This appears to be a recurring issue with other health and social care professions who also highlight lack of education in their professional training courses (e.g. Belcham, 2004; Gilligan and Furness, 2005).

The MHF (2006) review, referred to above, acknowledged the importance of spirituality in the context of mental health. It concluded with some recommendations for health professionals. It advised that health professionals should not pathologise, dismiss or ignore religious or spiritual experiences and suggested that health professionals working in mental health services should establish on admission and throughout their care the service user's spiritual needs. This information might then be used to help the service user identify aspects of their life which offered hope, meaning and purpose to help with recovery. However, although there was acknowledgement of broader aspects of spiritual experience earlier in the document (it was acknowledged that some experiences of spirituality might arise from an appreciation of art, music, nature or architecture and that the spiritual feelings thus evoked might not be well met by, for example, contact with a spiritual or religious leader), many of the key recommendations seemed to deal with practices and behaviours more associated with religious practice. A key recommendation was that the 'mechanics' of spiritual or religious needs were provided for - for example, safe spaces to pray, worship or meditate and to form strong associations with religious or spiritual groups within the community. A further recommendation was to offer the service user contact with a religious leader or group even for those who did not regard themselves as spiritual. This illustrates the difficulty in fully understanding spiritual needs when approaches to spirituality are based on a set of behaviours. The report acknowledged this limitation and stated that the content and tone reflected the bias of the researcher towards Christian religion as a mediating factor between spirituality and mental health as opposed to addressing spirituality as a more general phenomenon.

Greasley et al (2001) concluded from their work that a more holistic approach to mental health care should be taken and suggested this would need a multidisciplinary approach to education in spiritual care to ensure cohesion and parity in practice. Whilst interdisciplinary collaboration may be important in this respect, it seems that collaboration between the mental health nurse and the service user is also vital. Barker's Tidal Model (2001) emphasised the importance of interpersonal connection and empowerment in mental health. The Tidal Model seeks to explore service users' lived experience as a 'person-in-care' and focus on that person's values and the meanings they attribute to their experience of life including their illness. This may extend

beyond 'care' and into their life 'outside' to include their relationship with their inner self and others. Barker (2001) suggested that in order to holistically care for an individual, the mental health nurse needed to fully understand the person and respond to their individual needs including the spiritual dimension by encouraging the person to speak in their 'own voice' and find a mutual understanding of spirituality between the service user and nurse. However, this suggestion fell short of providing what a formal definition of what the spiritual dimension was in the context of mental health nursing. The difficulty of subsequently supporting spiritual need is then finding a common understanding of spirituality between the nurse and service user in the absence of an agreed formal definition. According to Barker (2001), spirituality *is* the person and the person would cease to exist without it. The Tidal Model ethos is rooted in the concept of holism, and spirituality is seen as integral to holism. Mental well-being needs a harmonious balance between mind, body and spirit. Although all are separate components each one affects the others (Barker, 2006). Professions like social work, OT and nursing use the concept of recovery when working with people who have mental health issues. Recovery relies heavily on supporting a person to use their own personal 'survival tool kit' which may include spirituality yet the emphasis remains on other aspects of holism which are far easier to address because of their quantifiable nature and their atunement with medicine or psychiatry. Whilst Koenig (2010) similarly concluded patients can use their spiritual resources as aid to support their recovery, he does however caution that there comes a point where they are too ill and may need a nurse to help support them to point in a direction where the patient can once again take responsibility for their spiritual wellbeing.

This joint approach to care fits in with Barker's (2001) Tidal Model and other person-centred approaches which place the service user at the centre of their own care: the nurse's role is to support the person in developing and using their own 'tool kit' for recovery. This approach considers the patient to be the expert in their own care and recommends nurses are guided by this in order to understand the person's relationship with their own illness and health. Spiritual needs therefore may be addressed but this is likely to be dependent on the nurse as an individual and may be as part of other approaches to care like person-centredness and holism. It seems that nurses' involvement in spiritual care enhances social support and provides a framework for

wellbeing and developing relationships with service users (Koenig, 2010). Mental health nurses who have skills in recognising a service user's values and spiritual dimension greatly improve the service user's chances of an early recovery (Mclaughlin, 2004). Compassion, listening and at least an attempt to try and understand a patient's 'pain' are some of the qualities of nurses who provide the best spiritual care. Many nurses, including mental health nurses, do not recognise these values as spiritual but none the less integrate them into their nursing approach (Rogers and Wattis, 2015). This suggests that spiritual needs may be met on some level whether the nurse or service user recognises it as such or not. Nurses who invest in developing strong therapeutic relationships are able to recognise signals, which could be identified as identifying spiritual need, and respond accordingly (Narayanasamy and Owen, (2001).

Greasley et al (2001) highlighted a problem when spiritual needs were seen as being the same as religious needs. Many nurses find it easier to address religion and feel they have fulfilled their obligation to support spiritual care merely by supporting religious practice. The sense of practical obligation was also found a study by Udell and Chandler (2000) who conducted a qualitative ethnographic study on OT's. They believed that the OT's approach focussed on the functions of religious practice and traditions. This implied that only people who have practical religious needs are spiritual and do not recognise others who have other more secular ways of expressing their spirituality, for example music, art or connection to nature.

The attitude and approach of the mental health nurse will affect the outcome of care, and any failure to address spiritual need may be the result of the nurse feeling unable or unprepared to address spiritual needs rather than deliberate neglect. Failure to address these needs is often unintentional and influenced by a number of environmental factors like time, peace, privacy and space, which are often restricted or controlled in many clinical areas (Elliott, 2011).

2.7 Conclusion

The literature indicated an emphasis on recovery and holism in mental health nursing and the broader social sciences. Spirituality can be seen as an integral part of this (Greasley et al., 2000; Barker, 2001; Koslander and Arvidsson, 2006; Elliott, 2011). Britain has an increasingly diverse population (ONS, 2015) which, as well as adding to the cultural enrichment of society, brings varieties of spiritual experience and religious expression. As a result, contemporary mental health nurses are expected to care for the spiritual needs of service users from diverse backgrounds, religions and cultures often with little guidance (Elliott, 2011). Yet despite this diversity academic literature on spirituality is heavily influenced by Christian values (Humphrey, 2015).

The NMC requires nurses to be competent in making a systematic assessment of patients and expects spiritual factors to be taken into account. Department of Health policy documents have stressed the importance of addressing spiritual needs but stopped short of offering mental health nurses clear direction on how this should be done. The CNO (2006) review of mental health nursing suggested that a service user's personal beliefs should be routinely considered when planning care and that it was essential to include spiritual and religious beliefs but again fell short of suggesting how this might be achieved in a consistent way. The research literature indicated that people who experienced mental ill health also identified spiritual care as an important part of their recovery but felt that this aspect of their care was often neglected (Koslander and Arvidsson, 2006).

One of the main reasons mental health nurses might experience difficulties in addressing this aspect of care is the many different attempts to define spirituality and the multi-faceted understandings of the concept. This lack of clarity adds to the confusion some mental health nurses feel when faced with addressing the spiritual needs of service users. In the absence of a clear definition of spirituality and its relationship to mental health, nurses are left to interpret the numerous definitions, to formulate their own understanding and translate this into caring for people with mental illness. Often they have no systematic preparation for this in their undergraduate or postgraduate education.

As a result of the confusion in defining spirituality, some mental health nurses approach spirituality as synonymous with religion which is often easier to address. Other mental health nurses may even refer a service user to a religious leader in an attempt to fulfil their spiritual needs because they do not feel it is part of their nursing role. For some service users, people they recognise as religious leaders - for example Imams, priests and chaplains - may be able to provide spiritual care to support recovery. For others, there may be less obvious sources of support in relation to their spiritual needs. This may have a negative impact on their mental wellbeing and subsequent recovery. Service users in Koslander and Arvidsson's research said mental health nurses should take the initiative when addressing spiritual needs. However, a question should be raised to ask at what point the patient does take responsibility in addressing their own spiritual need or at least to highlight this as an issue as suggested by Barker (2001) and Koenig (2010).

Despite the literature stating the importance of spirituality, the evidence considered here suggested the spiritual dimension of the patient was often poorly addressed, even neglected or ignored in mental health nursing and the social sciences. The NMC and the CNO rely on Higher Educational Institutions to take the lead in raising spiritual awareness in pre- and post-registration nurse education, without being specific about what is required. Government policy recognises the importance of this area but does little to support appropriate provision. This is still an area which is often ill addressed or neglected. This may indicate a deficit within the practice element of mental health nurse education. The evidence indicated that spiritual needs were being addressed in some shape or form (by following the concept of holism) but this was achieved almost implicitly or as a side effect to other aspects of caring and often without either the mental health nurse or service user recognising it as such.

Overwhelmingly the evidence in the literature review agreed that the concept of spirituality was individual and applied both to service users and nurses alike with no two people having exactly the same needs as each other (Narayanasamy, 2004). However, there were commonalities shared by religious and non-religious people and if those commonalities are at least respected then most will feel satisfied that some attempt at spiritual care has been made. Spirituality as a concept is recognised as integral to

caring for people with mental health needs yet how this is achieved remains open to interpretation (Swinton, 2001). There is little in the way of clear recommendations as to how service users' spiritual needs may be consistently addressed and more research is clearly needed into how nurses understand and provide spiritual care in practice.

Overall, the evidence reviewed here suggests that spirituality can be an important part of recovery for people with mental health needs, but that mental health nurses are not always comfortable with the concept of 'spiritual need' and are often ill equipped to assess and provide for such needs. Additionally, there has been little research to explore what mental health nurses understand by the concept of 'spiritual need', and there is clearly a need for a greater understanding of what this means from a mental health nurse perspective. Exploring how mental health nurses understand spirituality and how they support the spiritual needs of service users could provide useful information for the development and provision of better education and support for mental health nurses around this aspect of their practice. To explore this topic, a suitable approach is required. Qualitative methods, concerned with depth as opposed to breadth and meaning as opposed to measurement, are widely recognised as an appropriate approach to take when exploring personal experience and understandings around topics such as spirituality (Coyle, 2008). The aim of this study was to explore mental health nurses' understanding of the spiritual needs of service users, using appropriate qualitative methods so as to facilitate an in-depth understanding of the mental health nurse perspective. I have already established my understanding (as a mental health nurse) of spirituality and for me the point of distinction is transcendence. However, I recognise that spirituality is intensely personal and that others may have a different understanding. Therefore, I needed to explore the mental health nurses' perspective more broadly particularly in relation to their understandings of service users' spiritual need and how this related to care. The following chapter will describe the methodology and methods used in this study in more detail.

Chapter 3: Methodology and Method

3.1 Introduction

This chapter is separated into three main sections which will describe and discuss the method and research design of the study. The first section will discuss the reasons for using the qualitative research methods employed in this study. The second section will discuss the study design in further depth: I will describe the study setting, study recruitment, the participants, the ethical considerations which guided the study and the process of data collection. In this section, I also provide more personal detailed reflections on the research process. The third section will introduce Template Analysis, the method used to analyse the study data, and explain how data analysis was undertaken.

3.2 Qualitative research and its utility in this work

There are many ways to explore human social and personal worlds, however exploring experiences, meanings, thoughts and/or emotions usually requires a qualitative approach (Bowling, 2014). Qualitative research is popular in health, particularly in nursing and social care, providing in-depth approaches to understanding experience and meaning (Polit and Beck, 2010). There are a range of qualitative approaches to research (Holloway, 2005). The choice of approach is dependent on what the aims and objectives of the study are, the research question, the skill and also the personal preference of the researcher. Fundamentally though, qualitative research is about meaning. The focus in qualitative research is usually on describing and understanding the ways in which an individual experiences and interprets their world (Bowling, 2014). Although there may be multiple interpretations of a situation, the intention is to avoid the assumption that the researcher's own perspective or viewpoint is the principal reality (Avis, 2005). This is rather different from quantitative approaches to research which tend to be primarily concerned with measuring external and observable variables (King and Brooks, 2017). Human experience, often the phenomena under investigation in qualitative research, is rather difficult to conceptualise in terms of accurate measurement and objective observation (King & Brooks, 2017).

The range of approaches to qualitative research is associated with different perspectives and procedures, and it is important that research questions are consistent with the approach taken (and vice versa). Often, qualitative research begins with a question that asks about how we as researchers we can explore people's subjective experiences of life. (Avis, 2005). This study is an exploration of mental health nurses' understanding of spiritual needs of service users. Therefore the research question for this study is: 'How do mental health nurses understand and care for the spiritual needs of service users?'

Qualitative research is underpinned by rather different assumptions about the world than the empiricist approach taken in quantitative research. Quantitative research assumes an objective reality which can be measured and whilst this is an appropriate approach to answer some research questions, it is not appropriate to investigate subjective human experience. However, there is not one particular stance taken by qualitative researchers, so it is important as a researcher to ensure that the approach taken is congruent with the research question.

In this study, the emphasis was on understanding how my participants (mental health nurses) understood and provided care in relation to spiritual needs. The attention was on personal understandings and considering these issues in relation to their relevance in applied 'real world' settings. I have therefore primarily adopted what King and Brooks (2017) have termed a 'limited realist' stance in my work. King and Brooks (p.18, 2017) describe a limited realist stance as follows:

"[a limited realist position has] a commitment to a realist ontology combined with a constructivist epistemology. Put simply, they [those taking this stance] believe the world has a reality outside of human constructions of it, but that our understanding of it is always limited by our position within it"

In this study, I explore individual personal experience – I am not seeking objectivity but am rather concerned with what is experienced as being true for my participants. Nonetheless, from an ontological perspective, I do understand the research as being part of a broader existence and recognise the world as having a concrete reality outside of human constructions of it (King and Brooks, 2017).

I am aware that my own standpoint and perspective will have an impact on the research and do not make claims for objectivity. As a mental health nurse who has worked for many years in practice I have experienced similar issues and challenges as the mental health nurses who have participated in this study.

My position as a mental health nurse has been an advantage in terms of establishing rapport but requires that I question my own assumptions throughout – reflexivity is an important part of the process. Similarly, I have my own view and understanding of what spirituality means to me (described in section 1.3) which cannot be wholly removed from this study. I cannot ‘un-know’ what I know or forget my experiences. My spiritual beliefs sometimes conflict with my mental health nurse training and the spiritual beliefs of some of my colleagues and service users. Whilst this has led to me keep my spiritual beliefs very private it has also empowered me with an openness to other people’s spiritual needs or expression which was useful during the interviews and encouraged in depth responses from my participants. During some of the interviews, the participants asked about my spirituality which may have been a way of gauging how their views may be received, but I only agreed to answer their questions after their interview had taken place to avoid influencing their responses.

Throughout the research process and analysis I have sought to acknowledge my spiritual and professional perspective and be aware of what this is and why in order to provide as credible an interpretation of the results as possible. In order to further enhance the credibility, the results and subsequent analysis of the data has been continually reviewed and discussed with the doctoral supervisory team. They are not mental health nurses and have different and varied understandings of spirituality and this process may therefore limit any personal bias and contribute to the wider

applicability and understanding of the research outcomes. Some similarities and differences were apparent in the discussions we had and showed a variety of spiritual understanding and an example of this has been explored in the section (5.1, p145) examining the concept of 'spiritually competent practice' (Rogers and Wattis, 2015).

3.3 Study Design

This section discusses the design of the study which used semi-structured interviews as the method of data collection. Data were subsequently transcribed and analysed using Template Analysis (e.g. King, 2012) which will be discussed in more depth in section 3.4.

3.3.1 Study setting

A local mental health NHS Foundation Trust kindly supported this study in terms of agreeing the process and allowed access to the mental health nurses who took part. The NHS Trust provides specialist inpatient and community mental health and learning disability services including medium secure care. It covers a large geographical area which has both rural and urban settings where over a million people reside and it extends its regional forensic services to a large geographical region. Over 4000 people are currently employed by the Trust and this includes many qualified mental health nurses (SWYFT, 2015).

The diverse characteristics and size of the Trust as an organisation means the potential sample included mental health nurses from diverse populations. The sample was restricted to mental health nurses caring for working-age adults but covered rural and urban communities including inpatient and forensic services. This NHS Trust was approached as the source of recruitment as its mental health nurses were more likely to be representative of the whole population of mental health nurses working in adult care than specialist or private providers.

3.3.2 Participants and recruitment

3.3.2.1 How many is enough?

Early career and even some experienced academics wonder ‘how many is enough’ when embarking on an interview study, yet there is no decisive formula of calculating ‘how many’ (Mason, 2010). Most experienced researchers if asked, would advise; it depends upon the theoretical perspective, time, context, what is being researched and practicalities. Resource implications such as finance and supervision opportunities also influence what may be an appropriate size for an individual study (Guest et al., 2006).

Notions of data ‘saturation’ can be problematic in relation to qualitative research (If we are focused on personal meaning, how is it ever possible to ‘know’ that we have indeed exhausted all possibilities, that another individual might not have something different to contribute? If we acknowledge, even welcome, subjectivity then how can we claim any researcher’s analysis is ‘final’ and confidently assert we have achieved ‘saturation’?) Nonetheless, the guiding principle for qualitative interviews is often saturation level where it is assumed once no new information is arising no further participants are needed (Mason, 2010). Creswell (1998) is more specific and recommends five to twenty-five participants for quality semi-structured interviews. Bryman (2001) however suggests it is impossible to identify a specific number of interviews at the onset of a qualitative study as data quality can affect a sample size. If participants are engaged, reflective and can communicate effectively, ‘saturation’ may be achieved with a smaller sample. The skill of the researcher may also determine the value of the interview as an experienced researcher will likely be more skilled at being able to put a participant at ease and teasing out valuable information or encouraging a participant to open up. The richness of data obtained and the depth of subsequent analysis may be more meaningful considerations in relation to assessing the quality of a qualitative study than particular sample size or saturation stipulations. Findings presented in this thesis come from in-depth interviews with seventeen participants which were analysed in depth: this process will be described in full in the remainder of this chapter.

3.3.2.2 Recruitment

When considering the appropriateness of the participants only qualified mental health nurses who had current direct contact with service users were felt to be appropriate. Many qualified mental health nurses have a managerial or leadership role which removes them from direct contact with service users and as a result could only have discussed their historical approaches. This might have affected the results of a study intended to focus on how mental health nurses currently cared for spiritual needs of service users. That said, historical recollections might be considered appropriate if a participant describes how these have influenced their approach in the 'here and now.' Inclusion criteria for the study therefore specified that participants should be qualified mental health nurses from the NHS Trust who had contact with service users. Exclusion criteria specified that (1) qualified mental health nurses, who did not have contact with service users; (2) those who were not qualified mental health nurses; and (3) any eligible person who did not wish to participate.

The research sample formed part of a professional doctorate. Whilst the NHS Trust was supportive in agreeing access to potential participants, the access was time restricted to a six-month period. Following email invitations (see Appendix 2) a total of twenty-two people responded in this timescale. One of the people who responded did not meet the essential criteria because although they were a qualified nurse working in mental health, their qualification was primarily in learning disabilities. Two other respondents arranged an interview then subsequently changed their mind and cancelled. A further two responded initially but then did not take up the opportunity to participate with an interview at all.

3.3.2.3 Participants

A total of seventeen participants took part in the study: ten female and seven male participants across a range of working age brackets. They ranged from the youngest and most recently qualified nurses in their early twenties to two of the oldest participants in the 60's age bracket, one of whom was preparing for retirement. The clinical background and experience of the participants varied including geographical location of

where the participant worked, clinical specialism and experience. The nurses provided care from a variety of geographical locations which included semi-rural community mental health services where the service users were mainly from a white British origin. Nurses in other areas provided care in inner city or densely populated community and inpatient services where the services users represented a more culturally diverse population.

The background of the participants was equally diverse in terms of their clinical experience with many of them having several years' experience in a variety of clinical settings. Further to this many of the participants' previous experience in other clinical areas added valuable historical information within the interviews. All the participants were white with none who identified themselves as being from a diverse or minority background. All participants have been allocated pseudonyms which are used throughout.

Table 3.1: Participant and interview length information

Number of interviews	Participant pseudonym	Staff Role	Gender	Approx. age: e.g. 30's	Approx. Length of Interview in mins:
1	Ann	CPN Insight	F	40's	45
2	Ben	CPN Adult services	M	40's	45
3	Chris	CPN community treatment	M	40's	40
4	Dawn	Forensic Female inpatient	F	20's	36
5	Brendan	Substance misuse specialist	M	60's	55
6	Freya	CPN Adult	F	20's	66
7	Harry	CPN Assertive outreach	M	40's	57
8	Isabel	Forensic Male inpatient	F	30's	62
9	Joe	Crisis resolution/Home treatment team	M	60's	63
10	Emma	Acute inpatient	F	50's	65
11	Kate	Therapy services	F	40's	61
12	Lisa	Crisis Resolution	F	40's	48
13	Mary	CPN Insight team	F	50's	61
14	Nick	A and E Liaison	M	50's	49
15	Olwynn	Dual diagnosis (LD/MH)	F	40's	52
16	Paul	Forensic Rehab	M	30's	57
17	Rachael	CPN Adult	F	40's	86

3.3.2.3.1 Brief participant descriptions

Below, I provide some brief information about each participant to give the reader a sense of who my participants were and to facilitate better understanding of findings presented in the following chapter (Chapter 4).

Ann

Ann had a long and varied career in mental health nursing but her current role was working as a Community Psychiatric Nurse (CPN) within an 'Insight Team'. The team she worked with care for people who present with first episode psychosis. Although they are known to care for very young people (as young as 14) the average age is working age adults up to 35 years. Ann came to interview with a set of notes she had made on spirituality and she was asked not to use them. She laughingly agreed but then said she might not be able to give the right answers. Overall she was relaxed throughout and very engaged fully with the whole process. She did not mention her religious or spiritual belief.

Ben

Ben was a CPN in a Community Mental Health Team (CMHT) which covered a large town area. He gave no insight into his career history so it was difficult to ascertain his experience as a nurse in other areas. Ben presented as 'prickly' at interview onset and throughout his interview. To describe him as hostile is a little too strong a description but there were elements of hostility in his behaviour. He often punctuated his statements by banging his hand on the table and was a little aggressive with his eye contact at times. Although he gave a good interview, it was not, as an interviewer, a comfortable experience. He said he was atheist.

Chris

Chris worked as a CPN in a community treatment team. One of his main responsibilities within that team was to administer intramuscular depot injections and monitor the

effects and side effects of medication. He had a long and varied history in mental health services including a stressful period on an acute ward which he said caused him to have mental health issues of his own. He had a very relaxed manner with a good sense of humour which was apparent in parts of the interview. He was also gentle and insightful in places and fully engaged with the process. An interruption in the middle of the interview disrupted the flow at one point but was quickly recovered. Chris did not directly mention his religious beliefs but said he was spiritual.

Dawn

Dawn was a few years into her first post as a mental health nurse on a forensic unit which cared for women who were mentally ill but had an element of criminal behaviour. She presented as energetic and said she was excited and looking forward to participate in the interview. She was fully engaged throughout the interview which was unfortunately terminated due to the sound of the emergency alarms on the unit which she had to respond to. However, despite the unexpected end to the interview she offered some valuable insights into her understanding of spirituality. Dawn described herself as being brought up Catholic.

Brendan

Brendan worked as part of a specialist care team which cared for people who misuse alcohol and drugs. He was an older nurse with a long and varied career in mental health services and higher education. Brendan was very relaxed throughout the interview. He was gentle and very softly spoken which sometimes meant he was difficult to hear. However, he was very personable and engaged well with the interview throughout. He described himself as being brought up Roman Catholic.

Freya

Freya was the youngest and newest nurse who participated in the study. She was still in her first post and preceptorship period of her career and she was currently working as a nurse on an adult acute ward. Freya was exciting to be with. She was full of energy,

wonder and enthusiasm which were infectious. In the initial stages prior to interview it was difficult not to be interviewed by her because of her inquisitive nature but she soon settled into her role of participant. She engaged openly and fully throughout and offered some very personal insights into her own belief system. She described herself as spiritual but 'picking out the best bits' of other religions.

Harry

Harry had a varied career as a mental health nurse including acute inpatient services but currently worked as a CPN in an assertive outreach team (AOT). Harry from the onset had a distinct and dark sense of humour which he used throughout. Some of his statements without the benefit of being with him appear a little disrespectful and could be seen as offensive at times; however this was far from true when the interview was taking place. The tone of his voice and his behaviour presented the opposite of his words and the intent was that of irony or sarcasm as opposed to the literal meaning of his words. He said he was nervous at first but settled into what was a very enjoyable interview. He described himself as being brought up Roman Catholic.

Isobel

Isobel was a clinical team leader on a male forensic unit. She had worked in forensic environments throughout her career. Isobel presented as very nervous and said she was anxious. Although she answered the questions fully she went very red in the face with embarrassment and said the interview was an uncomfortable process. The interview lasted 30 minutes but a lot was said as she spoke very quickly. However after the interview, which she participated fully in, she said it was enjoyable and she was pleased she had decided to participate. She did not disclose any religious beliefs or background

Joe

Joe like Brendan was one of the most experienced of the participants. He was preparing for retirement and had had a long and varied career in most of the mental health services. His latest role was as a Team leader in Crisis resolution and home treatment team (CRHTT) which assess and care for acutely unwell people who may need admitting to the inpatient services. Joe's gentle and self-assured experience was obvious from the onset of the interview and he related many examples of service users he had worked with. He also offered a deep insight into himself and he was very open about his personal history and beliefs. This interview was extremely interesting but drifted off point in areas however it was a fascinating insight into his life which wasn't always apparent in the other interviews. Joe said he was brought up strict Methodist.

Emma

Emma had been a mental health nurse for twenty years and currently worked in a community therapy team. Her most recent history was on an adult acute ward which she said was the worst experience of her life. She said working there had contributed to her own mental health problems. Emma was angry about what she described as the horrendous nature of mental health services from the onset of her interview, to the point where she stated that she was unsure whether she wanted to continue working as a nurse. She was very distressed throughout but declined her right to terminate the interview or take advantage of the strategies to support participants. She cried a lot during elements of her interview and gesticulated aggressively at times but was not aggressive per se. She disclosed many personal insights into her belief system and personal life which included she was primary carer for her husband who was mentally and physically ill. This was an uncomfortable, difficult but fascinating interview to facilitate. Emma said she had a Christian background but afterwards described herself as Pagan.

Kate

Kate was another nurse who had worked in mental health services for more than fifteen years. She had worked in acute services for many years before her most recent post as a CPN in a CMHT. Kate was assertive during her interview and had periods she was clearly frustrated at times with mental health services. She said she had 'lost faith' with services and described herself as almost burnt out. However her passion to care for people was apparent and the burnout she described was clearly self-directed and had not affected her ability or will to care for other people. Kate did not disclose any religious belief but described herself as spiritual

Lisa

Lisa was a CPN in a crisis team. Her career history included acute inpatient and forensic services. Lisa had a very strong personality and was anxious to get across that she was a 'psycho-pharmacologist by trade' and believed in the 'scientific application of treatments'. She also described herself several times as a concrete thinker. In her interview her comments superficially seemed to be true but as her interview progressed and became a little more in-depth, it became apparent that she was a lot more open to less concrete approaches than she portrayed. She used humour in parts of her interview and was engaged throughout. It was a little difficult at times to interject with a question and she tried at times to direct the interview herself. However, she gave some valuable insights into her understanding of spiritual needs. Lisa said she had been brought up Catholic with Buddhist influence.

Mary

Mary worked in adult acute inpatient services but had a clinical background with child and adolescent mental health services and the insight team. Mary was quietly spoken and giggly during the first part of her interview. She was particularly worried about 'giving the wrong answer' and jokingly shouted at one point 'I want to stop, make it stop'. Later when asked whose responsibility is it to address spiritual needs she again jokingly shouted 'Yours, all yours and yours alone'. There were times when she was exasperated with herself because she felt the questions were difficult but she gave

some other valuable examples of how spirituality may be supported from her time working with young people and the comparisons with adults. She also disclosed elements from her personal life to illustrate her points and to raise questions. Mary said she had Catholic influences and had to convert to the Catholic faith in order to marry her husband.

Nick

Nick had always worked as a CPN facilitating assessments with the police and other emergency services. Nick found it very difficult to give examples of spiritual need other than in relation to religion. However, it was also apparent that he wanted to support spiritual need and felt that for the service users at least this was very important although he stressed that 'religion is not for me'. He was a little challenging to interview as he 'directed' the interview himself and did not initially fully answer the questions posed. There were times when it was necessary to bring the subject back to the topic as he veered off to discuss the merits of the emergency services or talk about physical issues of 'patients'. He described himself as a former Catholic having been brought up as one but as now being a 'free thinker'.

Olwynn

Olwynn worked in a service which provided care for people with a primary diagnosis of mental illness but who also had a learning disability. She was a very 'open' person and talked about spirituality in terms of person centeredness. She was overall relaxed throughout the interview but like other participants talked in the third person at times particularly when she had to give a question some deeper thought. She described herself as Catholic and said that although she considered herself a practicing Catholic, she felt that she didn't agree with everything that was expected in terms of that religion.

Paul

Paul worked in an inpatient service which addressed the forensic rehabilitation needs of people who were still subject to MH act or other legal requirements. He described spirituality in terms of religion and admitted to not giving it any real depth of thought prior to interview. He said that he was uncomfortable in the interview and described it as 'a bit personal'. He said that he was not religious or spiritual but accepted that it was important to others and for that reason he felt it was important. He was friendly and open in his interview but apologised for 'not knowing much' prior to the formal interview starting.

Rachael

Rachael had been a CPN in a CMHT since she qualified 3 years ago. Rachael was extremely open and engaging from the start of her interview and used humour to illustrate some of her points. She talked about some very personal issues including the tragic loss of her baby. She also disclosed some spiritualist and clairvoyant beliefs in detail and how this affected her as a nurse and the care of service users. Rachael was easy and fascinating to interview and answered the questions fully. She described herself as a version of Roman Catholic.

3.3.3 Ethical considerations

NHS IRAS and all necessary local governance approvals were obtained prior to study onset. Full written consent was provided before the interview began, and both the researcher and participant signed the consent form. It was made absolutely clear to all potential participants at all times that their participation in the research was entirely voluntary and that, if they chose to participate, they could change their mind if they so wished. As no managers were involved in contacting potential participants at any point prior to or during their participation there were no issues regarding coercion in this respect. All transcripts, audio recordings and field notes were anonymised and personal and place names were allocated pseudonyms to ensure anonymity.

It was made clear to the participant if any abuse or serious malpractice including risk of harm to self and/or others was described, I would have been forced to breach confidentiality and this would have been reported via the accepted NHS Trust organisational policy. This was specified as a condition in the information and consent form given to potential participants prior to interview.

I did not envisage any need to provide psychological support to participants as a result of the interviews given their job role and the nature of the topics under investigation. However, where any areas of concern emerged, I offered the participant a break, or to postpone or terminate the interview. An offer of immediate emotional support where this felt to be required and contact details for appropriate local support services were provided. I felt confident to make an offer of such support because of my professional qualifications as a mental health nurse and my knowledge of appropriate services from nursing and researcher perspectives.

Safety procedures in relation to my employing organisation's lone working policy were adhered through the interview process. I carried a mobile phone and made my itinerary known to my lead supervisor and safe return was confirmed.

3.3.4 Interviews

Semi-structured interviews were undertaken with participants (see Appendix 3 for the interview schedule). This approach encouraged the participant to describe in their own words their personal thoughts, feelings and perceptions of spirituality and spiritual needs. The semi-structured nature of the interview focused responses on the research topic whilst maintaining the participants' personal understandings and experiences in relation to the subject.

Prior to beginning the interview, participants were handed the information sheet and consent form to ensure they were fully informed about the study (Appendices 4 and 5). Although all the participants had signed the consent form previously, at the beginning of

the interview I revisited the information as a way of double checking that they fully understood the procedure. As the interview began I reiterated the aims of the study, what was expected from them as participants and gave them assurances about how confidentiality would be maintained. To reassure the participants I reinforced verbally their right to withdraw from the process at any point and highlighted this in their consent agreement. I began all of the interviews with some informal chat whilst I set up the digital recorder in a discreet location. I used my experience and knowledge as a mental health nurse to show how similar I was to them and to indicate how I would understand the experiences they may be about to share in a non-judgemental way. This was with the intention to alleviate any anxiety the participant felt and connect with them at their level in order to make them feel psychologically safe and gain their Trust. Polit and Beck (2010) asserted that interviews are more successful when the interviewee recognises there is a mutual understanding between them and the interviewer which ideally should be established at the start or prior to the interview. I chose a discreet location to try and put the participant at ease and not draw their attention to the fact that the recording was taking place, although they were fully aware of its location and no attempt was made to hide it. Most participants did not appear unduly conscious of being recorded and relaxed very quickly as I eased them from social chat into the interview itself.

Three key initial questions provided a guide to frame and structure the interviews. The first question was *'what is your understanding of spirituality and spiritual needs?'* This initial question was intended to focus the nurse on the topic and to encourage them to think about their own perspective on spirituality and spiritual need. At the appropriate time I asked other probing questions to clarify their points based on what they had talked about. The second key question; *'how would you assess or recognise spiritual needs in service users?'* was intended to refocus the nurse's thoughts directly to service users to encourage them to discuss what if any assessment strategies were used when caring for a service user's spiritual needs. Probing or explorative questions were again used as appropriate to encourage the participant to think deeper about their responses or clarify a point. I was also careful to leave the participant to think for a while during naturally occurring pauses. The third key question *'What would you do with this information?'* asked the participant to discuss service users' care in relation to spiritual needs and tease out any other influences that affected care or indeed how spiritual

need affected care. Sometimes the participant addressed the questions before I had asked them. In these instances, I referred back to what they had already told me in this regard but nonetheless asked the question anyway to try and encourage the participant to further explore the concept. Whilst revisiting points I paraphrased some of their responses and asked if my understanding of what they had said was correct. This helped to clarify my understanding but also showed the participant that I was interested in their thoughts. I was confident that my skills in communication as a mental health nurse would show that I was open to thoughts around spirituality and to nurture rapport throughout the interview which encouraged rich and valuable data.

Other than these three predetermined questions, the participant was encouraged to talk freely about what mattered to them in this context. Unless the participant mentioned a point I felt needed to explore further, I was careful not to introduce a concept that had not been specifically mentioned by them. The length of interviews varied between the shortest at approximately thirty-six minutes and the longest at eighty-six minutes. The mean length was approximately fifty-five minutes in total with most of the interviews lasting about an hour. Some of the interviews were longer because the participant spoke slowly or took longer pauses. Barker (2006) suggested mental health nurses encourage service users to use their 'own voice' to explain their thoughts and feelings which was a strategy I also employed in this present study. I was careful not to interject at these points which allowed the participant the opportunity to arrange their thoughts and be clear in their own mind about what and how they wanted to share. This is an approach I have used successfully many times with service users in mental health nursing and is particularly useful when people are discussing issues which are very painful or personal to them. The length of the interviews does not denote value of content as the shorter interviews also elicited valuable data. Interviews were undertaken in a private room at the participant's place of work. This was partly to do with the likelihood of the ability of more people able to take part as the stretch in resources may mean the nurse could not be released to leave their place of work. DH (2017) have acknowledged difficulties in staffing mental health services which negatively impacts on how mental health nurses are able to attend development opportunities like research and education.

3.3.4.1 Personal reflections on undertaking the research interviews

One of the first considerations prior to facilitating the interviews was to prepare. I ensured I had the correct date, time and address prior to leaving. I also telephoned ahead to confirm that I was expected and the participant was still willing and available for me to attend. This proved useful for two of the interviews where the participants had changed their minds and no longer wanted to participate. For some of the interviews where I had little idea of the whereabouts I had a 'dry run' to ensure I was familiar with the area, parking and safety facilities. The 'dry run' also gave me the opportunity to leave enough time to arrive on time as a late start may have affected the availability of the participant and jeopardised the interview. As a novice researcher, particularly in the first few interviews I felt nervous. Although I was confident in my ability to initially engage with the participant I was more familiar with assessing and interviewing service users and felt a little anxious about how this type of interview would develop. The dynamic surrounding research interviews was different for me and I did not know what to fully expect. Familiarising myself with the route and area helped to alleviate some of the anxieties I felt and present myself in a manner which showed confidence. As my experience increased so did my confidence in my interviewing ability which was reflected in the quality of the later interviews where I tended to probe more effectively and not be afraid of exploring the participants thoughts in more depth.

Bowling (2014) suggests there are several important qualities for a good interviewer to develop. One is an ability to put the participant at ease and establish a good rapport with a wide range of people. This is achieved by displaying qualities like sensitivity, friendliness, a positive outlook and the ability to be a good listener and not to interrupt the participants. A non-judgmental manner and an ability to remain neutral will encourage the participant to respond freely. In addition to these desirable qualities, the interviewer needs to be mindful of any characteristics which may cause bias. Some of these qualities may be unavoidable and unanticipated for example the response of a female participant to a male interviewer. However other examples may be anticipated and bias minimised as a result (Parahoo, 2006).

With this in mind, I planned carefully how I presented myself in interviews. As I was the only interviewer facilitating this piece of work, little could be done in terms of my gender. However, some aspects could be controlled in an attempt to minimise bias for example how I dressed. In order to control how I presented myself, I dressed according to the host Trust's recommended dress code and chose to dress in fairly casual clothes to emulate the likely dress of the participants. I deliberately avoided 'power' clothes like suits because I wanted to avoid appearing as an authority figure as this may have created a reluctance to speak freely with me. I undertook a deep reflective process as part of my development prior to facilitating the interviews to minimise any potential personal bias relating to my own belief system. This enabled me to identify aspects of my own behaviour which might have influenced the participants' responses. This in itself was not particularly difficult as my behaviour and dress were already modified to 'fit in' with my professional peers. For example, my clothing at work reflects my professional position which is different to what I may wear in my private life. By using this awareness I was able to address potential bias by being mindful of my non-verbal presentation and inadvertent verbal cues. I also avoided wearing certain jewellery which the participant may have identified as a possible affiliation to a particular religious or cultural group, for example a crucifix pendant, Celtic or pagan symbol. Under normal circumstances I regularly wear a cross (belonging to my late mother) which is usually identified with Christians. Although I wear it in remembrance of my mother, it would not be unreasonable for a person to assume I may be wearing it as a Christian symbol. This in itself might have created a bias where the participant may have withheld some information for fear of offence or believed that I wanted them to respond in a certain way.

Some of the data was collected from mental health nurses who have known me personally from my previous employment as a nurse. In some ways this helped in terms of how relaxed and open they were in the discussion. However sometimes the familiarity within the interviews was evident and extra care was needed not to become too familiar and drift off topic or disclose too much of myself which might have affected the interview. None of the participants who knew me had any knowledge of my spiritual affiliations because of my approach to personal privacy. Conversely in the interview with mental health nurses who had never met me before an element of personal disclosure helped to set them at ease as they then knew I was a mental health nurse and therefore

'onside'. Again care was needed not to over disclose and bias the interview as a result. This type of strategy was described by Ashmore and Banks (2002) in their research on self-disclosure in adult and mental health nursing students. A potential drawback with sharing my background as a mental health nurse may have been the nurses speaking in the closed or semi-coded speech many mental health nurses use with each other. Although I could not fully understand this restricted way of conversing this was something I was anxious to avoid in the interview and consciously modified any language that would encourage this type of interaction. My aim was to open up the nurses to articulate their viewpoint and not make the assumption that I knew what they were conveying through facial expression or closed phrases and jargon. To get around this issue I reminded them that I had not been in clinical practice for some time and had forgotten everything I knew so could they remind me or explain a little further. This appeared to have the desired effect in most of the interviews where the nurses talked freely about their thoughts and feelings.

Sometimes, there were points in the interview where the participant seemed unsure or hesitant in their answers. At this point the natural way which I could have responded would be to nod in reassurance. I was anxious not to bias their response and therefore I smiled supportively and verbally encouraged their explanation or repeated their words as a question for them to affirm or negate. I also reminded them there were no right or wrong answers, only opinion and my aim was to explore that opinion. During some of the interviews I was asked my views and I explained that I would be prepared to discuss them but only after the interview as I did not want to bias any discussion.

During preparation for interview I tried to consider as many eventualities as possible including the fact that spirituality for some people is a sensitive topic and there was the potential for participants to be emotional. Strategies to address this have been discussed in my ethical issues section (3.3.3) above. What I did not anticipate was the response of one of the participants who had strong feelings about how people with mental health needs were cared for generally and their emotional response to reflecting on particular service users' issues. The interview was with a female participant who presented as very angry to very distressed in equal measure. Her distress was towards what she saw as "inhuman" care offered by the mental health system and her anger

was directed at the system, law, society and the organisation where she worked. She was very tearful in parts but declined terminating the interview or accessing any of the support strategies I had planned should anyone need it. She was happy to participate in the interview and felt that this was an opportunity to voice her feelings on spiritual care and how the lack of it, in her opinion, was part of mental health care generally.

For my part I was a little shocked. As a mental health nurse and an academic, I am more than familiar with people becoming emotional quite quickly however the strength of her emotion was not something I anticipated in an interview of this nature. My position suggests that I am a good and willing listener and this alone helps people to open up about their inner thoughts and feelings reflected in the way many of the participants in this study disclosed their personal views. However, I was not prepared for the anger and rage presented in this interview. At no point did I feel threatened as it was clear that she was angry at the 'system' not at individuals and her passion came from a place of wanting to care for people at a basic human level but I felt the frustration emanating from her.

After my initial surprise at the strength of this response my first thought was to support her during and after the interview. As a mental health nurse I have experienced people becoming very emotional, very quickly and so my skills as a professional enabled me to support her through this period and still maintain a good connection.

Fortunately, as the interview continued her reflections on her approach to the care of service users and the care her colleagues provided put certain points in perspective. She still appeared to rage at the 'system' but was calmer and I was able to guide her towards more balanced discussion. Following the interview I remained with her for some time and discussed her feelings. She said she had shocked herself as she did not expect to feel as she did during the interview but also said she felt better for having participated and felt that her participation might have contributed towards some improvement in care one day. I again offered her the support strategies but she said she was fine and towards the end of our interaction she was laughing and joking about how embarrassed she felt about her behaviour. Although she described feeling

embarrassed, I felt this was one of the more powerful interviews, certainly in terms of her strength of conviction around how service users should be cared for and the effect this type of care had on her personally was evident.

Another of the participants presented as irritable throughout the interview, although verbally, he responded really well and explored his thoughts and feelings about spirituality and spiritual needs. His body language was closed and his tone and intonation suggested he was not particularly happy. I asked if he was happy to be interviewed and stressed that he could withdraw at any point but this seemed to irritate him further and he declined the offer to withdraw. This particular participant was one of the early interviews and the only time I experienced this type of behaviour. I felt uncomfortable during the interview and felt like I wanted to disengage, although I was aware of my feelings and modified my body language so not as to communicate this and potentially cause more hostility. He looked at his watch regularly throughout the time we were together and I was personally relieved when the interview ended. I think had he been less hostile, I would have asked more probing questions particularly around his thoughts on the afterlife but his presentation suggested this may not have been appropriate at that time. Although he had volunteered to participate (which I reminded him of a one point) I felt that he resented me asking questions and I wondered why he had volunteered to participate in the first place. However, he interviewed well in the end and provided some good insights and valuable data.

Two other participants were really open and explored their own spirituality as well as their perspective of the spiritual needs of service users. One of them talked openly about spiritualism and the sad death of her baby but provided insights into how this translated into caring for the spiritual needs of service users. I was initially concerned for her when she started to disclose this very personal and emotive information but she said she was glad to talk about her baby and said she did not need any of the support that was in place for participants. I felt very honoured that she felt able to be so open with me and hoped that I responded in a way that she felt this. Another young nurse talked openly about her own spiritual beliefs and how she was aware that she was changing as she grew and developed. Again, I was a little surprised at how open she was with me and how she felt able to disclose these very personal insights into herself.

This time however I felt reassured she did not need any other support outside of the interview. Although I was surprised at the candidness of some of the participants, I was not altogether surprised by what they disclosed about the nature of their own spirituality. I have had much experience of other people's varied spiritual beliefs both in my personal and professional life and my openness helped the participants feel supported in articulating their thoughts without judgement. Polit and Beck (2010) said that nurses are especially sensitive to people's behaviours and attitudes which is particularly useful in the study like this present one.

3.4 Data Analysis

Data for qualitative research usually consists of people's stories, thoughts feelings and expressions. Their participation is a process of 'sharing' their experience with the researcher and presenting them with their 'story' which is something that featured strongly in this particular study. To talk about their experience of something, particularly if the subject is personal or painful, is disclosing an intimacy that is their existence as a human being and forms part of the process of data collection (Holloway, 2005). I have identified that I have taken the position of limited realist (section 3.2 page 41) in this study and because of my personal views towards spirituality I have been able to offer an alternative perspective within the analysis from the strong Catholic influences of some of the study participant's responses. After data collection, the next part of the research process according to Polit and Beck (2010) is to process the data. This is done by transcription, coding and classifying in a way that enables analysis, interpretation and subsequent dissemination.'

One of the researcher's tasks is then to select enough elements from the data to allow description and understanding which are part of the development of new knowledge for the purpose of explanation or practice improvements.

3.4.1 Template Analysis

Template Analysis (TA) (King, 2012) is a particular style of thematic analysis which was chosen as a suitable method for data analysis in this study. TA has been used previously in healthcare research, including research with healthcare professionals

(Waddington and Fletcher, 2005). It involves the development of a coding template, which summarises themes identified in a qualitative data set through a process of coding and organises these themes in a meaningful and useful manner (Brooks et al, 2015). TA is a pragmatic technique which can be applied within a range of different qualitative research approaches and is adaptable to the needs of a particular study (King and Brooks, 2017).

A particular feature of Template Analysis is that, in contrast to some other forms of thematic data analysis, a coding template may also reflect lateral relationships *across* theme clusters. Themes which permeate several distinct clusters are referred to as *integrative themes*. For example, in a study of diabetic renal disease (cited in Brooks et al, 2015) King et al. (2002) identified 'stoicism' and 'uncertainty' as integrative themes which pervaded discussion no matter what was being talked about in the research interviews. In the present study, as will be discussed in the following section, the ability to identify a theme as integrative proved a very useful way to analyse and present the findings.

3.4.2 Analysis of the study data

There were seventeen interview audio and transcripts which were to be analysed. As this was a relatively small study I was able to read through the data set three times to familiarise myself with the data. I found this part of the process particularly interesting. Sometime had elapsed from the interview through transcription and each process offered me a different perspective on what was said. It was strange listening to an interview I participated in and I noticed there were some parts in the dialogue I wished I could have revisited to explore further. Similarly, the written word again offered another perspective and showed emphasis on words and phrases that were not obvious through listening. Following this I then carried out preliminary coding. As I reviewed the transcripts I highlighted any statement, word or section which seemed to meaningfully contribute to the research question. After initially highlighting the emergent themes, they were organised into clusters and this was facilitated by using sticky-notes and flip chart paper. This method was chosen because it allowed me to easily move or replicate extracts and put them into other themes or clusters whilst still being able to view where

they were in order to have a visual overview. This part of the process helped group the themes into meaningful clusters in preparation for further analysis. It was at this point I transcribed the extracts on sticky-notes into a word document which was further refined into an initial version coding template. Further work was undertaken to apply this initial template to data – further analysis showed that some replication had occurred and that clearer delineation was needed in relation to some themes. Some existing themes were amalgamated or further refined into other themes or sub-themes. I found that in the early part of the process I used many terms for similar things that offered far more detail than was necessary and made the data difficult to manage. This was until other headings were used to encompass the various detailed meanings. There were also other elements to the interviews that interested me but did not really apply to the research question and I had to consider what I could use as evidence for my study and what was interesting but not relevant. The initial stages of the template formulation appeared time consuming and difficult but as the coding and re-coding continued an improved version of the template was devised. Polit and Beck (2010) said that the goal of research is to produce data of exceptional quality and every decision made by researchers about data management is likely to affect quality and therefore the quality of the study. I found the simplicity of the sticky notes offered a visual perspective that cannot be achieved on a computer screen. I also felt it was less stressful for me to practically manage as I was not having to navigate unfamiliar computer software. However, this process may be more difficult if a team of people were working on the data where computer access to a single data set would be more appropriate. How data mapped onto and evidenced themes became increasingly easier and apparent and a hierarchical structure was developed with four main top-level themes (each with sub-themes). One of the main themes was an integrative theme ‘fear and anxiety’ which permeated across the others. The top-level themes identified were:

1. Role of spirituality from personal perspective
2. Influences on professional understandings of spirituality
3. Nursing spiritually
4. Fear and anxiety (Integrative)

Following this the coding template was applied to a subset of the data to ascertain its utility. After working through five transcripts, some further modifications were made to the template at the subtheme level with some reorganisation and some existing sub-themes further re-defined or deleted. The supervisory team then each applied the template to a number of sections of contrasting data to establish its effectiveness. When a final version of the template was developed that was agreed to be an effective representation of the data, I then applied it to the full data set (see Appendix 6 for template).

The final template and interview transcripts were then uploaded on to an electronic data analysis program NVIVO. This substantially helped in coding data to the template's themes and subthemes which could then be easily presented to show the hierarchical structure and findings and show how the theme 'fear and anxiety' integrated across the other themes.

3.5 Chapter Summary

This chapter has discussed how this qualitative study was facilitated and justified the qualitative approach taken and my philosophical position as a limited realist. It has described the study setting and the participants who took part. It has discussed the use of interviews and justified this choice as an appropriate method to enable participants to fully discuss their experiences. Data was analysed using a specific type of thematic analysis called Template Analysis: a rationale for its use has been provided and the process of data analysis described. Elements of the chapter are direct reflections on the research process and show the need for sensitive reflexivity in a study of this nature. Additionally, I also reflected on the challenges and learning opportunities which presented themselves at a personal and professional level.

In the following chapter I will present the results of the study and consider in turn each of the themes identified in the data.

Chapter 4 Findings

4.1 Introduction to the chapter

This chapter provides an overview of the findings from this study, which explored mental health nurses' understanding of service users' spiritual needs.

Data were analysed using Template Analysis (4.4.1). The final template was made up of three main top-level themes, with each theme made up of various sub-themes (Appendix 7). An additional integrative theme ("Fear and anxiety") was also identified. The main themes are thus:

1. Role of spirituality from personal perspective
2. Influences on professional understandings of spirituality
3. Nursing spiritually
4. Fear and anxiety (Integrative)

In this chapter I will present and reflect on each theme in turn. I will also reflect on how the integrative theme of fear and anxiety permeates throughout. I will achieve this through both drawing the reader's attention to such permeations in the course of discussing my main themes.

4.2 Role of spirituality from personal perspective (Theme 1)

This theme is concerned with participants' personal views of spirituality, derived from their personal life rather than from their professional role as a nurse. It includes influences on the participant from their personal background and history including their family, school, social life and friends. These influences have shaped participants' understandings of spirituality and appeared to affect their professional approach towards service users, particularly with regards to understandings of a service user's best spiritual interest. Personal influences on beliefs about and understandings of

spirituality are presented as distinct from understandings developed through learning as part of nurse training or continued professional development. Under this theme I will first look at what the participants saw as being important influences for them growing up (4.2.1 Social development influences), before moving on to look at how participants described understanding the role of spirituality in their own lives (4.2.2 Understandings and models of spirituality).

4.2.1 Social development influences

*“Where do you learn your faith? Where do you learn the understanding of who you are?
It doesn’t emerge naturally”*

Brendan

This sub-theme describes how participants’ own life experience particularly in childhood influenced their personal understanding of spirituality. Although I did not ask specifically about their personal background it appeared to be a natural starting point for many of the participants and contextualised their current position in relation to spirituality. Participants perceived various influences from their past as being significant. Both family and wider social networks when growing up were discussed in this regard. For example, Harry described his family as Roman Catholic and this was described as a significant influence in childhood.

“We went to church because that was the done thing. We didn’t know any other way. Easter....Being a Catholic and going to Catholic school, there’s never any other option, we were all the same. I don’t know any other way so I’ve nothing to compare it to. I was raised, I was conditioned growing up. This is me now and it’s probably because I was raised this way.”

Harry

Some participants described how they had, as adults, chosen to reject their family’s religion. For example, Joe described his rigid Methodist upbringing and its impact on

the development of his own understanding of spirituality. Joe described the resentment he felt towards the Methodist faith when talking about his parents who both died when he was young and the fear and anxiety he felt as a young boy:

“Where did that (their faith) get them? The last place my mother went before she died was bloody chapel to play the piano even though she was dying at that point.What I was brought up with was basically all about fear, it would be about earning your way to heaven and if you didn’t you ended up in hell. Fear, death and dying. Yeah, Extreme fear. When you are very much at risk or your frightened of the unknown. That is when your spirituality is tested. The common denominator is fear of one thing or the other and that’s where spirituality can give you strength or helping someone with their spirituality to give them strength. Because dying and staying alive might seem one and the same thing to some people in great distress”

Joe

He went on to describe how he rebelled against the rigid structure of what he perceived as a restricted Methodist life to join the “Hells Angels” motorcycle gang and dabble in occultism:

“I got involved with a bit of witchcraft, not black magic spells or anything like that but I found it fascinating. I was trying to find a belief system that was right for me because what I was brought up with was basically about fear and anxiety. It was about earning your way into heaven and if you didn’t you ended up in hell”

Joe

Eleven out of the seventeen participants described themselves as having a Catholic upbringing but did not identify themselves as Catholic at time of interview, despite drawing on this when describing their current spiritual beliefs. Like Joe above, participants with a Catholic upbringing who now identified themselves as ‘lapsed’ discussed what they perceived as the restrictive nature of their upbringing:

"I've got my pragmatic side which says [of spiritual belief] not a lot of it makes sense. But my spiritual side, if you want to call it that, doesn't make sense but it makes it easier for me to get through life. Maybe if I'd been brought up different? If you do bad things you will go to hell and bad things happen to you and maybe I'd be a psychopath. Maybe I am a psychopath and the only reason I'm behaving like this is because I'm worried about going to hell or retribution"

Harry

"It wasn't until I became a free thinker I began to question. I wouldn't say I was forced, err well I suppose Catholic school is a lot of pressure. That was quite difficult"

Nick

This notion of 'beginning to question' introduced here by Nick was common across participants. No participants reported that they fully identified with all prescribed aspects of a particular established religion. Often, participants described how they might still draw on elements of the religion with which they identified as a child, but as adults, felt more able to use those elements they found helpful and discard those that did not appeal. For example, Rachael described herself as Catholic but her outright belief in Catholic doctrine had changed: she said that she now *"picks and chooses"* elements of the religion she felt fitted in with her life now and was selective about what she taught her children in relation to spirituality.

"I have my own beliefs, my own things. I believe there is a God but I don't believe that it's always the way it is when you go to church and what's shoved down your neck"

Rachael

This eclectic approach and choosing to pick and choose elements of established religion was also referred to by participants who had not been affiliated to a particular traditional religion in childhood:

“My beliefs are a pick and mix of everyone else’s that I’ve grown up with. But I don’t subscribe to a fixed set of anybody’s I don’t think. I’ve come across lots of different religions and belief systems but I don’t subscribe to a fixed set of anybody’s”.

Lisa

“From Christianity and Buddhism and stuff, I take what I think I need, make up my own and carry on. I just take little snippets of what I like and create my own. I love the fact that I can carry some sort of spirituality and I’m still trying to find out exactly what that is because I’m only twenty one, I’m still young and that makes me happy as well. I’ve a lot to find out about myself and that makes me excited.”

Freya

“After her diagnosis my mum would grab on to all these religious ideas and take them for her own and kinda mixed them up. I worked for her and I went with it and I was grateful for that because it helped her in a way that I couldn’t”

Isabel

There was a clear sense amongst participants that ‘whatever works’ is more important than adhering to a particular set of religious practices or beliefs. Despite this, it was evident that experiences of and beliefs about particular ‘traditional’ organised religions were described as having a significant impact on participants’ current understandings of spirituality. Participants reported taking elements they found useful from religious belief and practice, but they also described past experiences as useful in providing something against which to (in Joe’s words) ‘rebel’. By questioning generic beliefs and practices, participants were able to come up with their own individual and unique understandings which worked for them, and in the next section, I will move on to discuss how participants described these: their own personal models and understandings of spirituality.

4.2.2 Understandings and models of spirituality

This sub-theme incorporates participants' descriptions of what they understood 'spirituality' to be. Spirituality was understood as a complex term that embraced notions of compassion and empathy, but that could also put people off and "*get in the way*". It was understood as related to but not the same as religion. Participants described spirituality as concerned with experiences of reality that evoked a feeling of connectedness. Spirituality was seen as a source of personal moral values and potentially of connection between people. It was related to meaning and purpose in life, and possibly to self-worth. However, participants often expressed discomfort about addressing spirituality.

4.2.2.1 Spirituality as a complex and difficult term

The term 'spirituality' was widely acknowledged as being difficult to 'pin down' – Chris confessed to 'looking up' a definition of spirituality at the very start of his interview which was because he felt embarrassed about his (self-perceived) lack of knowledge (a behaviour which exemplifies the integrative theme 'fear and anxiety' permeating here: a fear and anxiety of 'getting it wrong' or of ignorance).

Ben commented that the term spirituality;

"Gets in the way cos it's a social construct and the term spirituality puts a block up"

Ben

Brendan also felt the term "*can put people off*" and Paul felt his discomfort with the term was because "*I'm not a religious person*". Many participants talked around spirituality or avoided using the term unless there was no other option. Others (Mary and Harry) laughed about participating prior to the interview saying they "*hated*" the word, Brendan similarly found the term problematic: "*The trouble is, it's the word spiritual*".

Yet despite discomfort with the term 'spirituality', there did not appear to be a consensus about what other term should be used. Although compassion and empathy were discussed, these seemed to be qualities that should be embraced as elements of spirituality rather than an alternative to the word itself. Mary, for instance, likened spirituality to empathy and compassion but she was evidently not comfortable trying to define the concept of spirituality, saying laughingly *"Don't, don't ask me any more! Compassion, because I'd like to think I'm a compassionate practitioner."* Compassion was a term also used by other participants to describe their understandings of spirituality:

"I think there are similarities between compassion and spirituality. Whether they're the same or not I haven't made my mind up... In the stuff I've read they talk about spirituality in kind of being one with the universe and nature and that kind of thing and kind of the wonder of it all and how it works. The values they associate with spirituality I think it's similar to compassion."

Olwyn

4.2.2.2 Spirituality as a personal moral code: perhaps related to but not the same as religion

As already discussed (4.2.1), many participants had either chosen to reject outright or to 'pick and choose' elements from their upbringing, past experiences and organised religion. Participants often discussed the role of spirituality in their own lives in terms of a personally derived moral code. Ben began defining his understanding of spirituality by his thoughts with talking about connection to *"whatever I thought God was"* but then changed to focusing more on values:

"Whether that's morality, ethics but also perhaps on expectations around behaviour, whether that's through one's own personal control, self-censorship, regulation or expectation of whatever religion. But somebody isn't their religion but a moral framework of living and thinking"

Ben

Isabel also noted that a person could be spiritual and not religious:

“Do not have to live by a religious framework...but if you live by something that’s meaningful to you then that’s what religion is. It’s meaningful therefore spiritual”

Isabel

Harry said that he derived his moral code initially from Catholicism but had adapted that code to encompass elements which Catholicism does not accept:

“Yeah, I believe in the God thing but I’ve got my own deranged understanding of that which allows people to be gay or have children outside of marriage or have their own opinions... I’m Catholic but in my view it’s ok to have kids, not being married myself. Plus, I haven’t burned any Pagans recently”

Harry

Harry clearly had thoughts which were at odds with Catholic doctrine but nonetheless identified himself as Catholic. Harry’s use of humour here (referring to his own *“deranged understanding”* and references to historical associations of *“burning Pagans”*) seemed to reflect some embarrassment or discomfort on his part, and may be seen as an example of the integrative theme ‘fear and anxiety’ – Harry seemed aware that his stance might be seen as incongruent by some, and, perhaps concerned that he might be challenged, effectively used humour to avoid further interrogation on this point.

4.2.2.3 Defining spirituality: what are the key features?

Literature around spirituality often mentions hope, meaning and purpose as key elements of spirituality and one participant, Ann explicitly defined spirituality early in her interview as *“it’s about hope meaning and purpose of life”*. Another participant, Kate, also related meaning to self-worth and *“that core feeling of who you are and what you define as right and wrong”*.

A significant number of participants talked about connectivity as a key feature of spirituality. This was talked about in terms of feeling an integral part of 'something bigger': this could include connection to other people (a sense of feeling connected to others) or connection to the natural world.

"So you've got sense of self, sense of connect, connectedness and relationship to people or to a higher intelligence being knowledge or something".

Kate

"It's what you understand about what's going on for you. It's how you make sense of the world and your part in it".

Lisa

Similarly, Ann described it as *"about how you connect, with what you value yourself as a person and what you value in other people and the world"* and used the example of her partner's experience with wild dolphins saying he described it as a *"spiritual moment"*. Connectivity was often described in relation to nature. A connection with the natural outside world was an important part of a spiritual experience for some:

"I find that a spiritual experience if you like? Like when it was really nice weather, just to sit and have the sun on your face. It gives you a level of what's the word? Eastern mysticism type of thing, or another plane."

Chris

"It is a beautiful environment that can kill you at any time and its closeness to nature is complete really... You've got something underneath you which is full of life. Little bloody fish jumping about all over the water around the boat and you think wow...I don't understand why but every single person who sees a dolphin or whale feels something, I don't know why scientifically speaking but I know it happens".

Joe

Joe talked about this connection as a universal experience, but this may not always be the case. For example, Kate recounted how looking at stars made her feel connected to the universe (*"It gives me a feeling of connectedness that they've always been there"*) and described her realisation that others did not necessarily experience this same sense of connection (she tried to share her sense of 'connection' with the stars with a friend who did not understand).

"I wanted to shake her like why can't you see this beauty? Why can't you feel this deep feeling that it gives me when I see these things?"

Kate

In this instance, it seemed that a lack of common understanding meant Kate felt connected to the 'universe' but very much less connected to her friend. It was apparent that whilst there might be common key features, spirituality was experienced and understood very personally.

4.2.2.4 A lack of evidence: okay for others but not for me?

Participants often struggled with reconciling a perceived lack of evidence for beliefs or feelings they discussed in relation to spirituality with their clear felt sense that there was 'something in it' that they found difficult at times to articulate clearly. For example, Joe talked about sailors (including himself) making offerings of pebbles or precious stones to Neptune when crossing the equator over sea, *"Most of them wouldn't consider themselves to be religious people but they all believe in something and they don't take any chances"*.

Notions of an 'afterlife' were raised by a number of participants in relation to their own understandings of spirituality, and for most others, this was talked about in carefully measured and uncertain terms (only one participant, Rachael, expressed any certainty in this regard: *"I think my daughter's somewhere better in a lovely place with my Nan and Grandad"*).

"I don't really think there is a heaven and hell but it helps me thinking there is something beyond"

Harry

"I'm very aware that it's incredibly important to people and that's what's important not what I think. I like to think that I can relate to it and I'd be lying if I didn't think that it would be a nice comfort to have in your last hours, your time of real need."

Nick

Participants seemed to take the view that what is found useful or comforting personally in terms of belief was more important than 'evidence' as such - for example, Lisa was happy to admit *"I believe there are some things I understand and some things I don't."* However, often participants seemed more accepting of others or in the abstract, and less understanding and sure of their own experiences and beliefs:

"It's just the same as if you worship Krishna or Mohammed or Jesus Christ or whichever. Whether it be, you know, if you worship a tree in a wood if that's what it is for you then that's what I've got to respect. I can't, I will never impose my view"

Nick

Whilst the fear and anxiety of imposing one's views on others will be discussed more in section (4.4.4.2.2) in a fuller elucidation of the integrative theme '*Fear and anxiety*', what should be noted here is that participants were often more generous and accepting of others' lack of 'evidence' than they were in relation to themselves - see Rachael's *"silly of me"* in the following quote. Rachael was talking about finding a white feather shortly after her close friend had died. She said finding a white feather meant an Angel, which is the spirit of someone close, has been sent to look after the living:

"I remember getting into the car and there was a white feather just laid on the seat and I picked it up and I remember thinking please, please if this is you. Whether it was silly of me to think it was anything to do with her but if it made me feel good does it really matter?"

Rachael

However, Rachael admitted that she tried to put such beliefs to one side once she had begun her professional life as a nurse:

“When you go onto a ward there’s somebody who’s quite psychotic and they are hearing voices and people are telling you ‘Oh god they are so unwell’ and I look at them and think, OK. Well is there something not right with me? You start questioning your own self.”

Rachael

Rachael’s personal fear and anxiety in this regard were another example of the way in which *‘fear and anxiety’* permeates here. How participants’ understandings of spirituality impacted on their professional practice will be covered later in this chapter (4.3), but here this quote well illustrates how participants could be quite uncertain about their own beliefs and personal models.

A number of participants, described associations between the term ‘spirituality’ and what were perceived as more superstitious or spiritualist practices.

“I remember once that people thought you meant spiritualism when I talked about spirituality like contacting the afterlife and mediums and stuff like that.”

Brendan

Many of the participants discussed such ‘alternative’ models of spirituality although no specific questions regarding this were raised as part of the interview schedule and often such approaches were discussed as similarly ‘lacking clear evidence’. Joe described some strange events when he lived in a house (*“it was a strange place. I could write a book about it, I only lived there for a year”*) which culminated in him having the house “cleansed”.

“I’m not sure of what I make of it now but at the time it bloody worked. I used to go into the house and say hello to the presences that were in the house and stuff like that and I didn’t have a problem after that. Things stopped moving about, the dog stopped being frightened, he still looked a bit wary and wouldn’t stay in a room on his own (laughs)”.

Joe

Harry, in contrast, was far more definite about his belief or rather disbelief of spiritualist medium concepts and likened them to magicians:

“I mean people like Doris Stokes and Derek Akora are very good at sort of like reading and leading peoples. It’s like watching Paul Daniels, you know what they do is impressive but it’s no real magic.”

Harry

However he acknowledged that many people derive comfort from such beliefs:

“There’s believing in God and believing in ghosts and there’s not an awful lot of difference. It’s more about the individual’s stance. I have a fairly pragmatic stance. There’s no evidence but if it makes me feel better [pause]. If it made me feel worse I’d have to re-evaluate.”

Harry

There is an evident but very understandable tension in this statement. The nurses’ statements in their interviews indicated that the participants explicitly accepted the beliefs of others, particularly service users, but also that a comprehensive understanding of someone’s spirituality was less important than how personally useful such beliefs were. Yet, there was nonetheless sometimes an uncertain or sceptical or apologetic tone to their talk in relation to spirituality in their own lives which suggested they felt that their beliefs might not be offered the same level of acceptance or value from others.

4.2.3 Summary: Role of spirituality from personal perspective

In this section (4.2), I have covered the theme *Role of spirituality from personal perspective*. I looked first at what participants saw as being important influences for them growing up (4.2.1 *Social development influences*), and then at how participants described understanding the role of spirituality in their own lives (4.2.2 *Understandings and models of spirituality*). Participants reported taking elements they found useful from important influences in their personal experience to come up with their own individual and unique understandings of spirituality. Spirituality was understood as a complex term that could be related to but was not the same as other notions (such as compassion, empathy and religion). Although there were some features often perceived by participants as key to explanations of spirituality (such as connectedness), understandings of spirituality were often very personal to the individual. Participants were often uncomfortable about their inability to 'evidence' their talk about spirituality: whilst they were accepting of this in relation to others' beliefs, they seemed less tolerant of themselves in this respect. The difficulties in 'finding the right word' or an adequate way of capturing their thoughts and beliefs was commented on by participants: spirituality is a difficult concept to 'pin down'.

Having looked at participants' understandings developed outside their professional (mental health nursing) role, I turn in the next section to look at ways in which professional training and experiences are reported by participants as impacting on their understanding of spirituality.

4.3 Influences on professional understandings of spirituality (Theme 2)

The previous theme considered what influenced participants' understandings of spirituality from a personal perspective. The following theme '*Influences on professional understandings of spirituality*' considers how a participant's understanding of spirituality may be changed or influenced by their nurse training, colleagues and professional expectations. The nurse may carry the 'spirit' of their beliefs which they have already

been exposed to in their personal life but may have changed their thoughts or behaviour in relation to their professional standing and as a result of their professional standing.

In order to fully consider what influences professional understandings of spirituality, two subthemes will be explored: *'Influences from nurse education and training'* (4.3.1) and *'Role of the team in nursing and its impact on understandings of spirituality'* (4.3.2) The integrative theme *'fear and anxiety'* will be discussed to show how it permeates this second theme.

4.3.1 Influences from nurse education and training

Nurse education is facilitated in both the university and practice area environment. Successful completion of both elements is required to register and maintain registration as a qualified nurse. The participants reported varied experiences of nurse education and many suggested that educators need to actively address the spiritual aspect of care in nurse training. However, all agreed the difficulty in doing so because of the complexity of the concept of spirituality and its place in mental health care. Some of the participants suggested spirituality was addressed in education but only as an aspect of holism or compassion. Olwyn in particular felt that spirituality and compassion were synonymous and said:

"In spirituality they talk about sacrifice and in compassion they talk about suffer with, so I think it's very similar".

Olwyn

Ann commented about her historical experiences during nurse training and as a qualified nurse when the expectations regarding spirituality in nursing did not have the same emphasis.

"I mean you're talking about going back to the early eighties when that sort of thing was rarely considered but even at that time if somebody said have you considered this person's spiritual needs, you'd have got, yeah he's Roman Catholic"

Ann

Chris also made a comment about historical approaches and like Ann said *“In years gone by you’d just ask them what religion they were”*

Some of the participants like Joe, Brendan and Lisa were more definite about their thoughts related to their professional understanding, particularly if they were nurses who had experienced the older style of training. Lisa reflected on a recent experience with a service user and compared it with the historical expectations of nurses in years gone by. Initially she described almost disparagingly how a colleague prayed with a service user who felt she had *“spirits in her head”*. Lisa had considered these to be symptoms of psychosis not a spiritual need and said:

“I never read a NICE Guidance that when people were distressed by hearing voices that the primary intervention was to get them on their knees in their bedroom and to pray alongside them in order to drive spirits out of their head.”

Lisa

However, she acknowledged that her attitude to this intervention might be attributed to her more dated nurse education and early nursing years’ experience and that this attitude was not as person-centred as they are currently. She went on to say;

I was taught in a more traditionalist manner really and it was if you saw this set of symptoms this is what you would do. It was a simpler time but a lot less dignified and negated people’s spiritual needs. I think if you treat people the same I think that’s the most fundamental thing against someone’s spiritual need.”

Lisa

Some discussed learning at university or as part of their nurse training as an early professional influence on their understanding of spirituality and highlighted the lack of spirituality as a concept within the nursing curriculum in university and practice. They reported that in their nurse training spirituality was only addressed as part of identifying a person’s religion.

“Back then spirituality was always something to do with religion. When I first started [Nurse training] if you’d asked somebody about their religion you’d covered spirituality”

Ann

“Through my training and experiences spirituality is almost taught as being synonymous with religion”

Ben

Mary also recalled her early nurse training however she felt there had been less significant changes in modern nursing approaches to spirituality.

“Are we trained to think around looking at people from a spiritual point of view? I think we have got better at it but it’s definitely lacking in spirituality. My understanding of spirituality and what it means to others is still very limited.”

Mary

Mary, Paul and Brendan felt that neither older nor modern nurse training addressed the concept of spirituality adequately but suggested pre-registration education in this area was something that needed to develop with the nurse, perhaps starting at undergraduate level but developing in further training:

“Ideally it would be a thread that would grow and develop as you would hope the students grow and develop. Something to revisit as a programme of study and further training”.

Brendan

“Potentially you’re looking at a cultural shift within nurses to make sure it is at the forefront of peoples thinking. Making sure it is delivered as part of the training or further training”

Paul

The nurses who had trained many years ago suggested that spirituality was not discussed in their training. However the nurses who had received university training had varied experiences. Dawn said that spirituality only passingly addressed but Freya had a different experience, however she credited this to the personal skill and sensitivity of one of her mentors as opposed to the formal university sessions:

“I only did one element of spirituality in uni, because I’ve only been qualified eighteen months and that part of it was looking at case studies”

Dawn

“My mentor was very spiritual and she was absolutely amazing. Her approach to everything is absolutely amazing and having observed her I think I picked up some of her strengths and used that as well in practice myself”

Freya

Rachael described how she deliberately changed her thoughts around her own spirituality as a result of her nurse training particularly during the practice element of the course. She was asked to reflect on her statement when she said that in some ways she had put her own spiritual beliefs about psychic phenomena to one side.

“You start questioning your own self. I thought oh God, I’m losing a bit of who I was and by the end of the course who am I? I’ve lost who I am. I’ve lost my spirituality”

Rachael

It was at this point the integrative theme *‘fear and anxiety’* was identified with her direct comment about why she questioned her own spiritual beliefs as a result of what she fears might be her colleagues’ reaction to her own spiritual belief and why she changed her behaviour and approach to service users as a result.

“Because I thought it was wrong to think that way. [Why?] Because I think when you go onto a ward there’s somebody who’s supposed to be quite psychotic and they are

hearing voices and people [mental health colleagues] are telling you they are unwell and I look at them and think, OK. Well is there something not right with me? You start to question your own self because of your beliefs.”

Rachael

Freya, who was the most junior nurse, only had her nurse training as a point of professional influence. However, she also felt there had been a change in her thoughts over the three years, particularly the learning which took place during her placements.

“I started my nurse course when I was only eighteen so I didn’t really have much life experience regarding people and mental illness and I think I’ve been quite lucky to get a wide range of placements in diverse areas. So I met quite a wide range of client groups and I’ve been able to connect with different people and learn about how different people present and that’s made me become a bit more intuitive.”

Freya

She went on to describe her experience with a service user who was suicidal and how that influenced her views on spirituality and understanding her spiritual vulnerability.

“I’ve never come across suicide before and it did disturb me because my view and my spirituality says life is a gift so why did this person take their own life? She was a massive learning experience for me and that’s made me more determined to help people find their themselves before it comes to that stage in life when they don’t want to be here because they don’t have a purpose so what ‘s the point in living?”

Freya

Although Freya did not specifically mention spirituality her thoughts were around the qualities needed for a spiritual approach to care and her ‘healing’ ability. She admitted to wondering if training to be a mental health nurse was really right for her

"I asked myself, Am I ready to do nursing? But now I know Now I'm qualified it's because I'm passionate and compassionate and I've got so much to give people and people see this in me and know that I'm a genuine person who cares".

Freya

'Fear and anxiety' in a different context was identified at this point with Freya's concern that she was too young and "not ready to do nursing". She overcame this fear and anxiety and qualified as a mental health nurse and now feels confident in her abilities.

Harry also talked about influences from clinical areas but his perspective was that of a nurse who qualified some time ago. He stressed the notion of evidence based practice in nursing although he tempered this with his personal thoughts. Based on his comments it is easy to see that he had conflicting opinions about what he described as 'evidence-based practice' and the more nebulous concept of spirituality in mental health.

"If we talk about spirituality as opposed to delusion, it's quite easy for me because I've got no great certainty, so it's easy for me to say to someone [service user], you could well be right."

Harry

'Evidence-based practice' of course underpins nurse education, but often participants talked about personal life experience as another important alternative form of 'evidence'. Rachael and Joe talked extensively about how the bereavements they had experienced shaped their thoughts about spirituality and about nursing and how this influenced their nursing approach. Some participants like Joe and Lisa were quite critical about nurse education generally and felt that life experience had more value in the eyes of service users. Joe in particular talked about how personal life events could be used to support service users

"It makes you understand things better and gives you credibility with people. If you've overcome difficulties it enables you to see things from a different aspects rather than

someone who has just read a book. I'm not down crying people who read books but they don't have that same connection"

Joe

'Fear and anxiety' in the context of credibility is identified in the Joe's statement but also in other participants' thoughts about how their personal experiences shaped their care of service users.

To summarise, the ways in which participants reported nurse education and training have influenced their professional understandings of spirituality, the main points have highlighted that education in spirituality appears to be inadequate. There are examples where participants identified some attempts in nurse education to highlight the importance of addressing spiritual need, but participants felt this was generally in relation to religion or culture. However, what is also apparent was that participants suggested current approaches to care are more person-centred than in the past and that a person-centred holistic style of nursing often addresses spiritual need indirectly if not directly. This seems, according to participants, to have been achieved primarily in the practice placement element of training as opposed to the theoretical aspect which is often facilitated in the classroom. The integrative theme of fear and anxiety has additionally been identified in elements of this theme.

4.3.2 Role of the team and colleague influences

This sub-theme addresses how spiritual care was approached using a team approach (an agreed way of working as a group of professionals) or team working (how an individual's strengths were utilised to benefit a service user or users) in order to show what influenced professional understandings of spirituality.

Mental health nurses rarely work in isolation. Both within the hospital and community environment mental health nurses practice alongside one another and other mental health professionals, for example psychiatrists, social workers, occupational therapists,

clinical psychologists and GP's. The large number of professionals and associated agencies adds to the complexities of mental health care with implications for both service users and carers. In order to provide high standards of care it is essential to work effectively as a team. However, within those teams there is also a range of personalities each with their own perspectives and views based on their personal and professional experiences. This may affect how a team functions and may influence or alter an individual nurse's preferred behaviour or approach within the team.

Some of the participants discussed their teams and the team's 'approach' or 'ethos' and how working as part of a team influenced care. Ann described her team as cohesive and she made reference to a situation where a service user's spiritual needs were at odds with a more traditional approach to care and discussed how the team she worked in tried to make the service users' spiritual needs a priority and person-centred:

"There were discussions around, do we go along with statutory services and see where that gets us or do we just go for other type of care? But she is unique..... Unique. Quite a serious consideration has been given to that [that being her unique spiritual need] and it's not unusual in this team."

Ann

She went on to discuss the team in positive terms of connectivity between the team members and their spiritual sensitivity and was asked if she felt that the spiritual sensitivity was unique to her within the team or whether they thought collectively. She responded:

"No, I don't think it's unique to me but then again, in terms of when you are working regularly with a group of people there's sort of a spiritual connectedness within that isn't there? You get a vibe about what's acceptable and what's not and the different ways people work. They are very different practitioners but they all come up with the same thing and they are quite spiritually minded in terms of how they work with people. They do it at different rates and in different ways but spirituality is always a consideration."

Ann

If Ann's statement is considered superficially the focus of her comment is about the positive cohesiveness of the team and how they work together for the benefit of the service user. However, her use of the word 'acceptable' in her statement suggested the integrative theme 'fear and anxiety' might need to be acknowledged at this point. The word itself suggested that it was common practice to have conversations and thoughts about spiritual needs of service users; they must fit in either explicitly or implicitly with the wider team approach. She stressed that as an individual within the team "*you get a vibe about what is acceptable and you work within that*". What was not explicitly said, was what would happen to the individual nurse should they put forward a viewpoint that was against the 'vibe' or collective team ethos.

Ben and Lisa felt that different teams placed a different emphasis on the significance of spirituality however Lisa stressed the importance of the team working together. Freya again related back to her nurse training and said;

"I've watched nurses and not always agreed with the approach they've taken. For example they seem to become resilient to people's problems and lack the empathy that is required"

Freya

However she intimated that even when this view or approach wasn't shared by individual nurses they acquiesced to the team's overall approach which might be inadequate and not support a service user's spiritual need.

Harry said a good team was made up of individuals who took the same approach for consistency. This might be one of the reasons why individuals acquiesced to the wider team. He went on to say the cohesiveness of the team he worked with played to individual strengths within it. If a team member was not confident about dealing with spiritual matters they would ask for help and he offered an example which suggested he felt that it was a mark of respect to admit if there was an element of care which an individual nurse might find difficult.

“An atheist person will acknowledge they’re not the best person to assist that person with their spiritual needs which is the good thing about our team because a lot of the things that I do that I’m not too sure about I bring back to the team [in meetings] and they would be respectful to that person’s spiritual need, this is my colleagues we’re talking about. There is no-one who would be disrespectful. They would say, I’m not the best person to help you but someone else in the team maybe. That’s how our team works”

Harry

As he elaborated however it became apparent that his personal approach to care could be modified or changed based on the team’s influence.

“With our team as well it’s all very well me going in and saying one thing but we’ve got a team approach so I could go in one day and there could be another person going in another day who has got a completely different take on it, you know? Personal beliefs and all that”

Harry

Brendan identified certain secrecy in that some teams did not discuss spirituality at all and said:

“I do wonder about my work colleagues and their take on it, because we don’t actually talk about it in so many words. We talk about the technicalities [of mental health care] and empathy and share experiences but not spirituality.”

Brendan

Mary, like Brendan said that the team she worked in never discussed spirituality.

“I can’t ever really think about conversations that I’ve had with colleagues around spirituality. Certainly about religion and certain cultural stuff, of course but actual spirituality, no I don’t think we ever have.”

Mary

Chris considered individuals within teams and the difficulties individual personalities and perspectives bring when trying to address spiritual needs in service users.

“It’s difficult because every member of staff is different and some are more likely to think that sort of thing [spirituality] is more important than others so they might just say I’ll not bother with that, because that’s what people do isn’t it?”

Chris

In this section the integrative theme fear and anxiety was again identified. Rachael described the fear and anxiety of being ridiculed or judged by colleagues within her team should she disclose her inner thoughts around spirituality. She emphasised the change in her expressed views as a result of fear and anxiety about ridicule within her team by giving an example from practice. A service user had expressed what were viewed by the nursing team as delusional beliefs but she personally believed were spiritual phenomena.

*“Can you imagine reading that out in your MDT meeting? They’d look at me and refer me to the NMC or get out the pink papers” [*application for admission to hospital under the Mental Health Act]. Because you’re scared that someone will think there is something wrong with you I think, that you believe that. They’ll think you’re not right in the head”*

Rachael

She was asked if she had, had any conversations about her own spiritual beliefs with other members of her team and the integrative element ‘fear and anxiety’ is apparent in her response:

“No. [Why?] Because you worry that they might think there is something wrong with you. Do you know what I mean? They might think, oh bloody hell what’s she on about here? So it’s a bit of a taboo I think. Yeah, you daren’t speak about it”

Rachael

Although Rachael was talking about her own experience and fear and anxiety she talked in the third person showing how uncomfortable she felt about expressing a taboo subject – it was as though she sought to distance herself from the concerns she was experiencing. This was not unique to Rachael – when participants became uncomfortable or felt the topic area was becoming a little too sensitive, many changed to using the ‘third person’ rather than ‘I’. For example, Isabel also switched to the third person and was visibly uncomfortable with a question around her own spiritual view and if she would be happy sharing it with the team. She said;

“I suppose some people might feel foolish, embarrassed in expressing what they find spiritual. I think it would depend on the individual. Some people aren’t forward with their religious or spiritual ideas are they for fear and anxiety of people judging them. And yet it’s what we do as nurses... form a judgement”.

Isabel

I discuss this use of language further in section 4.4 (*Fear and anxiety*).

Freya was another participant who discussed an element of the theme ‘fear and anxiety’ in relation to worries of ridicule from her team and she covered up her personal anxiety with humour when she relayed a situation where she had experienced such ridicule within her team.

“Not everyone understands what I understand and when I’ve spoken about it I’ve been told I’m totally bonkers [laughed] so I keep my spirituality to myself and just be friends with people. I’m nice to people”

Freya

This use of humour is similar to that exemplified by Harry earlier (see 4.2.2.2 and his references to ‘burning Pagans’) – and will similarly be further explored in section 4.4 (*Fear and anxiety*) later in this chapter.

Overall this sub-theme has considered how a mental health nurse's team's collective thoughts affected care in relation to individual service users. Some of the participants talked about team decisions around spirituality and the openness with which the team discussed the service users' needs to ensure that they were spiritually secure in some way. However, teams did not always afford the same respect to each other. This resulted in some participants being secretive about their own spiritual beliefs and needs which affected or changed how they approached care in service users.

4.3.3 Summary: Influences on professional understandings of spirituality

Overall this theme has described and considered influences on participants' professional understandings of spirituality, including how mental health nurses' teams' collective thoughts affect care in relation to individual service users. Some of the participants talked about team decisions around spirituality and the openness in which the team discussed the service users' needs to ensure that they were spiritually secure in some way. However, what is apparent is that teams often did not always afford the same respect to each other which resulted in some participants being secretive about their own spiritual beliefs and needs, which affected or changed how they approached care in service users. What is also evident in this section is how fear and anxiety permeates this theme – most clearly in this context in relation to fear and anxiety of ridicule from colleagues.

4.4 Nursing Spiritually (Theme 3)

The central focus of this research was to explore mental health nurses' understanding of the spiritual needs of service users. The first two themes (covered above, 4.2. and 4.3) illustrated what influenced this understanding in relation to participants' personal and professional experiences. This section will look at the third top level theme identified which is '*nursing spiritually*'. '*Nursing spiritually*' considers how the mental health nurses applied their understanding of spirituality, derived (as established in the first two themes) from both personal and professional experiences into caring for service users in practice. This theme also describes factors which are described as influencing decisions around how best to provide care for spiritual needs. These are considered in relation to

service user characteristics and in relation to organisational systems and requirements. The integrative theme *'fear and anxiety'* also permeates this third theme, and the ways in which fear was reported as impacting on *'nursing spiritually'* will be described.

The interviews produced rich complex data in relation to this particular theme with many lengthy explanations and reflection from participants about their thoughts and actions. I will start by identifying the broad defining elements of nursing spiritually as described by participants in the first section (4.4.1). I will then move on to discuss factors influencing the way in which participants reported that they cared for service users spiritual needs in sections (4.4.2) and (4.4.3).

4.4.1 Two broad approaches to nursing spiritually

Although there were differences between participants, overall two broad styles (distinct but not necessarily mutually exclusive) of *'nursing spiritually'* were identified: pragmatic and spiritually empathetic. In the remainder of this section, I describe and explain these different approaches to *'nursing spiritually'*.

Participants talked about *'nursing spiritually'* in either what I have termed a *pragmatic* or *spiritually empathetic* sense. Those who talked in a pragmatic sense tended to focus on very practical aspects of nursing – for example, on ways of providing the service user opportunities to practice their religion. For example, some participants discussed how their clinical service provided prayer rooms, artefacts, facilitating visits to places of religious worship (church/temple/mosque) or asking religious leaders to visit. Their talk was very much in line with NICE guidance regarding the support of patients' religious needs. (NICE, 2013). In contrast, when participants talked in a spiritually empathetic sense they recognised that supporting religious needs might not fully address spiritual aspects of the person. Those participants who talked about *'nursing spiritually'* in what I term a spiritually empathetic sense felt that the spiritual aspect, although an element of holism, was distinct and described in terms of 'unspoken' acknowledgement and recognition of a spiritual connection with the service user.

4.4.1.1 A pragmatic approach

As mentioned above, participants did not necessarily adopt either a pragmatic or a spiritually empathetic approach all the time. However, some participants clearly leaned more on one approach than the other. Nick was one of several participants who talked about nursing spiritually in a primarily pragmatic sense:

“In my world and my belief system, spirituality is about religion and what religion you are. Once you’ve said what religion you are, that immediately defines everything that you believe in terms of spiritualness, spirituality, so therefore you’ve answered my question. You’ve said you’re C of E and that means that you believe in a god. You believe in an afterlife. You believe in a relationship with God. You have relationship with God.”

Nick

Chris was another participant who was pragmatic when asked how he supported the spiritual needs of service users.

“With some people it might be something like I want a priest to come on [the ward] and meet me and errrm...discuss things. That is up to them to say, ‘I’m religious’. There was once or twice when I said do you want the priest to call? Do you want the vicar to call? Do you have someone, who is your vicar? Where’s your, where’s your patch or it could even be a Rabbi? It could be anything, whatever religion it was, do you want me to get in touch with them to come in and see you? Because they’re far more skilled and deal with it every day than I was.”

Chris

Paul described religious objects some people could relate to and felt it was important that the service he worked in provided such things, ready for service users who might need them to enable their spiritual needs to be met.

“Basically assessing needs and also having sort of religious artefacts and stuff, within a unit such as this. So having, you know, is the Koran available for them? Do they have prayer mats or is there a bible for people that go to church or? Erm, is there other sort

of, err, religious artefacts that they need? Maybe so that they're accessible, so they can continue with their spiritual, err, spiritual beliefs, despite being under the Mental Health Act"

Paul

The pragmatic approach also included developing a service user's care-plan to ensure that the person's spiritual needs were met even when their care-co-ordinating nurse was not there.

"We built up quite a good sort of faith package for him, in terms of making sure that he could go to the mosque and he accessed social activities, centred around sort of his religious, religious, err, beliefs and you know, that sort of worked quite well and there was quite a lot of sort of activities that he could then get linked into within the church and that helped him with his own sort of recovery,"

Ann

A pragmatic approach to addressing spiritual need was not necessarily confined to more widely recognised 'traditional' religions. Dawn described how she provided a service user the opportunity to express their spirituality through what she described as alternative beliefs: she still felt it was important to pragmatically approach the practicalities of what his specific needs were.

"We had one gentleman... who raised his spiritual needs about what he needed. Every six months they went to this certain point in York... and it was to do with the eclipse of the sun and the shadow it a cast on that. Err and they used to do their routine there, their ritual or what-ever they used to do. And every six months he used to go to that. I don't know, it was something to do with a lunar eclipse or something, but we made sure we could take him"

Dawn

During the interviews, depending on what the participant was saying, some of the participants who had described a pragmatic approach were asked to reflect on whether they felt spirituality was inextricably linked with religion. Freya responded:

“Yeah I do.... Yeah, I think it is linked.... Because, say that someone is a Christian and they’re carrying the whole spiritual sense of God and the sense of being and that God is benevolent... and I’ve forgot what the other one is omnipotent... so yeah.... So they’re carrying some sort of meta-physical sense with them and they pray to God”

Freya

Some participants described favouring a pragmatic approach but considered that whilst spirituality might be a component of religion it might also be separate and a concept in its own right and they were able to adapt to both.

“It isn’t about asking people what religion they are and ticking one of them 16 boxes. Although it’s tempting for someone like me who is very process driven to think it’s just ticking a box but it certainly isn’t.”

Lisa

Whilst describing his own pragmatic approach to ‘*nursing spiritually*’, Ben leaned towards a more spiritually empathetic approach when describing his understanding of the link between spirituality and religion and the way he would consider it in order to ‘*nurse spiritually*’.

“I think is probably about a person’s own interpretation of how they, they perceive and want to act within their life really. Erm and again, so you can get some people who can be quite religious people. Other people, erm, obviously less so and they might, err, want their spirituality treating in a different way as opposed to somebody who could be quite, erm, quite sort of very religious in a way that’s quite, it’s very important to them, so it’s about understanding the difference, err, understanding the way they sort of interact”

Ben

Nick, whose description of his own pragmatic approach to '*nursing spiritually*' is above, gave a direct and honest answer when he was asked whether there was a possible link between spirituality and religion and how he could support someone's spiritual needs outside of religion. He succinctly replied "*I haven't got a clue.*"

4.4.1.2 A spiritually empathetic approach

The following section describes what I identified as descriptions of a spiritually empathetic approach to nursing spiritually. Although some participants said that '*nursing spiritually*' happened naturally as a result of another approach to care (that it is an integral part of holism or compassion or person-centred care), for some addressing spiritual need was viewed as a distinct aspect of holistic/person-centred care that was not always included under these terms.

"I can't say that we really specifically thought oh right I'm going to address this person's spiritual need. I think in some ways we might have done it as a side effect of something else, you know, like if people have expressed sort of what's my meaning of life and my purpose, why am I here, I think we've done it as a side effect. But to actually sort of recognise it as a spiritual need, we might have given it other names"

Paul

Many of the participants described '*nursing spiritually*' in terms of seeing the whole person in a wider context that arguably went beyond notions of holistic or person-centred care. The sense was of going beyond what might be seen as the usual realm of care to recognise and facilitate something deeper and more profound for service users. This description, which I would identify as a spiritually empathetic approach to '*nursing spiritually*', talks about helping the person achieve their 'dream':

"He'd got quite a profound learning disability and he was a severe epileptic and he wanted to ride a bike, you know, every year, we do like a person-centred plan with him and we knew what he were going to ask for, he were going to ask to ride a bike, to ride a motorbike. He wanted, he wanted his own motorbike, that's what he asked for every

year and erm, and we could never obviously buy him a motorbike, although he'd got plenty of money in the bank. But it were never going to happen. So we used to look at things that were as close to that as possible. There were one of the staff that had got a motorbike, so he used to have a sit on that and put helmet on and things like that. Erm, we used to take him to bike shows, we used to take him to, you know, bike racing. So we used to find things that, that were as close to that as possible, so he weren't missing out completely, but he were never, we could never really buy him a motorbike, because it were, you know, it were, just weren't ever going to happen. But it's kind of spiritual, but I think it's kind of, it's kind of making sure that he got a good quality of life and he were, he were happy with his lot in life and he didn't feel like he were missing out on things and that's kind of moving towards self-actualisation and I think spirituality."

Olwynn

Other participants also spoke about understanding the 'passions' of a service user and said it was this ability that made them spiritually empathetic.

"I would say spirituality is not religion, it's about the person as a whole, and it's what makes that person who they are, everything about them really, their interests, their passions, what makes them who they are as a person. That's my understanding of spirituality; it's not just about supporting their religion it's about supporting them to be who they are. Spirituality is about a person and who the person is and what makes that person who they are"

Rachael

To be able to recognise and respond to deeper values, there was an important need for connection, and a number of participants emphasised the centrality of genuine connection to facilitate 'nursing spiritually':

"It's not necessarily about supporting religion, it's about how you connect with a person and what you value yourself as a person and what you value in others and what you value in the world. So for me it's about how do I help a person to connect with that or how do I connect with them? In terms of working with people with a mental illness, I think that is a spiritual approach"

Ann

“Because for them it’s about knowing the sense of self, sense of relationship with others, sense of relationship with higher being or connectivity with things outside yourself. So a relationship to a deity or universe your connectedness and relationship to people.”

Kate

Another participant talked about connection but in terms of a sense of disconnection or void.

“People lose track of it, there’s a gap and that gap gets filled with something to help them deal with life and that’s where the drink or drugs come in. It underpins an awful lot of what’s called mental disorder and without a formal religious faith but a set of understandings and beliefs and if that doesn’t happen, then you’ve [you=service user] got this void. You can deal with the physical damage very easily, however you’re left with this gap and the people who succeed have usually found a sense of purpose and that’s what helps get them through. For some it’s religion, some find God and for others it’s helping people and connecting with them.”

Brendan

In terms of connection some participants emphasised it as a natural occurrence and suggested that a conscious strategy to gain and/or maintain a connection in order to ‘nurse spiritually’ was not always necessary.

“I believe there is a spirituality acknowledged or unacknowledged and is in every person, every creature and probably everything on the planet. There is something in it that I can’t understand or explain and I don’t need to anymore”

Joe

“I’ve been able to connect with different people and learn about how different people present and that’s made me become more intuitive, it’s not a conscious thing but you have got that connection with them”

Freya

The spiritually empathetic approach was also described by participants in terms of 'unspoken' acknowledgement and recognition of a spiritual connection with the service user examples like *'Light in their eyes'* *'light'* *'spark'* *'spirit'* and *'spirit loss'* featured in many of the accounts. Kate was a participant who talked about this in relation to service users

"The spirit within me recognises the spirit within that other person. Spirit and soul I think is probably the same thing. In my head it's the same and the inner part you that you recognise in others. In service users which gives me feeling of connectedness"

Kate

Some participants said they could identify a spiritual need in people who did not recognise it as such for themselves. Participants said they were still able to continue to address the spiritual needs of that person. Rachael was asked about this directly:

["So you can nurse spiritually?] Yes [Even if person's not at all spiritual?] Yes [and says, go away I'm not interested?] Yes, because your idea of spiritual, what you're coming under the umbrella of when you so, might not be them so, so you know they might say no I'm not interested in spirituality I haven't got a problem with it but I do have a problem

Rachael

4.4.1.3 Which approach to adopt and when?

Whilst participants may have seemed to favour one type of approach to nursing spiritually (pragmatic or spiritually empathetic) over another, often both approaches could be used depending on both participants' own experiences (their approach could change over time) and what they perceived as being needed for the individual service user.

Isabel described an experience which resulted in her changing her pragmatic approach towards a more spiritually empathetic one. She described how after supporting a service user with their religion she regretted not intervening when she overheard a member of the care team she worked with speaking to them. This may be seen as an example of the integrative theme *'fear and anxiety'*. Isabel was concerned about 'getting it wrong' in terms of care of the service user and the judgements some mental health nurses make.

"I mean I've heard a member of staff saying what are you praying for? There's nobody up there that's gonna help you. By letting her just say a little prayer, makes her feel better so what's the big deal? Well it's not true to life is it? That's not what real life's about. So I it might not be for you but for that individual; it might be more, or what she needs right now and it might be a reality when she leaves. Who are we to judge?"

Isabel

Brendan worked in an area which cared for people who misused alcohol and drugs. He reflected on how his approach to nursing spiritually changed from being focused on the pragmatic physical needs of the service user towards spiritually empathetic based on his experience in caring for other service users with similar issues.

"Given they're qualified to come into the service usually dependency of some description. It's bingeing or problematic use of mind altering substances. There is a tendency to focus on the physical dimension, but underpinning it is nearly always something spiritual in that they wanted to change how they reacted either to their internal world"

Brendan

Sometimes, participants acknowledged that their own beliefs and attitudes towards spirituality could make it potentially more difficult to support spiritual needs. Harry described how his attitude towards spiritual needs changed between service users and colleagues. He compared spiritual expression with delusions:

"If that makes you happy then that's fine, then I won't take the piss; much. It's my cynicism. I struggle with my cynicism when it's not a punter but when it's with a punter

then I'd hide my cynicism and say well that's what you believe, this is what I believe and this is how I would speak to someone with their delusions"

Harry

It is interesting to consider, in the light of the 'genuine connection' highlighted earlier as a facet of spiritually empathetic approaches, whether nurses who find it necessary to 'hide their cynicism' as described here might be limited to the more 'pragmatic' end of the nursing spiritually continuum.

Lisa was a nurse who described herself several times during her interview as a concrete thinker and her preferred approach to nursing spiritually was pragmatic. However, she described how she observed a spiritually empathetic colleague working with a person and how her thoughts on her preferred pragmatic approach were challenged.

"I have worked with nurses who are registrants like me who do not believe in the biological model of psychiatry and whilst I appreciate there are other things that influence our treatment pathways, I am by trade a psycho-pharmacologist and medicines management technician within nursing and so I adopt a lot of biological underpinnings to some of the work I do. But I've worked with some people who truly believe that evil spirits have occupied an individual and made them psychotic. We both agree they're psychotic but we have very, very, very different opinions about how they've got to be that way and perhaps what we want to do about it as well. I never read NICE guidance that when people were distressed by hearing voices that your primary intervention was to get them on their knees in their bedroom and to pray alongside them in order to drive spirits out of

[Interviewer: What was their argument?]

That the person was occupied by evil spirits and the quickest and easiest and most effective method would be to drive them out by prayer. There were other methods, physiological methods that we don't allow by law in this country to use but the best way they thought they could do it at that time was to both kneel and actively really robustly

pray. In the hope that the spirit would leave them at least for the evening to get them some respite and get them some sleep.

[Interviewer: Did it work?]

No but PRN [extra medication] didn't work spectacularly effectively either. So there were no winners in that situation."

Lisa

Some participants do seem to find it difficult to approach spiritual needs of service users in any way other than pragmatically. Others who may prefer the pragmatic approach in terms of being able to evidence how they support spiritual need may also use a more spiritually empathetic approach when they perceive the need to do so.

In this section I have described how participants talked about '*nursing spiritually*' in two broad (although not exclusive) senses. I will now discuss some of the reasons why nurses may choose to take a particular approach. I will look first at particular factors relating to the service user which influenced nurses' attitudes towards understanding of and the specific care then provided for service user spiritual need. I will then consider system requirements and factors which impacted on how '*nursing spiritually*' was undertaken.

4.4.2 Factors relating to service user which impact on how nursing spiritually is undertaken

This section discusses three sub-themes: (4.4.2.1) the '*religious and spiritual history of the service user*,' (4.4.2.2) '*the person's diagnosis*,' and (4.4.2.3) the '*care setting*' in which care was provided.

4.4.2.1 Religious and spiritual history of the service user

The first main factor which influenced the nurses' attitudes was the religious and spiritual history of the service users. Participants described how they tried to understand service users' religious and spiritual history. This was often described in relation to assessing needs at the onset of care. Participants acknowledged the importance of trying to understand a service user's views before making a judgement on their mental health needs. They acknowledged that knowledge of a service user's stated religion as well as their mental health history would impact on their nursing approach:

"When we first meet someone we try and get a gauge on what they believe and that's spiritual inclusion. So their beliefs about that and their irrational or paranoid beliefs"

Harry

"Are they going to be more distressed as a result of this? Or is it going to impact on any other aspects of their mental health. And are they vulnerable? Those are the three questions that would probably dictate any response to it"

Lisa

Generally, participants described how their approach to nursing spiritually was clearly influenced by the religious and spiritual history of a service user. For most participants, their starting point in considering someone's spiritual needs was simply to ascertain the religion of the service user. Harry explicitly explained how mainstream faiths and religions were easier concepts to understand (and provide care for) than alternative spiritual beliefs.

"It's just getting it across that you're respecting what they are saying even if you don't agree. Normal religions tend to be better known to people so you're not going off and just not knowing how to respond... with some people it's straight forward. Like the time of year, like in Ramadan. People who are actively fasting, that's fairly clear"

Harry

However, some did think about need in this context more broadly:

"I think they [Nurses] should understand it. I think everyone must have a degree of understanding of what's meaningful or what's helpful and purposeful for a person"

Isabel

Some participants said they would take into consideration alternative or less common belief systems but acknowledged that these belief systems might be misconstrued, particularly in the context of a mental health care setting:

"Something that you've got to bear in mind is that everybody's God is different you know? For some it might be a woman, some it might be a bloke, some it might be, you know a multi handed elephant but it's incredibly important to people"

Nick

"It's making sure you're assessing what sort of spiritual, religious or cultural needs to keep them undertaking those activities or their interests as much as possible. Assessing what religious beliefs they have whether it be Catholic or Muslim and working within those needs like going to a mosque on Friday. But potentially an unusual belief away from the social norm could be dismissed as a sort of delusional thought as opposed to them saying this is my spiritual belief"

Paul

Some participants discussed how a team might approach supporting spiritual needs particularly if they felt they needed something more 'alternative'. Ann described how the community team she worked in worked together to come up with solutions:

"She's unique... she's not doing anything wrong, it's just that she's not doing the same as what we all do, so how are we going to accommodate that? She doesn't see anything wrong with that and the people that she surrounds herself with don't see anything wrong with that so why should she be treated the same as everybody else? So

there was this discussion about how are we gonna accommodate that then around her values and her spirituality”

Ann

Finally, in relation to assessment of beliefs and need, it was evident that spiritual need in relation to death and dying was considered somewhat differently and more benevolently – it seemed that beliefs, if providing comfort in relation to death and dying or at the fringes of life, were less open to judgement:

“We’ve had two people who have found some solace that they are in heaven now and happy now whoever they have lost”

Harry

“I’m very aware that it’s incredibly important to people and it’s that, that’s important not what I think. Would I think I can relate to it and I’d be lying if I didn’t think that it would be nice comfort to have, that in your last hours, your time of real need, if you were a big believer, a spiritual person that believed in your God. Whichever God that may be to take cold comfort that in your last hours there was somewhere else”.

Nick

Ann discussed a service user who had deep spiritual beliefs and was anxious about his funeral arrangements, should he die, to the point where this was impacting negatively on his mental health. She described how she supported him to make the practical arrangements (in line with his religious preferences) himself despite estrangement from his family:

“He was able to do things like arrange his funeral that was because of this religion. It has to be done in a certain way and in a certain timeframe and he was really desperate. Making the arrangements for his funeral offered the service user comfort and decreased the stress he was feeling”

Ann

4.4.2.2 Service user diagnosis

The second sub-theme I will consider is the service user's diagnosis: participants described how this influenced their approach and attitudes to nursing spiritually. Evidence of psychosis, personality disorder and schizophrenic disorders affected how the nurse approached nursing spiritually. For some participants, service user expressed beliefs could even be used as a measure of mental health (it is worth reflecting here that whilst people with physical illness might turn to religion and/ or spirituality as a coping strategy, in mental health settings this might be seen rather differently and as a potential sign of deterioration).

Lisa made reference to her difficulty in understanding some people's beliefs and her tendency to see an alternative belief system as a sign of mental health issues. She talked about when she had discussions with service users who believed in the afterlife and returning as a spirit to guide their loved ones in life. Although she acknowledged that some people believe in the afterlife she found it difficult to be objective.

"People would tell me they would come back in some spirit form and have some orchestration over that. It was a difficult conversation"

Lisa

Some participants felt that a person's diagnosis affected how nurses might understand (and subsequently care for) the spiritual needs of service users. Some participants were concerned that, for some cultures, what might be a part of spiritual expression, particularly when grieving, might be misunderstood as symptoms of mental illness. The 'fear and anxiety' of 'getting it wrong' and 'imposing one's own beliefs' was evident.

"If anybody mentions a reference to spirituality it's deemed a delusion or some psychotic feature. There was a lady who used to sit behind a door and rock and wail. And that was interpreted by the nursing staff on the ward that she was distressed by unseen stimuli. And when it all came about she was mourning for a family member who had passed away and for six months and it was part of her way, her culture her spirituality, her grieving process which was completely misinterpreted and given a wrong label".

Dawn

Ann similarly described her perception that nurses could identify more with the experience of some mental health problems than others. She suggested that because nurses were more likely to have first-hand experience of a mood disorder as opposed to psychosis, they could empathise more easily with the service user and were more likely to support their spiritual needs as a result. In the previous section (4.3.1), I highlighted how, whilst some participants were willing to take into consideration alternative or less common belief systems, they acknowledged these might well be less readily accepted than 'traditional' religions. Similarly, certain mental health conditions, particularly those with which others seem more easily able to empathise, are seen as more 'socially acceptable'. Here fear and anxiety is clearly evident as the participants show that there are some mental illnesses where it is socially acceptable to express spiritual beliefs. The nurses' fear is evident in that they are relieved to be able to only identify with certain experiences and that other, less 'acceptable' illnesses only happen to 'others' and spirituality is less likely to be supported in these instances as a result.

"Most people can identify with depression 'cos in your life people do experience a mild form or even more severe, but a lot more people can identify with anxiety and depression than they can with psychosis. Not many people can identify with hearing voices. There is a similar thing with puerperal psychosis, most women would think there but for the grace of God but you know you can empathise with that, that situation."

Ann

Kate also discussed how a person's diagnosis affected the attitude of nurses in terms of how they viewed that person, particularly in relation to how their spiritual needs might be met. She identified that certain 'illnesses' were a collection of symptoms and not everyone had the same collection but, once a diagnosis had been made, many nurses wrongly assumed that the person had all the associated symptoms and this might overshadow their objectivity when considering spiritual needs:

"We have an idea of what schizophrenia is and we put the whole thing on the person when they've been given a diagnosis and people don't have everything in the box. It doesn't work like that and, actually, I'm not entirely sure how useful it is for a health professional to have a diagnosis. I think sometimes it can be more damaging than use."

Kate

Chris similarly highlighted the impact of a particular diagnosis on considerations of and understanding of spiritual need.

“I think a diagnosis affects things all the time I mean if somebody has a diagnosis that’s more problematic... like a severe personality disorder, I think people are generally very cagey anyway around everything”

Chris

Isabel felt that it was not just the diagnosis but also the point where the person was in their recovery that affected the nurses’ approach:

“It would depend at what point in their illness they are, because some people find it very difficult being diagnosed with something like schizophrenia because as soon as other people know it they’ve got their reaction to it as well.”

Isabel

Whilst all participants recognised the difficulties apparent in distinguishing between expressed spiritual beliefs and needs as either genuine or symptoms of illness particularly in a mental health setting, participants differed in the extent to which they described using such beliefs as a “barometer” to judge service users’ mental health. Here ‘fear and anxiety’ was identified in the nurses’ concerns regarding the difficulties in sometimes assessing the difference between spirituality and some symptoms of mental health. Emma expressed some discomfort at using a person’s expressed spiritual needs or beliefs as any kind of barometer to gauge mental health needs. When asked how she could tell the difference between spirituality and psychosis she said:

“You don’t, you might not know because that’s not the point is it? The point is how distressing it is for that person by something that’s going on in their head. What I’m worried about is that we give medication for that and we don’t explore first or even part of anything, because it’s [spirituality] looked upon by society as no-one has it proven. And it’s out of the ordinary and you can’t act like you believe it because then you’re encouraging that belief. But it’s not right.”

Emma

Other participants like Harry had strong views on how a person's spiritual or religious beliefs might affect his attitude towards and beliefs about their mental health, particularly if their expressed beliefs differed significantly to his own:

“You know if someone is saying I've got a ghost in my house and I need an exorcist I'd be hesitant about supporting that. Because my first thought would be because they are nuts”

Harry

However, although he had strong views on certain aspects of spiritual beliefs, Harry also added the team would allocate a person who had more understanding about the service user's needs to ensure the best care, and in the following section I move on to discuss how participants described practical issues which needed to be addressed when supporting service user spiritual need.

4.4.2.3 Care setting

Participants in this study worked across a range of mental health care settings, and it was apparent that 'nursing spiritually' was approached rather differently in different settings. I cover this finding here as the settings in which a service user was cared for was likely to be related to his or her condition (and therefore a factor related to the service user). However, particular care settings are of course dependent upon health care system factors and requirements, which are the focus of the next section (4.4.3). Considering the impact of care settings on nursing spiritually at this point therefore links well between this section (looking at factors relating to service users which impact on nursing spiritually) and the next (which addresses system requirements and factors).

For those who worked in secure settings, it could understandably be very difficult to work flexibly. Isabel described how the service she worked in could have specific difficulties in meeting a service user's spiritual needs because service users were secure inpatients. The service she worked in had spiritual leaders within the hospital

but service users were expected to visit them. She identified the difficulties this posed in terms of legal requirements.

“We can’t take anybody anywhere. Going back to religion, we’ve got a pastoral services on the main site and they do counselling and all sorts of different things and there’s people from all different faiths that work there but you go to them. They do come to us but once a week which is probably not enough for some people. But we can’t take people over there because some of them are obviously transferred prisoners we can’t take them anywhere. If we do take them it’s got to be within the criminal justice system and it takes six weeks for them to come back with a decision.”

Dawn

Similarly, and in the context of a forensic rehabilitation service, Paul also talked about his team and the challenges and limitations they faced:

“I suppose being in a secure environment, it’s sort of restricted, or some service users are restricted in terms of their involvement and whether they can sort of come and go freely as people who aren’t here can do. Obviously, we’ve got locked doors and people usually have escorted leave and escort time can be quite precious, so you can only do a few hours maximum. You might go to church on a Sunday morning and it’s very difficult to facilitate that, due to escorting staff problems, so you may only get an hour or a couple of hours at church, where some might want to spend all day there. So again, there’s those sort of limitations”

Paul

Olwyn worked in dual diagnosis service with service users whose primary diagnosis was mental illness but who also had a learning disability. She discussed the specialist issues people in her care faced when trying to express their spiritual need. However, she also said that nurses who worked with service users who were in long term care had time to develop therapeutic bonds with people.

“They have communication problems all the time and people’s behaviours are misconstrued because they can’t get their point across. There’s nowhere quiet on the ward where you can go, even to your bedroom. It’s no retreat or sanctuary because two doors way she might have her music on at two hundred thousand decibels. But you

know they will have people that's worked with them for a long time and it'll be quite intuitive, instinctive so they know how they're feeling so I think that's a bit more spiritual"

Olwyn

Participants who had a background in general inpatient services also talked about staff availability and the impact this had on the spiritual care of the service users.

"They have to get escorted by a member of staff. It's like this afternoon, I've been taken out of the staff team to facilitate a secure escort for another unit. We've only got three staff on our ward and somebody is in a tribunal so you've only got two staff. So if one of our women turn round at three o'clock and say I need to go to the multi-faith room for some time to myself to sit, to think, to relax, to reflect, whatever it's like we haven't got time for staff to do it I'm sorry"

Dawn

Emma was particularly negative about acute inpatient services' ability to meet spiritual needs. She described services as *"horrific and inhumane"*:

*"When that lift door shut and I realised you couldn't get back out again without someone pressing a button. That's real f*** head stuff and I'm not a patient. I ran down the stairs and it's even locked there. I actually started to panic and I was only taking my time sheet in. I thought this isn't a ward it's a prison. It's horrific. I used to believe that one person could make a difference but you don't get time for that any more. Certainly not in acutes".*

Emma

Emma also described nurses in this inpatient environment as adopting a "tick box mentality" to addressing spiritual needs which she felt was inadequate. She blamed lack of time for this practice; *"Yeah, that's the spiritual dimension, you've ticked that box, because that's all she's got time to do"*.

Lisa identified the differences in context between inpatient and community services with regards to how the same spiritual need might be approached:

“I was visiting people at home who had no roofs on their houses so that God could talk to them and I saw people who believed that they had to go out in tin foil caps so that the UFO’s wouldn’t be able to infiltrate their brain and all these things that if they had been in a residential or inpatient services they would have been behaviours that I was wanting to change. In community, it was none of my business. But in a community team I could spend a lot more time exploring an appreciating and writing care plans for people’s spiritual needs”

Lisa

Ann who worked in a community team described how her team worked together to come up with solutions to support the spiritual needs of a service user whose beliefs and practice were more alternative:

“She’s unique... she’s not doing anything wrong, it’s just that she’s not doing the same as what we all do, so how are we going to accommodate that? She doesn’t see anything wrong with that and the people that she surrounds herself with don’t see anything wrong with that so why should she be treated the same as everybody else? So there was this discussion about how are we gonna accommodate that then around her values and her spirituality”

Ann

In this section, I have looked at factors relating to service users which impact on how ‘nursing spiritually’ is undertaken. I have look at how participants describe a service user’s religious and/ or spiritual history and their particular diagnosis as impacting on understanding of and care for their spiritual need. I have also looked at the way in which setting of care was described as impacting on ‘nursing spiritually’. The set-up of particular care settings depends very much upon particular health care system factors and requirements – these are the focus of the next section (4.4.3).

4.4.3 System requirements are factors which impact on how nursing spiritually is undertaken

This section considers how system requirements and factors are reported by participants as impacting on how they undertake *'nursing spiritually'*. 'System' in this context may refer to the health organisation both local and national, Mental Health Act (MHA), NMC standards and other aspects of the law, relating to forensic patients. In this section, I will reflect on how participants described their efforts to meet and address the individual needs of service users within the limits of system requirements which were often perceived as unhelpful. Often, participants described how they had to attempt to reconcile individual service user needs with overarching system requirements – this section covers descriptions of how the nurse or team managed the specific requirements of the system so that they could *'nurse spiritually'*. I will present three categories which I have characterised as: (4.4.3.1) Needs not addressed; (4.4.3.2) Needs only addressed partially because of conflict with system requirements; and (4.4.3.3) Needs are addressed more fully.

4.4.3.1 Needs not addressed

Many of the participants felt that service users' spiritual needs were often not met or could not be addressed and this might be because they were not identified or prioritised. The participants suggested that one of the reasons why this might happen was because there was not a clear way to adequately assess spiritual need. As an aspect of care which is not easily quantifiable or 'ticked off' (in the way that ethnicity is) spiritual needs tended not be addressed as part of the assessment process according to participants:

"I don't think we do address it. It's not part of our assessments"

Mary

"Spirituality isn't prioritised but ethnicity is"

Ben

"I don't think it is addressed, not properly. It's only considered as an afterthought"

Chris

“It’s not considered. Wrongly: But maybe it’s not considered important enough to ask or maybe you assume that people will come and tell you about it which they certainly won’t”

Mary

Participants suggested that spiritual need is not, in their experience, routinely assessed and acknowledged that acquiring such information is not straightforward. Emma describes assessment in terms of *“just a tick box mentality and that will be it. We’ve covered spirituality. You certainly wouldn’t have these big locked doors”*. Isabel similarly reflects on the difficulties of assessment in relation to spirituality and spiritual need:

““At the point of admission, they’re probably not able to tell you anything [about their spirituality] and I don’t think that it’s revisited at any point. I don’t think that we address it at all. I think if we focused more on people’s spiritual needs they’d recover a little bit quicker...It’s the gathering of the information in the first place that’s difficult and we don’t have any standardised way of asking people or make them feel comfortable to approach us even or making people aware that they can do that”

Isabel

As Olwyn comments below, if not identified as part of assessment, this aspect of care may then not be considered in the formulation of care plans:

“I think the fact that it’s not there on care plans or certainly on the care plans that we used and certainly in this area where I’m working now, and I think it’s a fantastic programme on looking at and reflecting on feelings and emotions. But there isn’t anything specific around spirituality”.

Olwyn

Participants suggested that the failure to consider spiritual need might in large part be due to the overwhelming focus on an evidence based approaches situated in a

dominant secularist culture. *'Fear and anxiety'* features here because many nurses fear ridicule in this situation as they may perceive the weight and credibility of evidence based approaches takes precedence over spiritual beliefs, and is evident in Brendan's use (below) of the word 'power'.

"I think it's totally overlooked and I think it's partly the medical power of medical training"

Brendan

In the following section 4.4.4 (in which I reflect on the integrative theme of *'fear and anxiety'*), I will address this issue (the perceived incompatibility of standard evidence based approaches with notions of spirituality) in greater depth. Chris suggested that even within the standard evidence based approaches there was an increasing focus on medication rather than therapeutic interaction.

"The idea that you can help someone with a mental illness by talking with them or having them talk with other people I think has faded away. You [The service user] just go and live in the community and you get a visit from a CPN who is mainly checking that you're taking your medication, which is a shame"

Chris

Other participants similarly described how both resource issues and legal restrictions impacted on the ability of mental health nurses to care for the spiritual needs of service users.

"The forensic patients' needs are not met because of the restrictions that are on them. I think it's really difficult. There's lots of little things that you come up across that you just can't do in here. It's just a funny environment isn't it? People can't even leave the corridor that their bedrooms are on at certain times never mind addressing any spiritual needs"

Isabel

“It should be everybody has the right to go and reflect and have time out and pray or meditate or do whatever it is that they do whenever they want to do it.... They’ve no chance between the hours of twelve pm and six am because there’s no inter-area patient transport so our women off the unit can’t go to the area where it is”

Dawn

“I think isn’t addressed properly. It’s almost considered as an afterthought, it’s something that’s talked about more these days but it’s like we haven’t time to do that or whatever”.

Kate

4.4.3.2 Needs addressed partially because of conflict with system requirements

This sub theme focuses on participants’ perceptions that system requirements did not allow for the personalised care required to fully meet spiritual need. Some of the participants intimated that spiritual needs were only partially addressed because of the expectations in the standardised assessments.

“Because the religious thing is something that we have to ask isn’t it? It’s something that we’re told we have to ask about”

Isabel

“There is the standard set of questions you’re given but I don’t think it covers enough”

Rachael

“Well it’s just on the documentation, isn’t it? But there’s nothing there about what they might find meaningful otherwise”

Chris

Many of the participants said that there was no standardised way of assessing and addressing spiritual needs, yet clearly described these needs being partially met. This was in response to one of the interview questions which asked, in the absence of a standardised assessment, how participants assessed spiritual needs of service users.

Ann talked about how her team manipulated the system to at least try and meet some of the service users' needs. She reflected on a situation where the service user was adversely affected by the terms of the restrictions of the MHA and concerns about the service user's spiritual well-being.

“She’s gonna be driven towards chronicity in terms of her mental health and that will impact on her spirit. More often than not, people are made to fit in that square space”

Ann

Ben also talked about trying to make service users 'fit' the system:

“Because if they are fitting in to our system, we are fitting into their life in a bigger way which will impact more upon them.”

Ben

Some of the participants felt they attempted to support service users' spiritual needs by referring a service user to pastoral services or religious leaders provided by the system but acknowledged that this was flawed.

“Because I'd referred somebody to psycho-therapy dun't mean to say that my responsibility for that particular problem ends, it's still there. I'd be looking at again working on their feelings. Trying to create comfort and some sort of something I could offer that would and sometimes that would be grounding and sometimes that would depend on what that person was having the problem with”

Paul

“We do have a multi-faith room on site within the hospital itself which can be accessed by anybody. Well, it’s there for anybody, but you have to have permission from your consultant to go”

Dawn

Some of the challenges and restrictions the service users experienced in inpatient or forensic services were highlighted:

“Everything’s kinda stripped from them and probably more so than prison environment, I think. And then you’ve got the medication on top of it. They can’t have a normal conversation it’s all very forced. You’ve always got people observing you and it’s all very forced and watching you. I hate it.”

Isabel

Kate said one of the ways they would attempt to provide some sort of spiritual care would be to ask the service user who they could contact to help.

“Is there anyone in particular at that church who you want us to contact or maybe who could come in and see you cos as things are you’re on a section and we can’t necessarily facilitate something else and just little things like that and I think that even if. Even if they don’t want it can help the admission seem more humane anyway”.

Kate

4.4.3.3 Needs are addressed more fully

The results indicate that nurses want to (and in fact do) ‘nurse spiritually’ but this was described as needing additional efforts by the nurses. Often spiritual needs were negotiated with the service user. Where the system is restricting the nurses’ efforts and impacting on the service user, often the nurse goes ‘the extra mile’ and there are attempts made to facilitate needs as much as possible.

“How are we gonna squeeze this round peg into this square hole of services? Because it’s not what she values, it’s not how she connects with people. How are we going to

accommodate that? We have to shave off things of the person to really fit in with the service because the service is unchangeable isn't it? So we've just sort of bashed her in. She's fraying a bit at the bottom slightly but hopefully we can sort that out when we move her into her own space and she'll spring back. The team has long discussions about how we can try and accommodate somebody's spirituality but the organisation doesn't"

Ann

Some of the approaches participants discussed were about ensuring the person had every opportunity within the constraints of the system to meet their cultural and spiritual needs. Sometimes this might be in a fairly straight-forward manner, for example as in Paul's quote below, ensuring that service users had what he termed the 'artefacts' associated with their religious practice available to them:

"So basically, assessing needs and also having sort of religious artefacts and stuff, within a unit such as this. So having, you know, is the Koran available for them, do they have prayer mats or is there a bible for people that go to church or, is there other sort of, err, religious artefacts that they need, maybe so that they're accessible, so they can continue with their spiritual, err, spiritual beliefs, despite being under the Mental Health Act."

Paul

At other times, addressing spiritual need was described in broader terms. In the quote below, Dawn described how something outside of 'treatment' but nonetheless very important and meaningful to the service user was facilitated (with some difficulty on an inpatient unit) by her team:

"We've got a lady in at the minute, she's Afro-Caribbean and she wants her hair doing properly. Our hairdresser who usually comes doesn't specialise can't really do it. So we've got a woman who knows someone who specialises in Afro-Caribbean hair that can come in for her and do her hair"

Dawn

Even when caring for the needs of service users in this manner was difficult (and not necessarily an obvious part of their nursing role), participants repeatedly described how they were prepared to make additional efforts to do this.

“Obviously, some people are gonna have things like that are unattainable like, I want to be on a desert island and what-have-you but you’ve got to negotiate what is the best way of achieving the optimum”

Chris

“I was giving him the only hope, keeping something. He would have had nothing going for him at all, it would have been the end for him. I said I’m prepared to put my job on the line for you”

Joe

As evidenced in both Joe’s quote above and in Mary’s account at the beginning of this section (where she described how her team provided highly personalised care to ensure that the service user ‘round peg’ could be accommodated in the ‘square hole’ of services), it is clear that participants perceived effective spiritual care as being very much about individuals. It seems that to address spiritual need requires that both the nurse and the service user must engage on a truly human level as real individuals. However, this might mean that the nurse went beyond standard ‘system’ conceptualisations of both their own role and ‘patient’ or ‘service user’, and doing so could lead to a real sense of vulnerability. I will describe the anxiety and fear this may provoke in the next section in which I will address the integrative theme of *‘fear and anxiety’*.

Theme three *nursing spiritually* is concerned with how participants described applying their understandings of spirituality to nursing care. I have identified two broad approaches to ‘nursing spiritually’ (pragmatic and spiritually empathetic). I have also considered factors which influence how participants provide care for spiritual needs.

Factors relating to the service user which influenced how participants 'nurse spiritually' included the service user's religious and spiritual history, their diagnosis and the setting in which care was provided. I have also explored how participants described their efforts to 'nurse spiritually' within the limits of system requirements. I have noted how providing spiritual care might require that participants 'go the extra mile' and that this could generate anxiety and fear. In the next section (4.4.4), I move on to examine this integrative theme in detail.

4.4.4 Fear and anxiety (Integrative theme)

Fear and anxiety' is an integrative theme, as described in 3.4.1. It has been identified in the previous three top level themes and highlighted at relevant points throughout this chapter. In this section I discuss fear and anxiety in further detail.

4.4.4.1 Permeating fear and anxiety

As discussed in chapter 3, integrative themes in Template Analysis are themes which permeate all other themes identified. As has been evidenced throughout the findings presented in this chapter so far, anxiety or even fear often clearly permeated participants' talk about spirituality. In the first theme presented in this chapter (4.2 '*Role of spirituality from a personal perspective*'), some participants referred to 'fear' in relation to their personal (religious) upbringing. Joe, for example, equated spirituality with existential anxiety, religion and fear in his account of his mother's early death.

"Fear, death and dying. Yeah, Extreme fear. When you are very much at risk or your frightened of the unknown. That is when your spirituality is tested".

Joe

There were similarly associations between religion and fear in Harry's discussion of his Catholic faith and upbringing. Harry still identified as Catholic, but talked about his inclusivity of all of the types of people which conflicted with what he said the Catholic faith suggested. According to Harry, the Catholic Church taught that people would "Go

to Hell” if they did not adhere to the teachings of that faith. He feared his inclusiveness and tolerance of people generally might impact on his own spirituality and afterlife:

“I’ve got my pragmatic side which says [of spiritual belief] not a lot of it makes sense. But my spiritual side, if you want to call it that, doesn’t make sense but it makes it easier for me to get through life. Maybe if I’d been brought up different? If you do bad things you will go to hell and bad things happen to you and maybe I’d be a psychopath. Maybe I am a psychopath and the only reason I’m behaving like this is because I’m worried about going to hell or retribution”.

Harry

Harry seemed aware that his stance might be seen as incongruent by some, and, perhaps concerned that he might be challenged and he effectively used humour to avoid further interrogation on this point. He referred to his own “*deranged understanding*” and references to historical associations of “*burning Pagans*” which seemed to reflect some embarrassment or discomfort on his part, and might be seen as an example of the integrative theme ‘*fear and anxiety*’.

Humour was often used in the interviews with participants using it as a strategy to cover their discomfort. Mary laughed at one point when I asked her a question about spirituality and shouted “*I don’t know, it’s too hard, turn it off*”. Rachael also used humour when she made reference to her colleagues’ reaction to her spiritual beliefs when she laughingly talked about them “*getting the pink papers*” [MHA ‘section’ documents are pink]. Participants talked about spirituality being a complex and difficult concept to understand, and during the interviews many participants laughed and groaned at various intervals when they perceived a question was difficult or probing. Participants’ concern about ‘getting it wrong’ will be discussed in detail below. Some of the participants became agitated at points during the interview and said they ‘hated’ the word spiritual which may also be seen as examples of the participants feeling fear or anxiety. Many of the participants displayed discomfort in their body language, for example they blushed, fidgeted, groaned and pulled faces. Perhaps as a result of the difficulties they found in answering questions, they often talked around what qualities made up spirituality and likened spiritual care to compassion rather than addressing

what it meant. Nearly all of the participants made references at the start of their interview to 'looking up' 'googling' or wishing they had looked up spirituality prior to their interview. This behaviour could be seen as indicative of the '*fear and anxiety*' they felt with regards to their perceived lack of knowledge about spirituality as a concept.

'*Fear and anxiety*' were then clearly apparent in discussion of participants' personal understandings of spirituality. The integrative theme also clearly emerged in relation to the second theme; '*Influences on professional understandings of spirituality*' (4.3). There were explicit examples of '*fear and anxiety*' identified, such as Rachael's account of how she questioned her own beliefs during her nurse training to the point where this affected how she approached service users. Fear and anxiety were noted when some of the participants talked about spiritual experiences and described themselves as "*silly*" for having such beliefs. They described uncertainty about acceptance from others yet were more willing to accept similar beliefs in others – for example Rachael's discussion of a seeing a white feather in relation to angels and spirits in theme one (4.2.2.4) was followed by her description of a perceived necessity to put her spiritual views to one side in order to practice as a qualified nurse and be credible. '*Fear and anxiety*' were repeatedly identified in participants' concerns that they were credible with both service users and colleagues. Participants also highlighted concerns relating to nurse training not preparing inexperienced nurses for the reality of professional life.

Nurses work in teams and it was apparent that often participants switched to speaking in the third person when they felt uncomfortable, talking in terms of 'we as nurses' or 'nurses will', rather than taking ownership of some of the statements they made in relation to care. This might well indicate their '*fear and anxiety*' in relation to their professional standing or fear of ridicule. Team influences were certainly very evident in relation to professional understandings of spirituality.

"You get a vibe about what's acceptable and what's not and the different ways people work."

Ann

The word 'acceptable' in Ann's statement around team approaches to spirituality highlighted the integrative theme at this point. The word suggested that regardless of Ann's personal thoughts around spirituality or spiritual care she would acquiesce to the team's attitude. She talked about getting a 'vibe' of what was 'acceptable' in terms of spirituality from the team and how this modelled and modified any response or approach an individual team member might take. This acquiescence was mirrored in Brendan's observations that some teams did not discuss spirituality at all and identified a certain secrecy about it whilst other participants talked about spirituality being a 'taboo' subject and said that spirituality was rarely mentioned in team meetings. Many participants described how they feared ridicule from their colleagues as they perceived the weight and credibility of the narrowly defined evidence based approaches took precedence over spiritual considerations.

The third theme nursing spiritually (4.4) considered how the mental health nurses applied their understanding of spirituality derived from both personal and professional experiences into caring for service users. '*Fear and anxiety*' were repeatedly evident in this theme. Fears of 'getting it wrong' featured strongly. This might be in relation to service user care – for example Isabel's account of when she disagreed with another nurse who had told a service user that 'praying was useless' and regretted that she had not intervened. Other participants highlighted how spiritual and cultural expressions might be used as a 'barometer' for assessing a person's mental health presentation: 'getting it wrong' was discussed in relation to misinterpreting spiritual phenomena as symptoms of mental ill-health. Anxiety around imposing personal beliefs also featured strongly in this theme. Some participants discussed situations where nurses imposed their beliefs on service users and expressed concerns that this approach might have conflicted with their spiritual needs. Participants also discussed how a person's diagnosis might have affected the nurse's approach, perhaps because '*fear and anxiety*' were more likely to be engendered in relation to certain mental health needs which were less well understood and more difficult to empathise with. Mental illnesses like affective disorders were perceived as easy to identify with because they were seen as being within the normal range of emotions human beings experience. However, psychosis was less easy to identify with and the nurses sometimes feared their own mental health

might be questioned if they challenged a collective belief about a set of symptoms which were commonly assessed as psychotic as opposed to spiritual. Some nurses reported how they experienced fear and anxiety when they addressed spiritual needs due to professional expectations to adhere to a system based on evidence based nursing practice and narrowly defined ways of working. Some of the participants were concerned about the impact of openly expressing spiritual thought because of the perceived impact on their professional identity. This was not unfounded as a statement made by Harry illustrates. He discussed how he respected spiritual beliefs in service users but described how he would “*take the piss*” (this is a direct example of how one colleague may ridicule another) out of colleagues if they shared certain beliefs, and in the next section I will address the issue of the perceived incompatibility of a standard nursing model with notions of spirituality in in two sections – ‘*Personal fears in relation to the job*’ (4.4.4.2) and ‘*Professional concerns in relation to service users*’ (4.4.4.3).

4.4.4.2 Personal fears in relation to job

Some of the participants expressed very particular fears and concerns in relation to their work. For example, Chris talked about his previous role as a nurse on an acute inpatient ward. He was a big man who worked with a predominantly female workforce and was expected to take the lead in some of the physical aspects of nursing care like restraining or dealing with violence from service users. He described himself as a quiet man and hated this aspect of his role. He disclosed that he left his job after a long period of sick leave because of fears over his physical and psychological welfare.

“I haven’t been there since I left. It still gives me the shivers. I spent half my working life scared. No, no sorry, it just feels like someone is dancing on my grave. So that’s my spiritual need. I need to stay away from that unit”.

Chris

Freya also described a situation during her work as a community mental health nurse where she was afraid for her own safety and described feeling frightened.

“I was scared because he had like knives in the house and stuff and he looked really lost and he didn’t really know what he was doing. He was torn between what’s good and

bad and that was a spiritual need. It made me feel frightened. I was even more frightened when I saw the knives there. He was a completely different human being that I have ever, ever, ever come across. It frightened me so much even getting back into the office I felt emotional. I'm really, really messed up"

Freya

For most participants though, the notion of spirituality raised anxieties in a more subtle way.

"I don't think nurses are as open as they like to think they are and any of us are perhaps self-aware and as comfortable in our skin that we would like to present to the world."

Ben

'Fear and anxiety' manifested almost from the beginning of many of the interviews. As briefly noted in the previous section, some of the participants had researched spirituality ('googled' 'looked up' 'read about') prior to their interview which is evidenced by statements like *"Actually, I've written some things down"* and *"I looked it up after I got the invitation"* whilst others said they wished they had or acknowledged it as an idea. Some participants were concerned that the answers they gave to questions in the interview were the 'correct' responses and looked for reassurance even though the participants were informed in writing and verbally that the study was an exploration of nurses' understanding and there were no right or wrong answers. Many participants often used phrases like *"Is that ok?" "Is that right?"*

"I haven't read up about it though so I don't know if I'll give you the right answers."

Dawn

"I don't know anything about it [spirituality] though so don't ask me owt hard, I haven't read up about it or anything"

Mary

Some of the participants suggested that many nurses deliberately avoided spirituality. Nick offered a possible reason why nurses avoid talking about or addressing spiritual needs based on his experience.

“I think lots of nurses avoided spirituality; through choice or ignorance, because people are embarrassed by it”

Nick

Although spirituality was something participants had thought about, they often did not talk about or avoided dealing with the topic with both service users and colleagues: for example *“Don’t rock the boat, don’t try and provoke by starting a conversation about it”* from Harry or *“I don’t ask people and they don’t ask me”* from Isabel. Joe similarly described spirituality as something he did not talk about – for Joe, spiritually was expressed through means other than talk:

I’ve changed a lot over the years, my thoughts about the world and everything in it. I’ve come into another plane of existence. I’m not a religious person as such, I don’t believe in that concept of a God but there are forces, energies, and that’s how I fit myself into that world. Energies. But I don’t really talk about it. I probably express it through sailing.

Joe

Some participants like Lisa simply felt that addressing spiritual need was not part of a mental health nurse’s professional remit which is why they did not discuss it.

“I don’t fundamentally think that’s my role. If a service user indicates they want to pray I would facilitate them being able to do that or I might call a chaplain down but I don’t think I’m qualified to engage with people purely spiritually”

Lisa

However, it was certainly not just in relation to interactions with service users that spirituality was, what Mary in the below quote termed, a *“taboo subject”* – it was with

colleagues too. Many nurses felt vulnerable when they talked about spirituality because to do so might leave them open to ridicule or criticism from colleagues:

"I don't ever really think about having a conversation with colleagues around spirituality. Certainly about religion or culture but not actual spirituality. It's almost a taboo subject".

Mary

"It's not something we talk about and that's how I find it with most people, because of the intolerance. It's weird that I believe in God because everything I do contradicts."

Harry

A number of other participants indicated that one way to avoid addressing spiritual need was to focus on practical or physical issues because they were perceived as easier to deal with. Chris said *"that can make you feel better then you don't have to mention the religious thing at all"*; Emma felt that nurses felt that it was *"easier to address psychosis and offer medication as opposed to addressing what may be a spiritual phenomenon"*.

"Sometimes the way we treat it is to try and offload it very quickly because it's not our bag and we don't like it. We can't stick a plaster on it so we don't want to know. It's shocking."

Nick

Nick was succinct in his explanation of why people were scared of ridicule *"Some people are incredibly dismissive, some people are embarrassed"*.

Rachael used humour to illustrate her point but the potentially serious professional consequence of disclosing some spiritual belief or phenomena is evident in this quote.

"Can you imagine reading that out in the MDT meeting? They'd just look at me and refer me to the NMC or get out the pink papers [application for admission under the MHA]. It's hard. It's a bit of a taboo, you daren't speak about it. You'd get bloody sectioned or lose your job. I've never really spoke about it"

Rachael

I asked Rachael if she felt comfortable talking about it to me in the interview and she said:

"I feel as if I've had some sort of therapy session. I've got stuff off my chest that I wouldn't dare tell anyone else"

Rachael

Mary also alluded to the possibility her colleagues might think that she had a mental health issue as a result of speaking about her spiritual views;

"Because you're scared that someone will think there is something wrong with you, that you believe that. I don't know It's too hard, turn it off"

Mary

Participants described fear and anxiety about revealing too much of themselves and making themselves vulnerable to ridicule or criticism.

"I think it's a means of protection, creating your own boundaries so you don't find yourself in a position where you're vulnerable to criticism. Because people are frightened to talk about it"

Joe

There was a clear difference between the 'professional' and the 'personal' identity. This was interesting in relation to the point highlighted in the previous 'nursing spiritually' theme – that a genuine connection was needed for spiritually empathetic nursing. Participants talked about a perceived need for secrecy in terms of their spiritual beliefs, and some reported that they would only disclose this aspect of themselves with certain others whom they perceived as sharing or being able to understand their spiritual views.

"I get a feeling for people, you know? There's nothing I'd write down but I can just tell tortured souls"

Olwynn

"I could sit here and tell you about Buddhism but if you don't believe you're not going to carry it with you so I keep it to myself. But I know other nurses who are aware themselves. My mentor was very spiritual and she was absolutely amazing"

Freya

"There was this one woman and I'm sure she was psychic. She used to talk to the nursing assistants and of course the nursing assistants used to ask her if she'd 'seen' anything, you know, on the side. And she was fairly accurate but as a nurse I can't ask her because it's out of the ordinary and you can't act like you believe it"

Emma

"This is her reason for living and her spiritual essence. So how can you support someone and give them what they need. I have to be careful as a nurse. Part of you wants to give as much as you can but you've also got to protect yourself"

Rachael

This section highlighted some of the concerns that the nurses had in relation to their relationships with professional colleagues. Participants reported that the thought of discussing spirituality engendered considerable anxiety and fear in relation to their personal and professional credibility with their colleagues. There was considerable anxiety apparent in relation to how participants felt other nurses might perceive their own mental health as a result of knowing their true spiritual views. The following section will turn to consider nurses' professional concerns but now specifically in relation to service users.

4.4.4.3 Professional concerns in relation to service users

In this section, I will consider how the integrative theme ‘fear and anxiety’ was apparent in discussion of the care of service users. I will focus on two related issues in relation to *‘fear and anxiety’: ‘imposing beliefs’* and *‘difficulties in reconciling the nursing and evidence based approaches with spiritual approaches’*.

‘Fear and anxiety’ in relation to imposing one’s own beliefs could be in relation to imposing either specific religious beliefs or a standardised model of care or ‘wellness’ that was not appropriate for a particular service user. Participants widely expressed the view that imposing a particular set of beliefs on a service user was a bad idea, and were particularly explicit about this in relation to religious belief:

“We have a gentleman who used to work in our place who was a very spiritual person and he used to speak a lot about his views. I can’t remember which specific church it was but he used to tell people how he used to talk in tongues at a service. He doesn’t work here anymore because a lot of the service users asked not to see him again. They were using terms like ‘he freaked me out’ and things like that. Or he was pushing his view on them so I think staff are hesitant about him. I would never push something. I wouldn’t push any spiritual ideas that I had on anybody else.

Harry

“There is a danger with some people of imposing their own beliefs and causing extra distress. Understand them from their perspective, possibly question their beliefs but not impose any beliefs”

Joe

“As a nurse I would be reluctant to impose anything that I believed on them because I don’t see it as my place to impose something you know?”

Olwyn

Whilst some of the nurses stressed their fear of imposing spiritual beliefs, other participants stressed the importance (and difficulties) of 'putting to one side' those beliefs'. They emphasised there was seemingly a need to recognise and acknowledge one's own beliefs whilst avoiding imposition:

"You know you obviously need to know your limitations. To not carry too much with you in your practice and take your own beliefs about religion and judge other people by what they're doing in their lives and that's completely wrong because you're not meant to be doing that as a practitioner. I feel I need to know why and I start thinking about it and then I get anxious because I'm over-thinking things".

Freya

"You are a person who brings all your belief systems, your prejudices and try and pretend that you haven't got them is probably the most dangerous thing you can do as far as I'm concerned."

Kate

Many of the participants described how another 'belief' system – that of evidence based nursing practice following secular western influences often seemed incompatible with providing the type of person-centred spiritual care the service users might need. Lisa, for example, described a conflict between the traditional evidence based nursing approach and what the service user apparently wanted. The service user had been prescribed Clozapine to get rid of her auditory hallucinations. She had experienced auditory hallucinations for many years and had reported that she felt no real distress as a result. However, because she was seen to be floridly psychotic, mental health services had intervened with what they viewed as helping her when in actual fact this was against what she wanted and, according to Lisa, badly affected her 'spirit'.

"We realised that what we had traditionally been doing our entire careers in trying to rid her of these experiences wasn't her goal or her treatment outcome"

Lisa

The situation Lisa referred to was one of a number of examples in which participants discussed how care was affected when nurses felt obliged to use standard medical approaches. Sometimes, accepted treatment approaches might not be congruent with a service user's spiritual, religious or cultural preferences as discussed in the *'nursing spiritually'* theme previously (4.4). Olwyn gave an account of a situation where spiritual and cultural differences caused conflict for the service user and potentially impacted on her treatment and recovery.

"We had a lady whose family felt that she was possessed and they came and did think it was a Jinn, they brought in the Imam and that was really difficult because it seemed like they were making her frightened and that wasn't helping. It was saying the opposite to what we were trying to say which was giving her a double message"

Olwyn

Conflicting views caused issues with approaches to care and this clearly concerned some of the participants. Participants also expressed concern in relation to distinguishing between what constituted spiritual needs or preferences as opposed to symptoms of mental ill health, as highlighted in 4.3 (*nursing spiritually*) previously. The following extracts evidence the uncertainty and anxiety participants described facing when making such assessments.

"I've often seen people's differences and the way they think and approach things I think could be potentially misinterpreted, like people's beliefs being misconstrued and labelled as psychosis or thought disorder, the sense of spirituality does not necessarily mean that's not right or not real for that person. Why does it have to be labelled as some symptoms, some element of mental illness, diagnosis?"

Dawn

"We have problems with things that aren't scientific in our society, we used to be very spiritual in our society but it's moved away from that, then it's very difficult sometimes accepting people's spirituality when you feel that it's damaging the person you want to be helping. If you hear voices in some jungle and you're a medicine man, you're revered as having special gifts from God. Say the same thing here and you get locked up and

pumped full of meds and we say it's psychosis don't we? Who's to say these voices aren't real but they are gifts from God or whatever, it's all so wrong".

Mary

Mary commented above on how *"We have problems with things that aren't scientific in our society"*. Nurses are trained and conditioned to assess in terms of a secular western healthcare models that emphasises evidence based practice. Their fear of ridicule and impact on professional standing (as described in the previous section) means that participants very understandably simply reported that they often defaulted to what they perceived as the expectations of their profession. The spiritually empathetic approach highlighted in the previous theme *'nursing spiritually'* (4.3) was more difficult as it was seen as having no, or limited, empirical evidence particularly when the person presented with psychosis.

"There is no scientific proof if, if you're a person that needs that then you're not going to have any spirituality because there isn't any proof of spirit as I've said before so how do you know it's not a delusional belief? How do we know that all religion isn't delusional?"

Kate

"When you hear people that have maybe been sexually abused as children and they're hearing the voice of the dead person that abused them, who's to say that the person still isn't torturing them? How can we say?"

Rachael

Some of the participants expressed concerns that spiritual needs were not addressed because of *'fear and anxiety'* that doing so might open up issues that were not able to be fixed or even exacerbate an existing problem:

"You could be opening a can of something that you don't really know how to fix. Or it could feed into. I think they're wary about feeding into something that could blow out of proportion"

Harry

Other participants expressed *'fear and anxiety'* around potential dangers of supporting a service user's spiritual or religious expression. Chris described a situation where a service user had been very ill and isolated as a result. During her period of recovery she became a Jehovah's Witness and regularly joined in church activities. As a result of being connected to this group she began to make a significant recovery in terms of her mental well-being. Chris welcomed this recovery but had reservations about how this could be maintained in the light of some of the teachings of that particular belief system and how mental health services could support her spiritual choice but encourage adherence to treatment. The following statement is from that part of the narrative and he talked about the positive social aspects of her new-found group of friends but he was clearly concerned about how the group's spiritual and religious belief might impact on her recovery.

"She's getting out and about with these other people so it's not like she's cutting her off and is just staying at home, she's is getting social contact, in fact she is getting more but if they persuaded her to stop having her medication then I might have to say it's not such a good idea"

Chris

4.5 Chapter Summary

In this chapter, I have presented the findings from my study. I have presented the four main themes which I identified through analysis of the rich qualitative data obtained in the interviews with my participants. The themes I have discussed are: *'Role of spirituality from personal perspective'*; *'Influences on professional understandings of spirituality'*; *'Nursing spiritually'*; *'Fear and Anxiety'*. In the following chapter, I will summarise my findings and discuss how these relate to and further contribute to the existing literature in relation to mental health nurses' understandings of and care for spiritual need.

Chapter 5: Discussion

In the following chapter I discuss the findings of my study in relation to the literature. I have structured this in relation to the three top-level themes and the integrative theme identified from the data.

5.1 Role of spirituality from personal perspective: discussion

This theme looked at participants' personal views of spirituality, and explored how experiences and understandings developed through participants' personal life influences and shaped their current understanding of spirituality. The personal element of this study was something I found particularly interesting. At the start of the interview or even before the interview recorder was turned on many expressed nervousness at participating in this type of research and some of that was to do with never participating in research before. This intensified when the recorder was switched on despite my attempts to keep it as low key as possible but I worked hard to create the type of dialogue that made the participants feel we were having a conversation as opposed to an interview where they felt they were answering questions.

Although I did not specifically ask participants about their family background, many used it without prompting as the starting point to contextualise their current position. Most began to answer the first interview question (*What is your understanding of spirituality and spiritual needs?*) by offering their description of spirituality with comments like "*what spirituality is to me*". It was evident that, for a significant number of participants, defining their understanding of spirituality involved them needing to explain how and why they had developed these views, and their personal histories were described as formative. Family and family religion were reported as having had a strong influence on many of the participants. Eleven out of the seventeen participants identified themselves as Catholic or having had a Catholic upbringing. The other participants either specified different religions or felt the need to tell me they did not follow a religion. All of the participants volunteered this information independently to contextualise their position with regards to spiritual beliefs. However, despite the reported influence and apparent importance of personal early experiences, it was not the case that these experiences

and learnings were simply absorbed and used in determining understandings in later life. Many participants described changing or rejecting their early spiritual learning. Participants also described other important life events which also influenced their understandings of spirituality – for example, bereavement and mortality were reflected on as significant in this context. I could empathise with many of the experiences described by my participants and I used this to sensitively ask the type of probing questions which aimed to elicit ‘real’ responses as opposed to the ‘official’ or the idealised nursing response. This was identified in this study and Jones’ (2016) study of occupational therapists where the participants also talked in the collective ‘we’. King et al (2013) also experienced this type of response and rhetoric from health professionals in research interviews; to overcome this (and to facilitate the exploration of genuine personal lived experience), they developed and used an interview technique known as ‘Pictor’ in which participants create a visual representation of their story by using arrow shaped sticky notes which is then used as the basis for the research interview. Adopting this type of strategy and using an appropriate interview facilitation tool may be particularly useful in research like this where the subject matter may be sensitive to the participants.

As noted above, a majority of participants described themselves as Catholic. Many of the participants seemed to have developed ways to encompass other thoughts and beliefs outside the main values of their Catholic religion. For some, their current behaviour and values had echoes of Catholicism rather than blindly following what they perceived as doctrine. This could cause some recognised incongruity - for example, opinions expressed by Harry were described by him as conflicting with his Catholic upbringing (such as being open to other people’s views, not seeing sex and having children outside marriage as evil, or discriminating against people because of their sexuality). His description of his own stance as ‘deranged’ in some way may indicate he still felt some element of guilt for going against the teachings of Catholicism. He used humour throughout his interview and I perceived this as a cover for the guilt and embarrassment he felt about his beliefs. There was an apologetic tone in his defiance of Catholicism which indicated the conflict he clearly felt about his Catholic background and true feelings. Harry’s friendly demeanour and humorous tone of voice was not apparent in the transcripts and when transcribed, the words he used seemed to have a

harshness that was not evident and clearly not intended in the actual interview. I found Nick particularly difficult to interview as there were limited natural pauses where I could interject or probe deeper. Even when I used my interpersonal skills and took advantage of a rare opportunity, Nick had already re-formulated what he wanted me to ask (rather like a politician) and answered that question instead. My attempts at probing deeper to encourage him to think more laterally were not fully achieved which showed evidence of the concrete nature of his thinking. Nick said he became a 'free thinker' when he decided the Catholic faith no longer helped him connect with the spiritual aspect of himself. His term 'free thinker' hinted on the strong influence Catholicism had on him at that point in his life. Even though he said he was 'free thinking' his actions and approach to service users in his care suggested his current values remained entrenched in his religious upbringing. His thought processes were concrete to the point where when he was asked if spirituality was synonymous with religion and although he said it was not and tried to explain further, he gave a religious example from a Catholic perspective. Koenig (2010) suggested that spiritual beliefs and practices have existed for thousands of years because people use spirituality as a coping strategy. Although participants like Nick, Rachael and Harry described how they had changed their views from that of a strong Catholic framework, the core values of that framework seemingly remained and were evident in their responses. While I found Nick challenging to interview in some respects, in others he was fascinating to me. It appeared that he was anxious for me to understand that he was (in his terms) a free thinker and gave the impression he totally rejected his Catholic upbringing but had no awareness that his views were very much Catholic. Even when I gently tried to unpick his thoughts it was clearly difficult for him to think more widely and although he recognised other religions, spirituality for him was deeply entrenched in religion and not the separate concept described by other participants. I was able to recognise this easily because of my own, close understanding of living with people who have similar faith system and their struggle to fully understand other people's beliefs. Koenig (2013) has similarly noted that spirituality might be affected by a person's spiritual background or culture to the point where it becomes an innate characteristic, and in this study some of these core formative influences were identified through participants' descriptions of their current views on spirituality. For example, Freya talked about using a "*pick and mix*" of what she had learned in school and from others growing up, whilst other participants described how their beliefs had changed but then related them to their current belief systems. The participants

described how their views on spirituality changed and led to the formulation of their own personal moral framework. Koenig (2010) suggested that spiritual beliefs and practices could help people make sense of the world and provide a framework for living which was evident in the personal narratives of the participants. I found there were similarities in the participants' understanding of spirituality and given that so many of them had Catholic backgrounds this was hardly surprising but I wondered if some of their thought processes and views were related to their age or generation. Yet, when I compared some of the points raised by the younger participants, there were no obvious age-related similarities in their responses and age did not appear to be a significant factor in their view of spirituality and spiritual need. Indeed, one of the younger participants (Dawn) had views more akin to some of the older nurses but again they shared Catholic backgrounds. Freya seemed to be an exception because of her free-spirited nature and the lack of entrenched religion in her family influences. Her views were predominantly shaped by school and their wider perspectives on religion and spirituality. I perceived that much of the participants' understanding was influenced by their young background and moreover the influence of their families just as mine had on me. I have already said that my study has taken a limited realist standpoint (section 3.2 page 41) and this is a clear example of how I cannot make a claim for true objectivity, however because of the critical conversations I have had with my supervisory team and my own reflections, I am able to provide a more reflexive analysis to the responses of my participants and therefore provide a discussion which enables my reader to understand potentially relevant issues here.

Although the findings from this study indicate the importance of personal history and experience in understanding how mental health nurses think about spirituality, this issue is not well covered in the existing literature. There are some examples of work in this area where authors recorded religious affiliations from respondents (e.g. McSherry and Jamieson, 2011; Narayanamy and Owen, 2001). However, there was no evidence in any of the literature reviewed which considered how much bearing upbringing had on professionals' current views of spirituality and spiritual care. Even where studies have similarly recorded some information with regards to religious identification, its influence on current approaches to care is seldom discussed in detail (Narayanasamy and Owen, 2001; Corrigan et al, 2003; Koenig, 2010). I have already identified that much of the

available literature has strong Christian influences and as I have found in my study it is difficult to extrapolate this to know if the participants' perspectives can be more widely generalised. I found that many studies on spirituality particularly from the social sciences are based on literature reviews or opinion. Yet the examples of empirical studies (which tend to be from adult nursing or psychology) are again often influenced by Christianity and focus on about what spirituality is and its value in health.

Social and developmental influences, which have not been fully addressed in previous literature, seemed in this study to have an important role in determining participants' current understanding of spiritual care and their approach to supporting service users' spiritual needs. Ashmore and Bank (2001) suggest that self-disclosure is an important process in developing therapeutic relationships. McSherry and Jamieson (2011) categorised their respondents in terms of religion but, in contrast to the present study, explicitly requested this information. As noted above, in the present study, participants volunteered this information independently to contextualise their position when asked about what they understood by 'spirituality'. They also tended to be more specific in their descriptions of their religious affiliation. They did not group themselves under the umbrella term of 'Christianity' used by, for example, McSherry and Jamieson (2011), but specified which type of Christian religion they belonged to (e.g. Catholic, Church of England, Methodist). As participants in this study proffered this more detailed information without prompting, it may be that this more specific classification is meaningful and important to individuals. It seemed to me that many of the participants were eager to have the opportunity to talk about their views on spirituality and I perceived that some looked for validation from me. Many used phrases like 'is that ok?' or 'am I right in thinking?' Their responses to me suggested they thought I was an expert in spirituality and seemed genuinely surprised when I reiterated that all I was doing was exploring what they felt were spiritual needs of service users and I was not able to validate whether their spiritual understanding was 'right' or not. Despite this revelation they were still enthusiastic about wanting to talk to me and having the opportunity to be heard.

Many of the nurses in this study found the word spirituality a complex and difficult term, and for some their talk seemed to suggest they equated spirituality with religion.

Narayanasamy and Owen (2001) suggested that the word spirituality is frequently misused because it is often associated with institutional religions like Christianity, Muslim or Judaism. Some participants in this study said they 'hated' the word spirituality itself or used non-verbal communication like laughing, groaning or body language to communicate their discomfort. The informal nature of the interview conversations where I mirrored their behaviour and language enabled the participants to express themselves in such a way to make them feel more comfortable but it was clear they found it difficult to articulate their understanding of spirituality. McSherry and Jamieson (2010) identified the complexities of the term in their study and suggested that understanding spirituality was difficult because the concept was nebulous and had different meanings to different people. However, I did not perceive that the participants in my study did not understand spirituality and spiritual needs, but only had difficulty or embarrassment in expressing that understanding. Some type of interview facilitation approach akin to the aforementioned 'Pictor technique' used by King et al (2013) and Brooks and King (2014) may have helped alleviate some embarrassment by encouraging the participant to focus on the pictorial representation of their thoughts and feelings. I would suggest this is a strategy that may be used in similar future research.

Whilst some of the participants in this study used the terms religion and spirituality synonymously they could also identify the terms as separate concepts, although many found this difficult to articulate. Many of the participants talked 'around' spirituality and described qualities or distinct features they associated with spirituality and spiritual need. The terms meaning, purpose and connection were commonly mentioned by participants in the current study. Jones (2016) conducted a concept analysis of spirituality in relation to Occupational Therapy practice and concluded that it was easier to describe spiritually competent practice than to define spirituality itself.

Jones's (2016) description of 'spiritual competence' from her observation of the participants in her research showed some similarities to the challenges met by the participants in this study. The term 'spiritual competence' arose in response to the efforts of policy guidelines and professional codes of conduct to standardise and embed spirituality in practice (Jones, 2016), with similar issues to those faced in nursing. Whilst

this type of standardisation may satisfy policy and professional guidance it can also be seen as a restrictive approach to a very personal issue.

Rogers and Wattis (2015) modified Jones' description to make it applicable to other health care professions:

“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 practising with cultural competency”.

Wattis et al (2017, chapter 1) suggested that there were three essential components to spiritually competent practice: spiritual competencies; (delineated in nursing by van Leeuwen et al, 2004), compassionate motivation and opportunity which was provided by the work environment to a greater or lesser degree. The participants in my present study described how a team approach could help meet the spiritual needs of service users which could be regarded as one way of providing the ‘opportunity’ element of spiritually competent practice. Participants also possessed compassionate motivation, in some cases sustained by a supportive team spirit; but, as reported by others (e.g. Narayanasamy, 2001; Koslander and Arvidsson, 2006; McSherry and Jamieson, 2011), found obstacles in the workplace related to lack of time and the way work was organised which reduced opportunities.

Rogers and Wattis (2015) acknowledged that a person is a ‘*unique spiritual being*’ and then suggested that a spiritually competent practitioner ‘*will provide a sense of meaning and purpose*’ and ‘*reconnect them with a community where they experience a sense of wellbeing*’. Some of this statement may be seen as an example of what I termed as a ‘pragmatic approach’ which may work well for someone who has specific religious needs but not for a person who needs the subtleties of the transcendent qualities of spirituality.

Whilst working on this study I had many discussions with my supervisors about the concept of 'Spiritually competent practice' and feel it is the word 'competent' that is problematic for me particularly when used in relation to mental health care. The term 'Spiritually competent practice' may strike more resonance in occupational therapy or in the adult field of nursing which is often task orientated (unlike mental health nursing and some health and social care services). Having said that, the NMC and government approved directives embrace the concept of competency driven approaches including mental health nursing and this may be a way of introducing a standardised approach (favoured by many health professionals) to meeting the spiritual as opposed to the religious needs of service users.

Superficially, 'spiritually competent practice' does not appear to embrace what I have termed 'spiritual empathy' or the seventh sense of knowing described by Humphrey, (2008) because it suggests that those who are deemed not to be 'spiritually *competent*' are therefore spiritually *incompetent*. However, spiritually competent practice involves what Rogers and Wattis term 'compassionate engagement' which is akin to what I have called spiritual empathy. Spiritual empathy or compassionate engagement has more affinity in mental health as it holds the concept of recovery which does not seek to 'fix' a problem but empowers the person to use their own 'toolkit' of which spirituality may be part. To be spiritually empathetic (or compassionately engaging) embraces the uniqueness of the individual and supports their ability to strengthen their own position to improve or maintain their mental wellbeing.

Rogers and Wattis's stated that spiritual competence requires the practitioner to be 'accepting' of a person's belief and values. In this particular context I understand that 'acceptance' was intended to be akin to the 'unconditional positive regard' that is a central tenet of Carl Roger's work (1961). However, I would argue that 'accept' may also be understood as a synonym for 'tolerate' and this alludes to the possibility of (perhaps tacit but nonetheless present) disapproval. 'Acceptance' in this narrower sense suggests that the practitioner may hold one set of values whilst recognising there are others which need to be tolerated, whereas a spiritually empathetic practitioner has a natural affinity with other spiritual beings regardless of the differences and therefore understands as opposed to accepts. To try and explain this type of 'acceptance' further

is in the way the majority of people 'accept' there are a minority of people with mental health needs. However, there is a disconnect between the two and the minority are accepted but never truly belong to the majority which is generated by ignorance and misunderstanding creating the type of stigma feared by my participants. This could be further explained in terms of '*Cultural Competence*'; a term also used by Rogers and Wattis (2015). Gilligan and Furness (2006, p1) wrote "*culturally competent practice depends, amongst other things on an understanding and appreciation of the impact of faith and belief*". To 'accept' a person's spirituality requires no real understanding, merely an acknowledgement of its existence. Therefore, in the context of 'spiritual competence' the term suggests the person may have 'mechanical' knowledge of the person's religion or spirituality but may not 'understand' the experience of living spiritually which arguably makes them incompetent at some level.

The term 'spiritual competence' may be useful in achieving the aim of the recommendations policy and professional standards to address religious and spiritual needs, but the term 'competencies' suggests that these competencies can be described (as by van Leeuwen et al, 2004) and may even be 'assessed' or measured in some way. It may be possible to measure the spiritual competencies of the practitioner to fulfil the pragmatic mechanics of assessing and supporting religious observation (McSherry, 2011). However, the spiritually empathic approach 'connects' (compassionate engagement) with another at a transcendent or idiopathic level and this has limited measurable qualities (Swinton, 2006). Bregman (2006) identified that for some people, the spiritual ideal lies outside religious practices but spiritual transcendence may be achieved in other ritualistic practices for example meditation, martial arts and music. Humphrey (2015) said for some, earth-centred transcendence may involve a person's struggle to survive, relate to the world, others and to craft and maintain what is important to them.

Humphrey (2015) wrote that academics and practitioners hide behind 'grand narratives' of spirituality which is often 'Christianised' and may prejudice research. Bregman (2006) also discussed the Christianisation of the word spirituality and described its use as a way to increase hospital chaplains "customer base" in the diminishing Church membership. This comment may have been made 'tongue in cheek' but there remains a

paucity of literature and research that is not strongly influenced by Christianity. I have already identified the high number of Roman Catholic participants in this study which has mirrored these and other Christian influences in health and social care research (e.g. Swinton, 2006; McSherry and Jamieson, 2011; Humphreys, 2015) and this will be further discussed as a 'limitation' and 'suggestions for future research' later in the thesis.

Humphrey (2015) identified that some protagonists (like policy and professional guidelines) assert the importance of spirituality to fulfil the needs of what may be a minority of people whose spirituality is a significant part of their life. Yet, there is a real possibility (highlighted in my present study, by the identification of fear of imposition) that spirituality may be imposed on everyone particularly if standardisations like 'spiritually competent practice' becomes part of mainstream policy. However, Wattis et al (2017) argue that the point of identifying spiritually competent practice (as something other than mere 'spiritual competencies') is to stress the need for compassionate/empathetic understanding on the part of the practitioner AND the organisation of healthcare in a way that facilitates a compassionate/empathetic approach to issues of meaning and purpose to live.

My findings suggest that encouraging mental health nurses to use their skills and the skills of their colleagues either pragmatically or spiritually empathetically may be more useful for service users and practitioners. This poses a challenge as, the integrative theme of fear highlighted by the participants in my study, showed that many nurses 'defer' to policy and professional expectations despite their true beliefs and also sometimes at the expense of what they believe to be needed by the service user. Given the acknowledged pressures on nurses generally and the evidence of fear provided by my study, quantifiable aspects of care like 'spiritually competent practices' may be easier for them to follow (Greasley et al, 2000). Rogers et al (2017)

Participants discussed spirituality in terms of being part of other understandings like compassion, humanistic and person-centred care, reflected in Barker's (2001;p 238)

work around The Tidal Model which emphasised the need for the nurse to use “*extraordinary courage and compassion*” to deliver effective care.

The difficulties expressed by participants in this study in relation to the concept and term of ‘spirituality’ reflect issues in the wider literature. In healthcare alone there are numerous definitions. Reinert and Koenig (2013) identified over twenty concept analyses in the last twenty years, and Unruh et al (2002) found ninety-two definitions in the Occupational Therapy literature, suggesting a lack of clarity in this area. In chapter two, I described the existing literature which addresses the difficulties of defining spirituality and described many definitions (Ellison, 1983; Narayanasamy, 1991; Benson et al, 2003; Cook, 2004; Tanyi, 2002; McSherry et al, 2004;). Swinton (2001, p12) described spirituality as a “*slippery concept*” within Western culture and said that whilst many themes are common there is not a single definition which fully captures what spirituality actually is. It is hardly surprising that the nurses interviewed in this study found it difficult to articulate and specifically define what spirituality was.

The nurses found one of the best ways to explain spirituality was to describe the qualities they felt were integral to spirituality or to relate it to religion which some seemed to find easier. Whilst spirituality itself was difficult to define, its relevance to the participants on a personal level was evidenced in their narratives. Many of the participants ‘picked out’ certain qualities from their descriptions of spirituality which they felt was applicable to them personally and key elements like core values, hope, meaning, purpose and connectivity were strong features. The sense of pragmatic and spiritually empathetic nursing approaches identified in the third theme (4.4 *‘nursing spiritually*) was evident here but implicitly rather than explicitly. These approaches will be discussed in detail later in this chapter, but it is worth noting that the nurses’ early influences appeared to contribute significantly to their understandings of spirituality and to their approaches to their professional role.

5.2 Influences on professional understandings: discussion

The second theme was *'Influences on professional understandings of spirituality'* (4.3) which identified ways in which participants described their understanding of spirituality having been influenced or changed by their nurse training, professional expectations or colleagues.

Nurses and midwives in the United Kingdom are required to successfully acquire competencies set by the Nursing and Midwifery Council (NMC) which is the regulator of nurses and midwives in the UK. The NMC is responsible for maintaining and setting standards to ensure that nurses and midwives keep their knowledge and skills up to date. They also provide mandatory guidance for partner organisations like universities to design and develop education programmes. Pre-registration education requires student nurses to successfully complete 2300 hours of theory (facilitated in university) and 2300 hours of practice which is facilitated in practice placement areas. Whilst in practice placements the student mental health nurses are supported by nurse 'mentors' (qualified nurses who have successfully completed a post registration nurse education module in addition to their degree in mental health nursing) (NMC, 2016). Many of the participants talked about their experiences during either their pre-registration or continuing professional development courses and described how this had influenced their thoughts around spirituality. The nurses had varied experiences and much of this depended on the skill of their mentors in practice placements. Some of the nurses described how they changed or questioned their personal views on spirituality as a result of their nurse training. As a mental health nurse, I have also had to undergo the type of mental health nurse education experienced by many of my participants. I have had very similar experiences in terms of the variety of skills of mentors and university educators as described by my participants. Although I have not consciously changed my personal views on spirituality, I have like some of the nurses in this present study changed my behaviour in relation to what I would be willing to share from a professional perspective and the application of my understanding in practice.

As discussed in chapter two, the Royal College of Nursing (RCN) commissioned a survey on spirituality (RCN, 2010). McSherry (2010), who conducted the study on behalf

of the RCN, concluded that addressing spirituality had the potential to improve quality of care but noted that respondents felt they had little guidance or support to enable them to confidently deal with the spiritual aspects of care and called for more education in this area. The results of the present study which was specifically focused on mental health nurses reflected some of the findings in the RCN survey although some participants did report having received some input in their training around spiritual aspects of care. Such input was often described as being in relation to another concept like holism or compassion. The Chief Nursing Officer's (CNO) review of mental health services (2006) recommended that mental health nurses address the spiritual needs of mental health service users and also utilise approaches such as holism and the recovery model. The mental health nurses in this study indicated that mental health care and education was designed and modelled around recovery based approaches but this did not always translate fully into the care setting. As noted in my earlier review of the literature (chapter 2), recovery models like the 'Tidal Modal' are based on a concept of holism in which spirituality is a key component (Barker, 2001). I have already identified that some of the participants in my study had a problem with the word 'spirituality' and perceived that the issue was around the connotations of the word and not with the values often associated with it like hope, meaning and purpose. Spirituality seems to have more ethereal quality that many people seem to struggle with but terms like hope, meaning and purpose are more widely used words, less contentious and therefore easier for many people to accept and discuss. The concept of the words hope, meaning and purpose to me seem less personal than spirituality because they are things that the majority strive towards and the issue of transcendence or God is not necessary.

McSherry and Jamieson (2013) found that, despite an increased interest in spirituality and healthcare, nurses were still not confident about addressing spiritual needs in patients and service users. This was reflected in the findings of the present study where many of the nurses indicated that, despite all the recommendations and guidance, they remained confused about the concept of spirituality and what this meant in healthcare. It was apparent from their responses that there was a dichotomy between what they viewed as spiritual from a personal perspective and what they believed was expected from them in their professional role. The confusion between their personal and professional perspectives might have developed during training when narrowly defined

evidence-based practice approaches were taught in terms of nursing care. This reflects the findings of Narayanasamy and Owens (2001) who also described confusion over the concept of the nurse's role in relation to spiritual care. McSherry and Jamieson (2011) similarly suggested a lack of confidence around nurses' understandings of how to address issues of spirituality in care, and called for further education around spirituality and spiritual need. For me the lack of confidence and confusion did not manifest itself in terms how the nurses personally understood and recognised spiritual need in others. The passion for the value of spirituality was evident in the face to face interviews that was sometimes difficult to discern from the transcripts. Their issue was how they could apply their understanding professionally. If they had felt 'allowed' to approach someone's spiritual needs without the worry of repercussions or effect on their professional standing, then I think they would have felt more confident and competent in addressing this aspect of care. I perceived it was marrying the two perspectives together that caused the internal conflict between their personal and professional views. The call for education was a request for advice on how to bridge the gap without fear of getting it wrong which featured highly in the integrative theme.

Rumbold (2007) discussed spirituality and healthcare and described models of care which included social, nursing and medical approaches. He asserted that whilst healthcare models were designed to be complimentary, the biomedical model remains predominant. Davies and Roache (2017) suggested that psychiatry (including mental nursing) sits uneasily between biological and psychosocial perspectives in relation to mental ill health and is under pressure from the biomedical model (which classifies mental disorders as diseases) to conform. The nurses in this study reported that mental health nurse training in university (which purported to be holistic and recovery based), felt similar pressures and actually focused on evidence-based practice (with 'evidence' drawn mainly from empirical studies with classic quantitative research designs). This type of education forced the students to rethink the social knowledge and values they had prior to nurse training. Even in placement areas they were exposed to the narrowly defined 'evidence-based practice' influences in care. The participants often spoke from this perspective. Some nurses even reported how they had questioned or changed their belief systems as a direct result of their nurse training. However, during the interviews and in order to explain their thoughts further, the nurses included their family

perspectives and personal views which were based on experience of 'real' life rather than 'scientific' evidence-based practices. Although literature like Rumbold (2007) and Davies and Roache (2017) emphasised the dominance of the medical model, I heard some of the nurses describe how their medical colleagues also battled against the same pressures, which suggests they may experience similar challenges towards meeting spiritual care needs as nurses or other social care professionals. As a mental health nurse I observed my medical colleagues work hard with nursing team members to accommodate service users individual spiritual needs, some of which I have already highlighted in the introduction of this thesis which helped to inspire this study.

McLaughlin (2004) suggested that the concept of spirituality was difficult to address in mental health care because of the scientific nature of healthcare as opposed to the artistry of spirituality and that nurses needed to find a way to incorporate the two which the nurses in this study said they found particularly difficult. Koslander and Arvidsson (2006) who conducted a study which included service user views on how their spiritual needs were supported indicated many mental health nurses lacked an understanding of spirituality and spiritual need. However, the results of the present study suggested that mental health nurses did have an understanding but were reluctant to share their thoughts with others, particularly in the work place. The narratives suggested that spirituality was almost a *"taboo subject"* which was a term that was highlighted by Swinton (2001) and some of the nurses in this present study. There was however certain defiance by some of the participants who reported that although they had experienced difficulties, it was possible sometimes with a pocket of like-minded colleagues to talk freely – this was described in terms of a sense of 'knowing'. I understood from the interviews that the sense of 'knowing' is difficult to communicate to someone who does not 'know' and was described as a special type of eye contact, body language and facial expression that communicated this 'knowing' to empathetic individuals (discussed further in section 5.3). Some of the participants described recognising this sense of 'knowing' between themselves and other colleagues or even service users. I perceived it almost like a secret club (and a taboo subject as Swinton, 2001 highlighted) and only talked about in secret meetings or cryptic conversations. Kate talked about an interaction with a service user who recognised her ability to 'know'

and despite trying to deny it and hide behind her professional standing was unable to convince the service user that she had no understanding of what she meant.

The role of the team and the influences from the nurses' colleagues were evident in the narratives (4.3.2). Some participants talked about their teams and how decisions about service users' care were made collectively. This was sometimes at odds with their personal beliefs yet participants described how they acquiesced to the thoughts of the team rather than put forward their views. This was not in keeping with Narayanasamy and Owens (2001) findings that nurses who described themselves as having a spiritual or religious affiliation were more proactive in facilitating spiritual care. Nurses in the present study, who were not specifically selected as describing themselves as having a spiritual or religious affiliation, prioritised team collective beliefs. Some of the nurses were asked why they had not been more assertive and indicated it was because they were concerned about the possibility of being wrong or ridiculed by their colleagues. It is likely that when participants were talking about their teams these would have been multidisciplinary including social workers, occupational therapists and doctors, with doctors often taking a dominant role. It seems not unreasonable to suggest that, for these professionals too (and whilst acknowledging other models of care) the scientific evidence based approaches features highly and this had influenced the nurses' attitudes to spirituality and each other. This, or selection bias, might account for the nurses in this study not appearing to be as proactive in supporting spiritual needs on an individual basis as the study by Narayanasamy and Owens (2001) inferred.

The CNO review (2006; p2) recommended "Mental health nursing needs to move away from a traditional 'medical model' of care and adopt a bio-psycho-social approach"; an approach which still does not explicitly feature spiritual need and resulted in nurses calling for more clarity in relation to the definition of the role of the recovery models. Rumbold (2014) suggested that traditional 'medical model' understandings of health may dominate when their capacity to treat (and/ or cure) disease is most apparent. The term 'disease' is not necessarily as fitting in mental health care because of the diffuse nature of the mental health service users' clinical presentation. The bio-psycho-social approach was first advocated by Engel (1977) as an alternative to the biomedical model for psychiatry and medicine more generally (Engel 1980). It has become central to

psychiatric practice in the UK (Davies & Roache, 2017). Though the bio-psycho-social model stops short of addressing spiritual need directly, it does move beyond the reductionist disease-focused approach of the more traditional biomedical model. The medical model is much maligned, particularly in nursing and social care literature. The term 'medical model' is identified with what may be seen as a misrepresentation of the evidence-based medicine approach. This tends to privilege knowledge of the kind derived from quantitative science (especially the ubiquitous double-blind randomised placebo-controlled trials) and does not consider the important interpersonal, person-centred care provided by many doctors and other healthcare professionals which was part of the individualised approach favoured by Sackett (1996) one of the originators of the evidence-based approach (Sackett et al, 1985).

Wade and Halligan (2004) suggested that the bio-psycho-social model's approach drew attention to the biological, sociological and psychological aspects of the person whilst holism expands this to other aspects like free will, identity, quality of life and spirit. McSherry and Ross (2014) asserted that holism's founding principles were based in the core values of nursing such as compassion, dignity and respect but warned that there was a danger of losing focus because of the increased demands in contemporary nursing.

What is also evident from the findings of this study is that nursing teams are often accepting and proactive in dealing with the spiritual beliefs of service users but are less tolerant of their 'educated' colleagues. Swinton (2006) said that science should learn to accommodate new perspectives for phenomena like spirituality to develop therapeutic understandings and to be comfortable with uncertainties. The findings here indicate that individual nurses are comfortable with the uncertainty that surrounds spirituality on a personal level but secular evidence-based practice approaches which dominate mental health care make it difficult for this personal comfort to be openly discussed in the wider team. However, the upsurge of recent interest in spirituality which has been evidenced by the unprecedented response to the RCN (2010) spirituality survey and the findings of other (often qualitative) research like the present study, indicates that the tide is slowly turning

5.3 *Nursing spiritually: discussion*

The findings identified two broad approaches to spirituality and I described them as pragmatic and spiritually empathetic (4.4.1). The pragmatic nurse tended to talk in a sense which focused on very practical aspects of nursing spiritually – for example, on ways of providing the service user opportunities to practice their religion. Narayanasamy and Owens (2001) conducted a spiritual incident study (which included all four fields of nursing) on how nurses responded to the spiritual needs of patients and described this type of spiritual care as ‘procedural’. Elliott (2011) also emphasised how nurses found it easier to address spiritual needs simply in terms of religion. This was evident in many of the mental health nurses’ narratives in the present study when they described how they facilitated religious practices. Greasley (2000) suggested that this might be because of the procedural cues found in formal nursing assessments that mental health nurses are required to facilitate. This can be viewed as symptomatic of the evidence-based culture which called for easily measurable and observable care results which may overshadow the spiritual element of holistic care. Swinton (2001) suggested that when spirituality is primarily defined in religious terms it made it relatively straightforward for a nurse to evidence how spiritual needs were met. This was reinforced by the nurses in the present study when they described their care services’ facilities like prayer rooms or provision of religious artefacts. Participants in this study talked about how they felt pressured at times by their professional expectations to adopt the pragmatic approach and they recognised this may have been a missed opportunity to fully support a service user’s spiritual needs. Swinton (2001) went on to say that if spirituality was only viewed in these terms, significant spiritual needs, experienced by people who do not adhere to an institutional religion, might be missed. Accounts given by many of the nurses in this study included talk about how spiritual care was ‘evidenced’ and how they were conditioned into a ‘tick box’ mentality.

In contrast nurses adopting the spiritually empathetic approach recognised that the pragmatic approach might not fully address the spiritual needs of a person (Swinton, 2001) and that the spiritual aspect was distinct from religion, reflecting Baldacchino and Draper (2001), who categorised spiritual coping strategies in terms of ‘believers’ and ‘non-believers’. They suggested ‘believers’ defined spirituality in terms of religion and a belief in God and said their needs were relatively easily facilitated whereas ‘non-

believers', described as agnostics, humanists and atheists, could find their spiritual needs being neglected. The participants who most used the spiritually empathetic approach in the present study discussed the so called 'non-believers' aspects of spirituality in terms of hope, meaning, purpose and connectivity. Connectivity as understood by nurses in this study included connection to the physical: the world, nature, people, and the metaphysical: a higher power, spirit, soul or mediumship. Adopting the values of spiritually competent practice (discussed in section 5.1 page 145) may help to bridge the gap between the 'tick box' pragmatic nursing requirements and the nebulous qualities of the spiritually empathetic approach.

Many of the participants also spoke of this approach in terms of an 'unspoken' acknowledgement and recognition of a spiritual connection with the service users and other like-minded colleagues and described it as a sense of 'knowing'. Swinton (2014) suggested that there are two forms of knowledge: 'nomothetic', obtained by science (narrowly defined) as in the evidence-based practice approaches described in the narratives. This is the type of knowledge taught in nurse training and favoured by the nurses in this study who preferred a pragmatic approach. 'Ideographic' knowledge, however, recognises experiences which may only occur once and are unique to that person at that time and in that place, but are no less significant or factual even if the knowing may not be generalisable or replicable. This type of knowledge or understanding can be more related to the participants' personal understandings which were developed from all the influences they experienced in their pre-nursing life (perhaps then before the emphasis on evidence-based practice) and in their personal lives. This 'ideographic' sense of knowledge may then be translated into how the spiritually empathetic nurse approached spiritual needs of service users. Humphrey (2008) described this sense of knowing as the 'seventh sense' which is the way a person can 'know' the spiritual connectivity of another person which is beyond average human communication and described by many of the participants in this study in their use of terms like *'light in their eyes'* and references to connecting with a person's *'spirit'* or *'spirit loss'*. I identified strongly with this description of 'knowing' and I recognised similar situations from my own experiences both as a nurse and a lecturer. I have had many 'secret' conversations and non-verbal interactions with colleagues, service users and colleagues that I would not be overly willing to share with people who did not

experience the same 'seventh sense' but could possibly why so many of the participants were so willing to share their personal thoughts and feelings on a difficult subject.

The findings identified that although many of the nurses had a preferred approach in terms of being pragmatic or spiritually empathetic they were rarely exclusive. Some of the nurses described how they could adjust to the other method or at least recognised its value in relation to the service user. Nurses who had felt uncomfortable responding in their non-preferred way reported having referred service users to another member of the team or religious leader who they felt would be best placed to provide that level of spiritual support. Therefore, it could be argued that they had successfully addressed the spiritual need of that service user, albeit by proxy. Baldacchino and Draper (2001) concluded, from a review of the research literature on spiritual coping strategies, that nurses providing holistic care should work with the multidisciplinary team, including hospital chaplains, and aim to facilitate patients' coping strategies to safeguard the wholeness and integrity of the patients.

I have previously discussed how the nurses in this study indicated they were required by professional expectations to facilitate standardised initial assessments. The nurses described these assessments 'at the onset of care' in the respect that they were designed to obtain as much information as possible about the person. These were supposed to be holistic in nature and take into consideration all aspects of the service user which was also recommended by Barker (2001). The nurses in this study felt the spiritual aspect of the person was often limited to their religious beliefs. Despite this, taking a religious and spiritual history was highlighted by the mental health nurses in the study as being one of the main factors which influenced their approach to the service user. Even those nurses who generally preferred the spiritually empathetic approach said that facilitating an assessment of the service users' religious and spiritual history was their main starting point. Swinton (2001) argued that talking about religious beliefs could access important aspects of a person's mental health depending on the significance of their meaning to that individual.

The nurses who said they felt that the religious and spiritual needs of the service user were important starting points rarely described how they would explore these further or how they could be used to support their recovery. Narayanasamy and Owen (2000) reported that the nurses in their critical incident study were more inclined to initiate spiritual or religious care if the patient expressed interest or involvement in such practices. They went on to conclude that this would foster a mutual feeling of Trust between service users and nurses. Their study included mental health nurses but the examples offered were mainly from an adult nursing perspective which clearly focused on biological health issues and was therefore more of a pragmatic than a spiritually empathetic approach.

The results of the RCN (2010) spirituality survey suggested that nurses see spirituality as an essential component of nursing and that this aspect of care should be integral to their duty of care, however the survey was not mental health specific and many of the examples used were again from a general nurse perspective. Although the findings of the present study also suggested that the participants felt spirituality was an important aspect of care, there was clear difference in the emphasis of how spirituality was assessed and what it meant to a person's treatment or recovery. The findings of the present study showed there was also a strong undercurrent from the mental health nurse perspective that the service users' expression of spiritual need could be used as a "*mental health barometer*" of deterioration or recovery. The participants reported incidents with service users which involved a lack of Trust or situations where spiritual care was destroyed as a result of their expression of spiritual needs: for example in one account where a service user accused nurses of "*taking her soul away*" and another interview in which a service user was described as "*frayed at the edges*". This sense of disTrust between the mental health nurses and service users in this study conflicted with the findings of the RCN (2010) spirituality survey. There are important differences in the meaning of spirituality in care between the two disciplines (adult and mental health nursing) where the adult nurses clearly said that addressing spiritual needs helped or comforted a person yet the mental health nurses in this present study said an expression of spiritual need might be viewed as evidence of deterioration. Koenig (2010) described the issues faced by mental health professionals, including nurses, when spiritual needs are considered. He said that although spirituality offers hope,

meaning and comfort in times of adversity, when the context is a mental or emotional disorder religious and spiritual beliefs can become entangled with that disorder and it is then difficult to decide whether those spiritual beliefs are supporting a person or are a liability. In the university I work closely with colleagues who are nurse educators from general adult nursing backgrounds, so I have a good understanding of the emphasis on different needs and the adult nursing values. Adult nurses do not often need to consider a person's mental health state when addressing their spiritual needs and so spiritual needs may be viewed more valuable to health in terms of recovery. As a mental health nurse, I experienced some of the dilemmas described by the mental health participants in this particular study and so empathised with the entanglements of values between supporting spiritual need and assessing a person's mental health or ill health as the case may be. As a nurse educator, I have a responsibility to support the student nurses to unpick some of their thought processes around this issue and encourage them to address not avoid these difficulties (see implications and suggestions section 6.4 page 179).

It was clear that the mental health nurses participating in the present study approached the expression of spiritual needs differently depending on the diagnosis attached to the person. A disorder which the mental health nurse could easily empathise with, like depression or anxiety, was more likely to result in spiritual needs being taken at face value, whereas a service user who experienced psychosis was more likely to have their spiritual expression seen as a symptom of their disorder. Koenig (2010) examined what spirituality meant in relation to people who experienced mental disorders such as depression, anxiety and substance misuse. Other mental issues, (which often include psychotic features) were not mentioned in this paper though elsewhere Koenig et al. (2012, p207-222) have discussed the issue of religion/spirituality and psychosis in some detail. In the present study the participants clearly described the challenges of supporting spiritual needs in service users who experienced florid symptoms of psychosis. Koenig (2010), like Swinton (2006) considered that spirituality might offer support and comfort but also highlighted situations where a service user's spirituality might have exacerbated their issues in terms of feelings of guilt, hopelessness and failure.

Findings from the present study suggested that, if a person was assessed as psychotic, their expression of spirituality or spiritual need was more likely to be interpreted as symptomatic of disease. I have already highlighted this issue in the introductory chapter in my story about Abdul. It is not unreasonable to draw the conclusion that this seems less likely to happen in other fields of nursing where such expressions were not generally assessed in relation to diagnosis or treatment outcome. Rumbold (2014) asserted that whilst spiritual belief might be important to a person, what mattered to the healthcare provider was how this contributed to clinical goals. This was reflected by the concerns expressed by the mental health nurses in the present study and highlighted the difficulties mental health nurses experience when trying to address the spiritual needs of service users.

There is little if any mention in the literature about how the mental health '*care setting*' (4.4.2.3) affected how spiritual needs were met. Much of the literature, like the research conducted by Narayanasamy and Owen (2000), in their '*critical incident study of nurses' responses to the spiritual needs of their patients*' viewed care setting in terms of groups of people with similar diagnosis but their examples were mostly from an adult general nursing perspective. They discussed how nurses responded to people who experienced a diagnosis of cancer, other chronic debilitating illness or accident. Many mental disorders, like the ones described in this present study which included psychosis as a primary feature, could also be classified as being chronic or enduring in nature but unlike patients with physical disorders, the findings of the present study indicated that some specific care settings and system considerations in mental health could present additional barriers to good quality spiritual care.

The present study identified issues related to the different care settings which included the physical environment where mental health care took place as well as the type of service offered. The RCN (2010) survey talked about the 'provision of spiritual care' but only in relation to the nurses' perception of what was seen to be good spiritual care and not restrictions that might be imposed by the 'care setting' itself.

The mental health nurses who worked in inpatient acute and or forensic services described similar issues, for example 'locked door' security and the legal restrictions imposed by the MHA or court orders. Corrigan et al (2003) conducted a study on *'religion and spirituality in the lives of people with serious mental illness'* and suggested that, despite little research in this area, spirituality and religion could play an essential role in a service user's recovery. However, the results did not mention the logistical challenges mental health nurses experience in supporting people who are admitted to inpatient services. Swinton (2006, p128) suggested that *'worship'* and *'church community'* was an important source of hope and meaning for people - however, the mental health nurses in this study described how difficult it was to facilitate church attendance or even attendance at the hospital's multi-faith room because of staffing levels, MHA or court restrictions and the location of the faith centres. Resources in relation to staffing levels were highlighted as having a perceived negative impact on how the mental health nurses in this present study felt they could facilitate spiritual care needs and some said that spiritual care could have been improved if more staff were available. This issue was also identified by Swinton (2006). He suggested that where it was difficult for a person to attend a Church or faith centre, spiritual comfort might also be enabled by providing symbols of faith like holy books, music or other artefacts. These strategies were described in the narratives of this present study indicating that the mental health nurses were spiritually sensitive to the needs of their service users. Despite the challenges of the secure environments, they worked towards providing as much as they could to meet the spiritual needs of service users which included those with more complex mental health needs. When listening to the participants accounts I picked up the sense of frustration at the system from some of the participants. The secure environment is by nature very restrictive but some of the nurses described incredible efforts to ensure the needs of the service users were met. That said I also gathered there was a great deal of respectful acknowledgement that the system they found frustrating was also there to protect them, the service users and the wider public. There was no way they wanted to compromise the security but that did not mean they would not take it to its limit to best serve the people in its care which I found heart-warming.

Although the mental health nurses in this study who worked in community and rehabilitation services also worked within MHA restrictions and low staffing levels, their challenges were different to those faced by inpatient services. Here the participants described how they managed challenges or influences from faith groups which the service user welcomed but could cause concern for the mental health teams. Whilst McLaughlin (2004) found that people who said they were spiritual had better outcomes in relation to recovery, some narratives in this study suggested that it could also make them vulnerable. One of the vulnerabilities identified in this present study included the risk of coercion from individuals within a 'faith group' who might encourage a service user to disengage from services. Other identified risks included some of the beliefs and practices expected of that faith which may have contradicted the recommendations of mental health professionals in terms of keeping the service user safe and well. However, the narratives also suggested that the faith groups offered a level of support that mental health services could not offer in terms of empowerment and social inclusion. This was also identified by Corrigan et al (2003). This type of situation created delicate situations for the mental health nurse to manage to maintain the requirements of the mental health service whilst including the positive benefits of the faith group. I perceived that the nurses who spoke about the influences of faith groups would have welcomed the opportunity to work with the groups even the one which Harry was dubious about but service user confidentiality requirements would not facilitate this. The participants spoke with respect for what the faith groups were able to achieve like their acceptance and value of people who had clear mental health needs.

The findings described how the nurse or team managed the specific requirements of the mental health 'system' so that they could '*nurse spiritually*'. During their narratives, the participants often described how they had to attempt to reconcile individual service user's spiritual needs with overarching system requirements which frequently conflicted. Some of the participants described times when they could identify that spiritual needs of service users were not met and suggested that this was at least partly due to a lack of guidance in terms of how spiritual needs were assessed. Swinton (2001) asserted that guidance for health professionals generally was limited in this area because the qualities of spirituality made it intangible. This threatens credibility when working in a culture where a narrowly-defined evidence-based practice approach is privileged over a

more personal approach. The present study also found that, perhaps because of a lack of guidance and confusion over the various definitions of spirituality, nurses remained hesitant about addressing spiritual needs. They sometimes relied on specific assessment tools rather than person-centred holistic approaches advocated in recovery models like 'The Tidal Model' (Barker, 2001). The nurses described how they relied on 'tick boxes' or waited for service users to openly express their needs without encouragement.

The call of Greasley et al (2000) for mental health care to adopt a more holistic approach with less emphasis on the more quantifiable aspects of care had still not been fully heard. Greasley et al (2000) suggested that this focus on the quantifiable might be attributable to the influence of medical culture where the more measurable and observable aspects of care were dominant. That said, the findings of the present study suggested that some nurses found it easier to blame the 'system' for why spiritual needs were often neglected. This supported the findings of McSherry and Jamieson (2011) who suggested that the relative neglect of spiritual needs might be due to the nurses' lack of confidence in addressing such needs. They called for more education and guidance on spirituality and nurses in the present study largely endorsed this call. Mental health nurses may also have been failing to address service users' spiritual needs because of a lack of confidence in this area, reflecting the lack of education and guidance as well as particular difficulties emphasised in the present study about addressing the spiritual needs of service users in the specific mental health context. However, based on the responses from the participants in this study, I feel that it is not particularly a lack confidence in understanding or education in spirituality, but a lack of confidence in putting their own spiritual understanding into practice. This may be where education may be helpful and the workshop I have developed (See implications section 6.3 page 179 and appendix 7) empowers nurses and indeed other health professionals to explore their understanding and develop their confidence in a protected setting.

Evidence in much of the literature and indeed the current study has 'blamed' scientific evidence based approaches and other system requirements like the MHA for issues around why spiritual care might not be given the attention it deserves. However, participants in this study also acknowledged the benefit of evidence-based approaches

and the system requirements in terms of overall outcomes for service users. Many participants agreed there were times when what they perceived as scientific evidence based approaches or 'the system' worked to support the mental health needs of the person and subsequently enabled both the service users and nurses to address spiritual needs. Rumbold (2014) asserted that evidence-based approaches worked best to resolve acute illness when a patient needed to relinquish control and this was evident in the narratives in this study. He went on to say that when patients handed over control of their health for a period it was assumed that the caregivers would act altruistically. Rumbold's study discussed this model in the general sense and not specifically in relation to mental health. The participants in the present study described specific difficulties around locked doors and potential coercion enforced by the MHA (2007). However, parallels to the type of altruism highlighted by Rumbold are evident in the accounts of the participants in this study.

There were many examples offered by participants in this study describing the lengths the nurses went to in order to support service users in meeting their spiritual needs. This included manipulating the system or environment they worked in. Many accounts indicated that spiritual needs were often accommodated but not necessarily in a way that would be immediately apparent (for example, clearing a specialist hair-stylist through forensic security to enable a service user to connect with their cultural or spiritual roots, or arranging MHA leave for a person to participate in an 'alternative' spiritual ritual). Other examples showed how teams worked together to salvage the 'essence' or 'spirit' of a person who had fallen foul of the restrictions imposed by MHA rules or staff shortages. I interviewed the participants in private areas of their own workplace and during this process I had cause to visit the secure unit on more than one occasion. I am reasonably familiar with secure mental health facilities and therefore the security process did not surprise me but entering the unit is always mildly anxiety provoking. There are several security requirements needed including strict dress codes, submitting personal items (such as phones, pens, hair clips and other everyday items which are contraband) before being escorted through an air locked facility and into the hospital. It must be particularly frightening for a person who is not familiar with this type of security, for example the hairdresser, to enter a facility of this nature to support someone who is quite clearly detained there. The nurses would have had to provide

detailed information and support to encourage the hairdresser (or other lay person) to perform what was asked of them.

Some of the nurses talked about the personal distress caused by their actions in trying to facilitate at least some spiritual needs of service users. Although the participants who felt distressed at times described how this affected them personally, it was also evident that the service users in their care were unlikely to be aware of this. This might be due to the practice of 'altruism' described previously by Rumbold (2014) but might also be because of concerns and fears about being open about spirituality as previously raised by McSherry (2011) and in the context of high profile cases highlighted in the media (e.g. BBC News, 2009).

5.4 *Fear and anxiety: discussion*

The very topic of spirituality seemed to invoke fear and anxiety for many of the mental health nurses interviewed in this study. This may in part have been due to uncertainty surrounding the lack of an agreed authoritative definition (Narayanasamy, 2001; Swinton, 2006; Reinert and Koenig, 2013). Throughout the interviews the participants expressed either implicitly or explicitly their fear and anxiety. Some of the implicit expressions of fear and anxiety were evident in the participant's body language, facial expression and verbal intonations and this is difficult to discern in the written words of the transcriptions. For example, some of the participants visibly squirmed in their seat and covered their faces with their hands at points which caused discomfort in their interviews. Others used groans, growls and exaggerated facial expressions whenever I asked a question they perceived as difficult. Many of the participants admitted to 'looking up' spirituality prior to the interview because of the perceived risk of exposing their lack of knowledge. Their manner showed signs of mild anxiety and they were visibly relieved when I reassured them of my intentions relating to the research. McSherry and Jamieson (2011) found that a lack of education and knowledge was a major concern amongst nurses who felt inadequately prepared to address spiritual need and said that many nurses, like those in the present study, looked for more support from their professional regulatory body the NMC, the Department of Health, or their University training. As a nurse lecturer I have experienced similar concerns and

reluctance from my nurse lecturer colleagues regarding spirituality. This has resulted in them deliberately avoiding addressing the subject in lectures in favour of workbooks or directed reading where it is less likely to have awkward face to face questions asked.

The findings indicated that many of the mental health nurses described spirituality as 'intensely personal' and some used humour to cover up potential embarrassment. Participants described in detail how they feared the responses of their colleagues and indeed their professional body should they openly express their spiritual beliefs. Participants also showed anxiety during the interviews implicitly in their body language which was demonstrated by fidgeting and blushing. Their verbal communication also changed and this was apparent when they were gently interrogated. This often resulted in a tendency for them to drift towards an idealised account of their working practices based on the ideology of their professional discipline as opposed to a genuine account of everyday practice which they really experienced. This type of behaviour has also been noted in previous qualitative research with nurses (see above - King et al, 2013, developed a visual interview tool- the 'Pictor Technique' - specifically to overcome such tendencies).

What appeared to be specific to mental health nursing compared to the other nursing fields was participants' fear and anxiety that they would themselves be labelled or diagnosed as mentally unwell. This was demonstrated by the participants who described how they feared 'the pink papers' [MHA section papers] or being ridiculed by their colleagues. Swinton (2006) suggested that some criticism of spirituality in nursing was necessary because this helped to develop further understanding which would lead to engagement and a certain refinement of the subject. However, it is not unreasonable to conclude from evidence offered in this study, that the nurses who work in mental health may find this particularly challenging and may avoid this type of debate because of their fear of ridicule.

Aside from the mental health nurses' personal *'fear and anxiety'* in relation to their job, the nurses also expressed professional concerns in relation to service users. One of the foremost concerns was the *'fear and anxiety of imposition'*. The mental health nurses'

accounts indicated that they were concerned about imposing their beliefs on service users who were already vulnerable. This would be in breach of the nurses' code of conduct (NMC, 2016). Rogers and Wattis (2015) said that to impose one's own beliefs and values onto a patient or service user was ethically unacceptable. Swinton (2006) asserted that some care givers (including mental health nurses) avoided addressing spiritual needs because of the fear of imposing their own views on a service user. As a result, they might have avoided questions which they feared might lead them to impose views or negatively influence those who they were trying to care for. This type of avoidance behaviour was described by the mental health nurses in the present study. The '*fear and anxiety*' the participants experienced concerning imposing their own views on a service user might have led not only to avoidance behaviours identified in the interviews but also to blaming the influence of scientific evidence-based approaches, or lack of education in this area. Much of the literature reviewed (e.g. Swinton, 2006; McSherry and Jamieson, 2011 and Rumbold, 2014) highlighted scientific evidence based approaches as negatively impacting on how nurses perceived the importance of spirituality. However, based on the evidence demonstrated in this integrative theme, there were also other more subtle influences like the fear of ridicule which affected the nurses' inclination to address spiritual need but these were not as easy to identify as the influence of scientific evidence based approaches. I have already mentioned that my nurse lecturer colleagues avoid addressing spirituality directly and given that they all have nursing backgrounds, like the participants in this study, it is not unreasonable to conclude they experience similar feelings of fear and anxiety for the same reasons. Since starting this project it is not uncommon for my colleagues to ask me to lead on this type of teaching requirements and express the same type of concerns (as the participants) about imposing other beliefs on students. This has led to the development of the spirituality workshop (see implications and suggestion section 6.3 page 179)

Some of the nurses expressed '*fear and anxiety*' concerning '*getting it wrong*' and feeling incompetent in relation to addressing the spiritual needs of service users. Swinton (2006) asserted that spirituality was often presumed by practitioners to be inextricably linked with religion which suggested that spiritual care should fall within the remit of a religious leader. The participants in this present study often discussed how they made referrals to other people who they felt were more qualified at offering the

specific religious or spiritual support the service user needed. However, the mental health nurses also described how they referred service users to other mental health nurses whom they perceived as more spiritually competent. Koslander and Arvidsson (2006) studied a group of service users in relation to how they felt their spiritual needs were met and the findings indicated that many service users in their study were referred to others or simply had their needs neglected. The findings also showed that the service users turned to each other for spiritual support and the study recommended that nurses should actively seek knowledge about how they could effectively support the spiritual needs of service users.

Rogers and Wattis (2015) suggested there was a clear distinction between religious and spiritual care. Spiritually competent care pays attention to religious needs where they exist but it is broader than religion and does not require the mental health nurse to be 'expert' in the service user's religion. So whilst religious care might be for specialist chaplains or faith leaders, spiritual care was for all practitioners. However, the narratives in the present study suggested that not all nurses felt prepared or indeed inclined to facilitate this aspect of care. Addressing spiritual need as part of religion was described as easier by many of the participants and was particularly evident in the nurses who preferred the 'pragmatic' approach. However, it also included the mental health nurses who preferred the spiritually empathetic approach. This may be because of the unease they felt with the concept of spirituality which was compounded by their perception that they lacked the guidance and support they needed. This perception of lack of guidance and support was identified by McSherry and Jamieson (2011).

Participants' accounts suggested that the mental health nurses in this study could be very creative in finding ways of addressing spiritual need. Despite this, many reported that they felt unprepared to fully recognise and care for the spiritual needs of others. This was also a finding of the RCN (2010) survey on spirituality. However, mental health nurses faced further complexities in terms of the specific mental health needs of the service users, particularly those who experienced psychosis. In the mental health context the spiritually competent nurses described by Rogers and Wattis (2015) clearly had further barriers to navigate in terms of the person's mental health presentation in order to address spiritual need. Swinton (2006) indicated that the emphasis in mental

health was on a service user's psychological distress and the possibility of a spiritual dimension to it might not be considered. During the interviews however, I perceived that there were occasions where the nurse had considered the spiritual dimension but rejected it in favour of a more acceptable theory that the person was experiencing mental ill health. The mental health nurses in the present study described how they feared they had misinterpreted spiritual need as symptoms of mental disorder but even when they were sure that the service user was experiencing spiritual phenomena they still had not felt able to respond to the spiritual need, except in psychiatric terms. Corrigan et al (2003) found that there was a paucity of formal research concerning spirituality and service users with psychosis. Although they believed that spirituality and religion had an essential role in recovery, the participants in present study found that while they appeared to recognise this as an issue, they were apprehensive about challenging the dominance of conventional evidence-based attitudes to mental health care.

5.5 Chapter Summary

This chapter discussed the findings of each theme in turn including the integrative theme 'fear and anxiety' which pervaded the others. The following chapter will highlight the key findings of the study before concluding with reflections on the nature and possible limitations of the sample and some suggestions for future research.

Chapter 6: Summary of key findings and concluding comments

6.1 Introduction

In this chapter, I will highlight what I perceive as the key findings emerging from this qualitative study. I will consider the implications of these findings, as well as the limitations of this work, and suggest fruitful ways of further pursuing this research area.

6.2 Key findings

The work reported in this thesis was motivated primarily by a desire to explore how mental health nurses understand and respond to the spiritual needs of service users. Previous work and practice recommendations have indicated that it is important that spirituality is taken into account in the context of mental health nursing (see chapter two), but there is little known about how mental health nurses understand or undertake this care. The rich qualitative data obtained in this study produced detailed findings presented and discussed in chapters four and five.

Some findings supported existing work – for example, the difficulty in defining spirituality is already well documented (see Chapter two - much of the background literature reviewed highlighted this as a major challenge for all practitioners, including mental health nurses). The participants in the present study similarly found defining spirituality difficult, yet they were able to articulate qualities associated with spirituality and how spiritual needs of service users were addressed indicating a type of ‘spiritually competent practice’ described by Rogers and Wattis (2016) (See section 5.8 pages 145-146).

Another finding which emerged from this study was the evident impact of early personal influences on mental health nurses’ understandings of spirituality. As noted in chapter five, although information about current religious affiliation is recorded in some studies (see section 4.6; McSherry et al, 2004; RCN, 2010; McSherry and Jamieson, 2011), there has been little attention paid to how this early personal influence might affect

nurses' current approaches to care. The present study makes a novel contribution, drawing attention to early personal development, and the impact this may have on how nurses approach spiritual care. For example, those who have remained committed to an early 'religious' upbringing may find it hard to separate spirituality from religion whereas those who have reacted against imposed religion may have a more open view of spirituality. Given that the impact of social development influences in this area has not previously been well covered in the literature, and the clear importance it had to participants in this study, this may be an area that warrants further research. As noted in Chapter 5 (Section 5.6), religious affiliation is often recorded in such work but then not commented on or analysed, and developmental influences on approaches to spirituality are not generally recorded in questionnaire based and quantitative research. This, incidentally, demonstrates one benefit of a qualitative approach. It can draw attention to phenomena the researcher did not know they were looking for. In this study, participants all volunteered early developmental influences without specifically being asked.

Some of the literature specifically categorised different approaches the participants in their studies adopted to address the spiritual needs of service users (Baldacchino and Draper, 2001; Narayanasamy and Owen, 2001). In the present study, I identified participants as describing two broad approaches to the provision of spiritual care for service users which I referred to as 'Pragmatic' and 'Spiritually empathetic' (see Chapter five, section 5.8). Unlike the categories described in previous literature (Narayanasamy and Owen, 2001; RCN, 2010), the two styles in this present study were not mutually exclusive. The spiritually empathetic approach was identified with a sense of 'knowing' or 'connectivity' (discussed in chapter 5, section 5.8). 'Spiritual competence' (Rogers & Wattis, 2015; Jones 2016) embraces the concept of personal connection and of facilitating connection or reconnection with service users' community contacts, whether secular or religious, and this broad appreciation of where people derive their sense of meaning and purpose from seems to fit well with the spiritually empathetic approach. Person-centred care, derived from the therapeutic theories and practice of Carl Rogers has demonstrable efficacy (Rogers, 1961) and can, at least to a degree, be taught (Pelzang, 2010). The spiritually empathetic approach embraces the concept of a different kind of knowing at a personal level (ideographic knowing or 'seventh sense' (as discussed in chapter five) compared to the kind of technical (nomothetic) knowledge

fostered by the narrow concept of evidence-based practices. This suggests opportunities for education about the spiritually empathetic approach alongside teaching listening skills and Rogerian principles. It also suggests further opportunities for research into this way of approaching knowing.

Much of the literature (see Chapters 2 and 5) suggested that education in spirituality and nursing was lacking and there have been calls on universities to facilitate this (RCN, 2010; McSherry & Jamieson, 2011; Elliott, 2011). This study of mental health nurses also found many felt ill-prepared by their nurse education for addressing spiritual care needs, however it was apparent that spiritual education was being facilitated in both university and practice but with a lack of consistency and not always explicitly (Chapter 4, section 4.3.1). The suggestions above provide one way of addressing this.

I discussed in chapter 5 how it could be difficult to keep participants focused on their own thoughts and experiences through the interviews (participants, especially when they seemed unsure or uncomfortable often talked in terms of 'we' [as in 'the team' or 'nurses'] rather than 'I'). The findings of this study suggest that colleagues and team relationships can have an important impact on how mental health nurses understand and respond to spiritual need – it seems that nurses' tendency is generally to acquiesce to their perception of what they see as the collective view (described in section 4.3.2). It has been noted in previous research that health and social care professionals are often very aware of the particular professional rhetoric associated with their role, and can tend to resort to 'official' or 'textbook' explanations rather than an account of their own lived experience in research interviews (Ross et al, 2005; King et al, 2014). Researchers need to be aware of the dangers of accepting an 'idealised' account of nursing practice at face value. Using alternative methods to elicit reflection in interviews with participants can usefully disrupt habitual ways of 'telling a story' and challenge participants to reflect on their experiences and thoughts in different ways (King et al, 2014). To develop a more detailed and nuanced understanding of ways in which individual nursing professionals think about, experience or respond to particular research phenomena, it may be worth considering how best to break through this habitual professional rhetoric. In the present study the 'insider status' afforded me by

my professional experience seemed useful in this respect (I reflected on this in more detail in Chapter 3, section 3.2).

The present study was undertaken with nurses working in mental health services. Much of the nursing literature considering the notions of 'spirituality' and 'spiritual care' has been undertaken in the context of (general) adult nursing, but it was evident from the findings of the current study that there are a number of issues in relation to these ideas which are specific to the mental health nursing arena; for example mental health assessments which focus on beliefs and behaviour, secure environments and MHA requirements which are issues that would not normally be seen in adult nursing (see chapter 4; section 4.4.2.3).

The theme 'fear and anxiety' was identified as an integrative theme (Section 3.4.1) which often pervaded participants talk in relation to many aspects of spirituality and spiritual care. Earlier research has reported, as was found in this study, that nurses may perceive their professional position as being at risk should they openly express their personal spiritual views (RCN, 2010). McSherry and Jamieson (2011) similarly asserted that, despite attempts by the DH to raise awareness of the benefits of spirituality in health, there was still a gap between personal belief and professional boundaries which was also found in this study (see chapter 4; section, 4.3.1). However, what additionally emerged in this study (undertaken specifically with mental health nurses) were their particular anxieties around misinterpreting spiritual need as mental disorder. Dein et al (2010) also found in their research into religion, spirituality and mental health that some religious communities were reluctant to engage with mental health services for fear of mis-diagnosis. Therefore strategies for engaging with mental health service users who express spiritual and religious beliefs could be a focus for future research.

The key findings from this study also suggest that the context of a mental health care setting has specific issues which may potentially affect the outcome of care for service users: for example; how spiritual care is managed in relation to the security of acute and forensic inpatient services and MHA (2007) requirements described in Chapter 4

(section 4.4.2.3). Other research (e.g. Narayanasamy & Owen, 2001) highlighted the positive impact spirituality has on health and shows where (general) adult nurses reported that their patients felt comforted as a result of their spiritual care. Some of that care was about enabling people to attend their chosen place of worship or visiting faith leaders. Although it could be argued that some physical debilitating conditions may make such visits difficult, it is rare that patients in general services need to comply with the restrictions described by the mental health nurses in this present work. Given this and the special and unique challenges in relation to care settings described by the mental health nurses in this study, future investigation into how spiritual care is facilitated in mental health services may be warranted with the emphasis on the practical restrictions of care settings and those imposed by the MHA.

6.3 Nature and possible limitations of sample

An invitation to participate in this study was sent to all qualified practicing mental health nurses in a particular Trust.

Although my sample of seventeen volunteers covered a range of ages, experience and gender, analysis of the data indicated that all of the participants were white and there was a high number (11 out of 17) who voluntarily identified themselves in the study as having a Catholic or Christian background.

Public information readily available from the Trust's website shows in the region of 4,700 people are employed (of which a percentage are nurses but this is not specified in the available information). On enquiry, they kindly provided me with additional information on staff ethnicity which indicated that 91.42% of the whole Trust currently identified as white but their religious or spiritual affiliations were not included. Nevertheless, given that less than 10% of the population of this group are non-white, it is fair to assume that diverse mix of religious and spiritual beliefs may also be somewhat limited. The Trust's figures show a higher percentage of white workers compared with national statistics where only 86% of the population identified as white. The ONS (2011) figures showed only 59% of the UK population identified as Christian, with Muslims as the second largest religious group at less than 5%. There is also an

increase in the proportion of people who report to have no religion whilst Christianity is decreasing.

Whilst my study provided rich, in depth data from my participants, the findings are limited to the population of nurses working as members of the Trust at that time and though they may have been representative of some other NHS Trusts' (Priest et al, 2015) they were not fully representative of the wider population in the area it serves (ONS, 2011). Webster (2015) talked about the national disparity of white to BME groups and described an '*uncomfortable truth*' regarding discrimination especially in leadership roles in the NHS which this particular Trust is anxious to address.

Priest et al (2015) looked at promoting equality for ethnic minority staff and proposed ways on how to address discrimination and promote ethnic diversity in the NHS. They recommended that mandatory policies are the most effective strategies in achieving diversity. In recognition of this, one of the Trust's 'core values' was to show a commitment to promote equality and diversity in the way it provides its services and as an employer. The Trust's *Equality, diversity and inclusion report* (2016), recommended a targeted recruitment strategy to improve the representation of Asian people within the workforce to reflect the communities it serves. There are also quality and policy documents supporting proactive strategies to ensure services respect and value differences readily available (SWPFT, 2017). These are aimed at meeting diverse needs of people for example gender, religion, disability, language and sexuality (SWYPFT, 2016).

The disparity in the diverse mix of the workforce in the Trust at that time may not be the only reason for the lack of diversity in this sample. Rugkasa and Canvin (2011) reported difficulties in recruiting people from ethnic minority backgrounds to participate in health research and said a comprehensive understanding cannot be achieved unless all sections of society are included as it might impact on the potential development of effective services. They go on to say that there is little published literature on practical ways to ensure qualitative research is accessible and meaningful to people from minority groups. Weatherhead and Daiches (2010) said some minority groups are

reluctant to access projects like mine because of the reputation of institutionalised racism evidenced by the lack of health professionals from minority backgrounds and the likely discrimination. Priest et al (2015) said that the experience of discrimination, bullying and harassment are higher amongst BME staff and this is harmful, not only the individual but to the wider organisation.

Whilst official figures from this Trust show minority groups may be underrepresented, as a former employee of the Trust my own experience was that there are in fact more non-white, non-Christian individuals working as nurses than these figures suggest. However, many of them are bank or agency workers because of the higher wages often afforded to agency staff and the opportunity to work extended or unsocial hours. Many of the agency nurses have families in other countries who are reliant on their income, hence their choice of employment but as a result would not have had the opportunity to participate in my study and would not be included in the Trust diversity data indicating a skewed perception of reality.

Another possible explanation for the high number of white Catholic participants may be understood from the interview invitation itself. Although the intention was to be inclusive of all mental health nurses regardless of religious, cultural or spiritual backgrounds, it is possible there were subtle indications within the message which may have affected the nurses in different ways. For example, I identified myself 'Ruth Elliott' and from this it is not unreasonable to assume I may be a female white Christian. Because of this, the participants may have identified with their perception of me at some level which could have affected their responses resulting in a large proportion of white Catholic participants. Conversely this may have also acted as a barrier to nurses from different cultures who may have been put off by this perception and might have responded more positively had my name reflected their own identity. This type of perception is not unusual in this type of study as Rugkasa and Canvin (2011) indicated in their reflection on recruitment of participants for mental health research in minority ethnic communities. They identified one of the main problems which affected recruitment was in relation to the gatekeeper of the study and whether the participant could identify with them. They reported that a barrier to including people from ethnic minority groups is a failure to take into consideration the ethnic composition of matching the interviewer to the

interviewees. They suggested qualitative research relies on the success of the researcher in using their own identities to connect with a particular group, such as age, religion, ethnicity and gender which could enable or constrain the research and data collection. The possibility of using certain identities or qualities may be a useful strategy in larger scale studies who have a team of people gathering data.

My study was an exploration of mental health nurses' understanding of the spiritual needs of service users and there was a good response to my small scale study. However, it may be argued that the responses to my invitation was taken up by people who had strong feelings on the subject and felt a need to contribute. Literature and policy guidance (e.g. Swinton, 2001; Narayanasamy and Owen, 2001; RCN, 2011; McSherry and Jamieson, 2010) strongly advocated the benefits and importance of spirituality in health care but studies like mine rely on interested parties and the nature of 'volunteering' means that only interested parties will come forward to participate. Other potential participants fitting my inclusion criteria with less strong feelings or opinions about the value of spirituality may well not have participated because they did not have any particular interest in the subject matter. Spirituality and addressing spiritual need may not be perceived as pertinent or indeed valuable to at least some mental health nurses and that emphasis on this aspect of care might be less important to those who did not volunteer. Therefore, the findings of research like this and indeed large-scale studies, like the RCN *Spirituality Survey* (2011), are limited to interested parties which suggests the true value of spirituality for the general population may be harder to assess. Nevertheless, the results and key findings of this study clearly show the richness of the data collected from the participants. However, the strong Christian influence within the responses must be acknowledged and may not reflect the understanding of spirituality from non-Christian religious and non-religious backgrounds. A research suggestion that could flow from this would be a repetition of the study but specifically recruit people from a broader variety of backgrounds including, purposive sampling of participants to include those identifying as members of other religious groups, atheist or non-religious.

6.4 Concluding comments and suggestions for future studies

Much of the existing literature has stated the importance of spirituality in mental health care but also suggested the spiritual dimension of the person is often ignored or neglected. This study explored how mental health nurses understood the spiritual needs of service users and how that understanding was applied in practice. Acknowledged limitations are that the study was undertaken with a limited sample in just one geographical area, so findings may not necessarily be more widely representative. However, the quality of the information collected in the present study suggested that the mental health nurses were able to express their understanding of the spiritual needs of service users. The findings presented in this thesis show the complex influences that affected participants' reported understandings and subsequent responses, and have identified new issues in relation to how the nurses' early social conditioning might directly affect care despite more recent experiences.

Much of the existing literature has stated the importance of spirituality in the context of mental health care but also suggested the spiritual dimension of the person is often ignored or neglected. This study explored how mental health nurses understood the spiritual needs of service users and how that understanding was applied in practice. Acknowledged limitations are that the study was undertaken with a limited sample in just one geographical area, so findings may not necessarily be more widely representative. However, the quality of the information collected in the present study suggested that the mental health nurses were able to express their understanding of the spiritual needs of service users and the methodology enabled rich, in depth data to be collected. The findings presented in this thesis show the complex influences that affected participants' reported understanding and subsequent behaviour. The study has identified new issues in relation to how the nurses' early social and religious/spiritual experiences might affect care albeit sometimes considerably modified by more recent experiences.

Below I will consider what the study demonstrated about current practice and implications this has for policy, education and future research. I will also briefly discuss

what I have already done to disseminate the findings of this research and possibilities for future work.

Although participants described a reluctance to address spiritual needs and obstacles inherent in time pressures and legal constraints with some service users, their accounts showed how the nurses attempted to address these issues, sometimes by 'working round' obstacles. The participants were mainly sensitive to the spiritual needs of service users despite not necessarily feeling well prepared for the task by their training and nurse education. They were conscious of their own strengths and developmental needs in this area. They gave detailed accounts of how this impacted on them at a personal level which showed the additional lengths they were willing to go to provide good quality care. Some examples of their understanding illustrated how they implemented practical solutions to support religious practices. I would use this as an example of a '*pragmatic nurse*' or as '*compassionate motivation*' which Wattis et al (2017) described in their work around spiritually competent practice.

Other examples were less quantifiable and showed how nurses 'connected' with service users and were attuned to their need for transcendence at times when they felt that doing this might affect their professional credibility. I have used the terms pragmatic and spiritually empathetic to describe these two main styles of approaches used. Nurses mainly favoured one style or the other but some used both flexibly. The pragmatic approach was broadly concerned with enabling religious and spiritual practice, whilst the empathetic approach was more concerned with a type of understanding described by Humphreys (2008) as the seventh sense of knowing. The present study found that nurses possessed varying degrees of ability and confidence depending on which style they preferred or had to adopt, despite lack of explicit attention to education in this area. They also possessed what has been described as compassionate motivation, in some cases sustained by a supportive team spirit; but, as reported by others (e.g. Connelly and Light, 2003; Narayanasamy and Owens, 2001; McSherry and Jamieson, 2011), found obstacles in the workplace related to lack of time and the way work was organised.

The nurses in this study were in varying degrees able to distinguish between spiritual and religious care. For this group, religion was not seen as synonymous with spirituality. In fact, some were frustrated by the bureaucratic 'tick-box' approach to religion. The respondents' understanding was founded on their personal religious and spiritual backgrounds; but they recognised their subjectivity and were anxious not to impose their beliefs on others. I found that despite the 'fear of imposition' nurses in this present study expressed, they were able use their natural spiritual care approaches as a basis for the development of workable strategies to influence future practice advancements.

A vital part of this strategy has already seen an increasing emphasis on the importance of including spirituality in new versions of documents like the NMC Code and in undergraduate and postgraduate education for nurses. Yet despite this, nurses, like the participants in the RCN spirituality survey (2011) and this present study, continue to describe mechanistic practices. Policies to promote a shift from mechanistic approaches to treatment to a more person-centred holistic model are already in place (Barker, 2006; NICE, 2015) but institutionalised working practices are slow to respond. The RCN has already taken steps to raise awareness in this area following its survey (RCN, 2011) and by developing a 'pocket guide' booklet on Spiritual Care approaches for nurses (RCN, 2011). Yet, to deliver good quality spiritually sensitive care, nurses need time and support. It is at this point where policy needs to ensure that valuable opportunities to facilitate this type of care are built into the design of services to become part of the culture of mental health nursing. Continuous pressure on policy developers at local and national level will be needed if a co-ordinated and coherent approach to spiritual care is to be achieved.

Some of the interviewees in this particular study reported that they received some support from colleagues in their teams in relation to facilitating spiritual care but careful supervision (which could be provided by peers) and management of workload are needed to facilitate good practice and spiritual care (Bush et al, 2016). Whilst there is a sea change in mental health services to develop self-care and user-led models, the current political climate and the continued squeeze on resources for healthcare suggests that although qualitative research like this study provides valuable insights to a

person's lived experience, policy developers tend to focus on what can be measured like staffing numbers, professional skills, types of services and financial justifications. For example, DH (2017) set out new proposals in the new document '*Stepping forward to 2020/21: The mental health workforce plan for England*'. The policy claims to have a patient-focussed, pro-active approach to leadership that reflects the values of diversity in the NHS as an institution, which if it is used intelligently with evidence from qualitative studies like this one may create innovative new ways of working. However, in order to justify the government's position and remain accountable, the policy's emphasis '*tests innovations*' to provide quantitative evidence of its success (DH, 17). For example, widening participation and expansion in terms of training staff in various mental health disciplines are to be commissioned and potential candidates are required to have a set of specific qualifications on entry. However, in reality there is nothing pertaining to requirements of valuable personal qualities in individual applicants and how this may affect service users. To coin a phrase I heard recently, the approach seems to be, "if you have got a PIN [personal identification number] you're in" suggesting quantity of staff at the expense of quality.

Participants in this and other studies highlighted the lack of confidence and hesitancy of nurses in addressing spiritual needs of service users. In this present study I also identified fear of 'getting it wrong' and 'fear of ridicule' amongst mental health nurses. Nurses in this and other studies (e.g. Mclaughlin, 2004; McSherry et al, 2004; Swinton, 2006; Jones, 2016; Snowden and Ali, 2017) felt that the lack of confidence could be addressed with better education and guidance from universities in pre- and post-registration training programmes which currently did not include or address spirituality adequately. This concurred with findings from other studies (e.g. RCN, 2011) which consistently reported their participants felt spirituality was inadequately addressed in nurse education. The nursing curriculum is developed by individual universities which are left to understand guidance from the NMC in relation to achieving the appropriate competencies and as a result varied emphasis is placed on difficult concepts like spirituality. Snowden and Ali (2017) found that consistent approaches to spiritual education in universities was lacking because of lack of clarity in policy documents and a feeling that education in this area was a matter of choice. They also highlighted the lack of confidence and expertise in educators which, given that nurse educators are

also nurses, is hardly surprising. I have already emphasised that nurses are educated by other nurses both in universities and clinical areas which means the reluctance to address spirituality will tend to be self-perpetuating, without specific attempt to change things. Educational approaches to spiritual care are developing and there is an increasing body of research in this area (Ali et al, 2015).

Collaborative work in the context of spirituality and adult mental health nursing with agencies like the NMC and RCN should be explored. This may be facilitated by building upon existing resources like this and other similar studies (Jones, 2016) to develop and provide workable, consistent education and guidance for nurses working with people with complex mental health needs. The nurses in the present study had often made up for lack of formal nurse education in this area by drawing on their own life experiences. There is a need to build upon this by recognising individual personal competencies and qualities with the means to develop them and their resilience to cope in a sometimes hostile environment (Bush et al, 2016).

Research evidence, based on qualitative as opposed to quantitative methods in healthcare, tends to be relatively undervalued with quantitative randomised controlled trials often being referred to as 'gold standard' (Bowling, 2014). However, qualitative research like this study is the kind of research that illuminates the inter-personal aspects of care vital to the healing relationship. Nurses and educators need to be encouraged to value all types of evidence by continuing to use both qualitative and quantitative methods appropriate to their research question. For some research studies this may mean using a mixed methods approach (Polit and Beck, 2010; Bowling, 2014). Greater emphasis on flexible and qualitative approaches to research may offer more of the evidence based material (valued by educational institutions, DH, NMC and other policy developers) about the relevance of less measurable aspects of care, including spiritual care.

This would help to humanise approaches to care and reduce the 'mechanical' approach to nursing encouraged by the standardised assessments described by the participants and perpetuated by current policy recommendations (DH, 2017). The design of my

present study could be adapted and applied more widely alongside other projects like '*spiritually competent practice in healthcare*' to facilitate a continuous improvement of the evidence-base in this area (Wattis et al, 2017).

I have established the literature review and the findings of this study have shown that most of the research done in this area is predominantly from a white Christian perspective. There is little research that specifically identifies and includes the perceptions of spiritual needs of service users from nurses who have non-white, non-Christian backgrounds. This may be because of the reluctance of this group to participate in research (discussed in section 6.3) (Weatherhead & Daiches, 2010; Rugkasa & Canvin 2011). Therefore, more effort from researchers may be needed to ensure valuable inclusivity from this group and to address the other issues inherent in working in a multi-cultural society. A way forward may be to facilitate a repetition of this present study but specifically recruit people from more culturally diverse backgrounds and include a group who identified as atheist. Rugkasa and Canvin (2011) recommend that to maximise responses from people from ethnic minorities, researchers need to reflect the identities of participants, so it is suggested that future facilitators of research in this area are representative of that group.

Despite some similarities with studies in other areas, the specialist area of adult mental health care identified its own unique challenges, particularly in terms of the perceived blurred boundaries between religiosity, mental illness, spiritual transcendence and the nurses' fear of addressing spirituality in a person with complex mental health issues. These issues suggest further avenues for research. For example, studies involving services users who have complex mental health issues and those who are currently receiving treatment in secure mental health facilities. Studies in these areas may offer an in-depth awareness of the spiritual needs of service users and offer suggestions to nurses about how best to support them.

This present study highlighted that spiritual care is often neglected and acknowledged the theme of fear which permeated the responses of the participants. I have identified new issues (not found in other studies) which show how the nurses' early social

conditioning affected their views on spirituality and spiritual needs. Further exploration in this area and how fear and anxiety might be managed, may provide evidence to enable nurses to be more effective when addressing spiritual needs in practice.

During the doctoral process, I have presented my findings and education initiatives at several conferences. One of the two mental health nurse specific conferences I presented at was organised by the RCN who commissioned the large spirituality survey in 2011. This particular conference was specifically aimed at mental health nurses and policy development for the profession. Another was a qualitative research conference where I presented the use of template analysis in my study and promoted the use of qualitative research in nursing.

As a nurse educator, I have developed an education workshop within my home (university) institution, concurrently with conducting this study (Attachment 7). This encourages students to explore spirituality and spiritual care within the context of mental health nursing. The workshop begins by asking the students to develop an agreed and workable definition of spirituality to highlight the difficulties and encourage them to be aware of other perspectives. The workshop then asks the students to consider what good spiritual care might look like before exploring how this might be achieved in difficult and restrictive environments. The workshop has received positive verbal and written evaluations which have been used to refine the session further. The success of it has resulted in the development of additional spirituality workshops tailored to suit other nursing and midwifery fields and Occupational Therapy students.

Although it was initially intended for pre-registration students the workshop there are proposals for it to be facilitated in post-registration modules aimed at developing the skills of qualified nurses and indeed other health professionals. I have recently been approached to develop a session with another colleague which explores sexuality through the lens of spirituality and although this is currently in its infancy we have had positive responses to our ideas from academic and nurse colleagues. This could link in effectively with additional education initiatives for nurses and help break the cycle of reluctance many nurse educators experience when teaching spirituality and other

sensitive subjects like sexuality. Following the success of the workshops, I presented at an international nurse education conference which promotes innovative nurse education programmes (NET, 2015) to disseminate my findings and education development.

The implications of this present study for practice, policy education and future research have been discussed and I have explained how the findings can (and are already) being incorporated into nurse education. Whilst this thesis adds to the wider body of knowledge which may contribute to the development of future practice and policy guidelines it is clear that further work is needed. However, this study's contribution and subsequent workshop may enable mental health nurses to be more confident and competent in addressing this aspect of care which in turn may enhance the service users' experience.

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Spirituality, mental health nursing & assessment

Ruth Elliott critically examines the literature regarding mental health nursing assessment and spiritual beliefs and considers whether a person's spiritual belief influences the outcome of a mental health nursing assessment and to identify possible strategies to overcome assessment bias or prejudice.

Key words:
Literature review
Spirituality
Mental health nursing and assessment

Exploration through research has identified that constructive approaches to spirituality can have a positive effect on health. The Office of National Statistics has produced figures from the census and shows that here in the United Kingdom (UK) we have a more diverse community than any other country in Europe, contributing to the richness of spiritual understanding (ONS, 2001).

The National Institute for Mental Health in England (NIMHE) and the Mental Health Foundation launched a two year partnership to review current ideas in how nursing practice approaches the area of spirituality and mental health. The results identified that people with mental health needs are increasingly identifying spirituality as a vital part of their recovery. The NIMHE (2003) proposed that the partnership between NIMHE and the Mental Health Foundation would promote the merits of spirituality in achieving good mental health. The Nursing and Midwifery Council (NMC, 2004) identified in their standards of care, that it requires a nurse engage in a holistic approach to care, therefore, the dimension of spirituality must be provided. It clearly states that the nurse must:

'Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients/clients/communities'

Figures from the Census (2001) show that over 70 per cent of people claim to have a religious or spiritual affiliation. That is despite the decline in the church attendance of mainstream faiths like Christianity. It is important for the nurse to be able to define a persons' individual resource in coping when assessing their needs (Forster, 2001). In order to fully assess holistically, the practitioner needs to understand an individual and respond to their identified needs. Nurses are often put in an uncomfortable or almost certainly unprepared position to assess spiritual needs without bias (Barker,

2004). Traditionally, the focus has been on the 'mechanics' of 'treating' a person's illness by allegedly using a holistic approach and ultimately addressing the dimension of spirituality inadequately. It is, therefore, easier to ask a person's religious belief and document it in their notes whilst ordering their 'special diet'. Practitioners may feel that by using this strategy they are showing how they have evidenced their commitment to facilitating a person's right to express their spirituality. To the individual who has a spiritual belief, it is as important as the dimension of physical or psychological (Barker, 2004).

To omit or not fully address one of the dimensions identified in an holistic assessment is to fail to care for the individual as a whole. The NIMHE (2003) identified spirituality as being vital to the recovery of a person experiencing mental ill health. It was furthered by identifying that the concept of spirituality is becoming more diverse and increasing along with the different cultures in Britain. Whilst there is extensive research and discussion surrounding well being and the significance of a persons spirituality, there are fewer studies undertaken on how the attitude of the nurse towards spirituality and their spiritual beliefs affects the outcome of a mental health assessment. Spirituality is a deeply personal matter and each individual has their own perception on what emphasis this has on their day to day life. The Chief Nursing Officers Review (2006) recommendation 10, directed mental health nurses to act in response to the identified spiritual or religious needs of the individual.

Search methods

This article describes a systematic critical review, the relevant studies that were identified were appraised and analysed for methodological quality and rigor. The reviewer was independent and the qualitative studies that were used were categorised by using an evaluation tool adapted for the review by Cormack (2000). Levels of evidence for qualitative

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Table 1: Based on the criteria set by the Joanna Briggs Institute shows Levels of Evidence for Qualitative studies

Level of Evidence	Description
A	Evidence which may include Findings that are matter of fact, directly reported/observed and not open to challenge.
B	Findings that are, interpretations, plausible in light of data They can be logically inferred. The findings may be challenged.
C	Findings not supported by the data

research were categorised by using a tool adapted from the Joanna Briggs Institute (2004) (Table 1).

In order to critically examines the literature regarding mental health nursing assessment and spiritual beliefs and consider whether a person's spiritual belief influences the outcome of a mental health nursing assessment searches were conducted using MetaSearch that included CINAHL, British National Formulary, Cochrane Library, PubMed and other data bases from the period 2000-2009.

The initial part of the search strategy was a search that was limited to the MEDLINE and CINAHL databases in order to set the benchmark parameters for a more in depth review of the literature. The search terms used were related to words in the title of the proposed review.

In order to review the current relevant literature it is important to refine the search area and use a carefully defined inclusion criterion. An initial broad search exercise helped to refine and identify the key points to include when searching the literature (Polit & Beck, 2006).

The second part of the search involved a more comprehensive search of the following databases, British National Formulary, Cochrane Library, Electronic Journals Service (EBSCO), PubMed, Science Direct. The search terms that were used were spirituality, mental health nursing and assessment. The search was restricted to articles in the years 2000-2009 to ensure currency of the papers retrieved. The third phase was conducted by searching the material manually from the bibliographies or reference lists used in the articles that had been previously retrieved from the search process. Papers were included if they were reports from qualitative research that employed methods like case studies, questionnaires, focus groups or individual interviews. All settings were considered, ranging from

inpatient services, nursing or continuing care homes and community based care facilities. Participants included mental health nurses patients or service users and or their carers and families. They involved service users both in the recovery or florid phase of their mental health and did not exclude people with a diagnosis of a psychotic or manic illness. There were no restrictions on age or gender. Studies published prior to 2000 were excluded with the exception of seminal works. Non English speaking and non-British articles were excluded.

Search outcome

There were a total of 666 articles retrieved that were potentially relevant. The numbers of articles retrieved from each individual database were as follows: British National Formulary and MetaLib could not retrieve the number of hits from this target, Cochrane Library = 339 hits, Electronic Journals Service (EBSCO) = 2 hits, PubMed = 23 hits and Science Direct (Elsevier) = 302 hits. Articles that were duplicated within the search were identified and eliminated. For the final review, a sample total of six articles which met the criteria were included. Others may have been suitable, however, these were either unavailable electronically or restrictions for access were applied. The literature surrounding this often contentious subject is non-exhaustive. Due to the constraints of this literature review the sum of the review articles collected was 'capped' at six to make the data manageable and, therefore, offering a depth of understanding of the data.

It must be acknowledged, however, that literature that was omitted through the exclusion criteria, unavailability or 'capped' selection may have been wholly relevant and valuable to the review but was not considered in this instance.

Synthesis

All the studies critically analysed were qualitative in nature. There were no

randomised controlled trials (RCT's) in the review. The findings of the review were synthesised using a narrative format and the articles were critiqued against the specified criteria and comparisons were made with each other.

Results

The importance of spiritual care in nursing as a whole was identified just as spirituality was recognised as an important factor in people's relationship with each other and themselves. There are recognised assessment methods to assess someone's spiritual beliefs, however this is limited to what a person believes and how it may be expressed.

Conclusions and recommendations

There appears to be little empirical research in how the nurse can avoid bias or prejudice when assessing someone's mental health. Further study of comprehensive and contemporary literature in the first instance may offer some indication on how to develop the formulation of an assessment tool for the future.

Results

Table 2 presents the six studies that were included in the review. They are graded according to criteria adapted from the Joanna Briggs Institute (2004) (Table 1) that identified levels of evidence for qualitative research. It must be noted that the results are limited due to the non-exhaustive literature available. Further to this the evidence may be generalised to other populations because of the culturally diverse nature of spirituality and the same principles may be applied across culture and beliefs.

Literature review

The article titles by Ledger (2005), Eeles *et al.* (2003), Coyle (2001) and Narayanasamy and Owen (2001) gave a good indication of what the research was about, however, only titles by Eeles *et al.* (2003) Coyle (2001) and Narayanasamy and Owen (2001) offered an indication on what type of research or review was to be commented on. Four of the titles suggested the paradigm and all of them identified the concept. All the titles suggested a phenomena, however, the title by Dein (2004) did not identify who was working with what type of people.

Abstract : All of the articles offered an abstract prior to the main findings of their papers however three of the articles abstracts were a comprehensive review of the main paper and concisely

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summarise the main points of the report. Naranasamy and Owen (2001) Greasley *et al.* (2008) Coyle (2001), and Eeles *et al.* (2003) specify the background, aims, method's findings and conclusions. The papers by Dein (2004) and Ledger (2005) were scant and offered little or no indication on the methodologies or main findings. Only three identified the sample used.

Introduction: The six papers all introduced their topic and identified the phenomenon of interest, however, only three stated the focus unambiguously and were therefore easily identified. Narayanasamy and Owen (2001) viewed that spiritual care in nursing has scope for improvement but indicated that there is little evidence in nursing literature. This view is supported by Eeles *et al.* (2003) who goes on to say the evidence available proves to be inconclusive. All showed the significance to nursing, however, three generalised the issue to all nursing disciplines whilst only Eeles *et al.* (2003), Greasley *et al.* (2008) and Dein (2004) specified mental health nursing. The subject matter was appropriate and approached the research by using qualitative methods of enquiry that matched the paradigm. Only Narayanasamy and Owen (2001) specifically addressed the limitations by saying that caution is needed when generalisation is being considered, given the relatively small sample size.

Literature review: The studies all considered the theoretical underpinning of their work that at least in part summarise the body of knowledge and background that surrounded their studies. Four of the studies use up-to-date and relevant supporting material as well as acknowledging seminal works, however, Greasley *et al.* (2008), Eeles *et al.* (2003) and Dein (2004) rely on some works that are outdated or have sufficient bias to make the review questionable. The Narayanasamy and Owen (2001) and Coyle (2001) critiques show sufficient evaluation of balanced material that suggests the focus both supports and challenges the position proposed. They also identify the need for further empirical research, whilst the other four articles merely allude to the need, rather than offer specific recommendations. All of the studies show comprehensive references, however, the subject matter is so vast and difficult to refine and define, it was challenging to regard which works should be included or excluded. It is with

this in mind that it is acknowledged that the six articles used appropriate references and therefore important ones did not appear to be omitted. That said it must also be acknowledged that Narayanasamy and Owens (2001) referenced several of their own works which would suggest bias. It may be then considered that the findings of this work and recommendations may be questionable. Their work was also referenced in other papers that were reviewed, giving rise to the acknowledgement of their expertise. Dein (2004) did not present a review of the literature however showed that the literature had been considered as this was presented in the introduction part of the paper.

Research questions: Five of the articles retrieved state the research question or statements. Dein (2004) made a broad statement and then proceeded to present case studies that appear to support the title, Narayanasamy and Owen (2001) and Greasley *et al.* (2008) had a very clear remit of the questions or statements that are addressed and are consistent with the philosophical basis and theoretical underpinning considered in their introduction and literature reviews. Dein (2004) and Ledger (2005) show weakness in this area compared with the other articles and against the critique criteria.

Method: Four of the research articles followed a different methodology. This included focus groups, questionnaires, semi-structured interviews and case studies. Ledger (2005) and Coyle (2001) chose to review the literature for their findings although they chose a different approach. Ledger chose to concentrate on the statistics obtained from the literature collected and Coyle (2001) chose to use a concept view indicator to extract the data required. The semi-structured interview was used in order to extract rich information and not limit the responses that may have been elicited with a more structured methodology, for example questionnaires or critical incident questionnaires. Case studies offered the value of the richness of information, however, may not be structured enough to offer specific information that may be needed to answer the question, statement or hypothesis stated in the aims (Cormack, 2000).

Samples selection: Four of the six articles reviewed stated the sample very clearly. Ledger (2005) and Coyle (2001) made no reference at all. It could be considered

that because the two relied heavily on documented literature for their findings that their research would not formally need to state sample size, however, it would have been interesting and useful to know the breadth of the literature used in order to analyse whether the result were reliable, valid and rigorous (Polit & Beck, 2006). Four of the articles that conducted formal qualitative research used samples that were convenient to them. Narayanasamy and Owen (2001) sample of 130 was relatively large compared to the other articles reviewed. The sample chosen in all examples were congruent to the methods chosen.

Data collection: The chosen review articles used a different method of data collection. All could be considered suitable for the aims and objectives of the individual research aims. Three of the studies discussed the validity and reliability of their chosen methods of data collection. Dein (2004), Ledger (2005) and Coyle (2001) made no reference to rigor within their data collection methods. Dein (2004) did not propose a method so it was unclear until the rest of the paper was reviewed. The reader had to conclude the method based on the material presented. Ledger (2005) used statistical analysis as the method of data collection, however as the article was qualitative in nature the findings, conclusion and recommendations were presented in a narrative format. Narayanasamy and Owen (2001) and Greasley *et al.* (2008) showed sufficient analysis that determined any significant differences that were not attributable to other variation. Greasley *et al.* (2008) considered that there could be a paradigm shift that could affect changes whilst Narayanasamy and Owen (2001) showed that there was a danger of bias based on the beliefs of the experts interpreting the data. Coyle (2002) and Eeles *et al.* (2003) showed sufficient analysis however differences in variables that may have affected the findings were not fully acknowledged. Of the remaining two, little or no reference was made to any variables that may have impacted on the results of their findings.

Only Coyle (2001) considered two other collection methods to achieve triangulation and therefore increase the rigor of the findings. Eeles *et al.* (2003) and Narayanasamy & Owen (2001) used questionnaires for their method both discussed their subjects questions and recorded the findings appropriately.

For the basis of the articles aims, four of

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the six articles showed that a sufficient amount of data collected was to be used in the first instance. Only Naranasamy & Owen (2001) and Greasley *et al.* (2008) showed sufficient depth and richness, however, it could be considered that as the subjects were students of the review the material may have been distorted by the behaviour of the subjects (Polit & Beck, 2006).

Rigor: Four of the six showed that the methods used would have enhanced the trustworthiness of the data and the presentation of those methods was adequate for the studies. The documentation of the research process and findings were sufficient that the material could be audited and therefore able to be confirmed. Ledger (2005) and Dein (2004) made little or no acknowledgement of those considerations which makes the findings in the reports lack validity and reliability (Cormack, 2000; Polit & Beck, 2006).

Ethical considerations: Ethical considerations were only confirmed in the articles by Naranasamy & Owen (2001) and Greasley *et al.* (2008) and these methods were approved and confirmed by the NHS ethical committee. The two literature review articles did not need formal ethical approval as the material used was readily available to the public at large. Of the remaining two one made no reference to ethical considerations at all whilst the last discussed potential considerations however viewed the method of data collection as voluntary so the ethical considerations were viewed as satisfactory by the researcher.

Data analysis: Management and coding of the data was clearly sufficient in four of the articles. Work done by Ledger (2005) and Dein (2004) unearthed relevant material however it was unclear where this had been derived from the data presented. Dein (2004) relied on the literature reviewed in the first instance as opposed to the results of the material studied in the research. The tables and graphs that were presented in the three where this method was appropriate were clear and adequate. Greasley *et al.* (2008) and Naranasamy and Owen (2001) tables were more in depth and offered further explanation in the narrative.

The issue of possible bias or weakness of the methodology was discussed in Naranasamy and Owen (2001) and acknowledges that this may suggest the findings may in part be viewed as questionable, however, this notion was later

addressed in the recommendations. The analytical procedures in the five remaining studies showed that there may be analytical bias towards the studies findings (Cormack, 2000).

Discussion: Overall, all six of the articles interpreted their findings appropriately within the social context. With four of the studies the major findings were discussed and in line with previous studies. Interpretation of studies done by Dien (2004) did not acknowledge the studies limitations and recognise this weakness in the interpretation. Naranasamy and Owen (2001) and Greasley *et al.* (2008) addressed the issue of transferability and acknowledged that the same issues may apply to other countries and indeed cultures.

The presentation of five of the studies were well-written, organised and had sufficient detail for the critical analysis. The weaker study by Dein (2004) although considered to be weaker based on the tool developed for the purpose of this review, presented good points for recognition and gave sufficient implications for the necessity of further study.

Conclusions/recommendations: Greasley *et al.* (2008), Naranasamy and Owen (2001) and Coyle (2001) recommended further study. Coyle (2001) furthered this and recommended that the framework developed be tested empirically in the future. The three studies acknowledge that the study that had been already embarked upon raise new questions and highlighted the need for further testing or review based on their findings. The recommendations appeared reasonable based on the findings of their research.

The remaining studies only made recommendations for the behaviour of nurses within the paradigm but offered no suggestions on how those recommendations may be achieved. These issues may be considered by another researcher who feels it necessary to explore the findings further (Polit & Beck, 2006).

Findings: All of the articles afforded definitions of the term spirituality and separated it at least in part from the term religion. Clarification of the term ranged from a deep rooted need to worship a deity or deities and follow a 'religion' that had its own doctrine or laws to abide by, to just a basic acknowledgement of an individual's role with in the world or universe. Their spirituality may be expressed in the wonder of nature, music, art, literature or their ability to

love or be loved (Greasley *et al.*, 2008). Eeles *et al.* (2003) advanced this by considering that what is considered a hallucination in one culture is evidence of divinity in another.

Spiritual care provision

Historically, nursing has strived to establish itself as a profession based on scientific evidence. The term 'evidence based practice' is often used in relation to care. Quantitative research particularly Randomised Control Trials (RCTs) provide the benchmark for quality research (Cormack, 2000). Qualitative research is less valued as control of the findings, paradigms and variables are not easily controlled (Holloway, 2005). To the purist qualitative research relies too heavily on subjectivity and opinion rather than the cold hard fact that is offered from an RCT (Polit & Beck 2006). Unfortunately, this gives rise to qualitative research having less emphasis and seems the poor relation in research terms. (Cormack, 2000). In real terms qualitative research is the way forward when considering topics like spirituality (Holloway, 2005) and with the emphasis from NICE guidelines and Department of Health objectives, qualitative research results should be given more recognition and respect. By utilising this approach it may serve to address some of the cognitive dissonance that may be felt by the nurse struggling to care for an individual and support their spiritual beliefs.

Nurse attitude consideration

As previously stated the UK Census (2001) has identified the culturally rich society we live in with people from a wide range of culture, religions and spiritual persuasions including the rise of neo-paganism in the western world.

The evidence has shown that nurses do not always recognise the spiritual needs of their patients and if they do they are often unable or ill equipped to assess and provide for the individuals needs. However, as the NMC (2004) instructs, the nurses duty is to ensure that the spiritual needs of the individual are addressed. The practitioner must learn to use the persons 'lived experience' and incorporate this into the persons toolkit for recovery (Barker, 2004).

The review identified that not all nurses feel able to meet the needs of their patients particularly if the beliefs conflict with that of their own whether the nurse is spiritually aware or atheist. Naranasamy & Owen (2004) considers that if the nurse is not in touch with their

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own spirituality or has strong beliefs that conflict with that of the patient then they are unlikely to be sensitive or able to offer the individual support in expressing their spirituality. This viewpoint supported by Greasley *et al.* (2008) who identified two distinct opinions within nursing staff, those of the 'believer' and those of the 'non-believer'. NICE (2005) identifies simple and practical ways often address some of those needs. The most simple could be allocating a quiet, private place for the individual to reflect or pray and equally importantly, time to do it.

In times of crisis, which would include mental ill health, patients often try to make sense of their suffering in terms of their spirituality. They turn to their beliefs for support doubt their faith in times of such pressure. These doubts could in turn cause distress and impact on the mental well being of the individual (Barker, 2004).

Assessment methods

The current available literature mainly addresses the need to facilitate someone's right to express their spirituality, but gives little consideration to the impact of a nurse's judgement when assessing someone's mental health who is expressing their spiritual beliefs (Eeles *et al.*, 2003). What is one person's belief is another person's delusion (Dein 2004). If that person is physically unwell then their beliefs at best may be respected and worst dismissed, but when a person is mentally ill then the judgement of those beliefs become the assessment criteria for delusional beliefs. In extreme cases, a person may lose their liberty by being admitted to hospital. Coyle (2001) suggested that it is impossible to define spiritual self, as this aspect is often obscure and symbolic in nature. Spirituality may not simply mean an individual's relationship with the divine or whatever deity is to be worshipped, spirituality is multi-faceted and may be the individual's concept of love, peace, compassion and their role within the universe (Greasley *et al.*, 2008).

Most people use metaphoric descriptions when expressing their spiritual thoughts and require a certain amount of subjective interpretation to put it into context within the mental health assessment (Dein, 2004). Interpreting these clues may leave the assessment open ended or ambiguous which may lead to misunderstanding and a biased assessment. Narayanasamy and Owen (2001) warns against eliciting thoughts from the

person that may transform a positive interview into an inquisition and that may have what could be perceived by the person as punitive consequences. This thought is echoed by Ledger (2005) who considers that an interview or assessment is rarely without bias and cannot be accepted that the nurse's judgement is not value free. Dein (2004) purports that certain thought or behaviours have different emphasis in different cultures. For example, if a person hears voices or experiences hallucinations it is considered that the person has a serious psychotic illness. In other cultures visual hallucinations may be considered a vision and hearing voices communicating with the dead or God. Even in British culture it is accepted in certain social settings or churches to speak in tongues or commune with the dead through spiritualist mediums.

There are recognised assessment methods to assess someone's spiritual beliefs, however, this is limited to what a person believes and how it may be expressed. The method may even go as far as to offer guidance to nurses in how to support the individual within that expression. The feeling of well being that this support may offer will no doubt assist in helping the individual to 'feel better'. These assessment methods may be transferable across the nursing and indeed any health professional discipline. Unfortunately, the assessment falls short when the assessment is in conjunction with assessment of mental health needs, particularly when the individual is experiencing florid symptoms of psychosis or mania. (Eeles *et al.*, 2003). With these concepts in mind the nurse who strives to implement evidence based practice must experience a certain cognitive dissonance when trying to marry the world of science and the realm of spirituality.

Recommendations

The questions still remain, where does spirituality stop and mental illness start? How can the nurse be sure that the assessment is not biased because of the nurses' influence if their belief differs from that of the person being assessed?

Whilst there seems to be no accurate consistency when assessing someone's mental health and supporting their spiritual belief it is recommended that further research and trials be embarked upon to redress this. There appears to be little empirical research as to how the nurse can avoid bias or prejudice when assessing someone's mental health in

conjunction with their spirituality, however, there is an abundance of literature that discusses some of the main issues. Further study of comprehensive and contemporary literature in the first instance may offer some indication on how to develop the formulation of an assessment tool for the future.

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Appendix 2: Invitation to Participate (email)

(EMAIL)

(date)

Dear

My name is Ruth Elliott and I am a senior lecturer at the University of Huddersfield and studying towards a Professional Doctorate. I am also a qualified mental health nurse and my background is working in adult rehabilitation and adult acute inpatient services. I am carrying out a research project as part of my Professional Doctorate to explore how mental health nurses understand the concept of spiritual need particularly in relation to service users. I am seeking to interview a representative group of mental health nurses about these issues and would value an opportunity to interview you for about one hour at a time and place to suit you. I have attached an information sheet to this email if you are interested in knowing a bit more. Please read it to help you decide whether you would like to take part. If you do decide you would like to take part I would be grateful if you could reply directly to me by leaving your name and contact details by telephone on 01484 471999 or email me on r.h.elliott@hud.ac.uk and I will contact you as soon as I can. Alternatively you may contact Sophie Phillips by telephone on 01484 473415 or email her on s.phillips@hud.ac.uk

Thank you for taking the time to read this and I hope to hear from you.

Kind regards

Ruth Elliott

MSc-HPE, BSc (Hons), HE-Dip, RMN, FHEA

Appendix 3: Interview Schedule

Research question.

How are spiritual needs of service users supported by mental health nurses?

Item	Purpose	Examples/prompts
Welcome	To introduce self and establish a rapport with participant to ensure they feel at ease. Remind participant that the interview may take up to an hour	
Re-establish consent and right to withdraw without prejudice at any point in the process.	To ensure that informed consent has been established and participant is comfortable and at ease with the proceedings.	
Consent to tape	Remind participant that the interview will be recorded and that the recording can be paused, stopped and or destroyed.	Turn on the tape.
Refer to information sheet	Check that the participant is giving informed consent and address any comfort needs, issues or concerns that they may have at this point.	
Confidentiality	Confirm with participant that the terms of confidentiality with regards to collection/storage/use and destruction of data are understood.	

Introduction

Item	Purpose	Examples/Prompts
Establish the context	Research title: The aim of the study is to explore mental health nurses understanding of the spiritual needs of service users	Check whether the participant understands that this is the topic area that is to be discussed.
Verification	Check that the participant	This is a personal and

	is comfortable with discussing the subject area.	often sensitive subject. Ask if they are willing to discuss it.
Clarification	Check if participant has any concerns with discussing this topic.	Re-visit the participants right to terminate interview at any point and offer support.

Interview questions

Item	Purpose	Example/Prompts
What is your understanding of spirituality and spiritual needs?	Intended to focus the nurse on the topic and to encourage them to think about their perspective on spirituality and spiritual need..	Display active listening. Eg, eye contact, open posture. Smiles of encouragement. Avoid 'leading the participant' eg nodding at points. Participant may feel they are giving the 'right' answer
How would you assess or recognise spiritual needs in service users?	Intended to refocus the nurse's thoughts directly to service users to encourage them to discuss what if any assessment strategies were used when caring for a service user's spiritual needs.	
What do you do with that information?	To encourage the nurse to consider service users' care in relation to spiritual needs and tease out any other influences that affected care or indeed how spiritual need affected care	

Conclusion

Item	Purpose	Examples/prompts
Opportunity for supplementary questions	To provide an opportunity to explore and capture an experience the participant may have had that will provide further information	Are there any other aspects of spiritual needs in relation to service users you would like to discuss? You mentioned..... Will you describe this a bit further please?
Debriefing.	To ensure the participant feels they have been listened to and their contribution is respected and valued.	Ask if the participant has enjoyed the interview and how they are feeling (offer appropriate support or referral if needed).
Opportunity for future support	To ensure the participant has all information to seek support post interview if needed.	Refer participant to post interview sheet and or contact numbers.
Confidentiality	Revisit confidentiality agreement	Confirm that their identification will remain anonymous and will remain confidential to the research team.
Consent and Data protection	Confirm that informed consent has taken place and relevant consent forms have been signed and obtained.	Double check that the participant is aware of what the data will be used for and reassert the participants right to withdraw at any stage.
Reflection	Review of the process so far	Ask the participants what part of the process went well from their point of view and what aspects could have been improved.
Conclude the recording	To mark the end of the interview formally	Tape off
Thank you	To communicate to the participant that they have made a valuable contribution to this research and to thank them for their time and effort.	
Dismissal	To ensure the participant is clear that the interview process has now ended and that they leave the room safely.	

Appendix 4: Participant information sheet

(on University Headed paper)

Participant Information Sheet (Mental Health Nurse)

Research title: An exploration of mental health nurses understanding of spiritual needs of service users.

Part 1

Essential Elements of the study- What the study is about

You are being invited to take part in a research study. Before you decide whether or not to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

You are welcome to contact me if there is anything that is not clear or if you would like more information. My contact details can be found at the end of this information leaflet. Please take time to decide whether or not you wish to take part.

The importance of spiritual care is recognised by service user group and government initiatives however following a survey by the Royal College of Nurses (RCN) in 2010 it was suggested that nurses on the whole know little about how to support a person's spiritual needs. It wasn't specified which field of nurses the results were taken however the results suggested that the main body of participants in the study were adult nurses. This study involves only mental health nurses who are currently in practice. We will be paying particular attention to how nurses identify, assess and support spiritual needs of service users. If you choose to participate you will be agreeing to take part in an interview that will last up to an hour.

The aim of the study is thus:

1. To explore how mental health nurses understand the concept of spiritual need particularly in relation to service users.

To establish how mental health nurses evaluate the concept of spiritual need in relation to service users

To explore how the nurses perception of the spiritual needs of a service users may affect the assessment process

Why have I been chosen?

In this study I will be interviewing mental health nurses currently in practice with service users. You have been chosen because you are a qualified mental health nurse with experience of working with people with mental health issues providing holistic care which includes spiritual need.

Do I have to take part?

No. There is absolutely no obligation on you to take part. Participation is voluntary and if you choose to participate you can withdraw without consequence to you at any time.

What will happen to if I take part?

Tick the box on the consent form indicating “Yes, I would like to take part in this study”. Please also fill in the contact details section and return the form to me using the stamped addressed envelope provided.

I will contact you and arrange to carry out an interview for about an hour with you at a time and place of your convenience. To ensure accurate recording I would like to audio-record it, with your permission.

Either myself or a secretary employed by me will transcribe the information. At this point, your name, the names of other people mentioned in the interview and any other information that might identify you will be anonymised. I may wish to use quotes from your interview in articles and talks arising from this research. Again, I will ensure that these are anonymised.

What are the possible disadvantages of taking part?

If you choose participate, we expect that you will find the experience interesting and enjoyable. It is possible however that you may find some of the questions sensitive but your wishes will be respected throughout the process and support available if needed.

What are the possible benefits of taking part?

It is unlikely there will be any direct benefit to you from taking part in this study. However the information may help inform nurse education within the university and formulate conference papers and presentations.

How will my information be used?

You will receive a summary report at the end of the study. You can also request a full copy of the final report if you wish. You will also be told about any events taking place in your area in which the results of the study are being presented.

A full report will be sent to South West Yorkshire Trust (SWYT) who have supported this study in terms of agreeing the process and access to nurses. There will be articles produced about the results of the study for academic and professional journals and the findings may be presented at relevant conferences.

No names of people taking part will be mentioned in any reports, articles or conference presentations about the study. Care will be taken to ensure that you cannot be identified. All information provided will be treated as confidential and will be anonymised. **The only exception to this will be if any abuse or serious malpractice is described. In this instance, this will be reported to line managers and dealt with in line with the host organisation's accepted organisational policy.**

Who is running and reviewing the study?

The interviews are part of a study towards a Professional Doctorate in Nursing which has been reviewed and approved by the University of Huddersfield ethics board. The result of which will formulate part of a thesis.

Who do I contact if I want more information about the study?

Ruth Elliott (Senior Lecturer)

Telephone; 01484 471999

Email: r.h.elliott@hud.ac.uk

Thank you for taking the time to read this.

Appendix 5: Consent form

(University Headed Paper)

Title of study: An exploration of mental health nurses understanding of the spiritual needs of service users

NAME OF RESEARCHER: Ruth Elliott

1. I confirm that I have read and understand the information sheet ***dated*** ??? for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and I have the right to withdraw from the research without offering a reason and without prejudice at any stage.

I understand that all information I provide will be treated as confidential and will be anonymised. The only exception to this will be if any abuse or serious malpractice is described and then this will be reported via the accepted SWYFT organisational policy.

I agree to the use of anonymised direct quotes from my interview in publications and presentations arising from this study.

I agree to the interview being audio recorded

I agree to take part in the above study

In addition to the consent form, please provide the following information to ensure that the participant sample is representative of the population of mental health nurses currently in practice.

Name of participant

Signature

Date

Appendix 6: Coding template used in data analysis (final version)

Theme 1

This theme considers spirituality from the perception of the participant's personal life as opposed to their role as a nurse. It includes influences from their personal background and history including their family, school, social life and friends. These influences shaped their understanding of spirituality and may continue to influence their professional approach towards service users and their perception of what they feel is in the best spiritual interest for them. However it is separate from what they have learned as part of their nurse training or continued professional development.

1. Role of spirituality from personal perspective (How spirituality features and shapes the nurses personal life, separate from professional but may influence decision making)

Social development influences: (Influence of own life experience on personal understanding of spirituality)

Family religious background (May include different religions or atheism but is essentially what the participant has been influenced by within family life and the perceptions they have on other people's lives including service users)

School (Considers the demography of the school and considers the diversity and its approach to spirituality and religion and its influence on the participant.)

Role of Formal religion for self (The participant may state they are 'not religious' in respect of one religion or doctrine. This may include atheism or agnostic)

Intellectual understanding and models of spirituality (Intellectual understandings considers what has been 'taught' to the participant, for example what religious leaders and religions purport to be true. It also included what the participant has 'learned' in the academic sense as opposed to the influences from role models in families and friends.)

Traditional religious 'models' of spirituality (The extent to which the participant describes themselves as subscribing to, believes, concords or acquiesces to the view point of a particular religion)

Afterlife (What the participant believes happens to a person following physical death including heaven and hell)

Alternative models of spirituality (supernatural*) (Supernatural in this context does not include or refer to a deity or God but to a belief in spirits/ghosts, extra sensory perception and/or ability to contact the dead or clairvoyance.)

How beliefs combine to produce personal lived experience of spirituality (This is the culmination of what has influenced the participant and what has been learned throughout their life. It is their personal thoughts and beliefs if left to their own approach without feeling pressure from others about what they feel the participant should believe.)

Personal definition of spirituality (spirituality is for me...)

Personally derived moral code (In the absence of a religious code this is what the participant believes is right or wrong or what is acceptable in terms of living in humanity.)

Eclectic approaches (comprising of elements of traditional religions or belief systems to formulate own code)

Provides hope, meaning and purpose (How spirituality is the motivational driver to live and feel valued in life itself particularly when life events cause a person stress, e.g. ill health, bereavement, financial or significant social issues)

Human development/conscious evolution (How and what a person learns and develops throughout their life through their interest in spiritual or life progression)

The term 'spirituality' (This is concerned with the participants own definition or understanding of the term spirituality)

Discomfort with the term (Some participants were uncomfortable with the term spirituality)

Alternative phrases preferred (other terms for spirituality were offered and compassion was linked and offered as an alternative.)

Connectivity (The extent to which a person feels an integral part of 'something else' which is wider than family and friends)

Connection to natural world (Natural world includes plants, animals and all elements which make up Earth)

Connection to other people (People include human beings as well as family and friends)

Connection to metaphysical (metaphysical what does not exist in nature or cannot be explained according to natural laws or physics. It's not physical or material but may be considered as part of the supernatural.)

2. **Influences on professional understandings of spirituality** (This theme considers how a participants understanding of spirituality may be changed or influenced by their nurse training, colleagues and professional expectations. The nurse may carry the 'spirit' of their beliefs which they have already been exposed to in their personal life but may have changed their thoughts or behaviour in relation to their professional standing and as a result of their professional standing.)

Nurse education (Nurses are educated both in university and clinical areas, both are needed to register as a qualified nurse and to maintain that registration)

Role of the team (How spiritual care is met using a; team approach (an agreed way of working as a group of professionals) or team working (how an individual's strengths may be utilised to benefit a service user/s)

Particular team ethos (An agreed viewpoint which may differ from an individual's view but is acceptable for all and used to benefit the approach used for the care of service users generally.)

- 3 Nursing spiritually** (Theme 3 considers how the nurse applies their spiritual understanding derived from both personal and professional values to caring for service users. It shows how this has both a positive and negative effect on the service user and how the nurse reconciles their values and conscience to the actions or inactions they take)
- 3.1 Factors influencing nurses attitudes to patients** (The extent to which the nurse may consider the expression of spiritual need is part of the service users mental illness)
- 3.1.1 Attitude toward people who are experiencing psychosis** (Extent to which a person's experience of psychosis and expression of spiritual need affects the nurses approach.)
- 3.1.2 Attitude toward people who are experiencing affective disorders** (Extent to which a person's experience of mood disorder and expression of spiritual need affects the nurse's approach. Does this approach differ if the person is depressed or experiencing mania?)
- 3.1.3 Attitude toward people who are experiencing death or dying**
- 3.1.3.1 Suicide** (This element considers suicide and how this influences the nurse's approach in the spiritual context)
- 3.1.4 shared belief system** (Participant who had the same fundamental belief as the service user who they are working with)
- 3.2 Assessment of spiritual need** (The extent to which spiritual needs of service user is assessed or not)
- 3.2.1 Formal assessment** (E.g. How spiritual need is ascertained through an 'Initial assessment')
- 3.2.2 Informal assessment** (how spiritual need is obtained through objective assessment of a patient made through informal means, e.g. 'chat')
- 3.2.3 Age of service user** (Age in this context remains that of an 'adult and does not include children or older adult. How a person's age and expression of spiritual need affects the nurses approach)
- 3.2.4 Context of care** (Relates to which service the SU is currently being cared for)
- 3.3 Reconciling individual needs with service requirements** (How the nurse/team manipulate the specific requirements of 'the system' (the system=the organisation, government, MH act, NMC, law) to the needs of the individual to provide spiritual care)
- 3.4 Treatment** (Treatment in this context relates to all general mental health interventions used in mental health services)
- 3.4.1 Medication regime and its effects on the service user** (The extent to which medication is used, increased, maintained on current regime following an assessment and if an expression of spiritual need effects it)

- 3.4.2 Non-medication based interventions (talking therapies) (The extent to which this type of intervention is used, increased, maintained on current regime following an assessment and if an expression of spiritual need affects it)**
- 3.5 Mental Health Act issues (The extent to which this type of intervention is used, increased, maintained on current regime following an assessment and if an expression of spiritual need effects it)**
 - 3.5.1 MH act restrictions enforced (community treatment order, reduction/withdrawal in leave status)**
 - 3.5.2 The effect on spiritual care following MH restrictions (The extent to which Mental Health Act restrictions has an effect on spiritual need or support)**

- 4 **Fear and anxiety** (This integrative theme permeates through all the other themes to a greater or lesser degree. Throughout the interviews the participants expressed either implicitly or directly their fear and anxiety and anxiety. Fear and anxiety of ridicule, embarrassment, 'getting it wrong', imposing their own beliefs on service users and colleagues. This often presented itself as a concern about how I would perceive them and their professional competence. To the extent that many of the participants looked up or intended to look up what spirituality is.)

Researched term prior to interview (The term research in this context include 'google' 'looked up' 'read about')

Impact on professional standing (Fear and anxiety in this context relates to the effect a nurses personal beliefs may have on their credibility as a professional and whether or not this will affect how other professionals perceive them)

Ridicule (Concern about the possibility that they would be ridiculed professionally by their colleagues)

Professional concerns in relation to service users (Fear and anxiety in this context relates to the effect that the nurse perceives their spiritual beliefs or approach may negatively affect a service user.)

Deliberately avoid topic of spirituality (Nurses avoided the topic of spirituality in discussion with either service users or colleagues)

'Getting it wrong' (Their approach to service users belief. Concerned with harming, hurting or offending a person)

Imposing own beliefs (Fear and anxiety of hurting or offending a person by expressing their own belief or values when it is unwanted)

Appendix 7: Spirituality Workshop (powerpoint)

[The Last Taboo \(click hyperlink\)](#)