Meaning of spirituality: implications for nursing practice

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Background. This research outlines some preliminary findings emerging from a grounded theory investigation into the ‘meaning of spirituality’. These initial results raise some important questions about the terminology and language that nurses use regarding the term spirituality. It seems that many of the policy directives and statutory guidelines make two major assumptions regarding ‘spirituality’. Firstly, patients and nurses are aware and understand the concept, and secondly, patients may require their spiritual needs to be met. These preliminary findings suggest that a dichotomy is emerging between professional assumption and patient expectation regarding the meaning of spirituality.

Aim. The study had one broad research aim, to gain a deeper insight into how patients, nurses, and people from the major world religions understand the concept of ‘spirituality’.

Design. A qualitative research design was used involving a grounded theory method of inquiry. It was felt that this qualitative method would aid the investigation of this subjective dimension of peoples’ existence, enabling existing theoretical constructs and arguments to be tested.

Methods. The constant comparative method was used throughout the data collection and analysis. Analysis was undertaken at two levels, ‘overview analysis’ and ‘line-by-line analysis’. This enabled the creation of categories and central themes. Two categories presented and discussed in detail are ‘definitions of spirituality’, and ‘diverse perceptions of spirituality’.

Conclusion. It would seem that there is now an urgent need for nursing to evaluate and perhaps adjust its vision regarding what constitutes spirituality. Such an approach may serve to reduce the gap between policy and public expectation.

Relevance to clinical practice. It seems that there may be no ‘precise’ terminology associated with the language used to define spirituality, raising possible implications for nursing practice and nurse education.

Key words: grounded theory, nurses, nursing practice, spiritual care, spirituality
Introduction

The concept of spirituality and the provision of spiritual care seem to be firmly fixed within the nursing and health care agenda. The evidence to support this is found in the vast amount of research (e.g. Waugh, 1992; McSherry, 1997; Narayanasamy & Owens, 2001; Baldacchino, 2002) and texts addressing the subject (e.g. Shelly & Fish, 1988; Harrison & Burnard, 1993; Cobb & Robshaw, 1998; McSherry, 2000b; Orchard, 2001; Narayanasamy, 2001; Swinton, 2001; Taylor, 2002). Interest in ‘spirituality’ has become far more professionally diverse with almost every health care profession contributing to the debate, including medicine (Gulliford, 2002). Despite this proliferation of activity and the ensuing academic discourse there is still a great deal of vagueness and ambiguity surrounding the meaning of ‘spirituality’ and whether the definitions being used represent the views of the service users.

This paper presents some findings of continuing research into the meaning of spirituality. Firstly, the political and professional context for spirituality within health care is provided. Secondly, a literature review of definitions of ‘spirituality’ is briefly described. The findings from the first phase of a grounded theory investigation are then outlined which suggest that discrepancy may exist between political/professional assumptions and patient expectations.

Political and professional context

There has been a drive, both politically and professionally, to establish spirituality as an important and integral part of health care provision. Reference to spirituality can be found in government publications (DoH, 2001) and is implied in codes of professional practice (NMC, 2002).

The first major ‘political’ attempt to locate responsibility for the delivery of spiritual care by National Health Service staff was The Patients Charter (DoH, 1991) supported by the Department of Health Circular HSG (92)2 Meeting the Spiritual Needs of Patients and Staff (DoH, 1992). The Patients Charter (DoH, 1991, p. 12), and more recently Your Guide to the NHS (DoH, 2001, p. 29) state:

NHS staff will respect your privacy and dignity. They will be sensitive to, and respect, your religious, spiritual and cultural needs at all times.

The Department of Health Circular HSG (92)2 provides guidance on how to meet the standard, highlighting spirituality as an important dimension of peoples lives (DoH, 1992).

These documents affirm the place of spirituality within the context of health care, presenting a case for holistic care. Orchard (2000) suggests that these initiatives led to confusion and false expectation with regard to patients’ rights. It could be argued that these initiatives highlight a political agenda that has been created for the provision of spiritual care without giving any real consideration to the implications of this for staff or patients. It is not clear whether any form of consultation was undertaken with patients, key stakeholders, or NHS staff prior to the development of these initiatives.

In response to some of the confusion and difficulties local National Health Services were experiencing in translating and implementing the Patients Charter (DoH, 1991), the National Association of Health Authorities and Trusts (NAHAT) (1996) published the document Spiritual Care in the NHS. A Guide for Purchasers and Providers. The primary aim of this publication was to assist providers of health care to implement the charter standards associated with spiritual care. The political and professional developments outlined in this document imply that patients and NHS staff have a clear, shared understanding of the concepts of spirituality and spiritual care.

However, the Department of Health (DoH) has recently undertaken a listening exercise canvassing views and thoughts on its document NHS Chaplaincy Guidance: Meeting the Spiritual and Religious Needs of Patients and Staff (DoH, 2003). This exercise is now closed but it signals a positive attempt by the DoH to consider and hopefully act upon people’s opinions and concerns with regard to the future direction of spiritual care.

The United Kingdom Central Council (UKCC), and one can assume the newly formed Nursing and Midwifery Council (NMC), in its publication Requirements for Pre-registration Nursing Programmes (UKCC, 2000, p. 13) declares the following competency should be achieved for professional registration:

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

While this competency statement was evident in Rule 18 A (UKCC, 1986), it has been revised to include the assessment of communities, thus extending and raising the profile of spiritual assessment. Furthermore, this competency seems to locate responsibility for spiritual assessment firmly in nursing without giving any consideration to any practical implications (McSherry & Ross, 2002).

Looking at the above policy documents and the UKCC competency statements, two assumptions may be being made by policy makers, and more recently by professional regulatory bodies. These are:

1. Patients and nurses are aware of their own spirituality, and understand the concept as presented in health care terms;
2. Patients and users of health care facilities expect to have their spiritual needs addressed.
These two assumptions signal a desire to establish and raise awareness of the importance of spirituality within the context of peoples’ lives. A counter argument may be that service users might not understand the terminology and language used in these documents and that this specialized discourse might therefore be difficult to translate into useable policy. It could also be argued that it does not fit comfortably with the practice of actively seeking the voice and concerns of service users to develop practice and service provision especially in the current situation where there is an urgent need to establish precisely what service users’ needs and wants are regarding the provision of spiritual care. Making assumptions in this area could lead to the provision of care that is not sensitive to the needs of individuals from diverse cultural and religious groups. A ‘one size fits all’ approach may lead to making generalizations about what peoples’ spiritual needs might be.

A review of the literature

A review of the health care literature was undertaken to identify how spirituality was being defined, and addressed both theoretically and practically. Some of the databases searched were CINAHL, MEDLINE, and EMBASE. Key words used were ‘spirituality’, ‘spiritual’, ‘spiritual care’, and ‘spiritual need’. Some 2000 papers were identified. Those that provided a definition, were empirically based, or contributed to the theoretical, conceptual understanding of the concept were included in the review (e.g. Carroll, 2001; Chui, 2001; Shirahama & Inoue, 2001; Coyle, 2002; Tanyi, 2002). The search, also brought to light several studies investigating spirituality that had used a similar research design namely grounded theory (Harrison & Burnard, 1993; Burkhart, 1994; Walton, 1997; Thomas & Retsas, 1999).

There are many approaches to the concept of spirituality. However these can usually be accommodated by two broad schools, those who believe in a God and those who do not (Cawley, 1997). Subcategories have been identified that provide further detail. For example spirituality is about: existentialism, finding meaning purpose and fulfilment in life, (Narayanasamy, 2001); a sense of connectedness, either individually or with the wider world (Reed, 1992); spirituality applies to all people, even those who do not believe in a God or Supreme Being (Burnard, 1988).

The study

Aim

The study had one broad research aim, to gain a deeper insight into how patients, nurses, and people from the major world religions understand the concept of ‘spirituality’.

Method

A qualitative research design was used involving a grounded theory method of inquiry developed by Glaser and Strauss (1967). It was considered that this qualitative method would aid the investigation of this subjective dimension of peoples’ existence, enabling us to test existing theoretical constructs and arguments using diverse groups of people.

The study involved 53 participants. This paper presents some findings from phase I of the study in which 22 individuals were interviewed during January 2001 and February 2002 (Table 1). Nurses, patients, and representatives from four of the major world religions were drawn from three areas: area I, a hospice; areas II and III, acute trusts, but residing in different geographical locations within Yorkshire, UK.

Participants were identified after completing a short questionnaire, indicating that they would be willing to be interviewed. Questionnaires were distributed to patients and nurses by the Charge Nurse and to representatives from the four major religions through the Trusts’ Chaplaincy teams. The questionnaire provided demographic information

| Table 1 Summary of participants in phase 1. Length of interview ranging from 18 to 57 minutes – average 37 minutes 20 seconds |
|-----------------|--------|--------|--------|
| Participants (age range) | Male | Female | Total |
| Nurse (34–57) | 03 | 09 | 12 |
| Patient (66–82 >) | 03 | 02 | 5 |
| Others (26–66) | 04 | 01 | 05 |
| Total | 10 | 12 | 22 |
| Religions represented | | | |
| Church of England | 00 | 07 | 07 |
| Roman Catholic | 00 | 01 | 01 |
| Buddhist | 00 | 01 | 01 |
| Sikh | 00 | 01 | 01 |
| Hindu | 00 | 01 | 01 |
| Muslim | 01 | 01 | 02 |
| Quaker | 01 | 00 | 01 |
| Bahai | 01 | 00 | 01 |
| Methodist | 00 | 01 | 01 |
| Pagan | 01 | 00 | 01 |
| No religious belief | 03 | 02 | 05 |
| Total | 07 | 15 | 22 |
| Practising | 07 | 06 | 13 |
| Non-practising | 00 | 04 | 04 |
| Not applicable | 03 | 02 | 05 |
| Total | 10 | 12 | 22 |

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(Table 1). One question asked the individual to select only one statement from four that best described their understanding of spirituality. The demographic information combined with the response to this question was used to identify potential participants for inclusion in phase I. This approach to sampling is termed open sampling (Strauss & Corbin, 1998). However, individuals at this stage were purposefully selected and invited to participate in the study. This approach fits one variation of open sampling outlined by Strauss and Corbin (1998, p. 208) who write:

The researcher may look for persons, sites, or events where he or she purposefully can gather data….

Ethical approval was obtained from the local research ethics committees, and institutional permission and access were jointly obtained. After gaining written consent, in depth semi-structured interviews were conducted.

Data analysis

All interviews were recorded and were individually transcribed. The constant comparative method was used throughout the data collection and analysis. This method ensures the quality and rigour of the theory produced. This analytical approach meant that the theory developed was derived from and rooted in the data which had been systematically gathered and analysed throughout the entire research process (Strauss & Corbin, 1998, p. 12). In keeping with other researchers who have used grounded theory, analysis was undertaken at two levels, ‘overview analysis’ a form of ‘macro-analysis’ and ‘line-by-line analysis’ or ‘micro-analysis’ (Glaser, 1978; Wainwright, 1993; Strauss & Corbin, 1998).

During the data analysis we developed broad categories to accommodate the themes emerging within the transcripts surrounding the meaning of spirituality. Two categories developed were labelled definitions of spirituality, and diverse perceptions of spirituality. These will be explored in more depth, focusing on some implications for spiritual assessment and nursing practice.

Results

Definitions of spirituality

The data analysis suggests that a dichotomy may be emerging in that health care professionals, in an attempt to implement and educate staff in the provision of spiritual care, seem to have constructed a definition of spirituality that may be specific to health care. All 12 nurses interviewed provided similar definitions of spirituality. Closer analysis of these revealed that several contained properties or descriptors outlined by Murray and Zentner (1989, p. 259) who define spirituality 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 good. The spiritual dimension tries to be in harmony with the universe, and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death.

The following excerpts illustrate the observation made:

I think it’s different to every person, to me spirituality is what makes me feel what makes me! The emotional side, the essence of living! It makes somebody feel whole. It’s the sparkle. Yeah it’s just Je ne sais quoi! I don’t know? (Nurse Area I)

For this nurse spirituality was about their essence, about what makes them unique, individual and ‘whole’.

I do actually think about spirituality. I couldn’t define spirituality. I think spirituality is something which is for me it’s like a thread if you like or stronger than a thread. It’s like you get rivers of stone underground. I forget what you call them (strata). It’s like that really that runs through all of our lives really. Well that’s what I think spirituality is! What that means for each individual. It does have to be some sort of bases of – it’s like a common denominator. (Nurse Area II)

For this nurse the concept of spirituality was not alien, in that they had given considerable thought to it within their life. Spirituality was described as a force that permeated every aspect of their life and being. Initially the nurse had some doubt about offering a definition.

Well I think it means different things to different people! As far as I’m concerned it’s not necessarily about their religious needs! I think everybody has a soul in my view so everybody has spiritual needs and I feel that you know our role is to respect whatever they may be. (Nurse Area III)

This nurse implies that spirituality is a universal concept. It applies to the religious and non-religious. The use of the phrase ‘soul’, like the previous definitions, seems to place spirituality at the centre of the person.

When comparing and contrasting nurses’ definitions of spirituality with that of patients there appear to be significant differences between the language, interpretation and understanding of the concept. Five patients from three setting (Table 1) were asked about their understanding of the term ‘spirituality’. All expressed difficulty in articulating a definition or even identifying with the term. One of the patients interviewed had never really given the concept of spirituality or one must assert the word, any consideration. For example:
I have not a clue. I really don’t know what it means. To me it is just about religion. I don’t know how you describe it quite honestly. That’s why when you rang up I thought to myself, I don’t know what I am going to say to you because I don’t know what it means. (Patient Area III)

Spirituality and religion are also viewed synonymously by some patients. For example:

Never has interested me even illness it’s never interested me has religion. It has done nothing for me. (Patient Area I)

Well that’s what I thought when I got this letter you know. Well I thought well again we’re back to religion! (Patient Area I)

The following definition provided by one patient continues this theme but also places the concept of spirituality within the context of supernatural, or spiritualist forces:

Spirituality I think it is personal, it depends on what the individual believes for example my mother believes spirituality to be psychic, ghosts and people coming back from the dead. Whereas I think it to be what religion you believe in your own aspects towards god or however it is that you worship. (Patient Area II)

In summary, this study shows that whereas nurses provided clear definitions of spirituality in line with Murray and Zentner (1989), patients were unclear about its meaning and considered it to be synonymous with religion. In this sample there appeared to be a mismatch between service users and providers perceptions of the term. Furthermore, Murray and Zentner’s (1989) definition and assumption that spirituality comes into focus at a time of illness or crisis was not reflected in the patient interviews.

Diverse perceptions of spirituality

Within nursing and more so in the wider community, there have been tremendous steps to raise cultural awareness, in an attempt to combat racism and racial prejudice without making generalizations, and stereotypical assumptions about the needs of specific ethnic groups (Gilliat-Ray, 2001). These advances have been achieved, in part through education, but more precisely by listening to the voice, and needs of specific groups (Henley & Schott, 1999). Attention has now turned to spirituality because it would appear that the definitions being created may be perceived by some ‘faith groups’ as being Judeo-Christian biased in that they seem to exclude and do not reflect the diversity of opinion and understanding of spirituality that may exist within other faith communities: ‘where there are alternative accounts of spirituality’ (Markham, 1998, p. 85).

One question that may require clarification is what is the view of ‘spirituality’ in the Judeo-Christian tradition? This question cannot be answered other than at a purely simplistic and superficial level within the context of this manuscript. Markham (1998), Bash (2004) and more recently Fawcett and Noble (2004) provide useful insights of spirituality within this tradition. Markham (1998, p. 74) indicates that the Christian will recognize that individuals are not just composed of a physical body but they are made up of a mind – spirit or soul. Christians live in a world created by God and the reason for existing is to worship a transcendent God who is: ‘the source of goodness, love and beauty’. The aforementioned works suggest that there may be a great deal of commonality or an ‘homogenous’ view as to how spirituality may be viewed within ‘Christianity’. However our suspicion is that if one delved deeper and explored the meaning and significance of spirituality within all Christian traditions then a more ‘heterogeneous’ picture would emerge (McSherry & Cash, 2004). Therefore the argument that definitions of spirituality presented within the health care literature are ‘Judeo-Christian’ must be questioned because they may not reflect the diversity that may exist even within the Christian tradition.

Recognition of a potential Judeo-Christian bias is emerging in contemporary health care writing for example Lie (2001, p. 191) states ‘Material on spiritual care emanating from Christian perspectives is widespread’ indicating there has been an absence of other faith communities contributing to or offering their understanding of the subject.

Five representatives from four of the major world religions (Table 1) were interviewed. Issue must also be given to the question to what extend were the individuals representative of their faith communities. The five participants were all actively engaged in their faith communities and practising their religion. However just because someone practises their religion does not necessarily mean that their views reflect everyone who subscribes to that particular belief system. Therefore by nature these findings, while shedding light on how an individual(s) from a particular world religion may view spirituality, by nature this will be ‘idiosyncratic’.

Box 1 presents five representatives perceptions of the word ‘spirituality’. Two seemed to have difficulty identifying with the word ‘spirituality’, struggling to offer a definition, whilst two viewed spirituality as synonymous with religion. Whilst one representative from the Islamic religion provided a definition of spirituality that resembled, or contained elements similar to those provided by some of the nurses, the majority did not perceive or think of spirituality in the terms or manner in which it is presented within nursing definitions.
Box 1 Perceptions of spirituality

**Muslim**: I didn’t feel I had enough knowledge about spirituality and as I got into the post and went to training and read up on my subject I found out things and realized the way people see spirituality, as a Muslim I probably don’t see spirituality in the same way.

**Muslim**: Well first of all spirituality exists within everyone whether you believe in God or not. To me personally it would be to overall, look at the patient overall and address their needs to the way that they would see it.

**Sikh**: Sikh religion is secretion of the spirituality. Spirituality is the main thing in Sikh religion.

**Hindu**: Yes spirituality is pertaining to religion and its principles.

**Buddhist**: I was gonna say it’s not a term we use in Buddhism as such! It’s a hard word to define actually (laughing) it’s just a difficult word to define!

What emerged in this study were differences in the way that the concept of spirituality was viewed by different groups of people, nurses, patients and representative from four of the major world religions \( n = 22 \). We are aware that the findings may not be representative of all the groups participating in this study or people who subscribe to a particular religious framework. However these excerpts suggest that the concept of spirituality (as used in health care) may not be universally recognized, emphasizing the need for caution when trying to apply directly the concept to diverse religious groups.

Again consideration must be given to the language and terminology that we are using to define spirituality because the excerpts reveal that ‘spirituality’ as a word may not feature in the vocabulary of all religious traditions or groups of people for example patients, at least not in the manner in which it is presented within nursing.

Further, deliberation must also be given to other factors that may explain the diversity of opinion and understanding of spirituality that existed between the groups. One factor that may account for the differences between nurses, patients, and four major faiths represented may be ‘professional education’. Of the 12 nurses interviewed several highlighted how postgraduate education had changed their understanding of spirituality from being perceived purely as synonymous with religion to a broader universal approach. Other variables that may need to be considered are age, gender, religious practices, and cultural influences for example ‘socialization’. These variables may influence and account for differences in the way that the concept of spirituality was viewed by the different groups.

We recognize the limitations associated with qualitative research and acknowledge that the findings cannot be generalized to the population at large. From the small number of patients interviewed (five) there was a great deal of diversity surrounding the interpretation and understanding of the term ‘spirituality’, ranging from the religious, and spiritualist focused approaches to what could be termed ‘new age’ or alternative. In addition, the findings imply consideration may need to be given to cross-cultural diversity, and intercultural differences, in that spirituality may be perceived differently by nurses, and patients. The findings also suggest there may be cultural difference within and between health care professionals.

**Implications for practice**

This article has presented some of the findings from the first phase of a grounded theory investigation into the meaning of spirituality. The results, whilst not representative, provide a valuable insight into how spirituality may be perceived by different groups. One finding outlined indicates that there may be diverse opinions and views surrounding what constitutes spirituality. It seems that there may be no ‘precise’ terminology associated with the language used to define spirituality, raising possible implications for practice.

The results imply that any attempt to define precisely what constitutes spirituality may be fraught with difficulty. The discrepancies that appear to exist between the groups interviewed emphasizes the ambiguity and subjectivity that surround the concept. Therefore, whilst policy makers and professional regulatory bodies should be commended for attempting to draw and raise awareness of this important dimension of peoples’ lives through legislation, they must guard against making assumptions with regard to what constitutes spirituality. This may be necessary because the findings of this study suggest that some groups of people may not identify with the term or articulate what they perceive spirituality to be.

The emerging data surrounding the language of spirituality implies that spirituality has different meanings and interpretation (Martof & Mickley, 1998). This may have implications when educating practitioners into matters relating to spirituality. Programmes of study may need to reflect this diversity of opinion, and therefore a broad universal approach may be required, ensuring inclusion of all views. However, one of the potential risks in adopting this perspective is that the area can be very subjective and the possibilities of what to include may be endless. The findings of this study also imply that there may be a need to emphasize the importance of adopting an individualistic, non-judgmental approach to care delivery. It would seem by adopting these two key principles within education this may help prevent ‘spirituality’ being taught in an overly generalized...
and simplistic manner. From this brief analysis it would seem more thought and debate needs to be given to some of the educational issues surrounding the teaching of spirituality (McSherry, 2000a).

The concept of spiritual assessment is still relatively new within the UK: the exact nature, function, and relevance of this are still being debated and contested both academically and practically (McSherry & Ross, 2002). One concern that originates from this area and that has been articulated by health care professionals is the fear and apprehension associated with not having the skills to assist, ‘messing up’ or ‘opening up a can of worms’, and being out of one’s depth professionally (McSherry, 2000b). One cannot deny that the potential for this does exist. Perhaps this study provides one reason for this because it reveals that spirituality is very subjective, diverse and complex. Therefore the need to provide individualized care in this area is of paramount importance.

Conclusion

One cannot ignore the voice of the public and health care professionals, which is cautioning us to revisit and perhaps revise our understanding of spirituality. Failure to listen to these concerns may result in the area of spirituality being inappropriately assessed and addressed within practice. If these reservations are not addressed it may result in spiritual care being provided that is not individualistic and holistic but fragmented being bureaucratic in nature. It would seem that there is now an urgent need for health care to evaluate and perhaps adjust its vision in this area. Such an approach may serve to reduce the gap between policy and public expectation.

Contributions

Study design: WM; data collection and analysis: WM; manuscript preparation: WM, KC, LR; research supervision: KC, LR.

References


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