

NEW INSIGHTS INTO SPIRITUAL INTELLIGENCE IN NURSE EDUCATION

by

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Abstract

Background

The topic of spiritual care is challenging with evidence suggesting student nurses feel unprepared to deal with these issues. Spiritual care should be included as part of holistic practice but is complex in the multicultural setting of healthcare. This thesis developed to explore student nurses' experiences to aid learning and develop best practice around the topic.

Study Aim

Explore undergraduate nursing students' lived experiences that develop their understanding of spiritual care.

Literature Review

A meta-narrative literature review was undertaken which produced four key themes: integrating spiritual care into the curriculum; self-awareness around spiritual issues; spiritual care as part of holistic care; and competency in spiritual care.

Methodology and methods

An interpretative phenomenological approach, based on Van Manen's work (2014), has been utilised for this study. Data were collected using a semi-structured interview strategy.

Participants

A purposeful sample of ten undergraduate nursing students took part in the study from adult and mental health nursing degree courses.

Analysis

Analysis involved descriptive and interpretative phases. The conversations were described using portraiture and interpreted using lifeworld phenomenological existential themes of lived body (corporeality), lived time (temporality), lived space (spatiality), lived relations (relationality), materiality (lived things) and technology (lived cyborg relations). A creative writing of the phenomenological insights was used to explore new insights into the topic area.

Results

The findings showed that there were significant similarities with current literature as presented in the earlier review. New insights from this study were the need to develop student nurses' spiritual intelligence as a way to combine the cognitive, emotional and spiritual aspects when providing spiritual care.

Discussion

A Spiritual Intelligence in Nurse Education Framework is proposed and discussed as a method to educate student nurses about the topic. The framework includes elements of meaning and purpose, transcendence, goals and decision making, and character as key in developing understanding about spiritual care, linking to holistic practice and building the student nurse's personal and professional virtues.

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Chapter 1

Background and Context

This thesis has emerged from my wondering whether spiritual care was taught in nurse education in a way that enabled students to understand and apply the material. The starting point of wonder made me probe my own educational setting approach to teaching the topic and highlighted that the material was concentrated in one module in the pre-registration undergraduate nursing curriculum. I wanted to know if this was the most effective way to teach spiritual care and whether other approaches would be more beneficial to student learning. My experience seemed to indicate that students found the topic of spiritual care challenging leaving them feeling unprepared to deal with issues (Koenig 2013; Vlasblom et al 2011; Cone & Giske 2018). Thus, I was interested in exploring how student nurses learnt about spiritual care so that they can incorporate this element into their practice as they progress towards being a registered practitioner. Research supports that there is a lack of clarity about how to promote education on spiritual care into nursing education (Burkhart & Hogan 2008) although it is considered an important aspect of providing quality care (McSherry & Jamieson 2011). I began to explore the topic of spirituality as a starting point for this work and realised that it is a complex area with many forms of expression, including religious and non-religious. This introductory chapter contextualises the labyrinth of issues that influence spiritual care delivery in United Kingdom nursing practice. These are the:

- Context of nursing practice;
- Context of health care practice;
- Use of terminology
- Person-centred care
- Models focusing on spirituality and spiritual care.

I am aware that, even during the writing of this thesis, the context of healthcare practice has changed and I will outline these, where relevant, considering any implications for this study.

Context of nursing practice

During 2016-17, the period of this study, there was a high-profile media case about a nurse being dismissed for praying with patients (Petre 2016; Rudgard 2017). This case created some debate about the perceived persecution of Christians in public life, with some supportive of offering prayer to patients (Onuzo 2016), however the appeal court agreed with the dismissal of the nurse (BBC 2017). The case may have heightened the student nurse's awareness of the professional issues around some religious activity during the study data collection as a result. There have been other media cases that have brought the issue of religious activity within the nursing profession to the fore. In December 2008 a Christian nurse was suspended for offering to pray for a patient (BBC 2009) even though she respected the patient's refusal and did not impose this. The nurse was eventually allowed to return to work (Staines 2009) but it sparked debate suggesting religion should be a private matter and not shared with patients (Ashurst 2009). Another case involved a nurse who wished to wear a crucifix but was refused whilst Muslim nurses had dress codes relaxed for religious reasons (Petre 2010). Therefore, it is not surprising that student nurses are worried about what is appropriate within spiritual care practices (Vlasblom et al 2011, Boswell et al 2013).

The Nursing and Midwifery Council in 2015 updated the Code of Professional Conduct and made the boundary of personal beliefs clearer by saying: "*make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way*" (NMC 2015 p 15); the Code has recently been updated to include nursing associate practitioners but the premises remain unchanged (NMC 2018d). Trying to identify what is inappropriate is challenging but French & Narayanasamy (2011) note that proselytising to patients risks loss of patient autonomy and the evidence base for the benefit of prayer is weak so discouraged these activities. However, what if the patient asks for prayer? Christensen et al (2018) presented a case highlighting that clinicians feel

unprepared for such spiritual requests, such as prayer. Neagoe (2013) felt that a nurse with individual religious beliefs can lead them into ethical dilemmas in professional practice. The Nursing and Midwifery Council recognises that some situations are contrary to members' values and provide conscientious objection guidance (NMC 2018a) although this is limited in scope.

Nurses have traditionally seen providing spiritual care as integral to nursing practice (Robinson et al 2003; Bennett & Thompson 2015) and this links with the recognition that spiritual needs may be more pressing for patients at a time of crisis affecting health outcomes (Walton 1999, Lucchetti et al 2011, Christensen et al 2018). The Nursing and Midwifery Council Code (NMC 2015, NMC 2018d) does not refer explicitly to meeting or dealing with patients' spiritual needs but the International Council of Nurses Code of Ethics for Nurses (2012) referred to providing care of spiritual beliefs. The NMC (2015) omission has been criticised by some people because it fails to acknowledge the holistic nature of nursing practice which includes spiritual care (Fouch 2015; Rideout 2015; McSherry & Ross 2015 & 2017). The Royal College of Nursing (RCN 2011) promotes spiritual care in a pocket guide, acknowledging the various approaches that can be utilised but focusing on the patient wishes. Thus, although the literature recognises that nurses may have personal spiritual or religious beliefs, the emphasis is on addressing patient spiritual needs in a professional way.

Educators still advocate incorporating spiritual care into curricula (Bennett & Thompson 2015; Cone & Giske 2018) to address nurses feeling unprepared to meet the spiritual needs of patients in practice (Ross 2006; Vlasblom et al 2011; Kuyen & Giske 2019). At the time of this study 'The Standards for Pre-registration Nursing Education' (NMC 2010 p18) referred to holistic assessment, explicitly including spiritual care, with an emphasis on competency development. However, the recently published 'Standards for Pre-registration Programmes' (NMC 2018b), which will be implemented in 2019, has changed the emphasis towards professional character development. This educational direction links with the 'Future Nurse: Standards of Proficiency for Registered Nurses' (NMC 2018c) which emphasises the values of the profession, person-centred care and competency but continues to include assessing and reviewing spiritual aspects (NMC 2018c p8). However, the

emphasis in nursing curriculum has changed since the commencement of this study, with more focus on person-centred approaches and proficiencies in the most recent United Kingdom professional standards (NMC 2018c see Annexe A and B).

A traditional view of nursing was that it was a 'calling' or 'vocation' (Hallett 2012) which developed from Christian history (Lindberg et al 1994, Hood 2010). Nursing originally provided a variety of caring activities in sickness and death which developed from religious orders in Western society (Koenig 2013 p173; Hallett 2012). However, Scott (2008) felt that nursing was moving away from this traditional view towards a competency model of care where relational aspects were less prominent. The drive to make nursing more professional (Horton et al 2007) has led to a medicalised model of nursing practice (Hull & Jones 2012) with Knott & Franks (2007) commenting that evidence-based medicine was the 'new religion' with a modernist slant. The drive for professionalisation of nursing has promoted the idea that nurses should be objective and rational which Clark (2006) thinks has translated into a negative slant on religion and spirituality within nursing texts. In the current registered nurse standards (NMC 2018c) evidence-based practice is promoted with a focus on competency. Hood (2010) felt that nurses were becoming a more autonomous practitioner who delegated to assistants and the role of the nurse, in the 21st century, is moving towards leading and co-ordinating care in a compassionate and evidence-based way (NMC 2018c).

Nursing education is further complicated as it is mainly based within university settings which are driven by the Teaching Excellence Framework (HEFCE 2017) to reward excellence and attract students. In addition, this study is set within a faith-based university which is part of the Cathedrals Group, Church of England, which has a commitment to promoting social justice and developing the whole person (<http://www.cathedralsgroup.ac.uk/>). The University's mission and values is around individual transformation, respect and nurturing through a friendly inclusive approach to education (<https://www.canterbury.ac.uk/about-us/our-mission-and-values/our-mission-and-values.aspx>) which highlights the setting of this research. In summary, there is a complex professional landscape

when educating students about spiritual care and I wanted to consider how individual student nurses navigate this to develop their understanding of the topic area.

Context of healthcare practice

Fifty percent of student nurses' education is spent within the practice setting and is an integral component to learning (NMC 2010, NMC 2018b). The purpose of nurse education is to prepare students to be registered practitioners in a variety of clinical settings. Person-centred care is the focus in health settings to meet patient holistic needs, of which spiritual care is one element (Health Education England no date; McCance & McCormack 2017). The university develops student nurses' understanding of spiritual care during a module on person-centred practice focusing on spiritual assessment, values clarification and meaning of spirituality using discussion, creative expression, lectures and directed study.

The geographical context of this study was the South East of England. The Office for National Statistics (2015) reported on the 2011 census about the changing landscape of religion in England and Wales (see Table 1.1). The number of people identifying as Christian, as a percentage of the population, had dropped whilst minority and no-religion groups grew. 59% of people identified as Christian in 2011 compared with 72% of the population in 2001, whilst 25% now identify as 'no religion' compared with 15% in 2001 (Office for National Statistics 2015 – See Table 1.2).

The decline in religious affiliation was across all age groups and gender (Office for National Statistics 2013) which may reflect a societal trend to a more secular approach. However, this does not reflect whether people have spiritual tendencies that do not align with religious affiliation, describing themselves as spiritual but not religious (Brown 2014), where spiritual activities include meditation, music or nature (Burton 2017). These changing dynamics within society has led to a more pluralistic expression of spirituality which is individually constructed and has implications for nursing application (Pesut 2009).

Table 1.1 - How religion has changed in England and Wales (Office for National Statistics 2015)

Thousands and percentages

			2001		2011		Changes since 2001	
			Level	%	Level	%	Level	%
1	Christian	White British	34,576	92.6	28,739	86.4	-5.8	-6.2
2	No Religion	White British	7,033	91.2	12,624	89.6	5.6	-1.7
3	Christian	Other White	843	2.3	1,618	4.9	0.8	2.6
4	Muslim	Pakistani	658	42.5	1,028	38.0	0.4	-4.5
5	Christian	African	330	0.9	691	2.1	0.4	1.2
6	Hindu	Indian	467	84.5	622	76.2	0.2	-8.3
7	No Religion	Other White	214	2.8	465	3.3	0.3	0.5
8	Christian	Caribbean	416	1.1	442	1.3	0.0	0.2
9	Christian	Irish	548	1.5	426	1.3	-0.1	-0.2
10	Muslim	Bangladeshi	260	16.8	402	14.9	0.1	-1.9

Source: Office for National Statistics

Table 1.2 – Percentage of population related to religion (Office for National Statistics 2015)

59.3% Christian 33,243,175		25.1% No Religion 14,097,229	
7.2% Religion not stated 4,038,032		4.8% Muslim 2,706,066	
		1.5% Hindu 816,633	
		0.8% Sikh 423,158	
0.5% Jewish 263,346		0.4% Buddhist 247,743	
		0.4% Other religions 240,530	

Nursing within the UK is set in the context of a National Health Service (NHS) which is more economic and target focused with a drive for efficient, evidence-based practice which promotes a modernist view (NHS 2017). Chaplaincy services are the main focus to address spiritual needs in the NHS with guidelines available (NHS England 2015) recognising the change towards different forms of spiritual, religious and belief systems for patients and staff. This emphasis on individualism and pluralistic spirituality aligns with a post-secular view (Bowie et al 2014). However, balancing the secular agenda, whilst addressing individualistic sacred needs, is difficult (Pesut 2009). Spiritual issues are recognised as affecting individual healthcare choices during the consultation process (Rumun 2014) and person-centred care views spiritual care as part of holistic nursing practice (McCance & McCormack 2017). Therefore, meeting both the economic organisational needs and patient individualist needs is difficult, particularly as spiritual considerations influence the patient decision-making process which nurses should be aware of.

The United Kingdom has a religious organisation that is recognised constitutionally in the Church of England and broad changes in the Church role have impacted on United Kingdom (UK) society, which are summarised below. In the last 200-300 years there has been a separation of the state from the church so reducing the church's influence in public life (Edge 2014). This period of transition was named the 'Enlightenment' with the industrialisation of society that prized objectivity and rationality (Usher & Edwards 2003; Speed & Gale 2013) and the religious power began to reduce. The 'Enlightenment' was a complex period in UK history which led to debates about the role of religion and science in society. During the 20th Century religion started to be viewed as irrational and subjective and became privatised (Swatis & Chistiano 1999; Paley 2009), so that faith beliefs were held secretly and actively discouraged in public life (Metz 1968, Neagoe 2013). This meant that society shifted towards a secularised stance where religion was generally irrelevant and Portier (2011) believed that religion would disappear but this has not materialised. As modernity progressed there was a desire to uncouple religion from societal structures (Swatos & Christiano 1999) and reduce power in the political realm. The United Kingdom is considered to be intellectually

empirically driven (Rowson 2017), and less religiously conventional than the United States of America (USA) or other European countries, leading to a more secularised focus within the healthcare setting promoting the idea of neutrality (Graham 2013). However, Cook et al (2011) question whether neutrality is possible and that the secular perspective is just one of many views. Healthcare aims to benefit the majority but concern has been raised that this can disadvantage some societal groups so questioning the moral stance of a secular approach (Dreyer & Pieterse 2010).

Various policies, such as the Human Rights Act (1998), have challenged the relationship of state and church further and the United Kingdom is seen as a multi-cultural society that should embrace a variety of religious views (Edge 2014). This influences healthcare as there is more focus on individualistic, person-centred care (RCN 2016; McCormack & McCance 2017) with Health Education England promoting partnership working (HEE no date) including a resource centre available through NHS Improvement (2017). However, the provision of spiritual care is unclear within this individualistic model; McCance & McCormack (2017) include spiritual care within their person-centred framework whereas the Skills for Health framework focuses on values to be encouraged in care (Skills for Health 2017).

Graham (2013 pXXiii) comments that: *“Religion is never simply a matter of personal or private devotion, but carries over into the believers’ life in all aspects of the public domain”* and argues that there should be a public theological discourse that examines public spiritual concerns. This discourse is growing to include a wider variety of spiritual perspectives but legally religious organisations in the UK are expected to adhere to the country laws, even if these oppose their own beliefs (Edge 2014). The focus is changing towards an individualistic nature where everyone is valued and rights are recognised leading to a post-modernist view (Usher & Edwards 2003). A pluralistic society, that encompasses a wider range of religious and spiritual expressions, is developing and Radford (2012) says that there is overlap between secular and faith, with both contributing to human understanding and experience, which can be referred to as post-secularism. The

globalisation of society adds to the complexity as, due to travel and social media, there is greater awareness of the multitude of different faith and spiritual perspectives (Paley 2009).

The healthcare landscape seems to maintain a secular view with some authors against the incorporation of spiritual aspects (Paley 2009). This highlights that the debate between the personal and scientific remains contested can be a conundrum for healthcare practitioners who are tasked with meeting the needs of individuals within a multi-cultural community (MacLaren 2004) and post-secular context (Bowie et al 2014). The movement away from religiosity towards incorporation of pluralistic forms of spirituality continues to develop and will influence healthcare in the development of professionals and the way they practice (Robinson 2008).

Universities pride themselves in enabling debate but East et al (2013) argue that the moral imperative for universities is the public good, particularly when educating professionals, and seems to suggest that the private life of the developing professional should be suppressed. Graham (2013) notes that suppressing individual views is not easy nor desirable and suggests that the private and public domains overlap, that there should be more acknowledgement of this and incorporation of individualistic aspects into public life.

Spiritual care is so individualistic and learning about spiritual aspects needs to consider the student as well as the person receiving care; therefore, the research aim 'exploring how undergraduate nursing students develop their understanding of spiritual care' needs to draw on the students' lived experience to enlighten what is important to them.

Terminology

The language used to explore spiritual issues within professional nursing practice is important to ensure there is clarity and consistency of use. Therefore, this section will outline meanings and definitions around the terms 'spirituality', 'spiritual care', 'spiritual intelligence' and 'spiritual care competencies'.

Spiritual is derived from the Latin words *spirare* and *spiritus* which mean 'soul' or 'breath' (Solgi & Safara 2018). Religion dominated discourse until the 19th Century when spirituality as a term appeared more frequently (Solgi & Safara 2018). However, religion is poorly defined (Sandberg 2018) and, in law, is based on outdated viewpoints when the Church of England was the only recognised religion within the United Kingdom.

The World Health Organisation (2019) constitution and the Royal College of Nursing principles of nursing practice (2019) put treating people equally, including religion, at the heart of their philosophies. The focus on meeting individual needs is evident within Royal College of Nursing principles (2019) and Nursing and Midwifery Code (2018d) of practice. Nursing has focused on the holistic aspect of care where the spiritual is considered an integral element (Pike 2011, McCormack & McCance 2017). However, the language, within nursing particularly, has moved away from using religious words and symbols which Clarke (2009) thinks may make spiritual care difficult for patients to relate too as they do not understand the nurses' meaning. The relationship between religion and spiritual will be outlined when discussing the individual terms to highlight the complexity and intertwining of issues.

Spirituality

Solgi & Safara (2018) note that the term spirituality began to appear in the 19th Century but was closely related to religion. Other authors (Narayanasamy 2001, Robinson et al 2003, McSherry 2007) also note the close link between religion and spirituality suggesting that religion focuses on the outward and institutional expression whilst spirituality focuses on the inward reflective elements. A more recent article (Vincensi 2019) outlines the difference as spirituality is the individual journey of interaction with others and self-knowledge whilst religion is the communal journey including texts, sacred space and beliefs. Spirituality has been viewed as central to the person (Greenstreet 2006), relevant to holistic nursing practice (Robinson et al 2003) and continues to be promoted as an essential area to address for person-centred care (McCormack & McCance 2017). However, a clear

understanding of the term spirituality and its concepts remains elusive in nursing taxonomies (Mesquita et al 2018) and this will be explored below.

The terminology used for spirituality is ambiguous, covering religious and non-religious beliefs (Lewinson et al 2015) making spirituality difficult to define (Nolan & Holloway 2014, Rousseau 2014, Rowson 2017). The difficulty in defining spirituality has led some authors to promote a pluralistic view of spirituality not aligning with one definition (Tilley & Ryan 2004). Clarke (2009) highlighted concerns about a broad definition as this made the term spirituality difficult to distinguish from psychosocial care within nursing. The contextual relevance of the term spirituality is emphasised by Pike (2014) who was concerned that the language did not reflect patient understanding. Both Clarke (2009) and Pike (2014) discuss the importance of spirituality concepts being applicable to practice and both describe the term as aligned to religion.

Spirituality in United Kingdom nursing has been influenced by Judeo-Christian ideas (Henery 2003; McSherry et al 2004) which has led to definitions that do not reflect the needs of other faith communities (Henery 2003). Recently, the term spirituality has been used to describe strategies such as mindfulness (Yang 2006) which focus on the inner self and development of spiritual intelligence. Spirituality is viewed as a dynamic, reflexive process, or a journey (Robinson et al 2003 p39) and a pluralistic view has been proposed as capturing the diversity of spiritual practices within the complexity of nursing practice (Tilley & Ryan 2004). However, this lack of consistency made applying spirituality within health care practice difficult for nurses to navigate (Narayanesamy 2001).

A consensus conference to clarify spirituality was held in 2009 (Puchalski et al 2009) and The European Association of Palliative Care developed a task force (2011) to further the work in spiritual care. A subsequent consensus paper, derived from further conferences, (Puchalski et al 2014) compiled a definition which the European Association for Palliative Care (2019) have refined and currently use as:

"Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and

transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred."

This definition focuses on the key areas of connectedness, transcendence and meaning in life that Weathers et al (2016) outlined in their concept analysis. Weathers et al (2016) has been influential in informing current conception of spirituality to develop a more consistent approach that can be utilised in nursing practice (Mesquita et al 2018). The diverse, pluralistic positions of spirituality which have an individual focus (Swinton 2010 p33; Rowson 2017 p31) are relevant to person-centred care (McCance & McCormack 2017). McSherry's (2007 p191) research found that nurses viewed holistic practice as part of spirituality which is also important to person-centred care (McCance & McCormack 2017). The danger of trying to capture the term spirituality in an all-inclusive way is that it becomes meaningless (Koenig 2013 p53) or indistinguishable from other aspects of nursing (Clarke 2009). Thus, the consensus approach has galvanised spirituality towards consistency incorporating Weathers et al (2016) key concepts of meaning of life, transcendence and connectedness.

Definitions of spirituality have debated whether the spiritual and religious should be separated or whether they overlap and intertwine (Nolan & Holloway 2014, Rousseau 2014). I found that some definitions gave lists of components of spirituality, such as belief, practice, awareness and experience (King & Koenig 2009) or love, death, self and soul (Rowson 2017 p23), whilst others felt everyone had a spiritual dimension whether they identify with religion or not (Moberg 2008).

Robinson (2008 p36) notes that *"spirituality is about the practice and outworking of the spirit and the ways in which someone connects its different aspects and relationships and sustains and understands it"*. Robinson (2008) proposes that the understanding of 'spirit' is a holistic, embodied idea that encompasses affective, cognitive and physical elements; meaning it is a complex and dynamic reality reflected in a persons' lived experience which is attractive to nursing as it encompasses person-centeredness (McCance & McCormack 2017).

Separating religion and spiritual has been attempted and Heelas & Woodhead (2005 p6) suggested '*life-as forms of the sacred*', focused on the religious expression through attending church, and '*subjective-life forms of the sacred*' focused on alternative expressions, such as acupuncture, yoga, reiki. Rousseau (2014 p478) termed these as '*institutional religion*' and '*personal religion*' but he notes that someone could be '*spiritual but not religious*' but wonders if a person who is religious would exclude the spiritual side. My view is that religion and spirituality are intertwined with a variety of broad and narrow concepts (Cohen et al 2012). Although Heelas & Woodhead (2005 p31) suggest religion and spirituality are two separate worlds they do not offer definitions; their research was in 2000 and the dynamic nature of the concepts (Robinson 2008) means that the understanding will already have changed. This creates difficulties in nursing as religion and spirituality can be viewed together or separately depending on the focus (Cohen et al 2012) and adds to the complexity when trying to understand a patient's perspective.

A universal definition of religion is also elusive (Moberg 2008; Morreall & Sonn 2012) and it is also an ambiguous term (Nye 2003 p18). Burse (2010 p5) notes that there is a wide variety of definitions for religion but the characteristics of religions, such as beliefs and practices, are more useful.

However, capturing characteristics of religion is difficult because of the diversity within each one such as some religions subscribe to a Deity and some do not (Morreall & Sonn 2012 p311). The language that we use confounds the understanding of religion further (Nye 2003 p7). Religion is used as a noun to describe a particular tradition or as an aspect of human culture, and religious to describe a behaviour or experience, an action of doing something 'religious'.

Religions are complex and have been described by what it *does* and by what it *means* (Kripal 2014 p89). The amount and size of different religious groups is also confusing and Nye (2003) concentrated on world religions which focused on the largest groups whereas Kripal (2014) included monotheistic, polytheistic, mystical and secular views around the topic.

A single definition of religion, or spirituality, is elusive and Moberg (2008 p 100) summarises these thoughts as:

“all people are spiritual, whether they recognise it or not and whether they identify with a religion or not. That is why every major people-group has developed a religious system based ultimately upon how its faith defines, verbalises, applies, modifies, adapts, organises and ritualises spirituality. It also explains why spirituality may be interpreted as either a religious or a secular concept.”

Considering my study, I acknowledge that the European Association of Palliative Care (2019) definition has been developed with a consensus approach and considered all the areas discussed regarding personal versus communal expressions of spirituality. The Marie Curie (2019) organisation remind us that spirituality means different things to different people and may include religion but not always be religious in nature. I will need to explore participants’ understanding of the terms to see which perspective influences their thoughts around spiritual care.

Spiritual care

Spiritual care is the practical application to address individual’s spirituality. Marie Curie (2019) considers that to provide spiritual care the professional must identify spiritual needs and recognise spiritual distress; therefore, these two terms will be included in this section, in conjunction with spiritual wellbeing.

Spiritual need is a term frequently used to describe the fundamental aspects for human existence (Narayanasamy 2001) focusing on meaning and purpose (Monareng 2012, Ramezani et al 2014, Marzband et al 2016), belonging and trust, and coping with suffering (Narayanasamy 2001, Robinson et al 2003, Greenstreet 2006). Clarke (2013) felt that the term ‘needs’ reduced people to a set of problems and preferred to focus on spiritual concerns. According to Riklikienė et al (2020) *“spiritual needs are composed of four main dimensions, i.e., Connection, Peace, Meaning/Purpose, and Transcendence, and are influenced by under-lying psychosocial, emotional, existential, and religious needs”*.

Identifying spiritual needs is the focus of assessment with several tools available to undertake this (Robinson et al 2003, Greenstreet 2006). However, Clarke's (2013) approach wished to focus on listening to the person, treating more holistically and was reticent about using assessment tools. The aim of many assessments is to identify spiritual distress which was seen as signs indicating the patients' inability to cope (Narayanasamy 2001, Robinson et al 2003, Greenstreet 2006). Numerous signs are listed as indicative of spiritual distress including resentment, ambivalence to God, inability to cope (Narayanasamy 2001), pain, insomnia, inability to invest in life, fear (Robinson et al 2003), anxiety, guilt, alienation and anger (Greenstreet 2006). Although all the authors relate different signs there is much overlap around despair, distancing from others and feelings of loss.

Spiritual wellbeing is generally described as the opposite of spiritual distress (Robinson et al 2003) with spiritual healing and adaptation (Ramezani et al 2014 and Marzband et al 2016). Aspects such as serenity, courage, coping and being real (Greenstreet 2006) or joy, peace, stable relationships and creativity (Narayanasamy 2001) are detailed. Clarke (2013) focused on the inner strength and connection for wellbeing emphasising the holistic nature between body, mind and spirit. Robinson et al (2003) noted that spiritual distress and wellbeing could fluctuate over time as part of the life cycle. However, spiritual needs or distress (Kang 2006, Monareng 2012, Petersen 2014) or religious beliefs (Ramezani et al 2014, Marzband et al 2016) provide an impetus for delivering spiritual care.

The term spiritual care builds on the areas above with a desire to identify, through assessment process, the patient spiritual needs (Greenstreet 2006), planning interventions and evaluating the effectiveness (Narayanasamy 2001). The assessment is focused on recognising individual needs in a holistic way (Greenstreet 2006, Kang 2006 and Petersen 2014). Spiritual care is seen as involving developing relationships and presence, enabling reflection and exhibiting values (Robinson et al 2003, Clarke 2013). Concept analyses by Kang (2006), Monareng (2012), Petersen (2014), Marzband et al (2016), and Ramezani et al (2014) all include the elements of relationship or connectedness as part of spiritual care.

The importance of nurse presence (Robinson et al 2003, Clarke 2013) transcended across papers but described similarly as caring presence (Monareng 2012) and healing presence (Ramezanie et al 2014). Giving hope was evident in some of the concept analyses (Peterson 2014 and Marzband et al 2016) but the focus was also around listening (Clarke 2013). Several authors (Robinson et al 2003, Clarke 2013, Monareng 2012, Ramezanie et al 2014, Marzband et al 2016) suggest that spiritual dialogue is important whilst Marzband et al (2016) specifically mention opportunities for prayer, which may relate to the Iranian context of this concept analysis as Muslims have a focus on regular prayer. Petersen (2014) explicitly suggests that exploring feelings is important but the context was focused on children's nursing which may have particular concerns about this topic. Nutritional care and gender considerations as part of spiritual care were only specifically mentioned by Marzband et al (2016), this analysis was focused on Islamic view of spiritual care and may reflect the important element these play in the life of Muslim believers, although there was inclusion of holistic approach from other authors (Greenstreet 2006, Clarke 2013).

The healthcare workers' own spiritual self-awareness and engagement was an important element in some of the concept analyses (Monareng 2012, Ramezani et al 2014, Marzband et al 2016) and this element is evident within person-centred framework to provide holistic care (McCormack & McCance 2017).

Spiritual care is a complex area which Greenstreet (2006) and Clarke (2013) highlight have many barriers in practice, such as lack of staff time, lack of education and competency around the topic area. A review of nursing texts for pre-registration students (Timmins et al 2015) commented that the term spiritual care was used inconsistently and the issue of assessing spiritual needs poorly addressed.

Spiritual intelligence

I have used the term 'spiritual intelligence' within this thesis based on Rousseau's (2014) ideas that it involves skills and capacities within a person that contributes to spiritual competency. Defining spiritual intelligence is difficult because of the complex relationship with other intelligences and

religious views and Wigglesworth (2012 p8) said it is "*the ability to behave with wisdom and compassion, while maintaining inner and outer peace, regardless of the situation*". Emmons (1999 p164) used components, including transcendence and problem-solving, to describe spiritual intelligence whilst Zohar & Marshall (2000 p5) called spiritual intelligence the 'ultimate intelligence' believing that combining cognitive and emotional intelligences alone did not fully explain the complexity of human intelligence. Emmons (1999 p166), Zohar & Marshall (2000 p59) and Wigglesworth (2012 p38) see spiritual intelligence as including capacity for virtuous behaviour, problem-solving and increased self-awareness. Gardner wrote several books about multiple intelligence starting in 1983, building on this in 1993 and reframing it in 1999. Gardner (1983 p64) emphasised the ability to problem-solve as a criterion of intelligence and thought that the spiritual aspect, although creative, did not meet this criterion to be included as a specific intelligence (Gardner 1999 p54) so dismissed it within his work. However, Greenstreet (2006) describes the different paths of spiritual intelligence including love, care for individuals and groups, advocacy, values and self-awareness; she felt all these were important for nurses to understand patients more holistically.

Intelligence is intertwined with brain function but Fontana (2003 p81) highlights that linking spiritual thinking to areas of the brain is difficult and Moreira-Almeida (2013) discusses the mind-brain relationship suggesting that the spiritual is a vital component. Henneberg & Saniotis (2009) outline the various explanations around the purpose of spirituality within brain evolution, including dealing with complex and social problems. There is evidence that spiritual activities, such as prayer and meditation, do activate areas of the brain on scans (Gupta et al 2018; Johnstone et al 2017) whilst some suggest improved brain function as a result (Kober et al 2017). Spiritual experiences have been associated with improved moral reasoning and decreased anxiety in police (Travis 2009) and shown to aid patients when dealing with traumatic stress (Bob & Laker 2016). The definitive brain root of spiritual experiences, sometimes called the 'God Spot' (Fontana 2003 p80), has failed to materialise but the role of spiritual intelligence in solving problems is gaining some credence (Hyde

2004). Emmons (1999 p162-3) felt spiritual intelligence was a factor that influenced the way in which people lived their lives and could not be dismissed but was key for peoples' motivation and purpose. Zohar & Marshall (2000) proposed that spiritual intelligence was a way to draw together the cognitive, emotional and spiritual aspects of a person. Griffiths (2019) agrees that spiritual intelligence is a whole brain activity that brings together the intellectual and emotional intelligences with the soul and needs specific training to develop abilities. Thus, spiritual intelligence is a term that is complex, overlaps with other terms and has different interpretations.

Spiritual care competency

Competency is defined as *"the ability to do something well"* or *"an important skill that is needed to do a job"* (Cambridge Dictionary 2019). Competency in nursing is a variety of skills, behaviours and attributes which is promoted to perform the role to a good standard (NMC 2014, 2018b) but achieving competency can be challenging. Underpinning competency are the behaviours and virtues which make a good nurse (Sellman 2011) and spiritual care competency is viewed as important to develop in nurses (Attard et al 2014).

Spiritual care competency has evolved as authors noted the importance of teaching spirituality within nursing (Baldacchino 2006; Attard et al 2014). Baldacchino (2006) found four areas were needed to be competent in spiritual care; the role of the nurse, communication with patients and team, utilising the nursing process and dealing with ethical issues. A spiritual care competency scale was developed and validated (Van Leeuwen et al 2009a) which refined these areas; this scale has been used to assess competency in nursing (Attard et al 2014, Vogel & Schep-Akkerman 2018). However, recently an in-depth literature review has identified spiritual care competencies (Attard et al 2019a) which has been used to inform a spiritual care competency framework (Attard et al 2019b). The aim of these papers is to further refine the knowledge and skills nurses require to provide spiritual care to a diverse range of clients. Seven core competencies were identified (Attard et al 2019b) for nurse education to include as: knowledge in spiritual care, self-awareness & the use of self, communication & interpersonal skills, ethical & legal issues, quality assurance in spiritual

care, assessment & implementation of spiritual care and informatics in spiritual care. It should be noted that these 2019 papers were published after the data collection for this thesis but highlight the complexity of spiritual care competencies that builds on previous work.

Person-Centred Care as the theoretical framework

The theoretical framework of this thesis is based on the person-centred framework developed by McCormack & McCance (2017). This framework encapsulates the holistic care aims of healthcare with an emphasis on the person with four core modes of being as 'being in relation', 'being in a social world', 'being in a place' and 'being with self' (McCormack & McCance 2017 p17). These elements are relevant to the spiritual components outlined above where spirituality includes the relational, transcendent and personal meaning elements (Weathers et al 2016). In addition, the person-centred framework focuses on working with the patient's values and beliefs to provide holistic care including presence which are concepts evident around providing spiritual care (Monareng 2012; Ramezanie et al 2014; Marzband et al 2016).

The importance of professional competency is outlined in the Framework (McCormack & McCance 2017 p 42-43) acknowledging the need for knowledge, experience and abilities which has been mirrored in the spiritual care competencies above. Health Education England (HEE no date) promotes strategies that embrace person-centred working practices which are individualised and inclusive and Puchalski et al (2014) have emphasised the spiritual as integral to the whole person. McCormack & McCance (2017) note that their framework is a middle-range theory and point the reader to other models to enable implementation of the components. Therefore, I will outline key models that have informed nursing regarding spirituality and spiritual care.

Models around Spirituality and Spiritual Care

Nursing has attempted to conceptualise spirituality in a variety of models (Miner-Williams 2006; McSherry 2007), but none have been aimed at student nurses for learning about spiritual care specifically at the time of this research. It is important to highlight these works to show the diversity

of approaches that student nurses encounter, but considering how student nurses respond to a spiritual encounter with a patient is lacking. Robinson et al (2003 p47-48) argues that spirituality has key strengths of inclusivity, person-centeredness, and other centred approaches which are dialogic, holistic, practical and dynamic. Attempting to make spirituality meaningful Miner-Williams (2006) put the 'pieces of a puzzle' together stating the areas involved were connectedness, meaning, transcendence, values & beliefs, and energy & emotions. She developed her ideas into a theoretical framework to show how these reflected the essence of being human (see Appendix 1 Model of Spirituality by Miner-Williams). A grounded theory study by McSherry (2007 p259) developed the 'Principal Components Model' (see Appendix 2) which recognised the personal (innate) aspects of spirituality and the institutional effects. He referred to the importance of individuality, inclusivity, integrated approach and inter/intradisciplinary aspects within the model. Another holistic model of spirituality by Rovers & Kocum (2010) focuses on faith (religious/theistic), hope (existential/meaning making) and love (community/relational) as key elements. One framework around spiritual care was proposed by Burkhart & Hogan (2008) highlighting the need for cues from the patient. These include the decision to engage/or not engage in a spiritual encounter, spiritual care intervention, emotional response, search for meaning, formation of spiritual memory and spiritual well-being. These brief overviews of various positions demonstrate that there are similarities between the models and Narayanasamy (1999) proposed the ASSET model to action spiritual care in nursing but operationalisation remained difficult (McCrae 2012). Nursing students need to learn how to operationalise spiritual care in the lived experience of health care practice, which can be demanding. Rousseau's (2014) 'Spirituality Systems Model' (see Appendix 3) outlines a variety of areas within spirituality and his model embraces both the transcendent and personal aspects. Rousseau (2014) included religious and non-religious expressions of spirituality, although he seemed keen to have a different philosophy of spirituality that is distinct from ecclesiastical ones. Spiritual intelligence and competency are outlined in Rousseau's (2014) model which were not evident within other frameworks at this time.

In summary the definition of spirituality, religion and spiritual intelligence are elusive with the pluralistic and dynamic nature of the concepts making the areas difficult to boundary or identify. The risk is that nursing can spend a considerable amount of time attempting to define the indefinable rather than concentrating on implementing the practical needs of spiritual care provision. I therefore suggest that nursing needs to move away from a debate about definition towards a debate about implementing a meaningful expression of spiritual care in today's evolving healthcare settings and societal context. An approach that embraces the plurality of religious and non-religious expression promotes person-centred care provision and enables nurses to be educated with an approach that helps them to navigate the complexity. The question is how nurses are educated in a way that they can identify the diverse needs of the patient population whilst enabling patients to draw on the spiritual resources they need during a life event or illness.

Research

This introductory chapter has set the context of spiritual care in nursing, outlined the difficulty defining spirituality due to its pluralistic and varied interpretations, and considered models and spiritual intelligence. It has also highlighted that there are different expressions of spiritual care although similar attributes, antecedents and consequences are evident across cultures. The exploration of these aspects reinforced my desire to understand how student nurses develop understanding about such a diverse and complex topic area. The aim of this research study was to:

Explore undergraduate nursing students' lived experiences that develop their understanding of spiritual care.

Aims

Areas to be explored included:

- *Explore nursing students' understanding of the terms 'spirituality', 'religiosity', 'religious needs', 'spiritual needs', 'spiritual care', 'faith', 'belief(s)'.*
- *Explore nursing students' lived experiences that influenced their understanding and/or delivery of spiritual care.*
- *Clarify factors within student nurses' educational experiences that help or hinder their ability to apply spiritual care in practice settings.*

I wanted to focus on the phenomenological nature of the question because of the focus on lived experience (Van Manen 1997) whilst addressing the pedagogical issues within healthcare (Galvin & Borbasi 2011). The aim was to develop new insights into the topic area and the focus of the study emerged using the phenomenological approach and this will be explored further.

A literature review was needed to capture current knowledge around the subject area (Todres & Holloway 2010) and is promoted in qualitative research (Giancomini 2010). I decided that a literature review was an important aspect for this thesis to map the current landscape around student nurses' learning about spiritual care and aid the direction of this work. The following chapter will detail the literature examining current evidence about how student nurses learn the topic of spiritual care.

Chapter 2

Meta-narrative review to explore teaching of spiritual care within undergraduate nurse education

Introduction

This chapter will outline research evidence around approaches to spiritual care education in nursing students. My rationale for undertaking a literature review is that it is important to contextualise this study within previous literature (Todres & Holloway 2010) and it will enlighten my understanding to explore the subject further (Dunne 2011). Creativity in authorship is required for doctoral level studies (Dunleavy 2003) and encouraged by Van Manen (2014) and a literature review will ensure that this study focuses on new insights.

Spiritual care within nursing has been highlighted as an important, but often neglected, topic in chapter 1, particularly in nurse education. I will use a meta-narrative approach for this literature review so that both qualitative and quantitative research studies can be included (Wong et al 2013) to provide a sense of the current knowledge base for teaching spiritual care to nursing students. This review aims to consider which strategies are thought most effective when learning about spiritual care in nurse education.

Objectives of review

Aim - Explore the understanding and learning about spiritual care for nursing students within pre-registration education.

Objectives:

- Explore the term 'spiritual care' and its use by student nurses
- Examine evidence base for teaching and learning strategies around spiritual care.

The aim and objectives will produce a narrative review with key themes that are evident from the literature about teaching spiritual care.

Methodological Approach

This review was undertaken before I commenced data collection for this study in 2016; therefore, literature that is relevant since this review will be included in later chapters. Realist and Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES) approach was chosen for this review because it values all type of evidence including qualitative, quantitative and mixed methods (Wong et al 2013). Spiritual care and education are diverse subjects and RAMESES approach is a way to illuminate a heterogeneous topic area (Wong et al 2013).

The six principles from Wong et al (2013) for meta-narrative evidence synthesis were used to guide the review process:

1. Pragmatism – the spiritual care topic area is diverse so knowledge of which concepts and information that will inform nurse education is unclear, thus the need for this approach;
2. Pluralism – the topic needs illuminating from different angles, such as secular, spirituality and religiosity, therefore I did not wish to start from a preferred stance which could exclude significant information;
3. Historicity – spiritual care has unfolded over time, particularly affected by the context and changing historical influences. For example, nursing care had strong religious affiliations originally which have faded as society has changed;
4. Contestation – data available are from differing research paradigms with differing views of reality and underpinning assumptions; this complicates the heterogeneous topic around spiritual care further and critique of the evidence is needed;
5. Reflexivity – I needed to reflect on the findings and be aware of their biases and assumptions; this will strengthen the review by illuminating limitations for consideration;
6. Peer review – an external reviewer is recommended to comment on clarity of findings. An experienced nurse with a Doctorate in Nursing undertook this review process.

These six principles meant that a detailed and thoughtful review of literature is undertaken to scrutinise the issues.

Scoping the literature

I scoped the literature through an exploratory process of considering the differing angles around the topic including the theological context, educational context, nursing professional context and healthcare setting. Scoping included the guidance within professional nursing organisations, such as Royal College of Nursing (RCN) and Nursing and Midwifery Council (NMC) and discussion at conferences. After considering the differing contextual perspectives a literature search strategy was developed.

The Nursing and Midwifery Council is the regulatory nursing body within the United Kingdom, was established in 2002. In 2004 the NMC produced 'Standards of proficiency for pre-registration nursing education' which amalgamated the previous authority's policies and documents on education. This document included reference to incorporating spiritual aspects into education and the revised version, 'Standards for preregistration nursing education' (NMC 2010), also refers to assessing spiritual components. These documents inform the 'Standards for competence for registered nurses' (NMC 2014) which expects qualified nurses to assess spiritual aspects. Thus, the literature search was restricted to 2004 to 2016 as this encompassed the current view around spiritual aspects within pre-registration nurse education.

The term 'spiritual care' was outlined in the introduction and for this review refers to the religious and non-religious components of a person's life that may be expressed through practises or beliefs, whether internal or external to the person. This understanding of spiritual care is based on a wide, inclusive, pluralistic view of spirituality that includes a variety of formats and understandings.

Literature Search Strategy

From the scoping exercise I decided that a process of reviewing empirical and theoretical literature of all types (qualitative, quantitative, mixed methods and systematic reviews) was needed.

SPIDER (Cooke et al 2012) was used as a basis for the search strategy as this has been developed as a method for searching different types of evidence, including qualitative, quantitative and mixed method. The SPIDER search strategy and keywords utilised are outlined in Table 2.1.

Table 2.1 – SPIDER search strategy and keywords

SPIDER	Area	Keywords Search
S - Sample	Pre-registration nursing students	"Prereg*" OR "pre-reg*" OR "undergraduate" OR "student*" OR "baccalaureate" AND "nurs*"
PI - Phenomena of Interest	Teaching & learning about spiritual care	"Curricul*" OR "educat*" OR "teach*" OR "course*" OR "module*" AND "spiritual*"
D - Design	Questionnaires, interviews, observation, focus groups, surveys, case study	"questionnaire*" OR "survey*" OR "interview*" OR "focus group*" OR "case stud*" OR "observ*"
E - Evaluation	Experience and understanding about practice of spiritual care	"view*" OR "experienc*" OR "opinion*" OR "attitude*" OR "perce*" OR "belie*" OR "feel*" OR "know*" OR "understand*" OR "compet*"
R – Research type	Qualitative, mixed methods, quantitative, systematic reviews	"qualitat*" OR "mixed method*" OR "quantat*"

The keywords were chosen to cover a variety of terms for nursing students that aimed to encompass international perspectives that might be relevant to UK practice, therefore baccalaureate was included. Adding 'nurse' meant that the literature should focus on nurse education rather than other undergraduate courses. The search examined titles, abstract and keywords to identify relevant literature for inclusion in the review.

Selection and Appraisal of Literature

Databases were searched individually utilising those that are related to nursing and education – specifically CINHALL, MEDLINE, ERIC and British Nursing Index. Search terms used were ‘spiritual’, ‘nurse education’, ‘pre-registration’, ‘student’, ‘learn’ with Boolean operator “AND” including truncated symbols (such as *) to include a wide range of literature. MeSH terms for each database were reviewed to ensure all relevant synonyms were utilised.

Literature search was date restricted between 2004 to October 2016. Using the ‘research’ aspect of the SPIDER tool led to a paucity of literature so this was excluded in the final searches. As Cooke et al (2012) notes, this may be due to the poor indexing of studies, particularly qualitative, or inadequate keywords. Each database was searched using the terms above and an example of process using the British Nursing Index is presented in Table 2.2.

Table 2.2 – Search using British Nursing Index Database

search	Searched for	Databases	Results
S11	S6 AND S10	British Nursing Index	25
S10	S5 AND S9	British Nursing Index	33
S9	S7 & S8	British Nursing Index	96
S8	S2 AND S4	British Nursing Index	513
S7	S1 AND S3	British Nursing Index	15554
S6	Experience* OR (view* OR attitude*) OR (perce* OR opinion*) Or (belie* OR feel*) AND (know* OR understand)	British Nursing Index	68819
S5	Question* OR (interview* OR focus group*) OR (case stud* OR observ*) OR survey*	British Nursing Index	55302
S4	Curricul* OR (educat* OR learn*) OR (teach* OR cours*) OR (module* OR compet*)	British Nursing Index	69031
S3	Pre-reg* OR (pre-reg* or student*) OR undergraduate OR baccalaureate	British Nursing Index	15554
S2	Spiritual*	British Nursing Index	2312
S1	Nurs*	British Nursing Index	280834

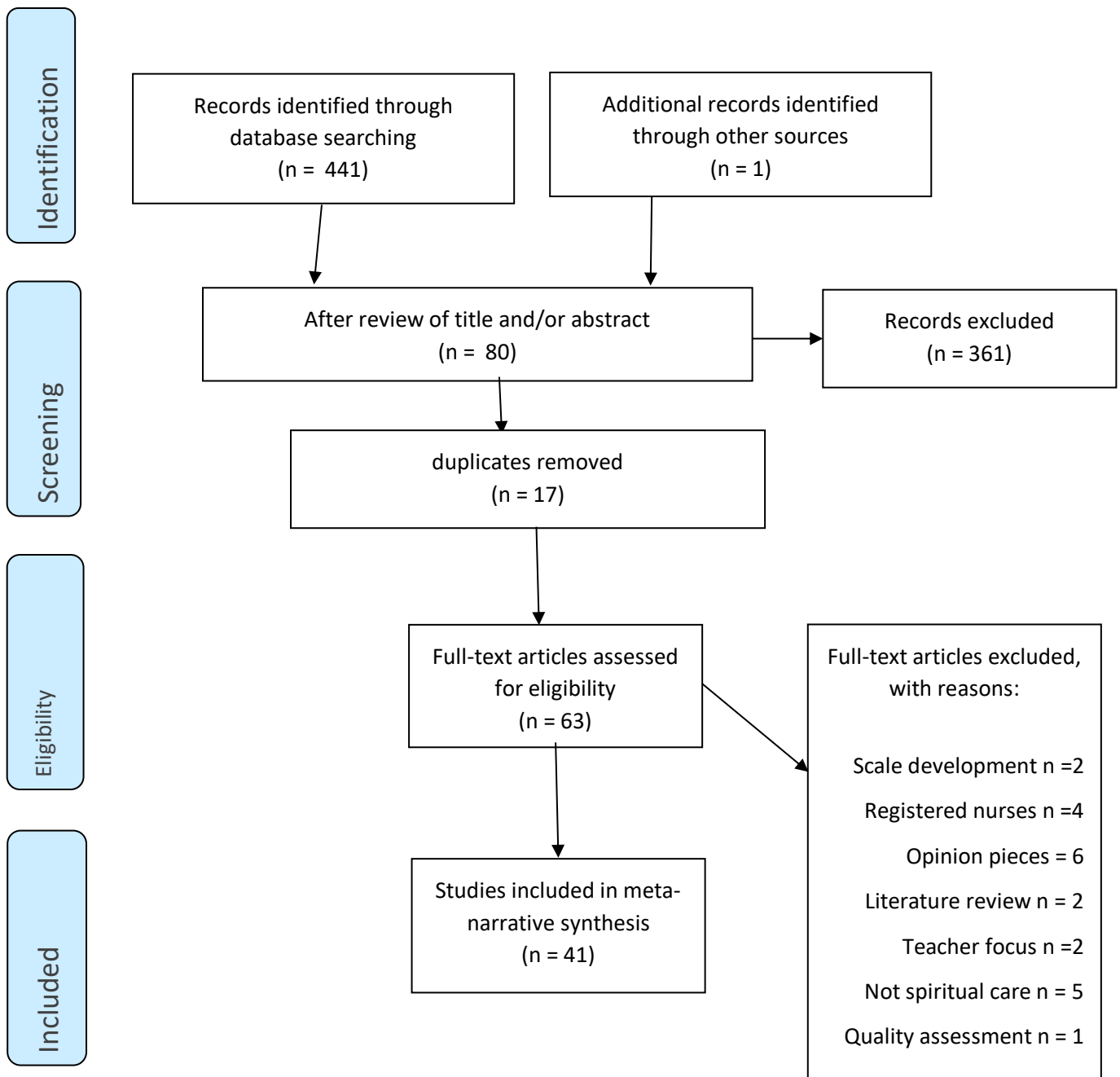
The search produced a total of four hundred and forty-two papers but only eighty were included after reviewing the title or abstract. This number was reduced further by removing duplicates. The full text versions of remaining articles were obtained and the list further refined if found to be irrelevant. If full text was not available, the abstract was utilised and included if consider relevant. After this process forty-two papers were included in review. See Figure 2.1 for PRISMA flow diagram summarising data extraction.

The Critical Appraisal Skills Programme (CASP – <https://casp-uk.net>) toolkits were used to ensure the papers included met minimum quality criteria (Nadelson & Nadelson 2014). One paper was excluded after quality assessment. The final included number of papers was forty-one (see Table 2.3 for full details).

Table 2.3 – Included articles from each database

Database	From search	Included by title, abstract	duplicates	Initially included	Full text obtained	Removed	Final number
CINHAL	137	52		52	50	18	32
MEDLINE	29	9	7	2	2	0	2
BNI	25	14	10	4	4	1	3
ERIC	10	2	0	1	1	0	1
British Education Index	4	0	0	0			0
Australian Education Index	114	0	0	0			0
Humanities Index	1	0	0	0			0
JSTOR	1	1	0	1	1	0	1
Periodicals Archive online	0						0
Taylor Francis online	115	0					0
EToHS	5	2	0	2	2	0	2
Google search	1 additional paper found						1
TOTAL							42
Excluded due to quality						1	41

Figure 2.1 - PRISMA Flow Diagram



Data Extraction

Each of the forty-one included papers had key data extracted including author, year of publication, number of participants, country of research, research methodology, key methods, key findings, key implication and limitations. Two papers had only the abstract was accessible which limited their usefulness but, as they were a different cultural perspective, it was deemed important to include. A table of the included studies is in Appendix 4.

Analysis and Synthesis

A thematic analysis technique, based on a realist synthesis process (Rycroft-Malone et al 2010) was employed to organise data. Realist synthesis is advocated for complex subject areas that work in different contexts (Rycroft-Malone et al 2010). This approach was useful for examining the pluralistic subject matter around spiritual care from different cultural contexts within education.

The synthesis involves comparing and contrasting findings to develop theory; this enables conclusions and recommendations to be drafted to inform future work.

The analysis process involved each paper being examined for key methodological processes, identifying key findings and outlining key recommendations. These were summarised into phrases or words that embodied the ideas within the paper. These phrases or words were then organised into themes and sub-themes particularly seeking confirmatory and contradictory findings as part of the synthesis (Rycroft-Malone et al 2010). The themes and sub-themes developed informed the discussion and recommendations of this review.

Results

This review included forty-one papers; seventeen papers were qualitative, two mixed methods, twenty-one were quantitative and one was evaluation with a variety of methodological approaches and methods undertaken. Table 2.4 shows the countries where research was undertaken which were all single context except for Ross et al (2016) who included multiple countries (Netherlands, Norway, Wales/UK, Malta). There was a range of countries from across the world included in the review, although literature from the USA dominated.

As discussed in the introduction spirituality means more than a belief in a particular religion. I have noted the affiliation of study sites in this review (see table 2.5) to highlight that many research studies undertaken in spiritual care have been informed by faith-based sites. This could potentially introduce some bias as these institutions, and participants, may have a heightened awareness of spiritual matters by having more emphasis on this within the curriculum than non-faith-based institutions.

Table 2.4 – Country where paper set

(Note: where more than one setting stated in paper - all are included in this list)

Country of setting/study	Number of papers	Country of setting/study	Number of papers
USA	15	Australia	1
United Kingdom (includes Scotland /Wales)	6	South Africa	1
Brazil	4	Ireland	1
Iran	3	Lithuania	1
Netherlands	3	Korea	1
Malta	3	Taiwan	1
Norway	2	Turkey	1
Singapore	2		

The process of thematic analysis refined the initial ideas into four main themes with several sub-themes (see Table 2.6). Full details of theming are in Appendix 4 (Table of Included Studies and Theming) and overarching thematic development is detailed in Appendix 5 - Thematic Analysis of Literature. The four main themes developed were ‘integrating spiritual care into curriculum’, ‘self-awareness around spiritual issues’, ‘spiritual as part of holistic care’ and ‘competency in spiritual care’. Each theme, and its related sub-themes, will now be discussed considering the quality of the sources.

Table 2.5 – Setting spiritual affiliation and/or predominate participants religious affiliation

Spiritual affiliation	Number of papers	comments
Christian	14	
Roman Catholic	3	
Muslim	2	
Secular	9	The organisation was secular where studies performed.
Diverse	3	Study stated a variety of religious beliefs such as Buddhist, Zulu
Not stated	10	Although not stated 5 were in USA, 3 in Brazil and 1 Ireland which have Christian focus. 1 was Iran which has Muslim focus.

Table 2.6 – Themes

Themes	Sub themes
Integrating spiritual care into curriculum	Benefits of spiritual care Knowledge development Definition and meaning of spiritual care Assessment skills Teacher role in education Constructionist approach needed Institutional philosophy affects incorporation
Self-awareness around spiritual issues	Attributes required for spiritual care Concerns about providing spiritual care Reflection needed Personal beliefs Involve chaplains in teaching
Spiritual as part of holistic care	Awareness of patient individual spiritual needs Living spiritual care in practice setting (patient autonomy place of prayer, interventions, use of self, not seen, little things may a difference, role of experience)
Competency in spiritual care	Emotional competency Understanding religious/cultural factors Professional role Role models needed in practice

Integrating spiritual care into curriculum

Integrating spiritual care into the curriculum was seen to be important for several reasons; student expectation that it should be included (McSherry et al 2008), preparation for dealing with spiritual issues, (Cooper & Chang 2016), process of spiritual assessment (Burkhart & Schmidt 2012), to treat

spiritual care as part of holistic practice rather than biomedical (Tiew & Drury 2012) and desire to incorporate spiritual care throughout nurses' education (Baldacchino 2008). A structured and systematic approach to spiritual education was suggested by Williams et al (2016) and Van Leeuwen et al (2008) with the opportunity to explore uncomfortable spiritual issues recommended.

'Benefits of spiritual care' as a sub-theme were providing equality and humanity by Riklikienė et al (2016). Attard et al (2014) and Burkhart & Schmidt (2012) both provided teaching on spiritual care and found that education improved student nurses' knowledge and skills of spiritual care. All three studies undertook a quantitative methodology with Riklikienė et al (2016) using a national survey at one point in time. Attard et al (2014) used a pre-post survey to evaluate a module and Burkhart & Schmidt (2012) used a pre-post questionnaire on two cohorts where one received the spiritual care intervention and one did not. Surveys are helpful to capture information from large populations and for comparing results (Calnan 2013). The survey approach seems valuable but Burkhart & Schmidt's (2012) study only included 59 students; 28 in the intervention group and 31 in the control group, which is too small to detect differences reliably. The context of all the studies is different to the UK as two were from Roman Catholic regions; Attard et al (2014) from Malta and Burkhart & Schmidt (2012) a USA Catholic university, whereas Riklikienė et al's (2016) study was in Lithuania stating it was a region where religious freedom had been repressed.

'Knowledge development' as a sub-theme included perceptions of students' preparation for spiritual care and methods of imparting spiritual care. Tomasso et al (2011) noted that 45% of students from one Brazilian university had not been taught about spiritual issues and felt unprepared to deal with this. Other authors (Baldacchino 2008; De Souza et al 2009; Espinha et al 2013) confirmed that students lack knowledge on spiritual care. Nardi & Rooda (2011) demonstrated that this knowledge gap might be affected by context as a USA faith-based institution showed higher awareness of spiritual care than a USA public one. A range of knowledge around different spiritual perspectives was viewed as important in Cooper & Chang's qualitative study (2016).

Teaching strategies have been studied, including Hoffert et al (2007) who used a seminar, Seymour (2006) used a short course incorporating stories and Yilmaz & Gurler (2014) used a participatory approach. All these studies demonstrated improved student knowledge. Although there were a range of qualitative, quantitative and evaluative approaches undertaken all the studies had potential bias. Sampling procedures were generally convenience (Cooper & Chang 2016) and could introduce selection bias (Houser 2012).

'Definition and meaning of spiritual care' as a theme highlighted that there is confusion about the terms used (Blesch 2013, Graham 2008, Moss 2007) and differences between spirituality and religiosity (Boswell et al 2013). McSherry et al (2008), Mooney & Timmins (2007) and Wu et al (2012) noted a wide view of spirituality among their nursing students. McSherry et al (2008) used a quantitative method in a longitudinal design to track students over three years using a rating scale. Although this is a useful methodology rating scale, responses are affected by the perceptions of participants which can influence findings (Jones & Rattray 2010 p 375-6). Mooney & Timmins' (2007) study was qualitative and used art to look at the subjectivity of spirituality. They recognised that the study took place in a country entrenched in Roman Catholicism and findings could be different within other settings.

Other authors (Riklikienė et al 2016 and Seymour 2006) noted the complex nature of spirituality discussing aspects, such as attitudes, character, social skills and emotion, which may all influence understanding. Yilmaz & Gurler (2014) state it is difficult for nursing students to understand the abstract concept of spirituality.

'Assessment skills' sub-theme was about undertaking spiritual assessment (Cooper & Chang 2016; Giske & Cone 2012; Graham 2008) but students felt poorly equipped to do this (Blesch 2013), and did not see enough examples in practice (Tiew & Drury 2012; Tiew et al 2013). All these studies used final year students, except for Cooper & Chang (2016) who were second year, which may influence their expectations of assessment. All the studies were qualitative, except for Tiew et al (2013), and

there was a concern that students would give socially acceptable responses (Jones & Rattray 2010 p379). However, the fact that the studies demonstrated a need for learning assessment skills adds to the credibility and transferability of the studies (Topping 2010 p139).

'Teacher role in education' outlines the importance of the tutor role when learning about spiritual care (Blesch 2013; Cobb 2004). Giske & Cone (2012) and Ross et al (2016) felt that teachers needed to raise the issues and enable reflection on spiritual care. However, Coscrato & Vilella Bueno (2015) found that educators needed instruction about practicalities of teaching spiritual care. All the studies were qualitative, except for Ross et al (2016) which was a multi-national cross-sectional survey. Coscrato & Vilella Bueno (2015) was a Brazilian study but only the abstract was accessible in English so it is difficult to ascertain any potential limitations in the approach or conclusions. Despite these issues, it seems that educators play a key role in broaching the subject area and enabling discussion that widens the students' understanding.

'Constructionist approach needed' was evident through the range of teaching strategies that were used successfully to teach spiritual care. Coscrato & Vilella Bueno (2015) noted during their observations that there was a predominance of technical-procedural approaches but they found that constructionist approaches helped students to unpick the problems in spiritual care. Fink et al (2014) found that students liked the simulation activities; Mooney & Timmins (2007) used a reflection on spirituality through using art as a medium and Seymour (2006) used story-telling as a method. Yilmaz & Gurler (2014) performed a quasi-experimental study that included interactive methods, such as discussion, case study, observation, and demonstrated that students undertaking this approach had higher scores post-intervention using the Spirituality and Spiritual Care Rating Scale (SSCRS). The SSCRS is an established tool to measure understanding about spiritual issues within healthcare but has been criticised for being opinion, rather than attitude focused (Garssen et al 2017); also, the scale was completed during class time so students may have felt coerced to take part (Jones & Rattray 2010 p380). However, Graham (2008) also performed a pre/post-test following a session on spirituality and concluded that participatory methods may assist learning.

Espinha et al 2013 found that students wanted more participation when learning about spiritual care including translation to the practice setting (Blesch 2013).

'Institutional philosophy' influenced incorporation of spiritual care into curriculum in a small number of studies (Nardi & Rooda 2011; Tiew et al 2013; Wigley 2013). Nardi & Rooda (2011) compared a faith-based and public nursing school setting and showed that spiritual care was emphasised in the faith-based group. Tiew et al (2013) compared three institutions in Singapore and noted that one did not enforce spiritual care education and thought that the faith or private setting explained the differences in groups; however, they did not discuss the culture or teaching of nursing as this may reflect different approaches to education delivery. Pastoral care for tutors was recommended by Wigley (2013) and this would require institutional support to implement. Wigley (2013) recognised that there was a poor response rate with only eight students taking part in this grounded theory study and theoretical saturation is unlikely to have been achieved as a result (Bryant & Charmaz 2007).

Self-awareness around spiritual issues

Issues around developing student self-awareness and attributes were evident within all but six of the articles in this review. Self-awareness included developing a deeper understanding of spirituality (Mooney & Timmins 2007, Tiew et al 2013) and developing self-awareness through educational activities (Beavers 2014). Students' own spiritual attitudes and perceptions were influenced by education and previous experience (Taylor et al 2009; Van Leeuwen et al 2009b, Wu et al 2012), this meant that there seemed to be a need to provide opportunities for students to develop self-awareness and how they may impact on spiritual care provision. All these studies were undertaken in countries dominated by Christianity, except for Tiew et al (2013) which included Buddhists and Muslims. Christianity is described as promoting self-examination (Drever 2016) and becoming more self-aware may be viewed positively in this faith group which could bias results. Sub-themes that emerged from this heading were 'attributes required for spiritual care', 'concerns about providing spiritual care', 'reflection needed', 'personal beliefs' and 'involve chaplains in teaching'.

'Attributes required for spiritual care' included a large range of interpersonal skills and personal development aspects that often overlapped within the literature. Boswell et al (2013) talked about the need for responsibility, communication, respect, trust and openness. Other authors' findings said that 'being with people' (Cobb 2004, Cooper & Chang 2016) or having 'presence' (Iranmanesh et al 2012, Valizadeh et al 2012) is required, suggesting developing a connection with clients (Giske & Cone 2012, Lovanio & Wallace 2007, Nardi & Rooda 2011) and relationship building (Riklikienė et al 2016). Respect for clients was highlighted by Van Leeuwen et al (2009), who noted the attitudes of students were important for this to occur.

Purdie et al (2008) used an alternative placement, by students accompanying sick or disabled people to the religious site of Lourdes, and found they developed interpersonal skills and trust, which boosted students' confidence, listening skills and relationships. However, Wu et al (2012) found participants were uncertain about building listening, respect and kindness but these students had very little clinical experience whereas those in Purdie et al (2008) study were final year students. This may indicate that students need relevant clinical experiences to build the skills and attitudes needed to provide comprehensive spiritual care. A more personal attribute was the development of the student themselves, such as building self-confidence (Fink et al 2014) and self-efficacy (Frouzandeh et al 2015).

The studies that referred to attributes were drawn from a range of institutions and contexts, including Christian and Islamic countries. Therefore, the attributes outlined in this section seem to apply to a wide range of contexts when dealing with patients' spiritual needs.

'Concerns about providing spiritual care' were aspects that often caused student apprehension. Boswell et al's (2013) narratives showed that students wanted to learn about the issues but were fearful of being inappropriate in the way they dealt with spiritual care. Students in South Africa (Du Plessis et al 2013) felt overwhelmed when dealing with spiritual care but this country has numerous religious groups which may be difficult to navigate. Feeling unprepared was a common element

which was evident in Graham (2008), Espinha et al (2013), Tomasso et al (2011), Wu et al (2012) and Moss (2007) studies. Moss (2007) found that students were concerned about when and how to seek permission to discuss spiritual care with clients and found that clergy from the relevant faith were helpful to address this. Dealing with spiritual issues was perplexing and uncomfortable for some students (So & Shin 2011; Williams et al 2016) and could leave students feeling helpless. Both So & Shin (2011) and Williams et al (2016) suggest teaching strategies that enable students to work through this discomfort, such as using chaplain practicum and communication strategies respectively.

'Reflection needed' is a sub-theme that linked to developing self-awareness (Van Leeuwen et al 2009). Burkhart & Schmidt (2012), Cobb (2004), Giske & Cone (2012) all highlight that reflecting on spiritual situations was important and Tiew & Drury (2012) felt time and space was needed for students to consider the complex issues. Other authors (Du Plessis et al 2013, Iranmanesh et al 2012, Kenny & Ashley 2005) suggest that reflection needed to be incorporated into educational provision. Reflection is seen as a way to gain insight (So & Shin 2011) and to uncover elements of the spiritual dimension (Seymour 2006). Although the studies suggest reflection will aid student learning the research methods included journal writing (Van Leeuwen et al 2009b) and semi-structured interviews (Cobb 2004; Du Plessis et al 2013; Giske & Cone 2012) which promote recognition of the consequences of action (Jasper & Rosser 2013) and, therefore, the research itself may have heightened students' awareness.

'Personal beliefs' seemed to play a role in the understanding and development of spiritual care practices. Personal faith of students was influential in recognising and providing spiritual care in Cobb's (2004), Kenny & Ashley (2005), Iranmanesh et al (2012), and Ross et al's (2016) studies, whilst Giske & Cone (2012) and Purdie et al (2008) found that a person's background could help or hinder student engagement in spiritual care; certainly Graham (2008) and Seymour (2006) noted that personal beliefs impacted on students' nursing care practices. The importance of respecting students' personal beliefs was noted by McSherry et al (2008) whilst Riklikienè et al (2016) and

Valizadeh et al (2012) found that religious students valued spiritual care within the profession. Nursing emerged from a background of vocational and religious orders (Hallett 2012) but it is unclear, from these studies, whether the students' awareness of their own faith, or other factors, heightens their perception of the importance of spiritual care. Despite the strong effect of personal beliefs, students felt uncomfortable with sharing this with patients (Tomasso et al 2011) which may be due to professional and societal expectations that religious belief of staff should be kept private in the work place (Ashurst 2009, NMC 2015, NMC 2018d).

The final sub-theme was 'involve chaplains in teaching'. So & Shin (2011) and Fink et al (2014) both involved clergy within their simulated activities and found this beneficial to students, however, these were both Christian based institutions and whether involving a wide range of different religious denominations is feasible, as Tiew & Drury (2012) recommend, needs consideration. In reality, there are numerous faith groups and focusing on the most prevalent within the society of the students might be more achievable.

Spiritual care as part of holistic care

Holistic care was referred to as 'seeing the person as a whole' by Cooper & Chang (2016) and incorporates mind, body and spirit according to Boswell et al (2013). Spiritual care was part of holistic practice (Hoffert et al 2007, Giske & Cone 2012, Cobb 2004, Lovanio & Wallace 2007, So & Shin 2011) and includes two sub-themes around having an awareness of patients' individual spiritual needs and living spiritual care in the practice setting. Holistic practice is a well-established ideal within nursing practice with a focus on person-centred care (McCormack & McCance 2017).

'Awareness of patient individual spiritual needs' consisted of enabling students to be sensitive to spiritual issues (Baldacchino 2008) and equipping students to deal with these needs (Beavers 2014). De Souza et al (2009) found that students had difficulty recognising the spiritual dimension and Nardi & Rooda (2011) found the importance of implementing individual spiritual care actions. The relevance of personal choice was outlined by Iranmanesh et al (2012), who suggested that the

patient needed to decide whether healthcare workers or family should meet spiritual needs on an individual basis. Four of the studies were based in Christian dominated cultures and it was interesting to note that Iranmanesh et al (2012), which is a Muslim culture, outlined the family role in supporting patient spiritual needs.

‘Living spiritual care in practice setting’ developed as a theme because students reported that they did not always see role models assessing and practising spiritual care (Graham 2008) and they wanted staff to emulate (Tiew & Drury 2012). Van Leeuwen et al (2008 & 2009) found that placement experience was important to learn about spiritual care as students learnt from colleagues and gained confidence. The two papers by Van Leeuwen et al (2008 & 2009) were the quantitative and qualitative components of the same study which might explain the similarity in these results. There may be differences between senior and junior students, even when the same intervention is applied, as seen in Wallace et al (2008) study. Wallace et al (2008) felt that the differences in understanding spirituality may be explained by the extra placement experiences that senior students had gained.

Competency in spiritual care

Several authors suggested that the lack of understanding about spiritual issues meant that competency to perform spiritual care was adversely affected (Graham 2008, Espinha et al 2013, Coscrato & Villela Bueno 2015). Ross et al’s (2016) survey showed that those with a broad understanding of spirituality had a higher perceived competency; however, this was a self-assessed questionnaire and students may have been inaccurate in their assessment of competency (Jones & Rattray 2010). The spiritual care competency scale was used by Van Leeuwen et al (2008) to assess changes pre and post a spiritual care training programme during placement. This showed that competency did improve with education and the scale used is a validated tool (Tiesinga et al 2009), although confounding factors, such as mentor input during the placement, are not explored. Competency in particular areas was evident and the sub-themes ‘emotional competency’,

‘understanding religious/cultural factors’, ‘professional role’ and ‘role models needed in practice’ will provide a fuller picture of the issues related to competency.

‘Emotional competency’ was only outlined in a few studies. Three qualitative studies (Du Plessis et al 2013, Seymour 2006, Van Leeuwen et al 2009b) all felt that the emotional and feelings side was part of spirituality and could impact on competency. Lovanio & Wallace (2007) pre-post intervention test design commented that students connected with being at peace; however, this study used prayer, chapel visits and reminiscence within the strategy and whether this is transferable to non-faith and other faiths is unclear. Emotions can be affected by a few complex issues (Niedenthal 2017), both personal and professional, so it is difficult to say that any changes are purely related to spiritual issues.

‘Understanding religious/cultural factors’ developed from studies that thought spiritual and cultural issues were linked (Du Plessis et al 2013) and, therefore, both aspects needed consideration. Educating about spiritual care and different faiths could help students understand both aspects more fully (Cooper & Chang 2016, Van Leeuwen et al 2009b). Attard et al (2014) believed that more research into the various religions/cultures and relationship to education was needed to aid teaching. As most of the articles within the literature review are dominated by Christianity, the exploration of spiritual needs relating to cultural expectations would be useful to understand the topic areas, particularly where the culture is in a minority and poor understanding may lead to stereotyping (Fiske 2017).

‘Professional role’ sub-theme focused around building professional relationships (Giske & Cone 2012, Tiew & Drury 2012) that fostered interpersonal skills (Purdie et al 2008) including comfort and communication (Nardi & Rooda 2011, Riklikienė et al 2016). McSherry et al (2008) highlighted that nurses would not disclose issues that might cause the client distress. Mooney & Timmins (2007) showed how educational activity had affected students’ incorporation of spiritual care into professional practice and Van Leeuwen et al (2009) found that students felt there was a professional

responsibility to provide spiritual care. A spiritual care practicum (So & Shin 2011) showed how incorporating spiritual care could enable the student to grow and students “*realised the most important aspect was to listen before initiating spiritual nursing care*” (So & Shin 2011 p233). Thus, building a nurse-patient relationship using interpersonal skills was key to instigating spiritual care for patients.

‘Role models needed in practice’ was evident as a way to demonstrate competency that students could emulate. However, authors (Giske & Cone 2012, Tiew & Drury 2012, Wigley 2013) found that this role modelling was lacking and spiritual care was not reinforced in practice (Graham 2008, Seymour 2006). All these studies were qualitative designs, except for Graham 2008 which was mixed methods. Qualitative allows for in-depth discussion of issues (Topping 2010) which encourages the exploration of a range of issues. Mixed methods combine qualitative and quantitative methods with the aim to better answer the research question (Halcomb et al 2009).

These themes demonstrate that there is a multifaceted approach to educating student nurses in spiritual care as part of a holistic approach to patients. However, it also shows that spiritual care is often poorly addressed, both in university and practice, and the participatory approach to learning seems to be more powerful for student education.

Limitations

RAMESES methodology is based around realist synthesis and, as Rycroft-Malone et al (2010) notes, the strength of incorporating a range of perspectives is also a limitation as the review is not easily reproducible. There is a danger that the literature review is poorly focused (Beecroft et al 2010) and, as I am a novice in the RAMESES method, this may have affected the reviewing processes. I was the only person who analysed and themed the literature although the meta-narrative was reviewed by a peer for comment and critique.

Most studies included have emerged from countries where Christianity is dominant and the themes may not apply to nursing students across other religious beliefs. However, as this thesis is based in a

Church of England foundation university, the findings may be more applicable to this group of students.

Recommendations

The themes highlighted show a number of areas that should be developed to clarify the issues:

- more research into diverse religious and non-traditional spiritual beliefs.
- increased education on spirituality
- greater engagement with the difficulties of meeting spiritual needs in diverse societies.
- consider how to translate spiritual care into practice in a meaningful way.
- identify the role of lecturers and mentors around learning spiritual care.
- allow opportunities to reflect and be challenged using participatory methods in learning.
- Research into whether personal experiences can change and develop understanding to provide spiritual care.
- Consider the use of simulation activities to explore spiritual care.

All these areas were highlighted in the review but the evidence base for which is most successful is unclear. Novel teaching methods, such as simulation, art, music, may be ways to engage students with difficult to define concepts like spirituality. Exploring issues such as meaning, and reflecting on the students own personal beliefs and biases seem important to change understanding around spiritual care to be truly holistic and individualised.

Summary

This literature review has shown that there are many methods of teaching and learning about spiritual care but it is unclear which ones are most influential for nursing students to develop understanding. There is little research from a students' perspective about the methods they experience that helped them to learn about the topic area. One of the recommendations of this review was around focusing research about student nurse experiences that changed and develop understanding to provide spiritual care. Thus, this review supports the need for a research study that considers the student lived experiences of learning about spiritual care during their undergraduate education. Therefore, the methodology chosen for my study was phenomenology and this will be justified as an approach for understanding student nurses' experiences that enable learning about spiritual care.

Chapter 3

Methodology and Methods

Introduction

My experience in nursing practice and education I had found spiritual care was a neglected area which students struggled to deal with; this is also highlighted in the literature (Vlasblom et al 2011; Kuven & Giske 2019). I wondered whether, as educators, we addressed spiritual care in a way that engaged nursing students and enabled them to explore the different perspectives, whilst developing their own personal insights and awareness. Thus, I wished to focus on the experiences of student nurses and needed a research approach that was compatible with this aim. This chapter will outline the research paradigm and methodological approach used within this study, an interpretative phenomenology, relating the benefits for the topic area.

The last chapter identified that there was a lack of clarity around student nurses' experience of learning about spiritual care which supports this thesis aim to "*Explore undergraduate nursing students' lived experiences that develop their understanding of spiritual care*". The previous chapter demonstrated few studies existed around the student nurse experience and a novel approach to the topic was needed to provide new insights on the issues. However, I need to discuss my own philosophical, ontological and epistemological position when utilising an interpretative phenomenological methodological research approach.

Spirituality was highlighted as a highly subjective and individualistic concept in the introduction and a research paradigm that enables this pluralism to be explored seems appropriate. Idealist paradigm embraces the subjectivity in a relativist way where all views are unique and valuable (Giacomini 2010). The nursing profession, however, needs a practical focus that melds human action with subjective perspective (Allsop 2013) and the qualitative interpretative paradigm enables this and is used in this study. Qualitative approaches to research embrace the diversity of opinions and perceptions to develop an understanding of the social world but recognise that this understanding is

incomplete, contextual and dynamic, encompassing post-positivist and constructionist philosophical positions (Streubert & Carpenter 2011 p4). This dynamic approach to research is important when researching spirituality because the issues are personal, change with cultural expectations and are individualistic in nature. The distinguishing features between realist and idealist ontologies and their epistemological positions is outlined by Giaconmini (2010 p130) whilst showing that there is flow and overlap between views.

I have used an interpretative approach in this study based on Van Manen's *Phenomenology of Practice* (2014) book. Van Manen's approach to phenomenology is seen as involving both descriptive and interpretative elements (Dowling & Cooney 2012) which allows the researcher to be creative and explore new insights. The research aim is interested in student nurses' lived experiences and their personal understanding. Phenomenology as a research approach is founded on describing and exploring lived experience, initially described as "*the study of phenomenon, the appearance of things*" (Cohen 1987 p31) which is still cited (McCance & Mcilpatrick 2008 p231). Phenomenology, according to Holloway & Wheeler (2010), is a philosophical approach rather than a method of inquiry and there can be confusion about the relationship between these two aspects (Dowling & Cooney 2012). The philosophy of phenomenology concentrates on the ontological and epistemological perspective around studying phenomena (McCance & Mcilpatrick 2008) whereas its methods discuss the elements, such as the hermeneutic circle and process of phenomenological interviews (Todres & Holloway 2010) but Van Manen (2014 p302) believes both areas are important in the construction of a compelling written study. Phenomenology has two main approaches as description or interpretation but Finlay (2009) felt that these two aspects were difficult to separate and that creativity in the phenomenological process, such as combining approaches, was beneficial. Phenomenology values the 'lived experience' but people attach meaning to these life events depending on individual factors (Smith et al 2009; Van Manen 2017b). Smith et al (2009) discusses how someone makes sense of this experience and, thus, it is a process of interpretation by the individual. The term 'lifeworld' is used within phenomenology and considers the natural context

(Dowling & Cooney 2012) and the personal and social context (Van Manen 2014) within which the lived experience takes place; therefore, the lifeworld is inextricably linked to the experience and can affect the personal meaning. For example, a bad experience of the healthcare setting may continue to make someone nervous of contact with the organisation, even if the subsequent experience is good.

Spence (2017) highlights that the researcher enters a hermeneutic study with their own experience and pre-conceptions which might influence the research. Phenomenology has two different views when dealing with the researcher's past experiences and understandings. Husserlian phenomenology takes a strict 'bracketing' approach to the researcher's view with the aim of being objective when examining data; whereas Heideggerian interpretative phenomenology embraces the researcher's understanding to inform the research (Dowling 2007). The influence of the researcher's subjectivity in phenomenological studies is either viewed negatively, thus 'bracketed out', or viewed positively as part of the intersubjective interconnectedness between researcher and participants which should be embraced to inform the research (Finlay 2009). I will acknowledge the influences that impact on myself, but I will be critically reflexive in my approach, and Finlay (2008) suggests, this is a dance between reduction and reflexivity. This reflexive attitude promotes novelty in the research, valuing participant and researcher insights into the phenomena, so developing a creative piece (Van Manen 2014).

I need to acknowledge my multiple roles professionally (as a nurse), academically (as a lecturer) and personally (as a Christian) which intertwine to produce my personal perspective and motivation within this study. This chapter will also consider the multi-layered landscape that influences my development as a researcher. The chapter then explores the hermeneutic interpretative phenomenological approach used for this study, considering the philosophical, ontological and epistemological issues; the approach to writing of the phenomenological inquiry based on Van Manen (2014) suggestions and outlining some critics of phenomenology.

What makes me who I am as a researcher? Considering philosophy, ontology and epistemology

I trained as a nurse over 30 years ago and nursing has a very practical focus to undertake specific tasks, solve problems and meet patient needs. This pragmatic approach is an engrained aspect of my identity as it links to my original vocation to be a nurse, my values to love others as myself as a Christian believer, and the values of the nursing profession to help people. Hallett (2012) noted that nursing was a vocation and was rooted in religious groups, and my upbringing was influenced by the values of love and care for others. Today's nursing context is trying to build a professional view, having moved to degree level education and a more autonomous role (Horton et al 2007).

Combining the vocational aspect with the development of nursing as a profession is highlighted in the values expected of nurses (NMC 2015, NMC 2018d). However, I am passionate about professional development which incorporates the caring attitude, knowledge, decision making, and specialist skills needed to be a good quality nurse in today's healthcare system.

I think that both the art and science of nursing are important but it is a dichotomy leading to debate about the epistemological basis of the discipline (Ou et al 2017). The science element of nursing can lead to a disproportionate emphasis on the empirical aspect (Chinn & Kramer 2011 p4) where the art is devalued. I embrace different ways of knowing including empirical, aesthetic, ethical and personal (Carper 1978) and emancipatory (Chinn & Kramer 2011). I think that these different ways of knowing in nursing reflects the complexity and multifaceted issues that face practitioners. The drive for nursing to be evidence-based has reinforced the empirical knowledge position (Bender 2017) but the practice basis of nursing means that this does not include the social and personal impact that nurses can have (Chinn & Kramer 2011 p2). I believe that knowledge in nursing should be a combination of holistic and emancipatory ideas (Chinn & Kramer 2011 p3) which informs pedagogy of nursing education.

The increased emphasis on theory, according to Bender (2017), means that nursing has focused on a reductionist approach to nursing science which aims to predict outcomes and effects. However, the

aesthetic, personal, ethics and emancipatory knowledge components are difficult to outline in a predictive way and Bender (2017) suggests that a focus on models that are adaptable individually should be pursued in nursing. My own epistemological view is that many areas of nursing are not predictable but are fluid considering the patient's individual wishes and the art of nursing is to incorporate these for the patient benefit. The focus on person-centred care means recognising and responding to individual needs for quality patient care (McCance & McCormack 2017). I think of this as treating others as I wish to be treated myself, which is an ethical perspective, and a desire to see the person behind the disease label. Therefore, for me, knowledge is shaped by our feelings of obligation (ethics), our inner self (personal), meaning of the situation (aesthetics) and socio-cultural aspects (emancipatory) as Chinn & Kramer (2011 p13) describe. The focus of knowledge for this thesis is around lived experiences which is informed by empirical, personal, aesthetic and ethical epistemologies where each individual understanding will be influenced by a variety of factors.

My background was in intensive care nursing which is considered highly technical area but has been criticised for loss of humanity (Dyer 1995). I was influenced by the fact that treatment had to be evidence-based with the medical personnel focused on objectivity of knowledge. I found this frustrating as it emphasised the medicalised model of care rather than seeing individual needs. I see nursing as a practice science (McEwen 2011 p5) drawing on a range of disciplines which incorporates different perspectives to understand the complexity of each person. The psychological and sociological effect on intensive care patients has highlighted the importance of a person-centred approach, and the nurse's role in this, to aid recovery (Caderwall et al 2018). I am very aware, because of this experience, that knowledge changes over time, it is not static or fixed, which Rescher (1993) termed 'pluralism'. Pluralism is a way of having a few options from several perspectives and deciding, through a rational approach, which is the most suitable. As a nurse, I have been expected to adhere to Nursing and Midwifery Council (NMC 2015, NMC 2018d) codes and be non-judgemental and accepting different views, so a position that embraces pluralistic positions is attractive, acknowledging the variation in a subject area.

As an educationalist and researcher my preference is a constructionist view that describes each person's reality as constructed based on their own experiences, interaction, and social context (Guba and Lincoln 2008; Moule 2018). The metaphysical basic ontological, epistemological and methodological beliefs of constructivism include co-constructed, transactional and hermeneutic elements (Guba & Lincoln 2008 p260). This interpretative paradigm considers that each person interprets experiences from their own perspective and meaning is ascribed to it (Allsop 2013; Moule 2018).

Constructionism recognises the complex interplay of many different factors, some conscious and some unconscious, that affects how people view the world. This is important when exploring nurse education because there are complex issues considering the student experience in practice/university and society. Constructionism promotes student-centred learning approaches to enable them to build their knowledge recognising the multiple ways of understanding this knowledge (Kala et al 2010). However, evidence-based practice has been more highly valued in healthcare (Knott & Franks 2007) as being a rational, or scientific, approach to find natural laws to guide practice with a hierarchy of evidence promoting this view (Moule 2018 p 60). Often referred to as positivism, there is a focus on a truth that can be found, natural laws to follow and the researcher just needs to find them (Allsop 2013; Moule 2018). However, recently there has been more critique of the positivist philosophy as devaluing the patient experience and promoting other forms of evidence to meet complex needs (Nolan & Bradley 2008; Moule 2018) which I welcome.

As a nurse professional I feel torn because I can see the value of positivism in relation to treatment options for patients but my personal values aspire for person-centred approaches that are individualised and complex, which is particularly relevant for spiritual care. For example, drug treatments are needed that are safe and effective which positivist research approaches embrace to identify the most beneficial treatment for the largest number of patients. However, Nolan & Bradley (2008) highlight that research methods has been applied to contexts that they were not intended for and often exclude the complexity of patients seen in practice settings. These are important issues

where the societal focus is changing to a person-centred, individualistic view which I value as enhancing patient experience and embraces spirituality. Moule (2018 p27) notes the rise of including service users in research studies which emphasises the importance of individual perspectives on a topic.

Patton (2002 p97) outlines the terms 'constructivism' and 'constructionism', which are often used interchangeably, and says the former is about meaning making for the individual and the later emphasises the way that culture shapes our view of the world. Therefore, constructionist philosophy is complex where we each construct our view and make interpretations based on our experiences, social and cultural situation, values and beliefs. This falls within the interpretivist philosophy (Moule 2018 p61) that we interpret our experiences based on several factors but, in research terms, this qualitative approach needs to be rigorous to be valued alongside quantitative studies (Nelson 2008).

My professional and personal beliefs are based on the idea that each person should have control over their body (whether physical treatment or psychosocial care) and that nurses should work with individuals to negotiate a course of action that is suitable for them considering their preferences (McCance & McCormack 2017). Ontologically I relate to the subjectivist position because each person has a unique interpretation and meaning to contribute to our knowledge of phenomenon, sometimes referred to as tacit, intuitive or personal knowledge (Moule 2018 p17). This position resonates with my own values, as a Christian and nurse, where everyone's needs, and experiences, are acknowledged and valued as part of person-centred practice.

I need to consider my educational role as a nurse lecturer where the values of the profession, as outlined above, link with the expectations of pedagogy in higher education. Students need the tools to construct their knowledge with the support of lecturers (Searle 1995, Mezirow 2009), so that they can adapt to the changing work place. Transformative learning theory proposes that learning for students is achieved by teaching experiences that transform their understanding and gives new

insights which is particularly important in health education as students are exposed to unfamiliar settings (Van Schalkwyk et al 2019). This approach encourages teaching methods that facilitate students to construct knowledge and build ideas which, for me, embrace the individuality of the student learning experiences. This approach means that the learning becomes student-centred by allowing learners to draw on different learning styles and knowledge basis, such as utilising previous experience for new learning activities. Knowledge development is not a linear process but one of adapting and incorporating changing perspectives over time (Mezirow 2009) and the pace of change is different for each person.

My Christian faith also influences the value I place on individuals and groups as the biblical principle of *'love your neighbour as yourself'* (Mark 12:30-31) informs the way I relate with others, including patients and students. The fact that my faith is so central to my philosophy means that I am personally aware of the impact life events, such as illness, can have on my personal faith perspective which makes me particularly interested in spiritual care in nursing practice. However, when exploring spirituality within a healthcare education context, the subjectivist understanding also makes me aware that other people may have unique, individual and different perspectives to my own which is no less important or influential within their life. Thus, spiritual matters are unique experiences for each individual and include a wide range of meanings and practices.

My experiences as a Christian has highlighted how faith, whatever form that takes, can be a source of comfort, meaning and community during difficult life events but made me wonder how much, as nurses, we consider this during an acute illness. Spiritual care is generally well addressed during palliative and hospice care with systematic reviews discussing this (Chen et al 2018; Gijssberts et al 2019). I was not convinced that spiritual care was evident within other nursing contexts and the literature available about the benefits of spiritual support is limited, noting that lack of time and resources are problematic (Kincheloe et al 2018). Thus, the topic of spiritual care is something that is important and I wished to understand student nurses' experiences when learning about this topic.

Silverman (2005 p109) highlights that the research approach undertaken should reflect the researchers' philosophy and the subject matter being explored but acknowledges that this is complex and paradigms are shifting. Considering my own philosophy, ontological and epistemological understandings and the subjective nature of spiritual care as a topic, a research approach that values individual views, constructs and interprets these within the context of the setting and is used to inform practice is needed. A qualitative approach that embraces pluralism within the social context, using methodology and methods to gain individual insights that may resonate with others, would be an appropriate research approach (Flick 2006 p11). Therefore, my research and educational philosophies complement each other and I position myself ontologically within a subjective position where epistemologically knowledge is constructed and impacted by multiple factors. Having explored my own perspective, I will now justify using phenomenology as a research approach for this study on student nurses learning about spiritual care.

Phenomenology – why use this approach?

The research aims for this study guided the choice of phenomenology as methodology (Moule & Goodman 2014 p80). I wanted to use an approach that would capture the lived experiences of student nurses within the study and a qualitative stance is seen as focusing on the human science (Schwandt 2000 p191). A philosophy that reflects nursing's individualistic approach and could grasp the pluralism in spiritual care was needed and phenomenology is consistent with these aims (McCance & Mcilpatrick 2008 p231). My own paradigm position needs consideration, which values diversity and experience to explore the phenomenon, and is important to aid commitment to the research aims (Silverman 2005).

I have chosen to use an interpretative phenomenological methodology based on Van Manen's (2014) *Phenomenology of Practice* because it utilises a blend of description and interpretation to offer new insights into phenomenon (Aagaard 2017; Van Manen 2017a). Descriptive phenomenology was founded by Husserl (1952 p105) who focused around consciousness and the relationship to interpretation of events, which is different for each person, reflecting their unique

fields of perception. This is useful for my research as it acknowledges different viewpoints around a pluralistic topic, such as spiritual care (Tilley & Ryan 2004) and enables a rich description of the phenomenon (McCance & Mcilpatrick 2008). Husserl (1952 p174) discussed the concepts of bracketing (epoché) and reduction as ways to suspend researcher apprehension and uncover the essences within an experience in a more objective way (Husserl 1952 p201-9) but I wanted to understand meanings in a novel way. Van Manen (2014) moves from description to a deeper level of interpretation as it progresses (Aagaard 2017), this is an important process for me to develop new insights into the phenomenon. I recognise that there is a balance between exploring new insights whilst perceiving participants understanding, so maintaining the phenomenological attitude is important (Finlay 2008) to be creative.

The pluralistic topic of spiritual care lends itself to a variety of philosophical and theoretical stances in qualitative research (Denzin & Lincoln 2008 p9) so a mixture of description and interpretation allows for exploration of various components. The qualitative paradigm recognises that neutrality and objectivity is at best difficult (Allsop 2013 p25) or possibly unachievable (Finlay 2009), particularly when researching experience, so has an opposing view to quantitative approaches. Phenomenology focuses on experience but was originally a philosophical approach with various schools of thought (Dowling & Cooney 2012). Phenomenology developed to include methodology and methods which can cause confusion around the boundaries between philosophy and methodology (Patton 2002 p104). Earle (2010) notes that the work of Husserl (1952), Heidegger (1962), Gadamer (2004) and Merleau-Ponty (1962) did not intend to offer research methods as the works were philosophical in nature, this means they are difficult to apply directly. Research in nursing needs to be pragmatic so that the findings can be used in practice; Van Manen (2014) work focuses on the pragmatic aspect in his phenomenological approach. Earle (2010) agrees that pragmatic interpretation was more useful in nursing research because of its ability to be applied in the clinical setting.

I wanted to explore meaning in a way that would encompass the various elements of experience and Van Manen (2014 p302-310) describes existential phenomenological themes which are explored further in the analysis chapter (see Table 6.1). None of the literature that I had reviewed (see chapter 2) had used these themes and I wanted to test their utility in discerning the topic. Examining the participant experiences using these themes would give a unique perspective on the topic to explore insights. The existential phenomenological themes were originally developed by Merleau-Ponty (1962) who explored spatiality, temporality, body as being and the world. Van Manen (2014) adds to these themes with materiality, and lived cyborg relations so extending into the world of artificial intelligence in today's changing world (Reuters 2016). Van Manen's (1990) work was founded on research in schools and is attractive to me as an educator as it is based on pedagogical ideals, although his research background was children whereas nursing students are adults. Nursing researchers have used Van Manen's phenomenological methods in several studies (for example: Hollywood & Hollywood 2011, Whitehorne et al 2015, Seo & Yi 2017) and so his work has an established utility within nursing practice internationally.

Van Manen's (2014) approach melds description with interpretation so that the research can exemplify knowledge in a pragmatic way to inform practice. Studying experience within a nurse educational context means that Van Manen's phenomenological approach is suitable because it can build on student experience to give novel insights into teaching practice. The use of the existential phenomenological themes gives focus to the work in an original way to produce a creative, yet reflexive, development work.

Developing a Hermeneutic Phenomenology

Hermeneutic demystification (Josselson 2004) is a way to unpick narratives and discover new relations that might be hidden within them. Originally, I wanted to understand the lived experience of student nurses but, as Van Manen (2017b) notes, at the time of exploring the experiences people have already reflected and ascribed meaning to elements. I could either take a purely descriptive and objective stance to the data or use interpretative approach to understand it (Aagaard 2017). I

found affinity with Josselson's (2004) views that description, interpretation and hermeneutics could be used jointly to offer creative insights into the phenomena. Caputo (2018 p5) says that interpretation is an art that unfolds layers and hermeneutics is the theory of that art; often the terms are used interchangeably. I wanted to relay the experiences students offered through narrative descriptions but understand the meanings underpinning these through process of wondering and interpreting to gain new insights (Van Manen 2017b). Ricoeur (1991) believed that the lived experience was brought to language to be interpreted, thus he focused on interpretation of discourse by others (Simms 2003). However, to offer a pragmatic element that is useful for nurse education I wanted to evoke, what Van Manen (2014) describes as, a 'vocative' creative piece. This approach moves the descriptive narrative towards a hermeneutic interpretation by giving voice to participants whilst decoding what is said or not said (Josselson 2004 p22). I have diverged from Van Manen (2014; 2017b) as he is wary of creating concepts and frameworks whereas demystification (Josselson 2004) looks for latent meaning, using a deconstruction and reconstructive mode, thereby offering a different perspective. Although I have constructed this study based on Van Manen's (2014) ideas, which are pragmatic and useful to nurse education, I recognised that the creative processes went further by proposing a framework for practice.

Phenomenology is not considered to be a problem-solving activity but addresses the mystery within experience which can lead the researcher down different paths (Magrini 2012) and developing a framework enabled me to achieve this. Phenomenology uses the phenomenological attitude, including processes of epoché and reduction (Heinonen 2015a), to aid interpretation and these are influenced by a variety of issues. I have already acknowledged my own presuppositions and experience which is important in interpretative phenomenology (Lavery 2003 p17). Hermeneutic interpretation recognises that researchers draw from participant data, using their own interpretative stance, which will be influenced by their individual personal factors (Patton 2002 p115). Therefore, acknowledging background is important because suspension of previous knowledge is not achievable (Heinonen 2015b). The phenomenological attitude (Finlay 2009) involves examining

yourself as a researcher, recognising your own assumptions, preferences, and considering their influence on the research process.

The interpretative process means that the reader of hermeneutic interpretations needs to know about the researcher, as well as the researched, to be able to place the study within the full context (Patton 2002 p 115). Hermeneutic research processes need to contextualise the study and consider the linguistic and cognitive aspects during the interpretation process (Smythe & Spence 2012).

Ricoeur (1981) defined "*hermeneutics is the theory of the operations of understanding in their relation to the interpretation of texts*" (p43). The researcher becomes part of the study by utilising their own knowledge, drawing on participants' understanding and incorporating both to produce a fresh view of the phenomena (Josselson 2004). A process of 'reduction' which, in phenomenological terms, means to 'lead back' (Van Manen 2014 p215) is a way to examine the phenomena in different frames and then return to the whole; this process is often termed the 'hermeneutic circle' (Heinonen 2015c).

Epoché and reduction are closely aligned processes according to Van Manen (2014 p215) and I will outline my epoché using Van Manen's ideas of concreteness, openness and wonder. Epoché is used in phenomenology to highlight the attitude needed when exploring a topic (Van Manen 2014 p215); it originated from a Greek word that means 'to stay away from'. Epoché is often called 'bracketing' (Aagaard 2017) because the aim, particularly in descriptive phenomenology, is to place assumptions to one side so that the researcher can be more objective when examining phenomenon. However, interpretative phenomenology acknowledges the contextual assumptions (Schwandt 2004 p194) and draws on them to open-up new understandings (Josselson 2004) which is the approach I have used.

Interpretation allows that there are many views, which are all valid, and leads to a relativist position, but pragmatism is needed so that the interpretation is applicable (Giancomini 2010). The resonance of the interpretation to practice is through dissemination of the work to see if other people dismiss or build on the understanding (Josselson 2004).

I have demonstrated openness through reflecting on my own presuppositions, influenced by my lived experience. Van Manen (2014 p222) said researchers should abstain from “*theoretical, polemical, suppositional, and emotional intoxications*” whilst being open to alternative interpretations. I have outlined above my educational frame, my Christian values and beliefs, and the nursing professional expectations (NMC 2015, NMC 2018d) that are embedded and I need awareness to ensure openness to alternative insights.

Van Manen (2014 p223) describes ‘wonder’ as the “*taken-for-grantedness*” that awakens an interest in a topic area. I think that I took for granted that everyone believes person-centred care and student-centred practices are important for nurse education. The stepping back that Van Manen outlines means that the familiar becomes strange and allows things to present themselves in a different way. This is particularly important when exploring the topic of spiritual care as the individual experiences of participants should allow what seems familiar to become strange, seeing it from another person’s perspective.

Concreteness, according Van Manen (2014 p225), is when abstraction is suspended. Van Manen (2014 p225) says “*Experience is the name for that what presents itself directly. Experience is what presents itself immediately, unmediated by subsequent thought, image or language*”. I think this is very difficult to do in the real world as, particularly as a nurse educator, abstraction and theorising is part of academic work. However, Van Manen (2014 p226) does not ignore the theoretical meaning but says that it should be used by initially bracketing for the phenomenological insights to develop. This familiar becoming strange means that you can draw on your previous knowledge in a critical reflexive manner to see new insights and gain different interpretations.

The hermeneutic approach I have utilised embraces the demystifying of meanings (Josselson 2004), which adds to the depth interpretation by unearthing what may not initially be evident within the narratives. Van Manen (2014 p235) felt that this method of reduction, which he called ‘originary’ or ‘inception’, allowed reflection where sudden new insights about the phenomenon could present

themselves. Inceptual thinking is different to conceptual one as it produces a richness, an individual uniqueness that leads to vocative writing (Van Manen 2014 p239).

My own approach has been constructed using my knowledge and experiences as a nurse, educator and Christian whilst wishing to understand and embrace the meaning of others. This leads to an interpretation that is constructed using theoretical, empirical and experiential perspectives which Schwandt (2000 p199) associates with weak constructionism. Weak constructionism avoids extreme relativism but acknowledges the pluralistic understanding of truth within evidence-based practice (Wieringa et al 2018), which is important for a profession such as nursing. Relativism has been associated with the postmodern movement and associated with a strong constructivism (Schwandt 2000 p200) supporting that the world is situated individually within a particular context (Williams 2001 p220). Fisher (1992) felt that a paranoia could develop in postmodernism because any interpretation is considered valid yet fitting this into social norms and political ideals can create dilemmas. An example of this in spiritual care is that individual spiritual expressions are valuable to patients, yet nurses are expected to be guarded in the way they relate their own beliefs within professional practice (NMC 2015, NMC 2018d), thus having to conform to cultural norms.

Van Manen (2014) highlights that different researchers reviewing the same participant data may come to different conclusions and expressions within their interpretation. This may seem unhelpful but, coming from a constructionist position, the acknowledgement that different interpretations are possible can open-up the field of inquiry into new avenues of exploration (Josselson 2004). Within the subjective and pluralistic area of spiritual care the ability to permit different interpretations values the diversity of expressions and influences that may affect people in everyday life. The context of nursing and educational practice is dynamic with a variety of factors, such as political, economic and professional, influencing the landscape. The whole context is interwoven with the history and culture of the setting (Symthe 2012) and promoting a dialogue about these can enhance interpretation and insights.

I have explored the pluralistic nature of spiritual care within healthcare and the learning processes involved for nursing students within this study. Van Manen (2007) discusses professional knowledge as the 'pathic' embracing the sense, sensibility, presence, perceptiveness and tact required in practice. Van Manen's (2014) work builds on other phenomenologists but embraces the changing context within education and healthcare.

Writing of the phenomenological inquiry

Van Manen (2014) puts emphasis on the writing of the phenomenological inquiry and outlines phases which mimic the phases of the research process:

- *Heuristic writing: what question? (instilling wonder)*
- *Experiential writing: what experience? (pushing off theory)*
- *Thematic writing: what aspects of meaning? (phenomenological thematising)*
- *Insight cultivating writing: what scholarly thoughts and texts? (insighting)*
- *Vocative writing: what vocative words, phrases, examples? (voking)*
- *Interpretative writing: what inceptual meanings? (deeper sensibilities)*
- (from Van Manen 2014 p376)

Van Manen (2017a) does not see phenomenology as a stepwise process but as something that evolves and develops with insights. He puts emphasis on the writing process as a significant part of the phenomenological inquiry (Van Manen 2006) which is reaching for deeper sources of meaning. I have incorporated a demystifying aspect to uncover what is latent within the narratives (Josselson 2004) to add new insights to the interpretation and deepen the writing element. This approach means that each phase of the phenomenological process adds depth, understanding, interpretation and meaning to the experiences explored.

I have utilised Van Manen's (2014) methodology by having a question around student nurses learning about spiritual care, I have interviewed students to gain their experiences using a phenomenological attitude, I have used the existential phenomenological themes to enlighten meaning within analysis, I have scholarly thoughts using portraiture and literature within the results to produce a vocative piece, and utilised interpretive writing to offer new insights into the

phenomenon giving examples. This process is not linear and the hermeneutic interpretation, using epoché and reduction methods, has been embraced to produce creative insights.

Data collection, in a phenomenological inquiry, is the human experience encountered in the participant's lifeworld (Van Manen 2014 p313) and I will outline the methods used to capture these experiences for this study.

Methods - Phenomenological approach to interviewing

I decided to use a method that enables student nurses to explore personal experiences using interviews. Van Manen (1997 p66) suggests that interviewing is a way to enable participants to explore their personal life story and has the advantage that the researcher can gather rich descriptions. I wanted to promote a conversational style within the interviews to elucidate the meaning of the experiences which deepens understanding (Van Manen 1997). The following will detail the processes involved considering the phenomenological stance, the semi-structured interview schedule, recording of interviews and researcher-participant relationship.

I chose to undertake interviews for this study using a conversational approach (Warren 2002) to gather detailed data about the participants' experience (Tod 2010 p346). Interviewing is commonly used in qualitative research but requires skill to make the conversation flow naturally while eliciting information that can be insightful (Richards 2005 p38). Interviewing is not the only method available to the phenomenologist for collecting data (Van Manen 1997; Flick 2009) and alternatives include written descriptions or documentary sources (Langdridge 2007 p54) but Todres & Holloway (2010) note that interviews are frequently used. The purpose of interviewing is that the researcher asks questions and the participant responds but key to this process is that the researcher listens. The interaction between researcher and participant will be influenced by a variety of factors, such as the questions asked, listening skills of the researcher, participants' willingness to share details and external influences (Bowling 2009 p411). Therefore, using interviews as a data collection activity needs thought and preparation.

Semi-structured interviews were used in this study and were carefully considered as the best way to answer the research aim (Gray 2004). Phenomenology focuses on the lived experience of participants and, therefore, an unstructured approach is suggested (Todres & Holloway 2010). However, unstructured interviewing needs skilled facilitation (Bowling 2009) and semi-structured interviews ensure that the topic area is addressed whilst allowing fluidity to explore diverse avenues participants may discuss (Gray 2004). I chose a semi-structured interview schedule as an approach to ensure experiences were explored but also to contextualise the participants' lifeworld, and meaning attached to terms, as these are important to interpret the lived experience during the analysis phase.

I had to consider many practical components when considering the use of a qualitative interview technique. The time to undertake the interviews is important to the participants, as well as the researcher (Warren 2002). The participants in this study are students on a full-time course with placement commitments so their time may be limited, therefore the interviews needed to be concise to be practical but in-depth enough to allow understanding of meaning. Economically there can be a cost, such as travelling, so the interviews were arranged to minimise inconvenience to students and were offered during their taught days in university. The interviews needed to remain focused on the study aims, particularly within phenomenology, because unstructured interviews can result in little or excessive data (Van Manen 1997 p 67), so a semi-structured schedule was employed.

Semi-structured interview

I designed the semi-structured interview schedule to explore the aims of the study whilst allowing flexibility so that a deep understanding of participants' experiences could be explored. Warren (2002 p90) notes that people like to talk about themselves and I, as the interviewer, needed to show interest in their responses. The topic of spiritual care is an individualistic and personal topic so it was important to develop the interview in a respectful way to build trust whilst valuing the student's

contributions and experiences (Bowling 2009). However, it was also important to consider the threats students may feel by questions about a personal topic (Tod 2010) so structuring the interview that builds towards the more personal experiences was used to make participants feel comfortable.

I wanted the interviews to prompt, rather than direct, the participants to converse about their experiences, which is considered more valuable in qualitative work (Warren 2002 p86; Bowling 2009 p410). Kvale (1996 p14) says that “*an interview is literally an **inter view**, an inter-change of views between two persons conversing about a theme of mutual interest*” but phenomenology specifically endeavours to focus on the lived experience of the participants (Todres & Holloway 2010; Van Manen 1997; Van Manen 2014).

I returned to the study aim when developing the interview guide which was ‘*Explore undergraduate nursing students’ lived experiences that develop their understanding of spiritual care*’. I considered areas that would inform this aim including:

- nursing students’ understanding of the terms ‘spirituality’, ‘religiosity’, ‘religious needs’, ‘spiritual needs’, ‘spiritual care’.
- nursing students’ lived experiences that influenced their understanding and/or delivery of spiritual care.
- factors within their educational experiences that helped or hindered learning about spiritual care.

Exploring these areas was important to understand their perspective on terms before delving into more personal aspects of experiences encountered. Therefore, the semi-structured Interview guide (see Appendix 6) commenced with general topic areas and then questions were focused on the lived experience during their nurse education. I chose to start with brief demographic data, then asked about terms to consider the participants’ pre-understanding, lived experiences of spiritual care learning, factors affecting learning and aspects that transformed understanding of spiritual care during their nurse education. The flexibility of the semi-structured schedule meant that experiences could be explored in-depth relating to all these areas.

I chose to collect little demographic data as phenomenology does not look for cause and effect (Tod 2010) but I wondered if the current nurse training year impacted on students' lived experiences. I wanted students to talk freely about personal aspects of their lived experiences, engaging them in the reality of their lifeworld during education, unpicking the meaning embedded and considering the factors affecting their learning. The section that I called 'transformation' aimed for students to reflect on and describe the meaning within their experiences which led to deeper understanding of spiritual care. I concluded the conversations by asking students if they had anything to add to ensure important data were not overlooked. The student participants may have insights that I, as a researcher, had not considered which would add depth to the data.

I wanted to build a rapport with participants to promote open conversation (Gray 2004 p221) and wanted the participants to feel their voice had been heard. I wanted the interview to be a favourable experience for the interviewee as it was an opportunity to have a prolonged dialogue about a subject of mutual interest (Kvale 1996 p 36). However, I was aware that the participants' concrete stories are most useful to understand the phenomenon and wished to ensure these were detailed (Van Manen 2014 p317). The use of a flexible and adaptable interview schedule facilitated the flow of the conversation and enabled experiences to be explored in more depth. I found that participants often answered future questions in the schedule and Flick (2009 p 172) cautions against following a semi-structured interview regime too rigidly for this reason. I needed, as the interviewer, to make decisions about where to focus the probing questions and this requires skill and practice (Tod 2010). I had undertaken research interviews previously within my Masters studies and within my educational role so had experience to draw on to facilitate the conversation.

Recording and transcription of the interviews

I decided to record the interviews (Kvale 1996 p161; Van Manen 2014 p315) using a digital voice device. I chose recording as students are familiar with digital technology and the devices are small so less intrusive than, for example, video (Warren 2002 p92). The interviews were transcribed to aid

analysis and verbal recording allows for this process. I utilised a good quality microphone which was integral to the recording device (Bowling 2009) and this meant that the conversations were clear and easy to transcribe verbatim. There were only occasional words within the recordings that were difficult to decipher but this did not appear to affect the underlying meaning of the interview.

I checked all equipment prior to interviews to avoid equipment failure and familiarised myself with the device to avoid human error (Warren 2002 p92). The digital mode of recording made it easier to upload to computer for transcription purposes and ethical processes were followed (see Chapter 4).

I was aware that participants sometimes talk in more detail once the recording device is switched off (Warren 2002 p 92) because they may relax and a note book can be used to capture this (Tod 2010). This did not occur within my study and participants seemed to forget that the recording device was present.

There are disadvantages to audio recordings, particularly capturing non-verbal cues that may be significant in detailing the emotions related to an experience. Therefore, I kept some reflective notes after each interview about the non-verbal cues that the participants displayed and detailed my own thoughts about the interview. For example, one participant received a phone call during the interview which disrupted the flow of the conversation and I noted this aspect.

I wanted to have consistency in the transcription process and one transcriber was used for this study to aid this. An experienced research transcriber was used and the transcripts were then reviewed by myself for accuracy. The transcriber highlighted areas that she could not decipher so that I could clarify when needed. The focus of the interviews was on the students experiences so an independent transcriber (rather than myself) was a pragmatic approach with time constraints. I was interested in the meanings of the lived experiences (Van Manen 2014; Todres & Holloway 2010), rather than the linguistic nuances, so any 'hms' and 'errs' were omitted from the transcription but repeated phrases were included. I found this aided the analysis process as there was consistency in format across the transcriptions (Kvale 1996 p171). I went through the transcriptions to ensure any

identifying features (such as names) were removed but participants had been cognisant of professional confidentiality requirements.

Participant-interviewer relationship and setting

I wanted to ensure that the setting was conducive to participants sharing experiences so I prepared for each interview to promote quality of data (Gray 2004). I booked small, private rooms so that participants' conversations would not be overheard (Tod 2010). The rooms had informal seating (rather than desks) and included a table for the recording device to be less intrusive. I found that the rooms used seemed to promote a conversational style (Bach & Grant 2011) and were free from interruptions because they were pre-arranged (Gray 2004). I arranged all the rooms on university premises because participants should find these easily and a familiar setting can reduce anxiety.

I wanted to focus on the experiences of the participants so I engaged a listening and exploring style of interviewing that affirms the participant (Kvale 1996 p117) whilst remaining sensitive to the topic. The interviews in this study were single events and I, as the researcher, did not know any of the participants prior to the study; this reduced the likelihood of transference or dependency as the time to establish relationship was short. The interviews lasted between thirteen to twenty-seven minutes but, despite this short time frame, the interviews produced some detailed descriptions of experiences and events. The participants freely divulged some personal details about their own faith perspectives which suggests that they felt comfortable with the researcher to share this detail. I had decided not to interview participants more than once for a variety of reasons, including that I was interested in their current experiences, their understanding could change over time and, pragmatically, it is additional demand on students' time to do further interviews. I felt that spirituality can be a sensitive topic and students may have been concerned about committing to more than one interview on the subject.

I detailed in an earlier section the influences within myself that might affect the research process and I recorded personal reflections after each interview. This process of recording insights is

valuable in qualitative research as an audit trail to consider the way the interpretation of the research area developed. This reflexivity is an essential part in Van Manen's work (1997 p33-35) for engaging with human science research.

Critics of Phenomenology

Phenomenology is not without its critics in nursing and consideration of this aspect is needed. Crotty (1996) and Paley (1997, 1998, 2002, 2005, 2014, 2018) were particularly negative about nursing's approach to phenomenology leading writers to wonder if phenomenology is still relevant for nursing research (Petrovskaya 2014). Crotty is now deceased (Barkway 2001) so the continuing vocal opponent to phenomenology in nursing research is Paley (Zahavi & Martiny 2019). Each of Paley's papers (1997, 1998, 2002, 2005, 2014, 2018) could be critiqued and discussed in depth but I will focus on some key features that concern this phenomenological study based on Van Manen's work. I will briefly discuss Paley's distinction between philosophy and methods, implicit assumptions about truth perspectives and omitted aspects of nursing history that, I believe, restricts Paley's understanding of phenomenology within nursing work.

There is confusion about whether phenomenology is a philosophy or a methodology (Patton 2002, Dowling & Cooney 2012) and in nursing research they have been linked (Van Manen 2014). Paley (2017) has published a book called '*Phenomenology as Qualitative Research: a critical analysis of meaning attribution*' which views methods separately for exploring lived experience, separating philosophy from methodology. Crotty (1996) and Paley (1997, 1998, 2005, 2014) criticises writers for misinterpreting the original philosophies, particularly of Husserl and Heidegger, arguing that the foundation of phenomenology in nursing is erroneous and flawed. A call for nurse researcher to reread these key philosophical texts was made by Petrovskaya (2014) agreeing that some elements were misread but highlighting the difficulty of grasping these complex texts. Another consideration is that both Husserl and Heidegger were originally written in German and then translated into English which Paley (2005, 2014) and Petrovskaya (2014) notes contributed to misunderstanding. The differences between objective and subjective views in phenomenology is highlighted as causing

added confusion (McNamara 2005) with Crotty (1996) and Paley (2002) promoting that objectivity should predominate. However, the development of phenomenology since its inception has altered (Barkway 2001) and Van Manen (2017c) felt Paley (2017) had ignored some of these developments. Van Manen's (2014) most recent work is not mentioned in Paley's book (2017), where he only refers to Van Manen's original text of 1990, so ignoring the detail Van Manen has added. The change to an interpretative approach is viewed negatively by Paley (2018) who focuses on objectivity in research but some authors think the new insights that are offered may still be useful (Zahavi et al 2019) with Petrovsaya (2014) being more positive about the creativity offered in Van Manen's ideas. The writings of both Paley and Van Manen seem entrenched in their beliefs and do little to clarify concerns; but underpinning this is Van Manen (2014) focuses on philosophy through his work whereas Paley (2017) focuses on methodology. Paley (2017) continues to call his approach 'phenomenology' despite awareness of the controversy this causes and is surprising considering his view that subjective lived experience is not present (Paley 2014). This has left nurses wondering if there is nursing phenomenology after Paley (Petrovskaya 2014) but Van Manen's (2014) background is education and has a focus on pragmatic application rather than being purely nursing focused.

There are some areas that have little consideration in Paley's work which would offer a rationale for the current position of phenomenology within nursing texts. Paley (2015, 2014, 2017) take a reductionist and objective view of phenomenology which is consistent with a correspondence truth position (Bridges 1999). Correspondence truth believes that there is a cause and effect that can be measured and Paley (2015, 2014, 2017) repeatedly emphasises the robustness of this research type. Phenomenology, according to Van Manen (2014) is a creative work that is pragmatic for practice-based professions, such as nursing, which Bridges (1999) describes as a 'what works' view of truth. Paley (2014) admonishes phenomenologists for theming and sometimes implying cause and effect, but I argue that these tools aid the pragmatic side (the 'What works') by offering findings that can be translated to practice. Nursing journals usually ask for implications for practice to be evident when publishing so this may promote authors stating practical application. I like Van Manen's (2014) view

that the reader of a phenomenological piece decides the value of the material presented because the writer must explain the research in a convincing way. Van Manen (2014) acknowledges that his approach has descriptive and interpretative elements (which I have used in this thesis) and that multiple perspectives are possible and the reader decides the credibility for their practice, thus reducing the criticism of small samples that Paley (2014) highlights. The truth perspectives have only been briefly outlined above but shows how Paley (2017) and Van Manen's (2014) positions are very different.

Another area that Paley (2002) oversimplifies is the history of nursing. Paley (2002) felt nursing was trying to distance itself from medicine and become distinct but he espouses the benefits of an objective, rational medical model of care. Nursing has a complex history (see brief explanation in chapter 1 'context of nursing practice') which evolved from religious orders. Nursing has wished to become more professional and focused on a person-centred approach (McCormack & McCance 2017) as a result. Nursing has evolved from a subservient role secondary to medicine (influenced by the dominance of men in medicine and women in nursing and inequality through history) towards an autonomous profession providing holistic care from assessment through to treatment (RCN 2018).

The discussion above is a brief overview of criticisms of phenomenology. Van Manen (2017c) gave a detailed response to Paley's critique around essence, epoché and reduction which have been explained in his 2014 book 'Phenomenology for Practice'. I have detailed my use of these processes more fully in the analysis chapter 5 and agree with Van Manen (2017c) that his work has been clarified and Paley (2017) book only detailed an earlier work. However, the critics of phenomenology cannot be ignored but this thesis has been explicit about the processes undertaken and limitations of the study, whilst adhering to the vocative style of writing which Van Manen (2014) promotes and Petrovskaya (2014) thought useful. This vocative style aims to provide new insights and Van Manen (2014) promotes a pragmatic approach which can be incorporated into nursing and education practice.

Issues that remain unanswered

The topic area of spiritual care and learning about this subject lends itself to the phenomenological research approach. Understanding the lived experiences of student nurses, when learning about the topic of spiritual care, is an important way to gain students' perspectives on how their learning is changed to deal effectively with this topic. I found the interviews in this study enlightening around participants' experiences of learning about spiritual care. I felt that the methods used were pragmatic and enabled the exploration of lived experience from the participants' lifeworld perspective. I felt honoured that participants were willing to share their experiences with me as a researcher. The ethics section discusses in more detail the ethical processes involved in this study.

This research was based in one university setting with a Church of England foundation and exploring students' experience in non-faith universities may be useful to compare, and contrast, experiences. The healthcare settings that students are exposed to during their studies reflect the South East of England, which limits their exposure to patients from different faiths. A future study that includes students who have placements in a multi-cultural setting may add insights into learning about spiritual care during practice. This study did not include lecturers' perspectives about teaching spirituality or applying this to practice experience which may enhance the understanding about students grasping this topic area.

Chapter 4

Participants and Data Collection Processes

Introduction

Data collection requires the researcher to identify participants that can inform the subject area and the researcher to be mindful of ethical considerations. The aspects of data collection, participant involvement and adhering to ethical principles are closely linked and will be discussed in this chapter. I will outline issues for selecting participants, formal ethical processes, researcher-participant relationship, data protection and consider the quality of data collection processes.

Ethical processes are required to meet local and national governance standards for research (Alderson 2013) and to ensure the welfare of participants. The principles of ethics underpin nursing, educational and research practice with key areas being beneficence (to do good), non-maleficence (to do no harm), respect for autonomy, fairness, truthfulness and justice (NHS Scotland 2012; Holloway & Wheeler 2010 p53). Registered nurses, like myself, are governed by the Nursing and Midwifery Code (NMC 2015, NMC 2018d) which reflects the ethical principles outlined for patients and colleagues; thus, I needed to apply these when undertaking research in nurse education. I needed to decide the most appropriate people who will be able to enlighten the research aim and gain these people in a truthful way, considering privacy, confidentiality and fidelity (Holloway & Wheeler 2010 p55). Therefore, the people invited to contribute to the research study needed to be carefully considered in relation to the ethical aspects.

Selecting Participants

I have chosen to title this section 'selecting participants' rather than using 'sample'. Qualitative research considers people who contribute as actively within the research process should be referred to as participants rather than subjects or sample (Holloway & Wheeler 2010 p56). Traditionally the term 'sample' is used for describing the people included within a research study and many methods of selecting a sample are available (Henry 1990). However, sampling within qualitative research is

problematic as it implies that a sample will represent a wider population which is not its aim (Maxwell 1995 p88). Gentles et al's (2015) paper gives a thoughtful discussion about the issues in qualitative research sampling, highlighting that each qualitative methodology has different approaches, and uses terms in different ways.

The phenomenological perspective means that a research group is not intended or designed to be generalizable to a wider population. Van Manen (2014 p 353) disliked the word 'sample' because it implies generalisation and he focused on gaining 'examples' related to the research aim. However, this does not help the researcher to identify people to approach to gain data or ways to attract them to contribute to the study (Rubin & Rubin 1995 p65). Van Manen (1997) gives little insight into these issues which can leave the researcher hoping that they have asked suitable people to participate.

A decision needs to be made about who will be the best sources of information on the topic to be studied. The important aspects to consider are selecting the setting and individuals to inform the study, which Maxwell (1995 p88) terms 'purposeful sampling'. However, purposeful sampling has many different connotations (Gentle et al 2015 p1778) and, to me, gives the impression that the researcher has selected the sample. In phenomenology the emphasis is on valuing the individual's unique experience and, therefore, each person's lived account is important.

Phenomenology requires the people involved in the study to offer experiences that are relevant to the issue being studied. Therefore, considering who will be invited to participate and where they might be located is relevant so that time, for both the researcher and participant, is not wasted. The aim of this study was to explore undergraduate nursing students' lived experiences that developed their understanding of spiritual care and recruiting participants that can contribute to this is required.

Rubin & Rubin (1995 p66) say that selecting people involves finding people with knowledge/ experience of the topic area; they need to be willing to talk and represent a range of views. However, in phenomenology there is less desire to find a range of views because the human

experience is considered unique and the study focuses on the phenomenological meanings (Van Manen 2014 p353). Thus, the people invited to participate in this study were:

- Nursing students within adult, child or mental health pathways
- Students in any year of the programme (which is a 3-year degree)
- Students who are willing to share their experiences of spiritual care
- Students who are willing to be interviewed and recorded on the topic area
- Students based at one university in the South East of England, which has two campuses.

It should be noted that there are four areas of nursing training (adult, child, learning disabilities and mental health) but the university setting, at the time of the study took place, did not offer learning disability nurse training. The university involved in the study had two campuses where student nurses were training, but both campuses offered the same curriculum, learning outcomes and shared learning resources. Nursing students undertook 50% of their time in practice placements as part of the programme, based in a wide variety of settings across the region, including acute hospitals, community, private providers, hospices and nursing care homes. This meant that each student had a unique experience that encompassed a set curriculum but with different lecturers delivering the content, and a different profile of placement opportunities. Phenomenology is ideal to capture experiences of students from such a heterogeneous population as it focuses on the individual.

There is a presumption that students who are willing to share experiences have one to relay to the researcher. However, phenomenology acknowledges that experiences are subjective, based on real events or interpreted meanings (Van Manen 2014) and the participant decides if they had something that they wished to contribute. This aspect, to me, was the exciting component of phenomenology because participants have diverse experiences where the meanings are unique to them, leading to an alternative viewpoint on the phenomenon being explored.

Ethics processes and Approval

There are several areas that particularly needed consideration within my study to adhere with ethical principles related to studying nursing students within my work setting:

1. The potential power relationship in my role of nurse lecturer interviewing student nurses may mean participants were not open with their thoughts
2. Spiritual issues can be sensitive and personal to each student and participants may not wish to disclose issues
3. The risk that poor practice could be disclosed during the research process which might cause distress to participants and need action professionally.

I will discuss how these were addressed through this chapter to respect participants, to reduce risk of harm and maintain a professional relationship.

Canterbury Christ Church University has a Faculty Research Ethics committee and, as a member of staff within the Faculty of Health and Wellbeing, the processes for this committee were followed.

An ethics checklist was completed and full ethical review was required due to the potential vulnerability of students being interviewed by a member of university staff. A full ethics application was processed and accompanied by a risk assessment form. Ethical approval was gained (see Appendix 7 Ethical Approval letter) in August 2016 - Ref: 16/FHW/16 003.

Potential power relationship

Student nurses are in a potential hierarchical relationship with university staff because the staff may be involved in examining work, teaching sessions or practice related activities. This hierarchical relationship could lead to imbalance in power, particularly as staff have ability to pass/fail work that could lead to the student not being registered as a nurse. At the time of the data collection I was cohort lead for one nursing group, teacher for one undergraduate module but did not have any undergraduate personal students. My lecturing role was weighted towards post-graduate students so I had less responsibility for undergraduate studies which meant that I had minimal contact with undergraduate students.

However, to reduce the risk that students may feel obliged to participate in the research, students who I had personal dealings with, either as a personal tutor or as cohort lead, were excluded from the study. 'Personal dealing' would include students who might have been subject to fitness to

practice or plagiarism investigation which the cohort lead was involved in. The module I was teaching at the time was assessed using an examination which was marked anonymously; the students' examination papers were distributed randomly through the teaching team and lecturers were not aware of the students they were marking, so the risk of influencing students was minimal. In reality, no students from that module group volunteered to be involved in the study.

Recruitment of participants was through advertising the study on the virtual learning environment (Blackboard), email to cohorts (see Appendix 8 – participant invitation letter) and through presentations to groups of students. Students were directed to the Participant Information Sheet (see Appendix 9) so that they had time to consider their participation and discuss with the researcher before committing to involvement. Nineteen students contacted the researcher about participating in the study. At this point students were asked their cohort and the university site they were based on so that interviews could be arranged. Some students did not reply to the request and a follow up email was sent but if this was not answered I assumed that the student had decided not to participate and no further contact was made.

Interview Process

Interviews were arranged with the student's convenience in mind. Students were offered interview dates and times when they were attending university for other lectures but made aware that this was flexible to meet their preferences. Before commencing the interview, the participant information sheet was available and students were asked to read it, but most said they had already done so. Students could decide at this point not to proceed or discontinue the interview if they wished. A consent form (see Appendix 10) was signed prior to commencing interviews. Students who completed the interview were given the option to withdraw from the study at a later date. One student failed to attend the interview as arranged and some had to be rearranged as it was no longer convenient for the student. The aim of these measures was to ensure that students felt in control of the situation and at ease during the interview.

The interview setting was a small, private room to ensure confidentiality. Students were reminded that the recording would be anonymised to maintain confidentiality after the interview. The informal nature of the setting aimed to recognise the potential sensitive nature of the topic area and allow the researcher to focus on the student experiences.

The interview questions used were semi-structured and the researcher reminded the students that there were no right or wrong answers as this was their unique experience. The nature of the questions aimed to ensure student autonomy as they could decide what experiences to share and the depth of disclosure. Personal questions about the student's own faith perspective were purposefully excluded from the interview schedule as this can be considered a private matter and students may feel uncomfortable sharing this information. However, students had the option to contextualise the questions around their experiences about learning spiritual care and many did disclose their faith or secular perspectives without prompting.

I was aware that students may become distressed during the interviews about sharing experiences. The university had chaplaincy and counselling services available that could be offered if students became distressed. Other 24-hour services were available, such as the Samaritans, that students could access if needed. Gray (2004 p235) noted that there is a risk that the interviewer transfers into a counselling role during the process and I was aware that this would not be appropriate or helpful when collecting data. Students also had personal academic tutors that they could discuss personal matters with if needed.

Professional and Data Protection

There was a risk that incidents could be shared that were unprofessional and, according to the NMC Code (2015), the researcher, as a registered professional, would be required to notify others and escalate concerns. The Faculty has a practice incident form that could be completed if an untoward issue was raised during the data collection process. Students were reminded at the start of the interview about the need to maintain professionalism and I asked them to maintain confidentiality,

such as not to disclose placement or patient names. Any names that were included in the interview would be removed during the transcription process to ensure confidentiality was maintained. All students respected this and no identifying features were disclosed during the interviews. One student referred to a lecturer by name, who had taught about spiritual matters, and this was removed during transcription. The experiences related by students had very personal meanings but no one disclosed items that needed action from a professional conduct perspective.

The collection of data needed to be stored as per university requirements with reference to the Data Protection Act 1998. The principles of the Data Protection Act state that information about people should be fairly and lawfully processed, used as agreed, accurate, not kept for longer than is necessary, processed within individual rights and kept secure. To adhere to these principles the following actions were undertaken.

The confidential items (such as consent forms and recording device) were transported to a university office as soon as practical after data collection. Confidential information was stored in a locked cabinet, in a locked office on university premises. Interviews were transcribed by an approved university provider and any names/identifying features removed. Transcripts were assigned a unique number and were stored on password protected computer. Data is stored for five years after the completion of the study and is either deleted or shredded at this point. Any concerns about the ethical processes were discussed with my doctoral supervisor or advice sought from the Research Governance Faculty Lead.

The ethics of research is complex and needs careful preparation and consideration throughout the process. The subject matter around spiritual care can add to the complexity as it can be an emotive and personal topic. Several students said that they thought the topic was worthy of investigation and showed an interest in the findings. I will share a summary on the virtual learning environment after completion of the study and offered to send this summary to participants, upon request, who have left the university so that their contribution was valued and they can consider the findings.

Characteristics of the Participants

The study was advertised from October 2016 - May 2017 on three occasions to all nursing groups (except students starting in April 2017). Students who commenced studies in September 2016 were not recruited until 2017 because they did not complete their first placement experience until end of 2016. Ten students signed the consent form (see Appendix 10) and completed the interview.

A homogenous group is often discussed as a positive attribute within qualitative research (Maxwell 1995 p91) but the meaning of homogenous is used loosely. Maxwell (1995 p91) talks about 'key informant bias' as a negative concept because participants may present a view that is not typical of the rest of the population but phenomenology is interested in singular items rather than general characteristics (Van Manen 2014 p353). The homogeneity within phenomenology is achieved by using participants who can inform the researcher about the phenomenon being studied. Diversity of participants, because they are treated singularly as offering unique examples of experiences, can be viewed positively in phenomenological work as the researcher is looking for components rather than generalisations.

The students within this study were from either adult nursing or mental health nursing backgrounds and spanned all three years of the course (see Table 4.1 –Participants across pathways and years). A larger number of adult nursing students participated in the study but this pathway is the biggest with approximately six times the number of students compared to other pathways. There was a bigger response from second year adult nursing students and students have a specific teaching session and activities about spiritual care during this year, so might explain a heightened interest in the topic at this time. No child nursing students chose to participate despite it being promoted in the same way as other pathways.

Table 4.1 – Participants Across Pathways and Years

Student group	Year of degree study	Numbers
Mental Health	First year	1
Mental Health	second year	1
Adult nursing	First year	1
Adult nursing	second year	5
Adult nursing	Third year	2
Child nursing		0
Learning disability	We do not train this group of nurses	

Quality of Data Collection

Phenomenology does not conform to validity criteria (Van Manen 2014 p348) because of the unique examples that are given by participants. The reflexive nature of phenomenology focuses on the lifeworld and lived experiences of participants (Holloway & Wheeler 2010 p 220) based within temporal and historical contexts. Data collection should acquire experiences that enlighten the phenomena considering intentionality of participants. Intentionality has different understandings (Van Manen 2014 p62) but relates to the way we think, feel and act with things in the world. The conscious thought and its relationship to subjectivity, human mind and body is not resolved with differing positions in literature (Holloway & Wheeler 2010 p214) but the key is for data to provide rich descriptions of the phenomena.

Phenomenology focuses on the structure of the phenomenon (Holloway & Wheeler 2010 p 221) and meanings rather than generalisations. I did not return interview transcripts to participants for member-checking for both practical and phenomenological reasons. Van Manen (2014 p 348) thinks that validity of a phenomenological inquiry is in the resonance of the writing stage rather than through validation of data provided as participants would reflect on the interview and their own interpretation.

It is the depth of experiences that are important in data collection, rather than the number of participants, so that a hermeneutic interpretation can be developed (Van Manen 2014 p299). Qualitative research often mentions data saturation as a way of demonstrating that enough participants have been recruited into the study. Data saturation refers to the point in a study when new informants are not relating any new insights to the topic area (Gentle et al 2015 p1781) and recruitment can cease. However, data saturation is not used in phenomenological studies as there is no attempt to generalise to a wider population and each person's experience is considered unique. Gentles et al (2015 p1783) does highlight that phenomenological studies tend to have up to ten participants with in-depth data extraction rising to thirty as a usual maximum. These numbers are pragmatic as it is time consuming to undertake in-depth qualitative data collection techniques. My study recruitment ceased because no new informants came forward on the final round of advertisements and the time limit for data collection was reached.

Qualitative research recognises that the context, or lifeworld, is key to the study and inclusivity of all positions is not accentuated because generalisation is not desired. I acknowledge that this study lacked some perspectives, such as child nursing pathway students and variety of faith positions. Therefore, experiences from students of different faiths (such as Hindu, Muslim) may enrich the findings of this study.

Summary

The recruitment of participants, data collection and ethics of research is complex and needs careful preparation and consideration. The subject matter around spiritual care can add to the complexity as it can be an emotive and personal topic. However, the data collection process is vital to ensure that detailed descriptions of the experiences and phenomenon being explored is related by participants. I have discussed my view of gaining participants as one that values each contribution as a unique experience and, therefore, data saturation is irrelevant to the study.

Chapter 5

Analysis

Background to analysis

In phenomenological studies there needs to be a balance between the experiences relayed by participants and the reflexive insights of the researcher so that a compelling piece is produced, that Van Manen (2014) terms 'vocative' writing. This chapter outlines the process of analysis that I have used which embraces Van Manen's (2014) phenomenological position but utilises a novel approach to interpretation.

Van Manen (2014 p376) describes these analysis processes in a linear pattern but the inductive process is not linear (Lathlean 2010 p423) and requires a back and forth approach so that the data and experiences are interrogated to ensure that interpretations being expressed are supported (Debesay et al 2008). The process of interpretation includes the meaning expressed by participants, interpretation of the researcher and the interpretation of the reader (Debesay et al 2008) and, therefore, there are different focuses to enlighten the phenomenon. However, the ability to apply the interpretation makes it useful to practice (Gadamer 2004) whilst recognising that interpretation changes over time or with development of understanding (Debesay et al 2008). This type of analysis requires time and a phenomenological attitude (Finlay 2012) to be open to viewing data in

challenging ways which I would describe as 'birth pains' to see the joy of bringing something inspiring and exciting to fruition. Van Manen (2014 p218) thought that an open mind in process of reduction and using epoché was important, this was outlined in the methodology chapter and is developed further in this chapter. I agree with Finlay (2012) who felt that the total separation of researcher pre-suppositions was not possible but needed to be acknowledged whilst embracing the experiences of participants and exploring implicit meanings as part of the iterative analytical process.

I have chosen portraiture as a means of presenting data coupled with the phenomenological attitude as an analysis strategy which will be explained further. The use of portraits as a research strategy in nursing literature is limited with only Cope et al (2016) giving one example. Other nursing literature that use portraits tend to be life histories, descriptions about service provision or processes for developing memories of patients, such as in Alzheimer's disease (Webster & Fels 2013). There is little use of portraiture within nurse education literature but an example by Kooken (2018) describes how artistic works have been used to aid nurse learning. Thus, the use of portraiture is a different way to analyse data and, coupled with the processes within phenomenology, should produce novel insights into the topic area.

Process of analysis – use of portraiture

Analysis in qualitative research is not a linear process and there is no one right way of undertaking it (Lathlean 2010 p423). However, phenomenology has an emphasis on analysing meanings (Todres & Holloway 2010 p 185) and presenting these in a coherent narrative.

The experiences that participants disclosed in this study were powerful and Van Manen (1997 p170) says that an analytical approach that reconstructs the life stories and includes anecdotes that reveal the essences within the phenomena can be used. I wanted to draw on the lived experiences of participants whilst painting a picture of the context of each participant and portraiture was embraced to achieve this (Lawrence-Lightfoot & Davies 1997a). Portraiture is advocated by

Lawrence-Lightfoot (1997a p3) who explains that “*the portraits are designed to capture the richness, complexity and dimensionality of human experience in social and cultural context, conveying the perspectives of the people who are negotiating those experiences*”. I used the transcripts, my reflective notes and reviewing the recordings to develop a portrait of each participant to capture the conversation.

The art and science of the phenomena is discussed by Lawrence-Lightfoot & Davies (2005) so that the aesthetic and empirical aspects within the data are included to provide insights to the phenomena. The portraits are a creative narrative that show the complexity within the individual but are also provocative whilst maintaining authenticity. Lawrence-Lightfoot (1997b) highlights that metaphors and symbols may be used aesthetically to highlight key essences within the data and this relates to Van Manen’s (1997) ideas that anecdotes can be helpful to explore the phenomenon.

Portraiture (Lawrence-Lightfoot 1997c p85) expresses a point of view and the voice used illuminates the epistemology, ideology and data embedded within the interviews, which are termed ‘conversations’. The ‘voice’ used by the researcher (or portraitist) can take a variety of forms but aims to discern the meanings through the dialogue with participants (or actors). Chapman (2005) sees portraiture as a method of giving voice to marginalised groups and students could be viewed as having less power in the educational setting. Students are often seen as consumers of knowledge in today’s education system (Nordensvård 2011 p157) but Bell’s (2014) study highlighted the importance of students being motivated and active in the learning process. The portraits developed should, like a painting, enhance the positive aspects of the phenomena and Lawrence-Lightfoot (1997d p142) thinks it is a way to show ‘what works’ within the data. Finding the aspects, or themes, for this study that enhance student nurses’ understanding of spiritual care by finding ‘what works’ is useful for pedagogy by focusing on positive practices (Van Manen 2014).

Although Lawrence-Lightfoot & Davies (1997a) developed their vision of portraiture from ethnography they believed that it was useful for illuminating lived experience. I have used single

encounters with participants and Lawrence-Lightfoot & Davies (1997a) noted that it could be used in this way.

Portraiture utilises the relationship between researcher and participant to enlighten the topic area but there needs to be an ethical stance that focuses on the research aims (Lawrence-Lightfoot 1997d p158). The individual semi-structured interviews within this phenomenological study allowed for this approach to 'hear' the experiences and stories of participants (Cope et al 2015), value these as unique to the participant and endeavour to empathise and listen to the meanings embedded within the experiences – all these aspects are key in portraiture (Lawrence-Lightfoot 1997d p158). Thus, portraits of participants were developed to show the context of the individual, their own understanding and the experiences that have shaped their perceptions of spiritual care so that essences can be seen (Wiz 2006).

Interpretation using Phenomenological Existential Themes

The portraits, in this study, have been used to describe each conversation as a way of shaping the story in a cohesive way, recognising the uniqueness of each participant (Lawrence-Lightfoot 1997e & f p247). The interpretative process explores meaning within the data to enlighten the phenomenon and find connections. This study examined the phenomenon looking at the lived meaning using the lifeworld phenomenological existential themes of lived body (corporeality), lived time (temporality), lived space (spatiality), lived relations (relationality), materiality (lived things) and Technology (lived cyborg relations) (Van Manan 2014). The existential themes were used to highlight scholarly insights into the data and enlighten meanings. Van Manen's (2014 p302-310) explanation of each existential theme was used as a basis to explore data and are outlined in Table 5.1 below.

Interpretations within phenomenology involves key processes of epoché and reduction (Van Manan 2014 p215). Phenomenology aims to understand the meaning and structures underpinning the lived experience. Reduction is a process to enable these new insights to emerge. Epoché is a suspension of issues that may obstruct the view of the phenomenon; this is sometimes called 'bracketing' (Van

Manen 2014 p 251). The suspension does not mean that the researcher is attempting objectivity but is acknowledging their own potential biases and perspective on the phenomenon which I have already outlined in the methodology chapter. This process engages the phenomenological attitude to examine the phenomenon in a unique way – a process Van Manen (2014 p228) saw as opening up to the phenomena and leading to new insights. This suspension process and leading back to new insights is the method of reduction (Van Manen 2014 p215). There are a variety of approaches to reduction, according to Van Manen (2014), including eidetic, ethical, ontological, radical and originary.

Table 5.1 – Summary of Van Manen’s understanding of existential themes

Theme	Summary from Van Manen (2014 p302-310)
Lived relations (relationality),	The connection of people and community to other people or things. Aspects such as intimacy, sacrifice, love, friendship, service may be considered here. The meaning underlying these.
Lived body (corporality),	Asks how the body is experienced during the phenomenon. Are we aware of body as subject or object? Aspects such as personal desires, fears, anxieties, being touched by others or things. Awareness of our bodies and how this manifest itself needs examining.
Lived time (temporality),	Considering objective (cosmic) time and subjective (lived) time. Aspects such as speed time passes, wishes, plans and goals. Historical and future time.
Lived space (spatiality),	How is the space experienced where the phenomenon happens? Do we shape the space or does it shape us? Aspects included are about the physical place, historical significances, virtual, imagined, inner or outer.
Materiality (lived things)	The significance of things. The way things are experienced. Things can be extensions to our bodies or external, things can tell us who we are. Aspects include macro (like climate), or micro (possessions). Even the immaterial may become material
Technology (lived cyborg relations).	Seen as gadgets, media, internet. Also, the resources and skills we use in daily life (technics). Cyborg relations and artificial intelligence are included here and the way we relate with these

I have explored the key characteristics from each participant's data, using the existential themes, using a variety of reduction viewpoints. These reduction methods were, in reality, closely linked and overlapping but were helpful to consider the different strands that may be present within the data to explore. Eidetic reduction focused on the essences of the phenomenon and key essences across different participants' experiences that were evident in this study. Radical reduction was used to outline latent consequences which are areas that are not always obvious when looking at data. Van Manen (2014 p233) calls this 'givenness' but does not fully explain this term. However, I have considered that latent consequence in this study led to students thinking about their own values and spirituality. Originary reduction is about inception and involves a 'coming upon' or 'fragile moment' where researcher has an original idea or grasps it (Van Manen 2014 p235). I recorded these fleeting insights using a journal as they can be important but might disappear if not captured. The process of gaining inceptual insights took a lot of time to reflect on, review material, write and rewrite to gain the novel insights particularly as I considered the role of spiritual intelligence.

Nurses deal with people at a time of vulnerability (NHS England 2015) and I used ethical reduction to explore how concern is shown for another person through provision of spiritual care, which relates to the virtues that a nurse needs to display as part of practice (Sellman 2011). Ethical reduction considers dilemmas for students and the professional context. Finally, I included ontological reduction to look at the way of being, or mode of being, to understand the experiences within the world, thus considering the wider context that influences experiences.

I found that reading, and re-reading, the transcripts, writing the portraits and ensuring I had captured the key elements, using the existential themes, relating to current knowledge, and recognising aspects that were missing within literature were instrumental to interpret data. I found that keeping the phenomenological attitude was, like Finlay (2008) describes, a dance between reduction and reflexivity. I acknowledged my pre-understanding through epoché but used reflexivity to exploit and build understanding to find new insights (Finlay 2012; Josselson 2004). Incorporating

these different reduction approaches is difficult and reflexivity aided self-awareness about my phenomenological attitude which was important to present findings in a compelling way.

Credibility of this study

I have taken an interpretative approach to this study. This means the credibility of this work is based on the rigour of the methods undertaken (Cutcliffe & McKenna 1999), the use of portraits to give a rich description of experiences showing the complex nature of the social world outlined (Cohen & Crabtree 2008), and its application to practice (Cutcliffe & McKenna 1999). As the topic area of spiritual care includes religious and non-religious perspectives, it is different for each person (whether patient or nurse). Understanding is interpreted according to the social context meaning the interpretative research approach captures the complexity of the topic. Several issues are raised as potential problems with qualitative research such as researcher bias, confirmability of results, and transferability, which I will discuss.

Researcher bias is considered a concern in phenomenological research (Cutcliffe & McKenna 1999) but the interpretative stance here has acknowledged the presuppositions and recognised their contribution to the research activity. I have been open about my perspective and the influences affecting me when undertaking this research within the Methodology Chapter 3. Interpretivism considers that every researcher's subjectivity is essential to the research process rather than leading to bias (Cohen & Crabtree 2008) and should be harnessed. Van Manen (2014) suggests that bringing yourself to the writing process promotes creativity. This was important for me to look at the phenomenon in a new way to gain different insights.

One way to confirm the researcher's understanding is to ask participants to review findings, called member checking (Cohen & Crabtree 2008) but, due to practical issues in this study, including some of the participants having completed the programme, this was not undertaken. Birt et al (2016) highlight that returning transcripts to a participant may lead to them changing their narrative and, for nursing students, they will have further experiences to add. Undertaking a second interview may

have addressed this issue but is time consuming for both participant and researcher. Birt et al (2016) and Livari (2018) suggested involving participants in the analysis process which may have been useful but was not undertaken in this study. Balancing the availability of participants, the commitment involved in undertaking research, the time constraints and academic work for participants on a full-time course were all reasons for not using participants further in this study.

Reliability is addressed through the process of supervision as part of the thesis process; Cohen & Crabtree (2008) say that peer review is a way to challenge and make the implicit explicit and the supervision process enabled this.

The interpretative process influences the way in which data is presented and validated (Cohen & Crabtree 2008) to present a credible and dependable picture of the phenomenon (Denscombe 2010 p92). Careful description and explanation of the research process has been used to enlighten the data. This study presented portraits of the participants and used direct quotations to evidence conversation content. The original interviews did not intend to be representative of the student population as the students who volunteered to participate may not reflect all student views.

However, phenomenology focuses on experience rather than generalisations and the rich descriptions presented in the portraits show the diversity of personal and professional experiences around spiritual care, which Cohen & Crabtree (2008) thought was important to establish validity.

I, as the researcher, had experience and training in facilitating conversations and Cutcliffe & McKenna (1999) note the important role of empathetic researchers to the data collection process in qualitative research. During the interviews I utilised my communication and empathetic skills to enhance data collection and Tod (2010) thinks this is an important influence on data acquisition.

The use of portraiture aimed to draw out the key features of the participants from these conversations that informed the topic (Lawrence-Lightfoot 1997c) so building on this empathetic understanding.

I kept a diary that included reflections at all points in the research process, influences that lead to change in my interpretation and notes on supervisory meetings (see Appendix 11 – Extract of Personal Reflections). Reflexivity (Lathlean 2010) is important to explore my preconceptions and strongly held beliefs so that I could step outside of the nurse educator role to consider innovative insights on the subject matter. The reflexive processes (Cutcliffe & McKenna 1999) were used during the interpretation of the interviews, focusing on the phenomenological themes, which helped to consider the diversity of experience within the conversations. The existential themes (see Table 5.1) enabled a focus to the interpretation that drew on literature available whilst allowing new insights to emerge. I found this type of thinking difficult initially and needed to interrogate my own motives and presumptions to be creative, but this enabled me to capture the participants' variety of perspectives in a novel way, relating the complexity of the topic in the social world. Discussion with colleagues, as well as my supervisor, aided this process of exploration and personal development and enabled me to navigate different ideas to conclude a coherent conclusion to the study.

I believe that the dependability of this research will be evident once findings are published and other nurse lecturers and students can consider and critique its relevance to practice (Cutcliffe & McKenna 1999). Therefore, this research will be disseminated through a variety of means, such as conference presentations and journal publications, to refine the framework and discuss its application to practice (Appendix 12 outlines Conference Presentations to date).

Summary

The analysis using portraiture, the phenomenological attitude, existential themes and reduction methods have provided a unique insight into the topic. This leads to a discussion that will provide a vocative writing around key aspects of the phenomena (Van Manen 2014) to engage the reader in the topic. The research aim was originally developed to instil wonder and ignite interest in the topic area. The interview data were collected, and analysis used portraiture to capture participants' experiences, initially pushing off theory by not referring to literature at this stage. Van Manen's (2014 p302-310) existential themes were used within the interpretative process to understand

embedded meaning in the data, incorporating scholarly thoughts and text, and the findings of this analytical process will be outlined in the next chapter. The discussion chapter follows incorporating a vocative writing style to explore the new interpretative insights from the findings.

Chapter 6

Findings

Introduction

Phenomenology is an act of writing according to Van Manen (2014) and the writing of the findings is integral to the exploration of experience. Thus, the aim of this chapter is to elucidate the phenomenological insights around undergraduate nursing students' lived experiences that develop their understanding of spiritual care. The vocative writing that Van Manen (2014) desires is one that is creative, enlightening and insightful. The method used to provoke this vocative style was the use of portraiture as outlined by Lawrence-Lightfoot (1997f).

The portraits crafted in this section will 'draw an image' of the conversations with each participant to show the rich and complex experiences and meaning for each person. The portraits intend to recognise, appreciate, respect and scrutinise the conversation within the cultural and contextual aspects of the interviews (Lawrence-Lightfoot 1997f). Each participant will be presented sequentially in date order; this is important as my conversational skills may have influenced the depth of information obtained as I developed proficiency in interviewing.

In this process of 'painting a picture' I, as the researcher, am the artist that draws and creates. The aim is to construct a portrait that magnifies the key aspects of the subject area and enriches the reader's appreciation of the issues involved. The portraits will explore each participant's understanding and definitions of spirituality, religion, and spiritual care considering the context and background that influenced the students' lifeworld. This sets the contextual scene for the students' pre-understanding before entering the conversation around issues about learning spiritual care practices. The experiences the students relayed will be explored considering personal and professional influences that might enlighten the portrait.

Direct quotations from the conversations have been used within the portraits to support the picture. These extracts are used verbatim to give the reader an understanding of the participants' language and detail. Thus, some of the expressions lack fluidity but this demonstrates the conflicts, understanding and issues faced by students when exploring spiritual care.

I reflect on each conversation and included extracts, where relevant (Appendix 11 details extracts of personal reflections). Data were collected between September 2016 and May 2017.

Overview of Participants

Ten Participants took part in the study and Table 6.1 outlines the key characteristics of each person, including nursing focus, year of study and personal spiritual perspective. Each participant was assigned a pseudonym to ensure confidentiality but reflecting the personal nature of the portraits, rather than assigning a number alone.

There was a dominance of adult nursing students in their second year and these students had commenced a module that included some sessions on spirituality which might have heightened their awareness of the topic area. Only one male student participated in the study but nursing, as a profession, is dominated numerically by women so this was not surprising. As phenomenology focuses on the lived experience (Van Manen 2014) at an individual level, the gender mix of the participants is valuable to contribute to the interpretation but needs to be considered within the lifeworld. The lifeworld may be influenced by the gender of the participant but, for this study, it is difficult to demonstrate whether any differences exist.

Four participant's portraits have been included in this chapter with pseudonyms applied (participant 2 Sarah, participant 6 John, participant 9 Amanda and participant 10 Lyn), and accompanying interpretative analysis. The four portraits represent the diversity of ideas within all the participants' stories, but the thesis word limit meant that not all ten portraits could be detailed here. A full transcript of participant 6 'John' can be seen in Appendix 13 as an example of data collected. Appendix 10 has extracts of personal reflections from each of these interviews in examples

numbered 3, 4, 7 and 9. The four portraits included in the findings section were chosen to demonstrate the breadth of information gained from a variety of student backgrounds (religious

Table 6.1 – Outline of All Participants with key characteristics

Participant	Pathway and year programme study	Personal spiritual perspective
Participant 1 - Emily	Emily was on the adult nursing programme and had just commenced her second year on the course	Emily was a practising Christian who believed people had a spiritual, as well as physical, side.
Participant 2 - Sarah	Sarah was on the mental health nursing programme in the second year	Sarah did not share her personal belief system or background but did not express any religious affiliation
Participant 3 - Minnie	Minnie was an adult nursing student who was in the second year of the programme	Minnie stated during the conversation <i>"I'm not really religious. I believe that there's good and bad but I don't really follow any religion"</i> ;
Participant 4 - Joanne	Joanne was on the adult nursing programme and had just commenced her second year on the course	Joanne did not refer to any personal belief system but noted that she had seen the benefits to patients of meeting spiritual needs
Participant 5 - Zena	Zena was in the second year of the adult nursing programme	Near the end of the interview Zena disclosed a Christian belief saying: <i>"my personal spirituality which is my relationship with Christ"</i>
Participant 6 – John	John was the only male in the study. He was in the final (third) year of the adult nursing programme	John identified that he had been on a spiritual journey, where he had engaged with different faiths, but now focused on stoicism as a philosophy which was the code of conduct for his life.
Participant 7 - Sonia	Sonia was in the third year of the adult nursing programme	Sonia said that the spiritual was important to her but did not specify whether this was a particular belief system or Deity
Participant 8 - Jane	Jane was nearing the end of her first year of the mental health nursing course	Jane stated: <i>"I'm a Christian, it doesn't really change how I feel about any other religion or spiritualism in general. It just, it tends to inspire me more to learn more about other people's ways of living"</i>
Participant 9 – Amanda	Amanda was at the end of her first year of an adult nursing degree	Amanda had been brought up as a Roman Catholic and this had influenced her values. However, she did not follow any religion but was interested in mindfulness
Participant 10 - Lyn	Lyn was an adult nursing student in the second year of the programme	Lyn was open about her Christian faith and the importance that had on her life saying; <i>"I think both in placement and in university I think what has helped me most is my religion"</i>

and non-religious), and a range of nursing experience from first to third year.

Adult and mental health nursing pathways were represented adding to the range of student experiences that informed the study findings about learning on spiritual care. Sarah did not state any religious history or affiliation, John described his personal spiritual journey towards a stoic position, Amanda outlined her religious childhood with a recent interest in mindfulness and Lyn was open about being a Christian believer. Three of the students were from adult nursing pathway and one was from mental health nursing pathway with first, second and third year of the degree programme being represented.

These four examples are presented as portraits to paint a picture of the conversation as outlined by Lawrence-Lightfoot (1997c & 2005). This is followed by the existential phenomenological themes as described by Van Manen (2014) lived relations (relationality), lived body (corporality), lived space (spatiality), lived time (temporality), materiality (lived things) and technology (lived cyborg relations) (see Table 6.1 for explanation). The interpretative phenomenological existential themes are explored in relation to each participant with relevant literature in Appendix 13. The chapter concludes with a comparison from the results with the meta-narrative review presented in Chapter 2 and offers new insights into the topic of learning about spiritual care for nursing students which will be detailed within the discussion chapter.

Portraiture and Existential Theme Analysis for Four Participants

Participant 2 (Sarah) Portrait

Sarah had seen the advert to the study which had sparked her interest in spiritual care. Sarah was a student on the mental health nursing programme in the second year but intimated that spiritual care had not been addressed within her experiences to date. However, she felt that the topic area could influence individuals' mental health, and their recovery from an illness, and the study advert had made her consider this.

Sarah did not divulge if she had any personal belief systems during the conversation and throughout was tentative in her answers, saying that she knew nothing about spiritual care. When she was asked her understanding of terms she said:

“Spirituality I suppose it’s personal beliefs or religion or practices and practices such as meditation for instance that people use in order to keep, to explain certain events, to cope with probably unpleasant events and to keep themselves healthy. And so this is something not materialistic that people employ in order to be able to cope with different events in their lives”.

The non-materialist element and use of various practices to aid coping were an important part of spirituality for Sarah. How other people expressed spirituality was the focus for Sarah but she highlighted that she thought everyone had a spiritual dimension:

“I suppose I believe that human beings are not just physical bodies and we do have spiritual parts in us”.

The quotation suggests Sarah saw herself, as well as others, having a spiritual part. This spiritual dimension could be expressed in a number of ways depending on the person and could include different religious and non-religious forms:

“For instance consciousness is a part of spirituality. I don’t think it’s a materialistic thing. And emotions, different types of emotions. This is a part of spiritual being of a human being. And different people have different religions. They have different beliefs. They use different practices to practise. Some people are agnostic and they don’t believe in anything, but in a way it’s a religion itself”.

Sarah initially struggled to think of experiences she had encountered related to spiritual care and said that she had not received any education on the topic area. However, Sarah then relayed an incident about a patient suffering from psychosis who was a Jehovah’s Witness. This seemed to cause some confusion for Sarah who noted,

“..she had very, very serious psychosis, it didn’t make sense to just go along with whatever she was saying but, to her obviously, it did make sense because she was referring to her beliefs a lot but I don’t think it would make sense in a normal way. It was making sense to her and she was given a diagnosis of psychosis. So I don’t know how fair that is because to her it made perfect sense”.

The mental health diagnosis of psychosis seemed to overshadow the lady's spiritual needs for Sarah. The patient's beliefs were important and at the forefront of her mind, but Sarah questioned whether the beliefs were bound up in the patient diagnosis, where the patient's spiritual thoughts seemed irrational from her view as a mental health nursing student. This seemed to trouble Sarah, recognising that the spiritual component was making sense to the patient, and made her question the assumptions within the diagnosis that these thoughts were irrational.

Another experience that Sarah had encountered was an elderly lady who said she was in discussion with God. For Sarah this created some dilemmas about how to interact with someone in a way that was respectful:

"She thinks she's talking to God and she's 82 but she thinks she's pregnant with twins from God. I would not try to say to her 'you know what? You're talking nonsense. You can't be pregnant. You're 82 years old. God didn't have any relationship with you' I wouldn't do that. I would just, what I did with her. I would just sit and listen. I didn't acknowledge but I didn't dis-acknowledge either."

Something that seems so improbable could make Sarah cynical about religion as it seemed ridiculous, but Sarah recognised that her role was to listen without offering a judgement. These extracts show the dilemmas that this nursing student faced when dealing with the complexity of a mental health illness combined with a religious belief. The confounding issues around the spiritual expressions which did not appear rational, the mental health diagnosis and the desire to respect the patients' beliefs, lead to dilemmas about how to approach these aspects.

Another experience that Sarah conveyed was a discussion with a patient and their perception of mental illness:

"She said 'you know dear, don't worry me in the nutters' house. We're not nutters. We're just divine'. So she considers herself, I've spoken to her, that mental health illness is a sign of being chosen by the god".

This was a patient interpretation that was unexpected by Sarah but made her reflect. Sarah compared this situation with historical events and how they would be interpreted if they happened today:

“In some religions, take Joan of Arc she was hearing voices and for that she was a Saint and that was the only way that she gathered all this army behind her because at that time in France, hearing voices was a sign of being a Saint. Or even if we talk about Jesus Christ. He was in desert hearing voices from Devil telling him jump off the cliff and I’ll give you the Kingdom. Nowadays he would be diagnosed as schizophrenic wouldn’t he”.

She later commented that Jesus had turned the whole world around but, today, he would-be put-on medication. This made her question the medicalised model of mental health practice to the point where she said:

“These are just thoughts that are going through my head and then I start doubting myself. Am I in the wrong profession if I’m not following the medicalised model of it?”

This self-reflection was in conflict within her own beliefs that everyone had a spiritual side and the medical focus within mental health nursing practice.

Sarah expanded on the difficulties in mental health nursing and thought that spiritual care was avoided for particular reasons. The main reason that Sarah understood for avoiding spiritual care was that staff had a fear of provoking conflicts between patients:

“They worry they’d be conflicts between them, different beliefs, clashes or maybe because people are practising something, they can, it can trigger something up, you know, promote the psychosis or whatever other illness. I don’t know. I don’t know why. Maybe we should be taught some sort of, like they do at school, religious education”.

The tentativeness of Sarah’s reasoning demonstrated her feeling that she lacked knowledge; this may have been knowledge about spiritual care or the mental illness diagnosis particularly considering the interactions between the two aspects. Sarah had the perception that discussing religion could cause disagreements, debates and lead to arguments amongst patients in mental health settings and, therefore, was avoided as a topic. However, she had no examples to support that this had happened and said that it was her ‘guess’ because it could trigger deterioration of the mental illness.

Sarah expressed confusion when talking about a patient who saw herself as divine:

“And then you start thinking and reflecting, where is the truth? Is it diagnosis or is she actually divine? Because that’s how she feels, what she thinks?”

The relationship between mental health and spiritual components caused Sarah to question more philosophically aspects that may be true to individuals. This experience seemed to cause Sarah to think about mental illness and religious experience differently, although she seemed unclear about how to address this relationship in practice and it seemed to raise more questions than answers.

These experiences had heightened Sarah's awareness of spiritual needs within mental health nursing. It made her wonder whether there should be a greater appreciation around patients who wish to attend religious services:

"..before the course I did come across with service users for requested to see a priest or to take them to church or take them to mosque. So we probably have to be given more insight into spiritual techniques or practices that can be used when we're working with the patients. Or if we come across with the patient like that how to deal with it, how to be able to help that person to access the service, the religious service they require"

The workplace culture, Sarah encountered as a student nurse, seemed to marginalise any spiritual matters or assume they were illness related. Sarah referred to previous placements, in learning disability and community settings, where she could not recall any examples of spiritual care.

Most of Sarah's conversation focused on the worries and dilemmas she encountered when dealing with spiritual issues, although she acknowledged that it could be important to individual patients.

One positive experience that Sarah gave involved patients attending a singing group, which often included religious songs, and she said:

"The patients were coming out from the sessions in much brighter moods, more chatty, even depressed patients, they looked different, they were, You could see a change to positive, to more positive. And afterwards they would even discuss it or talk about it. And sometime in those groups, people who are on the same ward and they particularly didn't talk to each other, after the group they would form the relationship and they would become friends".

Sarah saw this singing group as a spiritual encounter, people could connect, form relationships and the activity had a positive effect on mood, which was interesting to Sarah but she had difficulty explaining. Sarah said that she would take someone to church or mosque if asked too, but the initiative was on the patient to highlight their need; Sarah made no mention of spirituality being part

of the nursing assessment process. Sarah saw her role as supporting spiritual care once the patient disclosed spiritual needs rather than being proactive in exploring this aspect of nursing care.

Sarah did see some little touches as boosting a patient's confidence and aiding recovery, such as brushing hair, positive reinforcement to improve mood and respecting diet choices, such as vegan.

Sarah thought that spiritual care was very personal and for some people it would be helpful and others a hindrance. She noted that the recovery phase may be a more suitable time to deal with spiritual needs noting:

"It's very interesting. In manic stages people might think that he's a god or she's a goddess or whatever because it probably happens on the acute ward. It's very interesting how to work in mental health with spirituality".

This gave a sense that there were specific times and places to deal with spirituality in mental health nursing to assist the patient's recovery.

Throughout the interview Sarah asked what education student nurses on the adult pathway received around spiritual care and reiterated the lack of teaching on the subject within mental health nursing.

The over-riding sense for Sarah was that spirituality caused dilemmas and personal emotional discomfort, but this area was not being addressed adequately within her nursing experience or education.

Sarah wanted to focus on treating people as individuals and considering how to change care to enable this. However, she seemed to be struggling with the practical aspects of incorporating patients' spiritual needs within the context of mental health nursing, which seem particularly complex.

Interpretative phenomenological themes in Sarah's portrait

The existential phenomenological themes evident in Sarah's portrait are:

Relationality (lived relations) – relationships in mental health nursing are complex, influenced by illness trajectory and personal context. Tees et al (2012 p11) showed how mental health nurses have a discourse related to the medicalisation of psychiatry rather than a person-centred approach,

which Sarah also noted. However, building therapeutic relationships is important and Clifton & Banks (2014) note that a change to a recovery model for mental health promotes social inclusion; Sarah's experience of the singing group highlights the benefits of this form of support.

Corporeality (lived body) – There was a recognition that the physical and spiritual overlapped and people had needs in both aspects (McCance & McCormack 2017). The therapeutic use of self (Brown 2012) is a key concept within mental health practice and the skills of listening and self-reflection were evident in the portrait. Sarah expressed fear about discussing spiritual care and confusion between the boundary of illness or spiritual concern; thus, how much was physically dealing with the illness and where relationships coincide on a more emotional level. Brown's (2017) thesis highlights similar issues for mental health nurses on spiritual care, that students had difficulty clarifying the physical illness from spiritual needs. Although an individualistic approach to patient care is evident within the portrait, the implementation of this, when confronted with spiritual needs, is difficult for students to grasp.

Spatiality (lived Space) – Sparking an interest in the topic area is helpful to develop student interest in spiritual care; Sarah's interest was lit by the research study but a learning environment that promotes exploration of concepts is needed for spiritual care. The culture of mental health nursing seems to continue to be medicalised (Clifton & Banks 2014) but there are several approaches to mental health practice (Stickley & Wright 2014), such as cognitive behavioural and psychodynamic approaches which focus on relationship and behaviour, rather than drug therapy. Sarah's portrait leaned towards a humanistic approach (Cassedy 2014), that emphasises building esteem and empathy, which were evident within her responses.

Sarah said that she would take someone to chapel if asked to; there was a recognition that a place may be important to the person, but the emphasis was on the person asking to attend which requires empowerment for the individual. In a medicalised mental health setting the patients can

feel disempowered and follow advice (Clarke et al 2018) rather than feeling emancipated; the awareness of emancipation of patients was not clear in this portrait.

Teaching around spiritual issues within university and by mentors was not evident in this portrait so the student has little opportunity to develop their competency and knowledge in this area.

Temporality (lived Time) – Historical time was explored by Sarah as she related how historical figures would be viewed within the current social context relating to mental health practice. Historical time is not mentioned by Van Manen (2014) but this portrait shows how past events can influence current understandings. This portrait highlights that time is a multidimensional concept that is influenced by other factors; something that was positive is now viewed negatively. Sarah gave the example about Joan of Arc hearing voices noting that this was seen as saintly in the past but would now be viewed as a mental illness. Mental health conditions can lead to confusion and altered perception in patients (Smith & Rylance 2016) leading to irrational behaviour; today the use of assessment tools and legislation is in place to consider the safety of the patient and others but historically, this was different. Time is needed to devote to another person as part of the therapeutic use of self (Brown 2012) and this commitment was evident in this portrait.

Materiality (lived things) and Technology (lived cyborg relations) - neither of these aspects were evident within Sarah's conversation. Smith & Rylance (2016 p140) say that the importance of spiritual and religious practices can be underestimated in mental health nursing believing that it aids recovery, particularly in certain ethnic groups. However, patients may not express spiritual preferences for fear that it will be interpreted as illness related.

Participant 6 (John) Portrait

John was the only male who agreed to take part in this study and the full transcript is available in Appendix 13. John's conversation identified that he had been on a spiritual journey himself where he had engaged with different faiths but now focused on stoicism as a philosophy, which was the code of conduct for his life. He described himself as:

“I am modern stoic in that I am an atheist and an agnostic so although I personally have no spiritual needs as such that most people would recognise as spiritual needs, I’m still very aware and very conscious of people that do”.

John noted that his wife was a pagan and she practised as a witch, but he had been shaped by his experiences of different faiths towards the stoic position. John’s stoicism ideas were stated in terms of ethical values, rationality and doing good. Spiritual aspects of care were important to John, but he saw spirituality as a wide area and referred to aspects such as magic and animal spirits, as well as religious practices, explaining:

“My personal understanding of the word is that spirituality covers any of those intangible forces behind an individual’s belief system and their own personal kind of code of conduct and behaviour”.

John’s overarching and broad understanding of spirituality was evident within his position as a third-year adult nursing student. Spiritual care was important to John, but his conversation highlighted the cultural aspects that affect engagement with the issue.

“It’s one of those topics you’re always taught never to mention at the dinner table. Never discuss politics, sport or religion. I often find that those are three topics that, generally speaking, that healthcare providers tend to avoid mentioning when they’re interacting with the patients, purely because they can be a culturally engrained source of discomfort when you’re speaking with someone who’s a stranger. On the other hand, if we come across a patient who is wearing a football top and they are lying on their bed we are usually quite happy to strike up a conversation about football even if we know nothing about it, yet it’s strange we have a like contrast and dichotomy where patients who are wearing, who are obviously wearing items of religious or spiritual significance don’t receive that same interest”.

John contextualised spiritual care within the cultural setting showing how it was easier to discuss football than religious aspects. His perception was that religion was avoided in healthcare and there was wariness about discussing spirituality. To John, this reflected the cultural norms where religion is privatised and not discussed in public due to fear of causing offence or saying something inappropriate. However, John highlighted that patients are often at a vulnerable point when needing healthcare and the spiritual support may be important:

“I think, in a hospital environment especially, people are most vulnerable. It’s the most time in life when people who do have a spiritual source of comfort are most likely to want to call upon it and need it”

John noticed that the focus was on physical aspects of care delivery and the busy healthcare environment detracted from dealing with spiritual issues. John’s conversation showed that all aspects of physical, emotional and spiritual health care were important to his practice when a patient was unwell. John kept emphasising that spiritual care was an important aspect to patients but was often overlooked or not discussed with the patient:

“..a patient who was palliative care, end of life and the section detailing spiritual needs would be blank. There would be a score through it or there would be no comment. And I have to ask myself how often that came about because a member of staff asked the patient and the patient said they didn’t want to talk about it. I rather doubt that that’s what happened most of the time”.

John’s comment seems to underline the thought that staff dislike talking about spiritual matters and are uncomfortable about doing this. Utilising other people to assist with spiritual care was also not sought; John commented that chaplains were rarely used:

“..it’s very rare in my experience to find a member of a clergy for any organisation regardless of their religion to be actually present in the hospital. Normally it’s a case of making contact with the chaplain or with the volunteer. And then the volunteer then coming out. Which in itself suggests to me that is not a great deal of demand for spiritual care in a hospital which strikes me as odd”.

The oddness that John talks about was related to the thought that spiritual matters were important to patients at a time of illness and, although the impression was that staff did not deal with these needs effectively. John longed to see more emphasis around spiritual care that was proactive saying:

“I would love to see healthcare practitioners actively promoting spiritual care rather than passively promoting it the sense that, or waiting for the patient to approach them regarding their spiritual needs”.

The conversation with John gave the impression that it was an area in practice that was avoided by staff and poorly addressed due to busyness of the healthcare setting and lack of awareness of the importance to patients.

John recognised that trying to describe spirituality and spiritual care were difficult and he emphasised the importance of being person-centred stating:

“The terms like religious needs or spiritual needs are very nebulous as well. Really I think with the spiritual needs or religious needs are essentially comes down to what the patient says they are”

This individualistic understanding of spiritual needs was addressed by practical behaviours such as listening, noticing and being aware of others’ needs. He felt health care staff should be more perceptive to this area and thought patients would value this:

“..it’s a case of being a little bit perceptive, perhaps noticing if a patient has anything in the environment that suggests they may have spiritual needs. For example, if they were wearing a crucifix around their neck or if you notice a bible on their table then it may be worthwhile broaching the subject with the patient. It might be that many healthcare providers are uncomfortable with the notion of doing that but I rather expect that many patients would be grateful for the subject to be raised”.

This ability to notice a seemingly small aspect, such as a religious item, was repeated by John through the conversation, so identifying cues that highlighted spiritual needs was important. Asking was also important to John:

“..because I think the only way to anticipate patient’s actual spiritual care and needs is to ask them what they are”

John had developed an awareness of things that might highlight spiritual needs to be addressed and used this as a way to ask the patient what was important to them.

During the conversation with John he communicated a set of experiences that had influenced his understanding and practice of spiritual care. John started by relaying an experience that happened on his first placement in his first year of nurse training:

“Probably one of the most difficult experiences I ever had, as a student on my very first placement. We had a gentleman who was very, very poorly ill. He was in fact a pastor. He’d fallen, obviously because of reasons of confidentiality I can’t go into specific details, but he’s fallen ill on the Saturday, been told on the Saturday evening he had perhaps a week, two weeks to live. And this gentleman had been married for less than two years and had an 18-month-old child and he was very young and very, very religious. And it was very difficult to watch. When his family or when members of his congregation were visiting him, he was very, very keen to put on a brave face and he did very well. But at night, especially when there was

no one around to watch and he didn't have to be strong any more he really struggled. And it was a very, very difficult experience to see a man in so much pain and torment, fuelled by his particular position in life".

John was now in his third year of nurse training, but this first-year experience was etched in his memory, including a lot of detail about the past events. John, at that time, did not know how to deal with the patient's spiritual distress although he said staff '*did what they could*'. However, John demonstrates self-awareness about the emotional effect it had on himself and that he had few resources to draw upon to help him. He showed awareness of his lack of understanding and this had perplexed him as he had been unprepared to deal with such an event. This reflection made John think about an aspect of spiritual care that he had not considered at the time:

"At the time I didn't think to suggest to him that perhaps he'd want a visit from another pastor from his particular faith because at that point my experience of death and palliative care and spiritual care was really very limited".

John went on to talk about the beginning of the second year where he undertook a module with content around spiritual care. This module incorporated time for discussion with peers where he shared the previous experience about the pastor and the response challenged him:

"..and that was when another student suggested to me 'why didn't you just pass the phone?' And that felt like a kick in the stomach. Something so obvious hadn't occurred to me. And that led to some moments of doubt in the sense of well, am I really giving spiritual care the attention and the time that it needs".

This encounter with a peer demonstrates that the opportunity to discuss dilemmas was important to John's learning. However, this was uncomfortable for John and led to emotions of doubt in his ability to promote spiritual care. John used it as a springboard to develop his understanding of spiritual needs, demonstrating some personal resilience within the situation and saying that he now felt more aware of spiritual needs. The metaphor John used that it "*felt like a kick in the stomach*" emphasised the effect this educational experience had on him, making him question himself, making him consider different options and making him more intent on learning about and incorporating spiritual care.

The challenge of this learning experience increased John's awareness of spiritual needs and led to him being more proactive in meeting spiritual needs in the future. John relayed this incident from the final placement of second year which demonstrates how he incorporated the learning into his practice:

"I'm much more aware of spiritual needs. On my last placement of 2nd year for example, we had a gentleman with palliative care. He was a very, very devout Muslim. And we knew he was going to die in hospital.... And I was very, very much aware that there are particular customs regarding the final offices for a Muslim who had died. In particular the fact that the body has to be washed and prepared by a member of their own faith and we did not have a single Muslim member of staff on the ward. And this caused me quite a bit of concern to the extent that I made a particular point of getting myself in touch with the local Imam chaplain at the hospital and I spoke with him, got some advice from him that was very useful and the next time the family attended I made a point of taking them into the family room and discussing what their wishes were"

This highlights that John was now proactive in his approach to spiritual care, had used the understanding he had gained to incorporate an individual approach and connected with the family to achieve this. John recognised that he had moved from a passive observer in the first year to an active promoter of spiritual care in the final experience. Not only was John more aware of issues but he ensured the team followed the patient's wishes at the time of death too:

"..so I made a point of making sure that all the ward sisters and the ward staff were aware that when the time came the final offices, we were to contact certain friends of the family and certain members of the family and that they would come".

This experience showed many personal attributes around John's motivation to provide person-centred care, commitment to achieve this and communication with staff and families to reach the goal. John had learnt from his first experience, from interaction in a teaching setting and now could adapt to new spiritual needs in a proactive manner; this also fitted with his stoic views.

The impression given in the excerpt below is that John felt a sense of pride in that he had addressed the spiritual needs of this patient, had developed his confidence in tackling the needs and gave him a sense of job satisfaction:

"..what I can say is that I felt as though I had done everything I possibly could for the gentleman and for his family especially. So rather than the feelings that I had in that first

instance we discussed, where I had let down the patient and the patient's family by not doing everything I could, I felt that I'd been able to give the patient and the family proper holistic care by encompassing all of their needs. So I felt that I had done a decent job".

This complete experience of learning, from John's perspective, shows how intertwined elements are with the development of self as a nursing student, desire to reflect holistic care principles and focus on the individual patient needs combine to achieve a 'decent job'.

Although John's development to incorporate spiritual care was evident, he felt that more sessions on spiritual care were needed within the curriculum saying:

"..the training of having spiritual care has been of quite a good quality but I think this is insufficient in terms of quantity. I don't think that the modern nursing culture places enough emphasis on spiritual needs".

John's conversation showed how the combination of his own philosophy, self-awareness, knowledge development, challenge and action all contributed to improving the spiritual care he provided to patients.

Interpretative phenomenological themes in John's portrait

Relationality (lived relations) – John demonstrated many of the aspects of McCance & McCormack (2017) person-centred framework because he wanted to engage with patients authentically, recognising the uniqueness of the individual to provide holistic care. John recognised individual personal beliefs and wanted to work with these values (McCance & McCormack 2017) but he also communicated with the team which NMC (2015) and Baillie & Black (2015) both advocate providing holistic care. Communication is a complex process (Arnold 2016) and John demonstrates a variety of communication skills, such as listening and asking, within his practice.

Corporeality (lived body) – Chan (2010) talked about factors that affected staff incorporating spiritual care into practice and noted that nurses who had higher perception levels towards spiritual care were more likely to include this into their care delivery. Although John did not follow a specific religion, he demonstrated self-awareness about his personal meaning and beliefs which Zohar & Marshall (2000) conclude is fundamental to spiritual intelligence. Spiritual intelligence is seen as a way to combine cognitive and emotional aspects of intelligence, according to Zohar & Marshall

(2000), to enable a person to transform their understanding of a situation. John developed a more proactive approach to spiritual care, so translated this spiritual intelligence into action, which was important to him as his experience developed. This development concurs with Ross et al's (2018) research findings demonstrating that student competency in spiritual care improved over the three-year nursing programme. Wu et al (2016) found that most nurses did not feel they had enough education on the topic of spiritual care, and this affected their willingness to provide spiritual care. John similarly felt there was not enough education on the topic of spiritual care which affected his ability to meet the spiritual needs of patients and feel prepared personally for the challenges of spiritual care (Rushton 2014).

John articulated his stoic beliefs, and this is a philosophy that focuses on virtues and character (Gill 2013). The relationship between virtue ethics, character and morals has been discussed within nursing literature but concern is sometimes raised about whether it is possible to change a person's character, although Sellman's (2011) book argues that virtues are important to make someone a 'good' nurse. John particularly demonstrated his desire to 'do good' and the person-centred framework (McCance & McCormack 2017) talks about the moral, ethical and values clarity needed to work towards individual patient goals and be committed to the job. The pride John felt when he achieved holistic care is something that Cook (2017) refers to as 'human flourishing' seeing it as an important aspect to develop caring attributes within student nurses. Tuckett (2015) noted that the important values for nursing have not significantly changed over time and are still an area to consider in education practice.

John changed from a passive onlooker to an active participant when delivering spiritual care and transformative learning theory highlights the importance of experience, challenge and reflection to change students understanding (Mezirow 2009); John's experiences with a peer and in practice is evidence of this process.

Spatiality (lived Space) – The healthcare setting as a place where spiritual matters were avoided was evident in John’s conversation and this may be due to historical context of uncoupling religion from state as well as the secularisation of healthcare (Swatos & Christiano 1999). NHS chaplaincy guidelines (NHS England 2015) note the vulnerability of patients during illness and John referred to patient vulnerability and highlighted the poor resourcing for chaplaincy services. A review by Roze des Ordons et al (2018) found that patients thought wards were too focused on the biomedical and spiritual distress was not tackled. Thus, conversations tended to focus on culturally acceptable topics but Strang et al (2014) highlight the importance of communicating about spiritual matters within a supportive context.

Temporality (lived Time) – Sharp et al (2018) found that busy wards could detract from person-centred care and John found this detracted from spiritual care, which is a central aspect for holistic practice. Roze des Ordons et al’s (2018) review found that time was a factor meaning that spiritual distress was not always dealt with by staff.

Zamazadeh et al (2015) noted that education tended to prioritise physical disease processes, and John concurred that spiritual care teaching was lacking and needed more time devoted to it.

Materiality (lived things) – John demonstrated ability to observe and assess for signs of religious activity in patients such as noting a crucifix around someone’s neck and a bible on the patient’s table; spiritual assessment is integral to history taking according to Hogan-Quigley et al (2012). The importance of things in our lives is supported by Van Manen (2014) and the meanings and values are very individualistic.

Technology (lived cyborg relations) - again there was no evidence in John’s conversation about the role of technology within spiritual care delivery which may mean this is the ‘taken for granted’ aspect that Van Manen (2014 p308) discusses because change is always happening in the lifeworld and so is not noticed.

Participant 9 (Amanda) Portrait

Participant 9, who I have called Amanda, was at the end of her first year of an adult nursing degree. She was French by birth and discussed her cultural upbringing. She noted that in France healthcare and education are based on secular principles and religion is not incorporated. Although attending religious institutions is allowed in France, it was unacceptable to bring religion, including a chaplain, into the healthcare setting.

Amanda had a religious upbringing by her parents which had affected her values and she saw this as a positive influence on her personal development:

"I've always been grateful for the values that I was taught as part of Catholicism and having that sort of education because a lot of them are about caring and about love and show regard for others and respect for others".

Amanda stated that she no longer followed a religion and noted that her mother had moved to an Anglican position. Amanda, in some ways, seemed to struggle with the opposing sides of secular state and religious upbringing saying:

"..there has been this sort of, this conflict perhaps always between this very secular French side and perhaps a little bit more religious and Anglican side of my upbringing"

There was some self-awareness in Amanda's conversation about her complex personal history and her perception of spiritual care within nursing:

"I, myself have a very complicated view of religion in that I'm half French and in French culture school is secular, health care is secular, everything in the public domain is seen as secular and the separation is very clear. So anyone who is religious and wants to attend a religious building is welcome to do so. But in the public arena everything is sort of secularised. And so, in that sense, you could provide spiritual care but it would be unacceptable to bring up your religion or to suggest even your religion."

The separation of state activities and religious ones was very clear in Amanda's thoughts, but she tended to focus on religious activities at the start of the conversation. When asked what she understood by spiritual Amanda outlined:

"..spirituality being sort of both religious and secular and it can mean positive things. It can mean that you have a greater awareness of yourself and of others or it can mean you bring a very religious sort of view."

However, when Amanda talked about spiritual care in nursing practice, she had an individualistic and person-centred perspective:

“..it’s one part of that holistic way of caring for the patient, seeing them as a whole person with their own spiritual needs.”

Amanda had started exploring meditation before commencing her nurse training, but university had contributed to her developing an interest in mindfulness techniques. Amanda noted that a teaching session had explored articles on mindfulness, related to nursing care practices, and she felt this was relevant to healthcare which had sparked her interest further.

“..it is a topic that I’m interested in because it’s a concept that’s sort of coming through mindfulness as something that really does improve care for patients but also the self-care of nurses and making sure they’re not burning out or stressed to the point of not being able to do their work anymore. So the idea of spirituality does interest me”

This interest in spirituality was around the care of all people, patients and staff, and made her explore related issues that might be improved by mindfulness strategies. I reflected that Amanda’s self-awareness was key to her understanding of spiritual care (see Appendix 10 - Example 7).

Despite seeing spirituality as beneficial to patients, Amanda noted that the emphasis in healthcare was on the physical needs of patients rather than spiritual aspects:

“I haven’t so much seen sort of secular spiritual approach to health care other than that I’ve seen a very biomedical approach of you know ‘take care of this immediate need of the patient and move on.”

This focus on the physical care meant that spiritual aspects were not a priority and Amanda believed that a secular approach, rather than religious one, could be beneficial. Mindfulness for Amanda enabled refocusing on the other person and she talked about having a presence with the patient.

Amanda explained spiritual care related to her emphasis on mindfulness practices, but this was not easy for her:

“Spiritual care? Um, that’s a difficult one. Having that caring approach that accounts for a more sort of wholesome I think way of looking after a patient. And again it comes back to that mindfulness, the way I have sort of seen it, is in the context of a more sort of secular mindfulness practice. So care that acknowledges the feedback you’re getting from the other person, awareness of your own actions and kind of a presence”

Mindfulness had been influential in the way Amanda approached spiritual care without focusing on a religious perspective which she appeared to struggle with.

Another university session that Amanda discussed was exploring nursing case studies that highlighted practices that were not professionally acceptable, such as imposing religious views on a patient. This seemed to make her particularly conscious of not including your own religious view, but she acknowledged that you needed:

"..understanding from someone's background and from what you know of their religion what kind of care they will and will not accept"

Again, Amanda focused on what was important for the individual patient and knowledge about their religious preferences. Amanda recognised that some people followed religious text and that there were many different forms of religion to consider. The education experience that Amanda had encountered covered both religious and non-religious approaches:

"We've talked a little bit about it in our degree in terms of mindfulness and meditation. So secular spirituality sort of ways of managing nursing as a profession and the kind of stress around nursing. So more sort of in those terms than in the sort of traditional connotation with religion and that kind of thing".

Translating this educational experience into the practice setting led to some struggles for Amanda because the English system allowed for more integration between spiritual, religious and secular positions. She expressed reservations about this and felt that values were more important within healthcare:

"I think it is a very dangerous path and everyone interprets religion differently. So as long as your values are good and you are sort of a good person".

This aspect of fear and concern about religious activity being integrated into healthcare peppered Amanda's conversation. Amanda related an experience on her first ward which had particularly concerned her. Many of the nursing staff, particularly the healthcare assistants, were religious and were open with other staff and students about their perspective. This provoked some discomfort in Amanda, although she recognised overall that the nursing care was good:

“..there was this view that people from certain religions were different and less worthy but it wasn't related to care. And that particular person didn't seem to change the care that she gave to those people. So that could reflect good professional values as well. I don't know. But I don't feel like peoples' care was affected.”

Amanda was perturbed by the discussions she heard between staff on this ward and, although these were not held in front of patients, she was concerned about the underlying beliefs present. The professional values were respected, and quality of care maintained, but Amanda stated:

“I was concerned personally that those views were there anyway, that they were present. So my view of religion being mixed in with healthcare was not very positive from a theoretical point of view but I can't say that the care wasn't good”.

Amanda expressed the discomfort she felt with mixing religious views and nursing practice, even though this did not affect the patient care delivered. This experience made her reflect on what was important, which focused on values, giving 'good care' and being holistic. Amanda's French roots meant that chaplains were not present in healthcare but her experience within her nurse training was positive:

“We also saw a chaplain a few times, come in and talk to patients. But really when I talked to her she said it was secular conversations really and if they have questions about religion then she's there to answer them. But in that way I think it was very positive because it didn't impose religion but it brought out sort of values that of caring and of asking questions and remembering sort of things that the patients were going through from one appointment to the next. That may be helpful to them from a sort of moral point of view. So overall it was positive.”

Amanda's upbringing seemed to emphasise the difference between the English healthcare system as less distinctively secular. She reflected on the positive and negative aspects of this, as she perceived them. Not imposing religious views seemed particularly important to Amanda but including spiritual care, as appropriate, could be beneficial. Amanda's preference for secular spirituality, such as mindfulness, meant that she was more comfortable with these types of expressions which conformed to moral and professional values. However, she expressed fear about religious activities, such as use of religious texts:

“..the potential of that being brought into healthcare and having an influence on how care is provided scares me a little bit”.

Other experiences Amanda had around learning spiritual care where focused on professional behaviours. She was concerned that this approach only applied to registered nurses and left non-registered practitioners more able to relate views that she saw as radical. One radical view she referred to was the belief that evolution did not happen and she wondered how a scientific based profession could believe that. However, she noted that:

"..health care professional talking about their own family members, when they're unhealthy, praying for them. Not necessarily praying for the patients themselves but having that view, that prayer does make people better".

The concern about radical views and religion influencing care were repeated throughout the conversation making her wary of formalised spirituality and religion saying that she intended to keep a distance from this. The experiences she had viewed had increased her anxiety around the way spirituality was practised saying:

"I'm more worried about religion in healthcare than when I started".

The one placement experience had coloured Amanda's view and she was debating how to reconcile her secular perspective with a system that allowed more integration of religious views from staff. For Amanda the emphasis was on values development and, the small amount of education provided in the nurse training, had influenced her thinking about how to incorporate spiritual care in a positive way.

Throughout the conversation Amanda emphasised the importance of having 'good values' whether these were related to your upbringing or professionally. Amanda's thoughts around spiritual care seemed closely linked to her upbringing and French culture so reconciling this to a different cultural approach was a challenge and caused conflict within herself. She had found mindfulness and related aspects of "being in the moment" and presence as key aspects to aid patient care and staff wellbeing.

Interpretative phenomenological themes in Amanda's portrait

Relationality (lived relations) – Amanda's spiritual care practices with patients were influenced by her beliefs and values and McCance & McCormack (2017 p46) state that beliefs are what people think is true whereas values guide people to the right action. Tuckett (2015) found that the important values for nurses have remained similar over time with a focus on person-centred care, which was evident in Amanda's portrait. Although healthcare is seen as secular, Knott & Franks (2007) study found that there were religious aspects embedded within it, and this is like Amanda's experience. Amanda saw disparity between staff language and actions and McCance & McCormack (2017) discuss the importance of beliefs and values for both staff and patients. However, the relational aspect for Amanda still followed the professional code (NMC 2015) based on respect and equity of care delivery but Amanda noted that underlying personal beliefs could be different to those which were espoused by some staff. Relational reciprocity was discussed by Pesut & Throne (2007) saying that nurses need to focus on the patient in a pluralistic society and this will minimise, what they describe as, ethical risks if nurses take on a stance of being expert on spiritual care. Amanda drew on her experience in relationships with patients but did not consider herself an expert suggesting that reciprocity happening.

Having a holistic view of care delivery seems to be embedded within nursing practice with many theories of nursing including the need to care or heal the whole person (www.nursing-theory.org 2016). The person-centred framework (McCance & McCormack 2017) includes the aspects of 'providing holistic care' and 'being sympathetically present' and both were highlighted in Amanda's conversation. Several authors (Hoffert et al 2007, Giske & Cone 2012, Cobb 2004, Lovanio & Wallace 2007, So & Shin 2011) agree that spiritual care is integral to holistic practice and, even though Amanda struggled with some elements, she agreed that it was an element of nursing care that was needed.

Corporeality (lived body) – Amanda talked about being '*in the moment*' and this is an aspect of mindfulness to help people cope with stressors. Jenaabadi's (2018) study linked the concepts of

spiritual intelligence and mindfulness to demonstrate how it reduced anxiety about death within nursing students. Zohar and Marshall (2000 p 14) discuss spiritual intelligence including elements of self-awareness considering personal beliefs and wrestling with questions and Amanda was dealing with all these elements within her experience and personal background. Amanda's experience made me wonder how easy or difficult it may be to separate your personal beliefs and values from your professional side; she talked about her values being formed at a young age and Carr (2014) emphasises the importance of learning virtues from youth and beyond. Amanda struggled with the interlinking of secular and spiritual within UK practice and felt uncomfortable with this aspect which she had not resolved.

Spatiality (lived Space) – Amanda found some of the situations in the practice setting unsettling and this may lead to stress. Mindfulness, according to Kelly & Tyson (2017), is a useful strategy for students to deal with stress and may explain why Amanda found this helpful. The French secular culture had influenced Amanda and Tveit et al (2015) noted the change from faith-based nursing to a more secular approach across Europe citing the difficulties this can bring. The changing landscape of European nursing towards a pluralist post-modern view (Tveit et al 2015) may be particularly important for someone transitioning to a different cultural perspective.

Temporality (lived Time) – Amanda's focus on 'being present in the moment' involved spending time with the patients (McCance & McCormack 2017 p27). Amanda saw practice as '*work time*', a subjective time to focus on presence with the patient (Mohammadipour et al 2017). Time that is spent not focusing on patients, such as the nurses talking about religious aspects, may lead to Amanda feeling uncomfortable. James et al (2016) discuss how socialisation of students is needed to help them feel confident doing practical aspects but feeling uncomfortable in the setting may impede learning.

Materiality (lived things) – Amanda was focused on values in her conversation and did not mention any material things that might influence spiritual care. Again, this may reflect her desire to focus on

presence and the individual, listening to their needs rather than predicting them (McCance & McCormack 2017).

Technology (lived cyborg relations) - Amanda did not mention any technological areas related to spiritual care.

Participant 10 (Lyn) Portrait

Lyn (participant 10) was an adult nursing student in her second year and she had received some education on the topic of spiritual care within one university module. Lyn thought spiritual care was important and influenced her to volunteer to participate in this research study. Lyn was open in the conversation about her own Christian faith and the importance that had on her life:

"I think both in placement and in university I think what has helped me most is my religion because whatever I do in life or however I treat somebody else it's what I've been taught, how I've been brought up, what values I have I believe in."

Lyn noted that her values were based on her Christian beliefs and her upbringing had been important in her faith formation. Her Christian beliefs and values also informed and influenced her nursing practice:

"I'm always going out there with my religious cap on, it's not written on my head, I don't tell them 'oh I'm religious' but it helps me to be caring, it helps me to be humble, it helps me to be loving, it helps me to care for people regardless of who they are, where they're from. It just helps me to live what I think is meant to be a normal or a decent way of living. So I think it has to do with my religion".

Different values about being a decent person are inherent in the description Lyn portrays. Lyn's personal beliefs were foundational to the way she practised nursing and she showed awareness of the importance this area had on her life. Lyn felt that freedom to express religious views was important within society, although she caveated this by saying that it was acceptable for patients to express spiritual beliefs but not staff; implying that discussing personal beliefs was not allowable in healthcare. Professional boundaries were evident in Lyn's conversation as she recognised the individuality of each person when considering spiritual care:

“..for some people it’s very therapeutic for them, you know it’s a therapeutic way. For some people it’s a no go area as well. So you need to know the line and the boundary and you know, where to cross and where not to cross”.

Not overstepping professional expectations was important to Lyn and she felt fearful about breaching professional boundaries giving the following as an example:

“..recently you’ve been hearing in the news where the woman was preaching to a patient in (named local area) where she got struck off. So hearing news like that and you’ve heard it in the past before where things are. So it puts you a bit on edge. So ok. What am I allowed to say? What can’t I say? Where do you draw a line? It’s kind of hard”.

Lyn frequently referred to concerns about saying the wrong thing and ensuring respect for the patient’s wishes regarding discussion about spiritual needs. Lyn felt that patients were wary of interacting about spiritual matters as well, saying:

“..It’s quite hard for some patients out there as well. Because one lady told me once ‘oh are you a Christian?’ And I was like ‘yeah are you?’ She said ‘oh no love I don’t want to get you into trouble’ and I’m like ‘no you’re not in trouble, you know you’ve brought it up’. So I understand where they’re coming from, I feel the same way sometimes it’s quite hard”.

The inter-relationship between Lyn’s personal belief, thinking that spiritual care was important part of holistic practice but being respectful of patient individuality and different beliefs was highlighted in her conversation. How to marry these elements, in a way that embraced her own beliefs without breaching professional ones, seemed to be a fine line that needed navigating. I noted this in my personal reflection about the dilemmas Lynn seemed to struggle with (see Appendix 10 -example 8).

Lyn’s description of spirituality was quite vague and mainly related to religions:

“Some people it means their religion, their spirituality based on their religion. And spirituality can be mean on the person’s beliefs or anything to do with the person”.

However, Lyn was very clear that she wanted to learn from others about different spiritual views and practices saying:

“I’m kind of open minded. Like when I meet the Hindus and they talk about their religion and I’m working, I learn a lot from them. And when I meet people who are also non-Christians it’s not in my place to go and meet and ‘oh why are you not?’ I also you know want to learn what they believe in, what makes their ideas come, when they bring issues like that. It’s fantastic to just know that they are different people out there, different beliefs, different opinions, different values”

Learning, for Lyn, was by exploring different beliefs and faith positions using a variety of methods, such as reading and discussing with others. This linked to her personal development enabling her to reflect on her own faith position and linked to how she practised as a nurse:

“I pray a lot but that’s helped me. As I said I’m a churchgoer and I also read my bible. I read a lot about spirituality as well. I try to, not just the bible but read people’s books and ideas and learn a lot and that’s helped me a lot to develop and that’s what I take into practice as well. And also sometimes meeting different people, different backgrounds, talking to them, different pastors, different ideas of what spirituality is all to them. I’ve learnt from a lot of, not just reading but hearing from other people being socialising from the universities, from lecturers”

Interaction with others, whether with colleagues or patients, was a recurrent way in which Lyn developed her understanding of different spiritual perspectives. Lyn was the only student who mentioned the university’s Christian foundation within her conversation but stated that this was not forced onto people but was a welcoming place. However, Lyn recognised the rules, regulations and standards that she, as a student, was expected to meet and talked about being a representative of the university:

“..they teach us morals, they teach us values, they teach us how to, you know. You’re not just a nurse but you are an advocate, you are representing the NHS (national health service), you’re representing the Government. So you need to be outside and understand that you are expected to talk and behave in a certain way. You don’t just go out in public and be doing what you think others do or what you used to do. Now you just don’t do that because you have a powerful profession, people’s lives will depend on you and people will be looking at you. So they teach us quite a lot in university, how to behave and spirituality is part of it as well”

This showed that Lyn wished to conform to the societal and professional expectations, and she recognised some of the virtues inherent within nursing, such as morals, values and behaviours. However, Lyn referred to external pressures that might hinder spiritual care and made her fearful about dealing with this aspect with patients:

“..they want to speak to you about their religion and now you have all this social medias and things going on and you should not speak or preach to the patient. Even though they’ve put it up it’s like you don’t know what to tell them, you don’t know what to say that is acceptable. You’re kind of scared because of the culture that we’re living in. Even I will never start a spirituality conversation or religious conversation with any patient but sometimes they want

to talk so if they bring it up 'Oh, what church do you go to?' and they will ask you. And you will like to, you know you just don't want to cut them off."

Lyn was worried that aspects of a spiritual care conversation with a patient could be misrepresented which made her fearful about being reported. These fears about recrimination from colleagues or other patients meant that Lyn held back from disclosing her own faith to ensure she kept within the perceived boundaries of the profession, this she viewed as hindering her interactions. Lyn perceived social media as influencing the way she engaged with patients on spiritual matters because of the possible ramifications if comments were displayed negatively. Despite these concerns Lyn said that she tried not to let this hinder the spiritual care she provided. She gave an example from her a cancer ward placement which particularly highlights the conflicts this could raise personally and professionally:

"She (the patient) was like 'oh have you heard that I'm dying?' and of course, at that point as a student nurse I'm not going to say 'oh yes I did' I just said 'oh' I tried to avoid the question but it was quite hard. And she was said 'but do you know one of my biggest problems, one of my greatest anger is that I'm a Christian and I believe in God so much and I pray and I give and I do everything and I don't know why. I've prayed for a miracle to happen. I prayed for healing. I really don't know what to believe anymore. I don't know if I should still trust this God' At that point as a Christian I sat down there thinking 'yeah, you know, I wish I had an answer to give to her right now' But that's one thing that sometimes us Christians we face a lot because bad things happen to us as well. And then what do you say to people going through that. It was a difficult period for me. It was a very difficult time."

This was a challenging encounter for Lyn, showing how a patient interaction could lead to personal inner dilemmas. Lyn could empathise with the patient from her own Christian belief but could not solve the patient's own spiritual distress. This encounter made Lyn consider the reality of spiritual care in practice and how to encourage the patient but also to be truthful:

"But all I could say to her 'you know what? Take one day at a time'. It was hard because I don't want to give her false hope. I don't want to either preach to her, either. I just keep telling her 'keep hold on to your faith. If that's what you believe in' And later on as time goes on I got to speak to her regularly and she told me 'you know what? I've come to terms with what I'm going through and I know God has a purpose' So it was like two different people talking. It was like she'd been reading her bible"

Lyn demonstrated communication skills by listening and talking with the lady, enabling her to think through the issues she was facing; this helped the patient to come to terms with her approaching

death and reconcile it with her faith. However, this encounter had made Lyn reflect on her own faith journey so that she could cope with the dilemma of God allowing suffering as she relates:

“So it’s a topic sometimes I wish I did not have to face. You know but unfortunately you come across it at work and I’ve come to realise Christianity or religion is a personal relationship you have with God, it’s not a group thing or whatever. I’ve come to the point in my life where believing in God is not based on what he does for me or what he doesn’t do. I’ve come to know who he is and know that we’re going to go through trials and tribulations in life but it’s not my place to tell another person, it’s for them to find it out and have that relationship with God themselves. So it’s a difficult thing to face on placement or workplace or anywhere”

This experience had not only drawn on Lyn’s professional boundaries but made her question her own faith which she explored herself to resolve. She discussed the difficulty of meeting the patient’s need, reconciling her own beliefs and the culture of the setting.

Lyn saw spiritual care as part of holistic practice, whether that was meeting religious needs or other types of spiritual needs. Lyn enacted this by going beyond expectations to meet the patient’s spiritual need. Lyn gave the example of a female patient who requested a bible because there was not one in the bedside locker, another nurse had stated that they did not keep bibles on the ward, but Lyn decided to address the spiritual need:

“..so I had to go up to her I said ‘Do you need a bible? I’ll go to the next ward and see if they can get you one’. This is her need because she’s been reading the bible all her life and she’s come to hospital she forgot to pack one”

Lyn then went and looked for a bible for the lady who was appreciative when she found one. Lyn demonstrated an awareness of the importance of the item to this lady, empathy towards her predicament and acted to correct this, even though it was not something promoted by staff on the ward.

Lyn went on to discuss the different types of mentors she might see in practice and their ability to demonstrate spiritual care practices:

“..the one good I saw was, it was a nurse who listened to her patients a lot. Also wanted to find out, she was asking them questions about their spiritual care, spiritual needs and really just. And she made sure that she provided everything that they needed. ‘Do you need to see a vicar? Do you need someone to speak to? Do you a bible, we’ve got it. Do you want

something?’ She provided it all for them and she was listening and she cared. She was not a Christian but she demonstrated that spiritual care in a fantastic way”

Lyn recognised that mentors could provide spiritual care without being religious themselves and she saw this as a good role model that she learnt from. However, Lyn had also experienced poor role modelling as she had seen a staff member who was judgmental although she justified this saying that it was related to her life experience and upbringing. Lyn contrasted this judgemental staff member with her Christian mentor on the ward, noting how they were so different in their approach but that she had still learnt a lot from both.

Lyn suggested a number of ways in which learning about spiritual care could capture people’s attention including booklets, the virtual learning environment and newsletters. Lyn reiterated the importance of role modelling spiritual care but felt this was lacking in practice setting:

“..it helps you to be a better role model if you invest in it, if you know what it means to be spiritual care. I think it would do a lot of good but now we’re not seeing much of it in practice right now”.

Underpinning much of Lyn’s conversation was the importance of equity for people within the clinical environment. Lyn’s Christian values were vital to her approach, but this did not affect the care she gave or the way she interacted with people who she saw as equal. She focused on the individuality of each person and listening to meet each person’s needs, noting that this could be quite variable.

Lyn conveyed that her own religious beliefs informed her values, but she was careful to balance these within the professional boundaries and expectations. Lyn reflected on experiences from her own faith perspective so that she could consider implications and how to overcome them in the future. Lyn reiterated that:

“..spiritual care or spirituality is a very important topic that people should really know about and not just put in a box”.

Interpretative phenomenological themes in Lyn's portrait

Relationality (lived relations) – Professional integrity is discussed by Blowers (2018) research noting that students needed understanding of professional boundaries and ability to speak up for patients. Lyn had a heightened awareness of the need to keep to professional boundaries and this caused her some anxiety about how she should communicate about religious matters to patients. Lyn was eager to listen to patients and showed relational reciprocity (Pesut & Thorne 2007) by enabling them to discuss spiritual concerns in a non-judgemental way. Lyn demonstrated interpersonal skills which McCance & McCormack (2017 p44) think is essential to build positive relationships with patients. Lyn demonstrated a variety of communication skills to listen, ask questions and understand the patient spiritual needs (Arnold 2016) but used a person-centred focus by trying to engage with the patient authentically (McCance & McCormack 2017 p56). Acting on the findings of patient encounters was important to Lyn which ensured that the holistic needs of the patient were met, not just the physical needs, and another indication of person-centred approach (McCance & McCormack 2017 p58).

The equity and fairness within patient relationships was important to Lyn and this reflects the professional code of conduct (NMC 2015). Lyn had a commitment to the job and desire to maintain professional expectations, again, these are relevant to person-centred practice to meet individual needs and support colleagues (McCance & McCormack 2017). Respecting the patients' beliefs and values within the relationship, even though this was sometimes very different to her own, was central to Lyn's approach and is cognisant with professional code (NMC 2015) and a person-centred approach (McCance & McCormack 2017). Lyn recognised that she could learn from patients, so did not act as an expert in spiritual matters which Pesut & Thorne (2007) felt would be unhelpful.

Effective staff relationships are considered vital to person-centred practice according to McCance & McCormack (2017) and Lyn outlined the role staff had played in role modelling spiritual care. Strand et al (2017) highlighted the importance of effective role models to aid student learning about spiritual care and Lyn demonstrated that this was important for her development in practice. Role

models are also considered important to develop courage (Leuon Lloyd 2014 p113) and this may help Lyn overcome some of the fears she had in dealing with spiritual matters openly.

Corporeality (lived body) –Lyn demonstrated a high self-awareness of her own values and beliefs which is ability to know self (McCance & McCormack 2017) but also relates to spiritual intelligence (Zohar & Marshall 2000). Lyn acknowledged that her religious values had informed her character, which were developed from childhood, influencing the way she worked and Carr (2014) described the relevance of developing character virtues early in life. Lyn showed commitment by noticing that little things made a difference to patients and ensuring those needs were addressed (McCance & McCormack 2017).

However, there was a reticence in Lyn about saying or doing the wrong thing and being reprimanded, which Blesch (2013) also found. Lyn was very honest about the importance of her religious life and activities. She could reconcile these beliefs with other views in nursing and had developed a clarity that McCance & McCormack (2017 p45) describe as being beneficial for person-centred care. However, Lyn wanted to provide individualistic care but seemed able to understand Christianity more clearly and Timmins et al (2018b) found that student nurses felt more competent when dealing with patients from their own religion.

Kay (2014) talks about rules that are followed in families, religion and society and Lyn had learnt much of her moral code from her background which influences how she acted herself. Lyn showed a 'distributive justice' moral framework (Kay 2014 p105) because she talked about the importance of equity but also treating people individualistically. These elements influenced her professional identity and she faced dilemmas in practice relating to her religious views; Timmins et al (2018b) also notes some of the challenges that are faced by students between their professional values and religious ideals meaning that students do not share their religious beliefs in practice. The values of both Lyn's religion and profession were important to her. Blowers (2018) noted the importance of developing students' values and integrity in nurse education to be able to cope with the challenges.

Lyn recognised an emotional effect from some of her experiences and Foster et al (2015) outline the importance of emotional intelligence in student nurses. Zohar & Marshall (2000) believe that spiritual intelligence links emotional and cognitive intelligence into a more holistic frame and Lyn seemed to combine her religious, professional and emotional identities to provide quality patient care. These emotions and experiences promoted reflection within Lyn, and this is an expectation for nurses, throughout their career, to learn from the past (NMC 2017).

Spatiality (lived Space) –Lyn struggled to know what was permissible within the healthcare setting with its cultural and workplace context; this resonates with Cole’s (2017) work around cultural competency discussing that staff wish to address issues but do not know how to do this in a culturally sensitive way. Gallagher & Polanin (2015) undertook a meta-analysis about interventions to improve cultural competency but no one strategy was effective. Lyn was the only student who specifically mentioned the university’s Christian foundation (www.cathedralsgroup.ac.uk) who’s values echo those of Lyn. Porteous & Machin (2018) note the difficult transition that students face into university life, but it is unclear whether a focus, such as a Christian foundation university, impacts on these experiences.

Temporality (lived Time) – Lyn noted that the research being undertaken had highlighted the issue of spiritual care to her. Ross et al (2018) found that student nurses’ competency in spiritual care increased over their pre-registration course. However, Lyn gave an example related to cancer care about conditions that are life-limiting and objective time heightens both religious and spiritual awareness in cancer patients (Lazenby 2018).

Materiality (lived things) - Lyn had an awareness of the importance of the material to express religious needs as demonstrated in her endeavours to find a bible. Van Manen (2014) highlights the importance of things in our lives and McCance & McCormack (2017) note that the physical and aesthetic environment needs consideration to provide person-centred care.

Technology (lived cyborg relations) – The potential negative impact of social media on student nurses was discussed by Lyn showing concerns about using this medium and Price et al (2017) found that a small proportion of student nurses were concerned about the negative effects of social media in teaching. The use of technology, such as smartphones (Stokel-Walker 2017), is changing formats available for spiritual expression so incorporating it in a positive way is vital.

Discussion of significance of findings considering literature review

The aim of this section is to draw on a novel interpretative process, using Van Manen's (2014) understanding of the phenomenological existential themes of relationality (lived relations), corporeality (lived body), spatiality (lived space), temporality (lived time), materiality (lived things) and technology (lived cyborg relations). This approach will identify similarities with the literature presented in Chapter 2 but will also describe gaps in understanding about student nurses learning about spiritual care. Many of the models around spiritual care and spirituality (e.g. Miner-Williams 2006, Rousseau 2014) focus on personal factors (corporeality) and relationships (relationality) with little in-depth consideration of the concepts of time, space, things and technology; thus, using Van Manen's (2014) understanding of these areas will enable exploration of the topic in an innovative way to highlight gaps and promote discussion.

The four portraits are from different religious and non-religious positions, and reflected key elements evidenced in the ten participants who took part in this study. However, there were overlaps in the portraits because their upbringing had influenced their values and had similar concerns about providing spiritual care. Thus, despite very different personal beliefs systems, the participants showed important similarities when learning about spiritual care that crossed the personal to the professional realm.

The interpretative process that I utilised, using Van Manen's (2014) phenomenological existential themes as outlined in the Analysis Chapter 5, utilised the data from all ten participants and drew on

experiences to build an interpretation and creative piece. Each phenomenological theme will be outlined below based on the findings of this study from all participants (see Appendix 14 – Interpretative Phenomenological Existential Themes for Each Participant) and related to the meta-narrative literature review from chapter 2 whilst incorporating related theory and evidence. Table 6.2 summarises that most of the themes and sub-themes from the meta-narrative review were evident within this study, thereby confirming previous literature. However, there is often interlinkage between different phenomenological themes when considering spiritual care which demonstrates the complexity of the topic area in the reality of the educational setting.

Several theories were particularly prominent, including person-centred framework (McCance & McCormack 2017), constructivist approaches to education (Kegan 2009) and spiritual intelligence (Zohar & Marshall 2000). Spiritual intelligence (Emmons 1999) and technology were two areas not discussed in any of the papers within the meta-narrative review. These will be explored further in the discussion section and recommendations made for future knowledge development.

Each phenomenological theme will be outlined separately, related to the meta-narrative review to show similarities and identify differences to explore further, particularly related to spiritual intelligence and technology. The interlinking of aspects will also be noted to demonstrate the complexity of the topic area.

Relationality (lived relations) interpretation

Participants in this study focused on the individual patient and wishing to meet their spiritual needs as well as meeting physical and emotional needs, frequently talking about being holistic. This was like the meta-narrative review which found 'Spiritual care as part of holistic practice' with many authors highlighting this element (Hoffert et al 2007, Giske & Cone 2012, Cobb 2004, Lovanio & Wallace 2007, So & Shin 2011). Providing holistic care is an essential component within the person-centred framework which explicitly refers to integrating the spiritual dimension (McCance & McCormack 2017 p58) that participants thought was beneficial to patient care. The meta-narrative

review also noted the perceived benefits of spiritual care to provide humanity and equity (Riklikienė et al 2016) and this aspect of fairness was evident in the portraits which reflects the professional expectations (NMC 2015).

The focus on providing person-centred and holistic care meant that participants focused on communication skills (Arnold 2016), such as listening and asking patients about their spiritual needs (Ross & McSherry 2018), which relates to the meta-narrative review area 'Awareness of patient individual spiritual needs'. Relational reciprocity (Pesut & Thorne 2007) was demonstrated as participants wanted to identify and address spiritual needs in a non-judgemental way; this was supported in the meta-narrative review with Baldacchino (2008) noting students' ability to recognise spiritual needs and Beavers (2014) dealing with needs in a non-judgemental manner. The person-centred framework highlights the importance of being professionally competent to negotiate and

Table 6.2 - Comparison of Meta-narrative Review themes with current study findings

Meta-narrative review Themes	Mata-narrative review Sub themes	Similarities in Current study
Integrating spiritual care into curriculum	Benefits of spiritual care	All participants felt that teaching on spiritual care was important but that there was insufficient time spent on topic. This was important to be person-centred and holistic. Materiality (lived things) gave examples of attending to items of importance, such as bible, for patients.
	Knowledge development	The time (temporality) given to development of spiritual care was considered too little. Knowledge development was aided by relational experiences in practice. Participants did not feel adequately prepared to deal with spiritual needs
	Definition and meaning of spiritual care	All participants found it difficult to define spirituality and spiritual care but all participants described it as including religious and non-religious forms which linked with the relationality to individuals.
	Assessment skills	Assessment linked to the lived space and the availability of role models in practice. Most students had not seen or undertaken spiritual assessments. Organisational culture was mentioned, but more related to practice experience and whether spiritual care was viewed as essential. Recognising material signs of belief, such as crucifix, was mentioned
	Teacher role in education Constructionist approach needed Institutional philosophy affects incorporation	A few participants mentioned teachers as role models, this related to lived space and time that allowed participants to learn about spiritual care Participants mentioned a variety of teaching approaches that were beneficial including discussion, simulation; which fitted with constructionist approach to education. This linked to lived body so that the students could become self-aware but required the space and time to enable exploration of the topic .
Self-awareness around spiritual issues	Attributes required for spiritual care	Relationality component of the findings highlighted the same attributes as being relevant to spiritual care such as respect, communication and having therapeutic presence
	Concerns about providing spiritual care	However, the participants mentioned dilemmas and fears in relationality about delivering spiritual care especially concerned about offending patients and damaging relationships.

<p>Self-awareness around spiritual issues continued</p>	<p>Reflection needed</p> <p>Personal beliefs</p> <p>Involve chaplains in teaching</p>	<p>The lived space (spatiality) needed to be a facilitative culture that promoted experiential learning, including reflection.</p> <p>Participants recognised as part of their own corporeality (lived body) that values, virtues and personal beliefs informed their spiritual care practices</p> <p>A teaching space that included chaplains was mentioned by several participants, both in university and within the practice setting.</p>
<p>Spiritual as part of holistic care</p>	<p>Awareness of patient individual spiritual needs</p> <p>Living spiritual care in practice setting</p>	<p>Person-centred care and holistic practice were evident in all the participant responses and this was particularly important in relationality to understand the patients' spiritual needs.</p> <p>Participants noted good and poor examples of incorporating spiritual care into practice which related to the culture (lived space) or was affected by the time pressures (lived time) on the placement.</p>
<p>Competency in spiritual care</p>	<p>Emotional competency</p> <p>Understanding religious/cultural factors</p> <p>Professional role</p> <p>Role models needed in practice</p>	<p>Emotions were part of the lived body (corporeality) for participants and they needed to deal with many dilemmas in a professional way.</p> <p>Participants noted the links between cultural and religious activities and how it was important to respect both as part of the lived relation with the patient</p> <p>All participants recognised the professional role of the nurse and listening to patients, they noted the need to embody the values and virtues of the profession as part of corporeality</p> <p>Participants noted the impact of good and poor role models in practice when learning about spiritual care. Role models in practice were particularly important to demonstrate incorporating spiritual care such as the small touches that made difference to patient spiritual experiences (materiality)</p>

provide holistic care for individuals (McCance & McCormack 2017 p 42) but also the ability to 'engage authentically' (McCance & McCormack 2017 p56) to connect with the patient. Engaging with the patients through communication and an individual approach was evident within the findings of this study. Relational reciprocity promotes a sharing and openness to the others' viewpoint, which is important within a pluralistic society with many religious and spiritual perceptions (Pesut & Throne 2007). However, this openness for participants was tempered with anxiety about saying something inappropriate or unprofessional which will be discussed later.

The participants in this study found it difficult to define spirituality but they described a variety of perspectives, including religious to non-religious forms, reflecting a wide view. This was like the meta-narrative review which also showed that student nurses struggled with definitions but demonstrated a wide view of spirituality (McSherry et al 2008, Monney & Timmins 2007 and Wu et al 2012). Riklikienė et al (2016) felt this reflected the complex nature of spirituality meaning interacting with the person about what was important to them was key to participants.

The meta-narrative review theme of 'Attributes required for spiritual care' was evident in all the participants' conversations and linked with behaviours which encompassed the person-centred framework about working with patients (McCance & McCormack 2017 p54). The areas of respect, trust, communication, developing connection and having a nursing presence were evident in this study and was evident within the meta-narrative review (Giske & Cone 2012, Lovanio & Wallace 2007, Nardi & Rooda 2011); these are all important personal and professional attributes. Linked with this element was the importance of professional boundaries (Blowers 2018), particularly as some participants noted that religious aspects were embedded within healthcare (Knott & Franks 2007) and staff language privately could be different to that displayed in practice. Embedding the professional values and virtues was important to participants and McCance & McCormack (2017) discuss the importance of values and beliefs in staff. Within the meta-narrative review professional approach to relationships was also evident (Giske & Cone 2012, Tiew & Drury 2012).

Participants in this study noted that there was overlap between religious, spiritual and cultural aspects which needed to be respected. The narrative review highlighted this issue too as 'Understanding religious/cultural factors' showing that educating about one aspect could increase students' knowledge of the other (Cooper & Chang 2016, Van Leeuwen et al 2009b). Participants in this study emphasised that they would respect individual patient preferences, even if these were opposed to their own beliefs.

Corporeality (lived body)

The physical and spiritual overlapped according to many participants in this study where they talked about inner self and mind, body and spirit as components of a person. Van Manen (2007) described professional practice as 'pathic' involving the sense, passion and mood from which the body acts, thus the lived body interacts with the world but is informed by internal processes. Personal values and beliefs were mentioned by all participants in a variety of ways as influencing their approach to spiritual care; some acknowledged a personal religious faith and others non-religious stances, but McCance & McCormack (2017 p45) felt that underpinning beliefs informed how people act. The meta-narrative review highlighted that students' faith was influential in their approach to spiritual care (Cobb's 2004, Kenny & Ashley 2005, Iranmanesh et al 2012, Ross et al 2016) and this was evident within this study.

There were examples in this study where participants discussed conflict and confusion with their personal history and spiritual aspect which Giske & Cone (2012) and Purdie et al (2008) also noted could help or hinder students' engagement in spiritual care. Many of the participants in this study related how their own values and beliefs impacted on their nursing care practice which Graham (2008) and Seymour (2006) had also found in their studies. Thus, the complexity of upbringing, previous religious and spiritual experience and other personal factors make each participants perspective on spiritual care unique.

The participants in this study talked about various emotions, such as happiness, anxiety, and how these were moderated when dealing with difficult clinical situations. 'Emotional competency' was

outlined in the meta-narrative review and this study concurred with Niedenthal (2017) that the emotional reactions were complex in spiritual care involving personal, as well as professional, reasons. Self-awareness was integral to participants being able to understand their own perspective and biases and this was a major area within the meta-narrative review. Taylor et al (2009), Van Leeuwen et al (2009), and Wu et al (2012) found that self-awareness was influenced by education, personal attitudes and experiences, and the variety of influences on participants was evident in this study. Participants discussed explicitly or implicitly about the virtues they used within spiritual care, such as courage, respect, and Seymour (2006) discussed the importance of character development within nurses. However, virtues were not explicitly outlined in the meta-narrative review, but is an area of interest in nursing, particularly when linked to character and attitude development (Sellman 2011). Spiritual intelligence (Kaur et al 2015) has been proposed as developing caring behaviours in nurses but this element was not discussed during the meta-narrative review. Many of the components of spiritual intelligence (Eammon 1999; Zohar & Marshall 2000) are evident within this study, such as meaning, purpose, transcendence, goals and character, but the meta-narrative review did not refer to this element although meaning and purpose is mentioned in current literature (Trueland 2018). The area of spiritual intelligence when educating about spiritual care will be explored further within the discussion chapter.

Person-centred care practices underpinned the participants' lived body with personal aspects such as commitment to the job (McCance & McCormack 2017), motivation (Tuckett 2015) and pride (Cook 2017) driving their spiritual care practices. Several participants highlighted issues that had ignited their interest in spiritual care such as teaching sessions, the research project or experiences with patients. This study showed that a variety of teaching and learning methods could be used to stimulate interest in spiritual care education which transformed their personal understanding and approach to the topic (Mezirow 2009). Participants talked about discussion, simulation, reflection, peer group work and taught sessions that had informed their practice and enlightened their views. Participants found a constructivist approach, which facilitated learning, was more useful to explore

the topic of spiritual care as it encouraged interaction; this was advocated in the meta-narrative review as it promoted problem-solving on the topic (Coscrato & Villela Bueno 2015). Other authors concurred with this study, for example Fink et al's (2014) study was positive about simulation activities and Mooney & Timmins (2007) promoted the use of reflection. Each student will have personal preferences for teaching and learning so incorporating a range to meet different styles is helpful to engage all students; this aspect of teaching and learning overlaps with lived space and time as these will influence the effectiveness of any participatory approaches to learning.

Several participants mentioned fears when providing spiritual care including anxiety about what is permissible to do and say. The meta-narrative review also had a theme 'concerns about providing spiritual care' with similar fears about being inappropriate (Boswell et al 2013) and this caused anxiety (So & Shin 2011; Williams et al 2016). Although this study agrees with Van Leeuwen et al (2009) that students feel there is a professional responsibility to deliver spiritual care, there was wariness about breaching professional boundaries; this links with the 'professional roles' aspect in the meta-narrative review and shows a link with the relationality aspect of these findings.

Participants were concerned about damaging relationships with patients through inappropriate words or actions as well as concerned about their own reputation as a professional nurse.

Reflection and self-awareness were closely linked within this study which was present in the meta-narrative review. Participants noted a range of resources they used to cope with the stresses of practice, some were facilitated by sessions, such as mindfulness, and others by their own religious activities, such as church. McCance & McCormack (2017 p45) recognise the benefits of staff drawing on their own resilience and coping strategies so that they, as well as patients, can flourish.

Spatiality (lived space)

Lived space refers to the setting in which experiences occur and may be at a micro, such as mentor to student, or macro level, such as organisational culture, level. Participants in this study outlined several key issues that affected their learning about spiritual care within the practice and university setting.

Role models to emulate and support participants was important in this study and they valued being able to observe from and be encouraged by these staff. Role models were included under 'lived space' as they are integral to the learning experience in the practice setting. The meta-narrative review found that 'Role models needed in practice' and 'Teachers role in education' were key to enhance spiritual care in students. Giske & Cone (2012), Tiew & Drury (2012) and Wigley (2013) all highlighted that there were insufficient role models for students to emulate spiritual care in practice and this study findings concur with these authors. Students in this study gave examples of lecturers facilitating discussions about spiritual care and Blesch (2013) and Cobb (2004) note the importance of teachers' role modelling when teaching or facilitating the subject area.

The busyness of placement environments was mentioned by most participants as affecting the incorporation of spiritual care into practice settings because staff focused on tasks rather than holistic care. The meta-narrative review outlined 'Living spiritual care in the practice setting' as a sub-theme which reflects the participants' views that the culture of ward areas meant that spiritual care was poorly addressed and lacked role models to emulate (Van Leeuwen et al 2008 & 2009). Participants gave examples of documentation being incomplete or avoided around spiritual needs and the meta-narrative review found that 'Assessment skills' around spiritual needs were not seen in reality (Tiew & Drury 2012; Tiew et al 2013). The meta-narrative review implied workplace culture was an issue within spiritual care and Manley (2017) feels that a facilitative culture is needed to promote change. Participants did see examples of incorporation of spiritual needs, usually within the palliative care setting which is supported by a systematic review (Chen et al 2018). Factors affecting spiritual care, according to participants, included the loss of patient autonomy where decisions are made by staff (Huddle 2016) and lack of social interaction for in-patients leading to loneliness (Adams et al 2016); both these meant that spiritual needs could be overlooked within the practice setting. Participants gave examples of commitment of staff to address spiritual needs and McCance & McCormack (2017) think that workplace culture is key to incorporate innovative practice into care. Participants who were supported and encouraged by staff to include spiritual care felt

that they had achieved something to meet the holistic needs of the patient, so this facilitative style was important for participants to learn spiritual care and is supported by Strang et al (2014).

Chaplains were mentioned by participants as a group of professionals that had informed their understanding both in the practice setting and within university teaching; this agreed with the meta-narrative review that 'Involve chaplains in teaching' was necessary. However, some participants struggled with the secular basis of healthcare with the involvement of faith (Tveit et al 2015). This is a macro level spatiality issue as, within the National Health Service, chaplains of various faiths are permitted to be involved with patients using the chaplaincy guidelines (NHS England 2015). Thus, students may need to develop understanding of the wider social-political space influencing the healthcare setting. The meta-narrative review noted that 'Understanding religious/cultural factors' aided competency in spiritual care (Cooper & Chang 2016, Van Leeuwen et al 2009b) and needed to be included in education.

Reflection was one strategy that participants used as part of experiential learning and enabling spaces that facilitated reflection helped learning. The meta-narrative review also found that reflection was instrumental in learning about spiritual care (Burkhart & Schmidt 2012, Cobb 2004, Giske & Cone 2012) and facilitative spaces to allow exploration were key to achieve this. Reflection needed to be facilitated within the learning space, whether practice or university, and this agreed with the meta-narrative review as developing self-awareness. Participants highlighted religious (such as church) and non-religious spaces (such as mindfulness) that were resources to draw on to help them cope with the demands of practice experiences. Although these are not direct teaching strategies, they were spaces that enabled the students to draw on their own coping strategies (Tiew & Drury 2012).

Temporality (lived time)

Participants in this study showed various perspectives of time such as discussing historical events, talking subjectively about having time to sit with patients as a student and outlining objective time such as being expectant about future teaching on spirituality and considering patients who are

approaching the end of their life. This study showed that time is a multi-dimensional concept and influences many aspects of learning about spiritual care.

Time spent with patients was a vital component to deliver spiritual care according to participants and this related to therapeutic use of self (Brown 2012) and being present in the moment (Mohammadipour et al 2017). Participants frequently cited lack of time as a factor inhibiting spiritual care which is echoed by Roze des Ordons et al (2018). The time pressure to complete tasks meant dealing with spiritual distress was secondary (Sharp et al 2018) and the pressure on time detracted from person-centred care. The same time pressures were noted in the meta-narrative review as affecting students seeing 'Living spiritual care in practice setting'.

Participants were keen to develop their knowledge of spiritual care but reported that there was a lack of time spent on the topic area. Again, this was similar to the meta-narrative review which noted 'Knowledge development' needed focused time on the topic with evidence that a percentage of students had not been taught the topic (Tomasso et al 2011) and other authors found students felt they lacked understanding suggesting that more taught sessions were needed (Baldacchino 2008; De Souza et al 2009; Espinha et al 2013). One participant, a third-year student, in this study clearly outlined his development of spiritual care competency over the course and Ross et al (2018) has found similar results in her study that competency developed over time.

Time for learning could be disjointed and some participants reported that they had missed learning opportunities or felt spiritual care was overlooked in sessions. A block of placement was seen by Birks et al (2017) as a more positive experience but this is still time limited. Time with skilled staff, particularly when dealing with palliative care patients, was viewed by participants positively.

Lazenby (2018) notes that patients nearing end of life have heightened perceptions of time, as well as spiritual and religious needs, so this links the spiritual care element with the importance of time.

Time and space were closely linked in this study with the pressures of the work setting being related to lack of time for spiritual care. Tiew & Drury (2012) note that time is needed to reflect on spiritual

aspects both within the practice and university setting. Pressures the participants faced included not having enough staff and poor working relationships which impacted on the time available for spiritual needs because of the care environment (McCance & McCormack 2017). Time pressures were also evident within university, according to participants, because of submitting assignments which could distract them from doing further exploration on spiritual matters as they focus on academic progression (Wray et al 2017).

Materiality (lived things)

Participants in this study highlighted a few material things that impacted on their understanding and learning about spiritual care. Similarities to the meta-narrative review was evident as 'assessment skills' included observation of spiritual practices, such as reading a bible or wearing a crucifix. 'Role models in practice', according to participants, recognised spiritual needs and implemented actions to meet these, such as connecting people to inner spirituality through nature (The European Association for Palliative Care 2010) which was seen by one participant when an intensive care patient was taken outside. Participants noted that dealing with these seemingly little touches in spiritual care had a benefit on wellbeing as part of a person-centred approach (McCance & McCormack 2017).

Recognising important items to patients was a component of spiritual care in this study and Van Manen (2014) notes that material items have personal significance, which participants acknowledged. Participants, particularly those with a religious faith, discussed items they used in their private life, such as reading a bible. Participants seemed to find it acceptable to attend to patients' needs by providing things, such as a bible, for the patient to use even if they did not use the item themselves. The use of spiritual items in private and professional lives of participants was different, although they recognised the significance of the items for individuals.

Non-religious items were included in the participants' discussions, such as the use of candles and nature, although religious items dominated. However, it was sometimes difficult for participants to

delineate whether a preference was cultural or religious, such as food and washing preferences, which Mendes (2015) comments on the complex relationship between religion and culture.

Technology (lived cyborg relations)

Technology and lived cyborg relations is an area that Van Manen (2014) discusses in a variety of terms including the labour saving that technology can achieve, the interaction that can be promoted through digital devices and the aesthetic component of loving technology because people enjoy the feel, look and uses it provides. However, within this study technology, as influencing spiritual care, was hardly mentioned and it appears to be, what Van Manen (2014) terms, as the 'taken for granted' aspect, meaning that it is so embedded in our lives that we are unaware of its influence. The area of technology was not evident within the meta-narrative review either suggesting that this is a hidden or emerging area within spiritual care nursing education.

One participant mentioned about technology related to providing spiritual care to an intensive care patient as the machines allowed the staff to take the patient into nature. Another participant mentioned about considering the use of drugs that fitted with the patients' beliefs. Drugs are technologically developed using a variety of components, such as animal flesh, so may contravene some patients' preferences. Another participant mentioned the negative effect of social media, particularly being concerned that they would be admonished for their spiritual views, which linked with maintaining professional boundaries.

The use of technology is expanding within healthcare and education, including the use of social media (Price et al 2017) and manikins in simulation (Power et al 2016) but they need to be relevant to real life situations. This is an aspect that would warrant further exploration in future studies as it may be important for enabling learning about spiritual care in different ways.

New Insights from comparison with meta-narrative review

This comparison has demonstrated that there are significant similarities between previous literature and the findings of this study. This study supports previous literature around the need to include

spiritual care as part of holistic practice and the importance of role models for students to emulate. The portraits mentioned a variety of learning methods, such as discussion, simulation, lectures, with a focus on constructivist approaches so supporting that various learning tools can be used. The value of practice learning for spiritual care is strengthened as a main source of learning for student nurses but needs to be within a workplace culture that enables this to happen.

New insights from this study, that will be further discussed, are the potential to develop student nurses' spiritual intelligence to combine the cognitive, emotional and spiritual aspects when providing spiritual care as part of holistic practice. Participants relayed the importance of knowledge about spiritual care and highlighted the emotional effects and anxiety about dealing with spiritual issues. Linked with spiritual intelligence is the development of character and virtues that enable a student to develop nursing presence within the nurse-patient relationship. The participants frequently mentioned the importance of areas such as respect, compassion, care, which are part of the virtues of being a good nurse (Sellman 2011). The role of spiritual intelligence will be explored further within the context of nurse education to propose that this could be used as a format for teaching student nurses about spiritual care and increasing their competency in the topic area.

The issues of resources, time pressures and role of technology were mentioned but generally in a negative way within this study. The role of the 'taken for granted' aspect of spiritual care that could be enhanced by utilising the various technologies will be incorporated into the building of spiritual intelligence. These technologies could be used productively to reduce the fear of engaging with patients about their spiritual needs and may need further research in the future.

The way forward

This chapter has presented the findings by showing four participant portraits and outlined the interpretation of all ten participants, based on literature, using Van Manen's (2014) understanding of the phenomenological existential themes. This approach shows the complexity of issues faced by student nurses when learning about spiritual care and the emotional, knowledge, professional and

personal hurdles students have to negotiate to apply spiritual care practices in a fast paced and culturally bounded context.

The following discussion chapter will unpick some of the aspects outlined above to consider new insights into educating student nurses to provide spiritual care within a pluralistic cultural setting with a focus on developing a spiritual intelligence for nurse education framework.

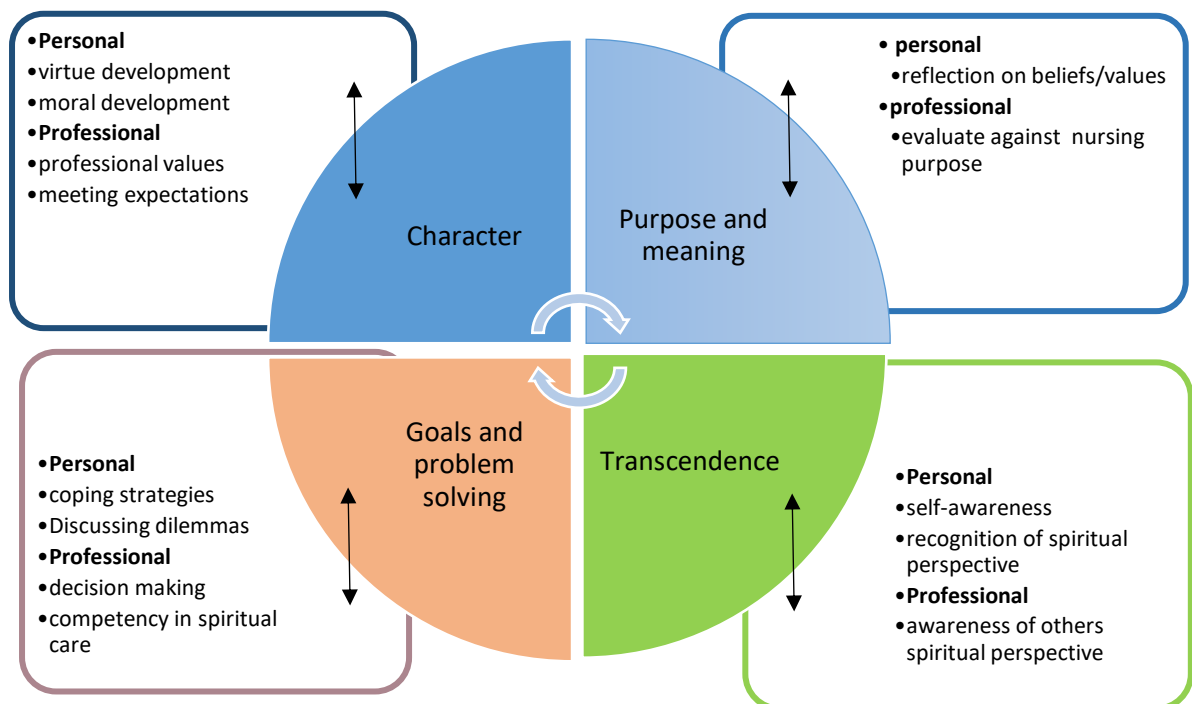
Chapter 7

Discussion

Introduction

The findings presented in the previous chapter highlight that there are many issues affecting student nurses' lived experience when developing understanding of spiritual care. I will present a novel way of addressing education around the topic of spiritual care by proposing a Spiritual Intelligence in Nurse Education framework, which is outlined in Diagram 7.1 below.

Diagram 7.1 – Spiritual Intelligence in Nurse Education



This chapter will highlight, from the findings of this study and literature, the process of development for this framework. The framework will then be utilised by giving an exemplar from John's portrait and an example of learning courage. John was chosen for this work because he demonstrated all elements of the framework in a more complete way than other participants, possibly because he

was the only final year student in the study. Courage was chosen to outline the use of the framework because it is a desired attribute for nursing students to ensure safe and effective care. Spiritual intelligence is rarely discussed within nursing literature, particularly lacking discussion in nurse education. However, I will propose spiritual intelligence as an important and underestimated aspect within student nurse development. Spiritual intelligence is an adaptive process that embodies the purpose and meaning within someone's life, incorporates their spiritual beliefs and influences their behaviours daily (Emmons 1999). Spiritual intelligence is fundamental to our being as a person (Zohar & Marshall 2000; Draper 2009) and, according to Zohar & Marshall (2000), unites other intelligences, including cognitive and emotional. It is important to distance spiritual intelligence from the more diverse and poorly defined concept of spirituality (Emmons 1999). This is because spiritual intelligence has key aspects that can be translated into nursing practice and education whereas spirituality is seen as very abstract. The areas of spiritual intelligence, according to Emmons (1999 p164) involves transcendence, heightened states of consciousness, sanctifying everyday experience, using spiritual resources to problem-solve and being virtuous. Rousseau (2014) felt that spiritual intelligence enabled people to use spirituality in an adaptive way, and Draper (2009 p14) felt it provided wisdom for the journey of life, both aspects are important for student nurses when dealing with complex issues.

I have proposed areas of spiritual intelligence that should be included within nurse education, with broad links to other intelligences that have been outlined above (see Diagram 7.1). Gardner (1999) did not agree that a spiritual intelligence existed, nor that it met intelligence criteria, but suggested an existential intelligence may be present. I argue that the intelligences are intertwined, making it difficult to know where one component ends and another begins, but that recognition of the areas involved in spiritual intelligence is helpful to develop professional virtues within a demanding and complex practice setting. Draper (2009) and Wigglesworth (2012) link spiritual intelligence with the inner ego relating to values and both offer strategies for development of the self, recognising the link to problem-solving ability this produces. Indications of a high spiritual intelligence include self-

awareness, ability to deal with suffering, being inspired by vision and values, reluctance to cause harm, being holistic and seeking answers to “what if” questions (Zohar & Marshall 2000). Many of the students in this study talked about various components of spiritual intelligence particularly demonstrating self-awareness, desire to give holistic care, and incorporating professional and personal values.

Becoming a ‘good nurse’ is related to demonstrating the virtuous behaviours of the profession (Sellman 2011) and the students in this study showed a desire to become caring nurses. However, there is a long list of virtues, such as humility, chastity, self-sacrifice and moral excellence, which Athanassoulis (2013 p40) notes makes a person’s character distinctive but has ability to change over time. I will argue that spiritual intelligence can be used in a constructive way to enable nursing students to develop an understanding of themselves and apply the virtues that nursing espouses into professional practice, particularly when learning about spiritual care.

I wish to consider spiritual intelligence as an aspect of nurse education that is poorly addressed, particularly in United Kingdom practice. There is little research about the use of spiritual intelligence in nursing and the few studies available have been undertaken in Middle Eastern countries. For example, looking at spiritual intelligence as a tool for exploring stress in nursing (Abbas et al 2018; Shahrokhi et al 2018) and related to education (Rahimi 2017; Yang 2006; Akbarizadeh et al 2012; Goode 2015; Karimi-Moonaghi 2015) with most of these papers based in Iran.

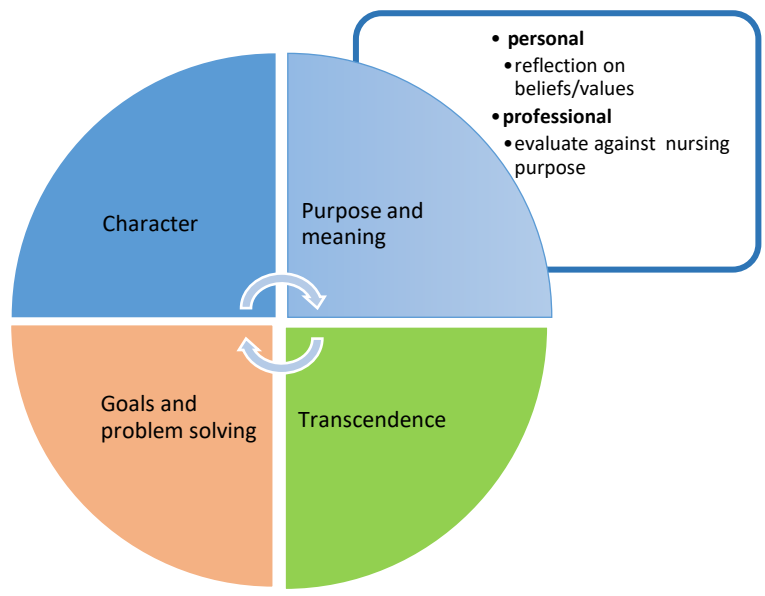
Developing the Spiritual Intelligence in Nurse Education Framework

I will start by explaining the origin and development of Diagram 7.1 ‘Spiritual Intelligence in Nurse Education’ framework. This framework emerged from applying theoretical perspectives about spiritual intelligence (Emmons 1999; Zohar & Marshall 2000) and relating this to the evidence from previous literature and participants’ portraits in this study. I will explain development of the four areas of the framework looking at purpose and meaning, transcendence, goals and problem-solving, and character. The diagram 7.1 represents the different elements sequentially but participants in

this study were at different stages. The stage was influenced by the experiences they had encountered and their knowledge development. The four elements are closely linked, often informing each other, and this intertwining will be explored through the discussion.

Purpose and meaning area is related to the drivers that motivate individuals to be a good nurse (see diagram 7.1a). The participants in this study talked about their beliefs and values as aspects that had stimulated them to provide quality spiritual care and these were related to the value they placed on people as individuals. I think that nursing students rarely consider the purpose of their life related to their blossoming nursing identity. However, this identity will influence the career choices they make, the experiences that they enjoy or dislike and the commitment they display. Meaning and purpose is very individual and is affected by family, culture and beliefs and this was evident within my study. Various tools to identify meaning and purpose have been outlined by Baldacchino (2010) but few were used with nursing students. Draper (2009) and Wigglesworth (2012) both talk about the importance of recognising personal meaning and purpose for our individual lives but this needs to be applied to professional practice for nursing.

Diagram 7.1a – Purpose and meaning



Participants in this study seemed to have similar aims to provide holistic care and respect other people's preferences, but underpinning their purpose and meaning was a vast range of beliefs. The participants came from religious, secular and stoic viewpoints that had been informed and moulded by their personal histories; they often recognised that this background affected their interpretation of others, although they accepted the differences. Understanding the meaning and purpose attached to one's own life will help the student nurse to be self-aware about biases, differences between themselves and other people's views and help to contextualise points of importance for them as a nurse (Wigglesworth 2012, Quinn 2018). Personal beliefs have been acknowledged by other authors (Graham 2008; Seymour 2006) as important in providing spiritual care and Dewing (2014) suggests a number of strategies that can be used to explore beliefs and values for healthcare professionals. Beliefs and values are also key areas for embedding person-centred care (McCance & McCormack 2017).

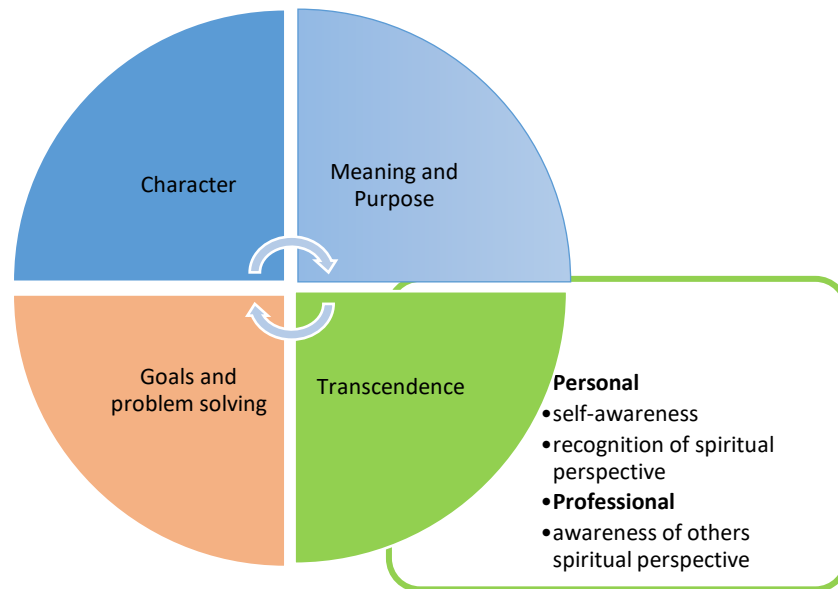
However, participants in this study recognised that they needed to comply with professional values and purpose also. Professional aims are clearly outlined in the NMC Code of practice (NMC 2015) and nurses are recruited based on their values (Health Education England 2016). Many of the area's participants highlighted are reflected in the NMC (2015/2018d) code, such as respect and communication. The Royal College of Nursing (RCN) Principles of Nursing Practice were first published in 2010 but remain at the heart of nursing's purpose. Participants in this study reflected the RCN principles as they wanted to provide comfort, meet individual needs, listen and ask patients. Thus, the framework developed to show that education could be used to enable students to reflect on their own beliefs, values and how that informs their purpose and meaning within their nursing life, but this is not divorced from the professional component. Students need to consider how their own beliefs and values complement or clash with professional ones so that they can meet their personal goals whilst complying with professional ones.

Within this study, participants talked about learning through reflection and Mooney & Timmins (2007) note the importance of reflection as a learning tool; therefore, reflection is a way to evaluate

your underpinning values and the important aspects that give meaning and purpose to your life. Meaning and purpose, from a spiritual perspective, can be related to a Deity, relationships, or life goals (Tanyi 2002; McSherry et al 2004, Draper 2009) and enabling a student nurse to understand what is significant for each person, and relate this to professional purpose, may be important to maintain a person-centred focus (McCance & McCormack 2017). Spiritual intelligence means you reflect on your purpose and meaning which may change over the lifespan considering experiences that have affected you (Emmons 1999 p50). For example, having children, changing careers, bereavement or illness can have profound effects on your personal meaning and purpose in life (Boyraz et al 2012). Sherwood (2018) reports that some people pray for family and friends, particularly at times of illness, even though they call themselves a non-believer and spiritual components become heightened when a life-limiting diagnosis is given (Public Health England 2016). Nursing students need to understand what influences them first to be able to appreciate other people's spiritual needs. Reflection is particularly important for understanding spiritual care because the student is aware of their own preferences but can develop an openness to other views. The awareness and openness enable the student to promote dialogue with patients yet being cognisant of their own spiritual position. Enabling the student to understand their own purpose may take time to unpick, require understanding of different spiritual positions and require discussion to clarify thoughts. This may not only aid clarity of beliefs but is important to enable nursing students to draw on coping strategies in the future, by being aware of what is significant in their own lives. Transcendence is seen as going beyond the physical and material (Emmons 1999) and can be a personal (inner) or external spiritual or religious experience (Tanyi 2002). Diagram 7.1b highlights that transcendence for my participants, involved the inner and outer elements, and recognition of their own and other's spiritual perspectives. Participants in this study talked about prayer to communicate with God or mindfulness as ways to be present in the moment, both viewed as spiritual forms of transcendence. However, I use

transcendence, in a nurse education sense, as a way for students to become aware of their spiritual perspective, whether this is a religious, secular or other spiritual stance. For nursing students who

Diagram 7.1b – Transcendence



have a religious affiliation, they can be encouraged to engage with their religious activities and experiences. Non-religious students can use different forms of transcendence, such as mindfulness or visualisation, to have a sense of being present in the moment. Students need awareness of their own biases and preferences but, as Timmins & Neill (2013) note, there can be ambivalence to spirituality due to secularisation, therefore, students having self-awareness about their spiritual views is important; Giske (2012) literature review also highlighted the importance of developing self-awareness in students. There are numerous tools available, some designed for self-development (Draper 2009, Wigglesworth 2012), some for use in practice (Baldacchino 2010) and others designed for use in research (Koenig 2011). Participants in this study valued opportunities to explore different approaches, such as mindfulness. Creative educational strategies may be appropriate to develop self-awareness such as visualisation techniques, mandalas (Dewing 2014) which are commonly used

in practice development. However, this personal understanding needs to be linked to other's differing understanding of transcendence and Ross et al (2014) noted the importance of broadening students' understanding to include the full range of spiritual needs. For example, a nurse with a secular view still needs to have empathy and compassion for a patient with a religious devotion and vice versa. The need for spiritual awareness in nursing students was found in Lewinson (2016) thesis showing that it led students to the process of spiritual assessment. The ability to heighten senses is important in nursing practice to develop interpersonal skills that lead to nursing presence, a caring and effective relationship (Turpin 2014). Nursing presence talks about aspects such as empathy and focusing on the other person which makes them feel valued within the relationship (Mohammadipour et al 2017) but Roberts (2018) notes the compassion fatigue this can cause nurses. Developing spiritual intelligence around transcendence could hone student nurses' skills in becoming present and aware of others, even during busy and demanding work pressures.

Professionally I see developing awareness of other's spiritual perspectives as enabling knowledge development of different views so that a student can be comfortable with their own spiritual perspective and be receptive to others. Developing knowledge and awareness of other views is important to promote person-centred care and equity (McCance & McCormack 2017). A nursing student may not agree with a different spiritual position but, professionally, they need to be able to respect and integrate those needs within their practice to meet professional standards (NMC 2015, NMC 2018d). This can be difficult to achieve if you are entrenched within your own position but considering other options allows professional perspective to develop. Students need to be enabled to accept another spiritual view whilst being comfortable with their own spiritual identity.

Knowledge about different faiths is encouraged to reduce bias and prejudice (Public Health England 2016). Unconscious bias is recognised in nursing students and reflection is promoted to address this (Gillespie et al 2017) so that they are more aware of their preferences and can balance them with professional expectations. The media reports extreme faith positions and events disproportionately

(Chalabi 2018) and this does not emulate real life which could bias opinion against certain faith groups, thus time to reflect on the wider issues is needed in education.

All the participants in this study were eager to understand different religious and spiritual positions but felt that they did not have enough knowledge to do this, and this was reflected in the meta-narrative literature review (De Souza et al 2009; Espinha et al 2013) and in Lewinson (2016) thesis. However, numerous ways to learn about other religions and spirituality were suggested by participants including chaplain visits, simulation exercises, lectures and discussion within university. The practice setting was a key place to grasp the areas around spiritual care (Giske 2012) and participants learnt from their mentors the principles involved, such as asking and listening to patients. Again, it was evident in the meta-narrative literature review that a variety of teaching techniques are valuable to learn about spiritual care including different religious and spiritual needs (Koenig 2013; Coscrato & Villela Bueno 2015). Ross & McSherry (2010) said there needed to be a balance between the art and science of nursing, so that the caring and knowledge aspects were incorporated, with Giske (2012) noting that the mentor role was vital to incorporate spiritual care into practice.

Chaplains were mentioned within this study as supporting learning and being a resource for patients. Chaplains support spiritual care (So & Shin 2011, Williams et al 2016) and NHS Chaplaincy guidelines (NHS 2015) promote their involvement in spiritual matters. Participants in this study had limited awareness of the role of chaplains but some literature suggests that chaplain aid coping during illness crisis (Żołnierz et al 2017) and offer a range of spiritual care services (Timmins et al 2018a) . Chaplains have been used for training healthcare professionals about spiritual care (Geer et al 2018, Gubi & Smart 2016) and in simulation activities (Connors et al 2017, Huehn et al 2019) to raise awareness of their role and input into healthcare. However, the interaction that participants in this study had experienced with chaplains had usually been unplanned but was positive in supporting patient spiritual needs. Students could develop a different area of their spiritual intelligence by

understanding the chaplain role as nurses make the most referrals to chaplaincy teams (Timmins et al 2018a).

I was surprised that participants in this study did not refer to any online resources that they could use, nor did they direct patients to any such support methods, yet we know that many website and online platforms are sources of information to patients, staff and students (Berard & Smith 2019).

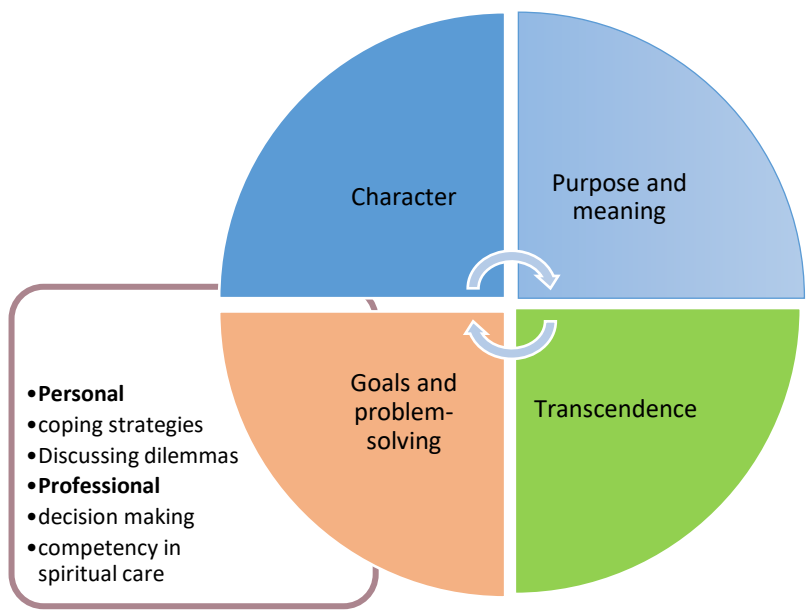
Initially, it would be easy to think that technology has no role in spiritual care but, as Stokey- Walker (2017) stated, the use of smartphones and digital technology is influencing religious practices.

There is growing evidence of the influence of various online platforms in healthcare, for example AlQarni et al's (2016) study discusses the use of Facebook© as a method of sharing information for patients with diabetes mellitus, showing that 10% of posts are providing spiritual support. Patients themselves are using social media platforms as a method of dealing with illness and Taylor & Pagliari (2018) reported a cancer patient's Twitter© feed where a few posts were related to issues of hope, expectations and spiritual beliefs. Blogs are also used as ways to discuss spiritual issues related to illness (see example <http://jsimmarshall.blogspot.com/>) so patients seem to be accessing a variety of tools to discuss spiritual needs at a time of illness. However, I wonder whether the use of internet and social media platforms as sources of spiritual support may be under reported in healthcare literature due to the prevailing secular climate. A framework for spiritual care competency has recently been developed (Attard et al 2019b) and this identified digital informatics as an important element so recognition of contribution may be developing.

The knowledge helped participants in this study to assess and plan spiritual care for patients whereas lack of knowledge made participants fearful to approach the topic in case they caused offence. Fear was highlighted in Ali (2017) thesis showing that breaching professional boundaries was a concern for students which was echoed in this study. Several participants noted that spiritual assessment was often overlooked and poorly addressed within practice so spiritual needs were missed which is echoed by Koenig (2013) and Lewinson (2016). Knowledge and practice improve confidence in broaching a sensitive subject area (Van Leeuwen et al 2008 & 2009) although the

importance of having a nursing presence, that can listen and accommodate patient preferences, is needed. Transcendence is about developing a knowledge of self and other’s religious and spiritual perspectives so that students can incorporate this into their spiritual assessment and nursing care. Goal setting and problem-solving are not new skills in nursing but, within spiritual intelligence (see Diagram 7.1c), this aspect is related to the meaning and purpose within a person’s life. Nursing students will set personal goals based on their life purpose and, equally, patients will have goals based on the ultimate purpose within their own life. Nursing often sees specific patient goals to be achieved but, in spiritual intelligence, goals and purpose may change over time and need to be reviewed.

Diagram 7.1c – Goals and Problem-solving



Patients are known to be vulnerable at a time of illness (NHS England 2015) and this is a period in life where many people may revisit past achievements and look for future hopes. Student nurses themselves will have changes in purpose throughout their life and career, for example, with a new nursing role or a change in family situation.

The goals and problem-solving element of the framework developed from the nursing theories which have overarching philosophical approaches to the way individualised care should be organised (Allgood 2014; Masters 2015). The nursing theories examine concepts of Person, Health, Environment and Nursing with an emphasis on knowledge development to identify and plan care to meet patient needs. Emmons (1999 p164) believed that spiritual intelligence involves the “*ability to utilise spiritual resources to solve problems*” and spiritual intelligence is a resource nurses could use to achieve this. Nursing has a history of using the nursing process to think critically and problem-solve (Wilkinson 2012) but spiritual care can be challenging for several reasons. Participants in this study talked about not knowing what to say to patients, not feeling competent in spiritual care and feeling that tasks dominated to the detriment of spiritual care; all these concerns are also evident within the literature (Giske 2012, Boswell et al 2013; Koenig 2013) and is evident in Lewison (2016) and Ali (2017) works. To enable delivery of high quality, competent spiritual care, students need coping strategies to deal with these fears. Asking the patient and learning from them is a key strategy as it promotes being in the moment so that a person can empathise with another person’s spiritual needs, even if they are contrary to your own (Arnold 2016). Spiritual intelligence, when considering spiritual care, focuses on problem-solving to meet the spiritual needs of the patient. Spiritual needs are wide and varied with the nurse needing to listen and communicate to assess the patient needs and problem-solve and address them. In this study, an example was taking the intensive care patient outside to connect with their love of nature and finding a bible for a patient who wanted to connect with their religiosity. However, problem-solving could be used by the student nurse themselves as a spiritual coping strategy to identify their own spiritual needs and plan to address these. Recognising and addressing spiritual needs, for oneself and others, is a part of spiritual intelligence so that people feel that the purpose of their life is being achieved to promote fulfilment and human flourishing.

Participants in this study related several experiences that had caused doubts and dilemmas when providing spiritual care, meaning that they felt they had not provided good quality care. A dilemma

may arise if someone has an extreme position, in this study this was seen in some patients with mental health difficulties, where the student nurse cannot discern if the spiritual need is illness related or not (Bassett et al 2015). Participants valued the opportunity to discuss experiences and gain insights into how to deal with these dilemmas, whether with a tutor, peer group or mentor and Giske (2012) emphasised the importance of an environment conducive to learning about spiritual care. Nurse education needs to facilitate opportunities for students to unpick these dilemmas as they can lead to fear and make students avoid spiritual care (Boswell et al 2013). The link between spiritual intelligence and fear of death in nursing students has been studied by Jenaabadi (2018) and he suggested developing spiritual intelligence, along with mindfulness, as strategies to reduce anxiety. Patient satisfaction and quality of life are thought to be linked but evidence related to spiritual interventions effectiveness is weak. Candy's et al (2012) systematic review around spiritual interventions in terminal illness were inconclusive citing poor quality of the research. However, more recently, Imeni et al (2018) demonstrated that meditation sessions improved patient satisfaction after amputation. The reality is that nurses do not have all the answers and need to learn to cope with uncertainty within their career. Lewinson (2016) grounded theory study noted the importance of enabling efficacy in nursing students to cope with spiritual care in practice. Bassett et al (2015) noted the uncertainty faced in treatment when dealing with patients with a mental illness who had spiritual needs. Uncertainty with nursing students was a theme in Porteous & Machin (2018) paper and the importance of supportive mentors and preparation was acknowledged.

Another fear for participants in this study was related to technology, particularly social media. Students in this study were fearful about being perceived as unprofessional and that reports about spiritual conversations might be misrepresented. Social media is being used more extensively within nurse education (Hasabahahi & Mazaheri 2016; Price et al 2018) as a teaching strategy. At the time of the study there was a high-profile media case about a nurse reported for praying with patients which may have heightened their concerns (BBC 2017). Strategies that familiarise students with the professional expectations of social media may reduce the fear that they display about the negative

effects of this medium. The NMC (2017b) has guidance for the use of social media, as does the university, and utilising examples related to spiritual issues may be a way to practice the principles safely.

Professionally there is an expectation that nurses are decision makers (RCN 2010) and have competency (NMC 2015) but these are difficult skills for student nurses to develop which takes time (Toofany 2008). Nurses deal with problem-solving physical issues frequently and, often, there are clear boundaries about the expected standard of care with National Institute for Health and Care Excellence guidelines (www.nice.org) to follow. However, with spiritual care this is complicated by emotional factors and personal goals so is not a straightforward decision-making process. There needs to be more emphasis on enabling patients to make decisions and offering them opportunities to draw on their own coping resources, such as for Christianity the use of bible or prayer. This was evident within this study as one participant (John) showed how he developed spiritual care competency and decision-making over the course and Ross et al (2018) also found that competency in spiritual care developed during nurse training. Education needs to enable students to draw on their coping strategies, some of which may be their own spiritual resources, although there is little literature available about spiritual coping related to nursing students. Participants mentioned how prayer and mindfulness helped them personally in practice along with opportunities to discuss dilemmas and Krok (2008) notes that people draw on spiritual support to help them cope. Clinical supervision (Stacey et al 2017) or group work may be useful methods to enable discussion of dilemmas. Participants suggested simulation to practice in a non-threatening setting but seeing good role models to emulate spiritual care was also important which is echoed by Giske (2012). Ali (2017) also proposed a teaching framework call SOPHIE (Self-exploration through Ontological, Phenomenological, Humanistic, Ideological, and Existential expressions), recognising that teaching practice was inconsistent across universities.

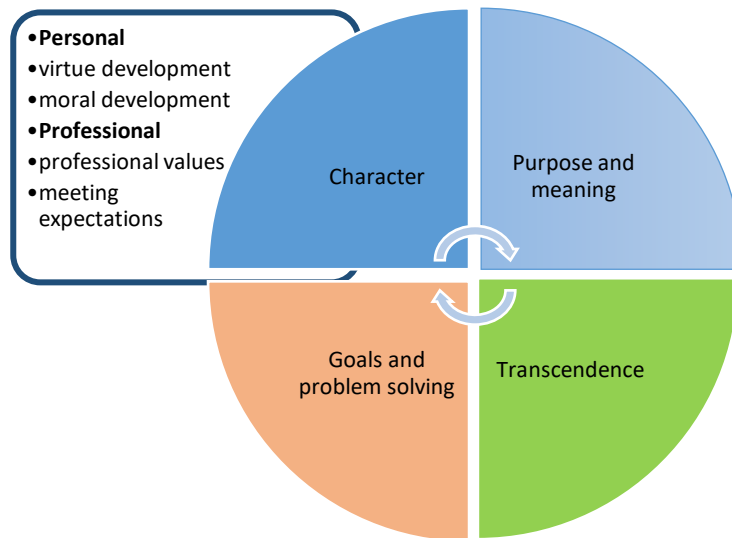
Some of the dilemma's participants faced were when they saw poor examples of spiritual care in practice and needed support to cope, considering how to change this in the future. All these aspects

enable the student to develop professionally in the areas of problem-solving and decision-making as they work through dilemmas. Problem-solving (Ancel 2016) has been found to aid student nurses' abilities and enhanced their practice so simulated scenarios that promote this is beneficial. Spiritual intelligence is not only the prerogative of nurses but patients will experience aspects of the framework; both the patients and the nurse may be at different points and understandings which can complicate interaction further.

The final area of the framework is character (Diagram 7.1d), considering how students develop personally and professionally to become, as Sellman (2011) says, a good nurse. Developing "*capacity to be virtuous*" (Emmons 1999 p164) is seen as a component of spiritual intelligence and I think it is the synthesising element which draws together the other areas to mature the nursing student. Participants noted that patients were vulnerable because of their illness and related the importance of virtues, such as compassion, communication and commitment, to ensure patients felt cared for. There are many virtues outlined (Athanasoulis 2013, NHS 2016a, Sellman 2011) that nurses are tasked to aspire too. Numerous virtues are discussed in the literature including wisdom, justice, courage, love (or charity), honesty (Carr 2014; Watson 2014) but many others are referred to including compassion, morality, and trust. However, virtues and moral work of nursing are closely linked according to Sellman (2011 p178) and educating students to ensure they are not only good-intentioned but take the necessary actions to do good and prevent harm is difficult.

Virtues are a hugely complex interlacing of different components, all influenced by an individual's beliefs and values. There is a personal understanding about many of the virtues which may not be agreed by all involved. For example, I may say someone is wise because of the example they give but another person may see it as foolish. Developing someone's character through virtues is a personal journey, linked to their purpose, ultimate goal and desires.

Diagram 7.1d– Character



In nursing the desire to have students with virtues consistent with the professional code of conduct is sensible (Sellman 2011). It would be difficult to promote trust with someone who had a criminal record, for example, so nursing excludes some people from entering the profession. However, people's characters change over time and formation of character to enact professional standards is required. Nursing has tended to focus on competency development rather than character and virtues. Although virtues can be seen in behaviours, it is possible to display behaviours that are accepted without embedding the virtue within your character. This was displayed in this study as one participant talked about the fact that staff were caring towards the patient but communicated different thoughts in private, showing that there was a mismatch between their beliefs and actions. This means different virtues may need developing within different contexts but it is possible to display a virtue without necessarily embodying it. Holding up a pretence of a virtue would be psychologically exhausting and could lead to burnout, so developing a character that embodies the virtue will be more natural, honest and sustainable. However, Felderhof (2014) wondered whether virtuous behaviour was possible in today's society, but it is an expectation of nursing practitioners.

There is a link between the personal virtues a person possesses and meeting the professional expectations as outlined in the '6 Cs' of courage, commitment, competency, communication, care, compassion (NHS England 2016a). Participants demonstrated some of the virtues through the way they acted during their experiences, such as showing courage by acting despite lack of support for spiritual care, showing compassion by taking time to listen to patient in spiritual distress despite pressures of other work around them. Displaying these virtues gives a more personal and engaging touch with patients but reflect the commitment to the job and risk-taking that McCance & McCormack (2017) consider as part of person-centred care. Whether you can change a person's character is debated because it is considered an ingrained part of the person (Houston 2014). However, Wigglesworth (2012 p113) gives examples of developing wisdom, which Carr (2014) described as a virtue, using boundaries and loving intention to address the issue. If a person has ability to learn, then aspects that challenge moral judgements, consider different moral stances and offer alternative explanation promotes critical thinking in a diverse culture (Kay 2014). Solutions to problems are not always easy or straightforward and students need to be able to cope with the conflicting demands and priorities for individuals, groups and themselves. Drawing on internal and external resources within spiritual intelligence is one way to deal with these issues (Draper 2009). In relation to spiritual care there are many moral considerations, such as religions that refuse blood products. These create ethical dilemmas for staff as they know the intervention will do good and feel that they are doing harm by adhering to the patient wishes (Nordhaug 2018).

There are debates about what is good for society versus the need of the individual and organ donation is an example in the UK. Currently people have to opt-in to organ donation so that, if they die, their wishes are known and recorded. However, changes in consent may be implemented in an effort to increase organ donation and improve transplantation rates, reducing the economic load on society and improving quality of life for patients. As a result, people would need to opt-out (NHS Blood and Transplant 2018) and state if their beliefs do not align to this requirement. The ability for

students to discuss morals and virtues needed within nursing helps them to be clear on their own views and establish their character in line with professional expectations.

I have outlined the components of spiritual intelligence within nurse education as 'purpose and meaning', 'transcendence', 'goals and problem solving' and 'character'. Each aspect has personal and professional components that could be used as a basis for educators to explore a student's spiritual perspective and link this with professional expectations. These aspects draw on the findings of this study, incorporating previous theory and research. Participants contextualised their own purpose and transcendent practices related to their beliefs, these influenced the decisions they made, and dilemmas encountered challenging their character and moral development particularly when dealing with spiritual care within a professional context.

I argue that spiritual intelligence is an aspect of nurse education that is poorly developed and often overlooked. I believe that this is an area of nurse education that could be utilised to develop individualised care, promote problem-solving, enable reflection, and develop professional character of nursing students. Spiritual intelligence is an under-researched area within nurse education, and I suggest that the proposed framework in Diagram 7.1 could be used to develop a teaching strategy. This is a different approach to teaching spiritual care but draws on a variety of strategies and approaches to enable students to explore difficult concepts and their own biases. A teaching approach, using the spiritual intelligence framework, should be evaluated to see its effectiveness and contribution to student learning. Participant 6 (John) was a third-year student who most vividly encompasses the aspects of spiritual intelligence and will be used as an exemplar to explore the potential use of Spiritual Intelligence in Nursing Education framework.

Exemplar from this study of Spiritual Intelligence

I will relate the example of John from the portraits to demonstrate how spiritual intelligence could be used as a teaching and learning strategy for spiritual care. I chose John as the case to focus on because he demonstrates all the areas I have outlined in Diagram 7.1 and illustrates the importance of developing spiritual intelligence in nursing students. The other participants included elements of

spiritual intelligence but had not demonstrated development in all areas, possibly because they were not third year students or, lacked experience in spiritual care, whereas John was in his final year and had several experiences to draw on.

John understood his meaning and purpose as he wanted to provide person-centred care and holistic care which is linked to nursing literature (McCance & McCormack 2017). His personal beliefs were instrumental in his desire to provide individualised care and meet patients' spiritual needs. In the recruitment stage of nursing there is an emphasis on finding students with the right values to become a professional nurse (Health Education England 2016) and John exhibited these traits. John had understanding of the professional values that he needed to demonstrate, such as respect for individuals.

John had self-awareness about his spiritual development and personal perspective which links to the 'transcendence' element of the diagram. He had been on a spiritual journey himself and had tried different faiths although he now followed a stoic position. He could relay his spiritual history but did not consider himself as having specific spiritual needs. In spiritual intelligence, the fact that he had no religious focus is not significant but the fact that he had worked through his faith ideas to be comfortable with his personal position is important. Faith development is a complex process and various thoughts around the moral, cognitive and religious development towards an autonomous position are outlined by Slee (1991). John demonstrated the area of transcendence because he had a clear understanding of his spiritual journey and current position, showing some spiritual maturity, although this did not include any religious affiliation. However, John had knowledge, awareness and acceptance of other religious and non-religious perspectives that, although different to his own, he respected which is vital for nursing practice (NMC 2015). John was at ease with his own stoic position yet had empathy for other faith positions, showing that he could have nursing presence to listen to patients' spiritual needs (Mohammadipour et al 2017).

John's goal was to provide good quality spiritual care but, initially, he lacked problem-solving skills when a dilemma arose. Problem-solving has many influencing factors, such as work demands (Lau 2014), and students need time to acquire knowledge and skills to be competent in spiritual care which develops over the course (Ross et al 2018). John had a dilemma in his first year of nursing as he recognised spiritual distress in a patient but did not know how to deal with this, thus he lacked a coping strategy and problem-solving at this stage. Ramos et al (2015) notes that student nurses may struggle with ethical issues as they deal with demanding situations and suggests that students need time to discuss these. Part of John's dilemma caused personal discomfort and it was something that he needed to explore to resolve. Discussion within university about his experiences meant that he could explore different options which Mezirow (2000, 2009) says helps students to learn. For John, a comment from a peer challenged him and made him question his own commitment to spiritual care. However, this challenge was a key learning point that helped John to problem-solve. McAllister (2011) discusses how education can transform understanding to consider alternative solutions. This ability to problem-solve helped John to cope with the situation as he could see alternatives and felt that he could be more proactive if faced with a similar situation in the future. This is part of transformative learning theory (Mezirow 2000, 2009) that strategies should enable the learner to change and develop in new ways. There may be a few options to develop problem-solving skills and coping strategies in students, such as group work (Robson 2002), clinical supervision (Pitkänen et al 2018), social network (McCarthy et al 2018) and simulation (Morrell-Scott 2018). A key educational need when dealing with dilemmas is to have a 'safe space' to discuss the concerns (Law & Chan 2015) where students can learn without fear of retribution. John said that the challenge had knocked him psychologically and made him doubt his abilities, thus a facilitator who balanced support and challenge may have channelled the feelings of failure more productively (Brockbank & McGill 2012). However, John showed some resilience to return with an invigorated desire to provide good spiritual care and Stacey et al (2017) thinks reflective strategies enable this to develop.

The discomfort and doubt John experienced made him reflect on his commitment to providing good spiritual care and whether he was adhering to his beliefs and values. This led to a reassessment of his character and how John would develop to ensure his values were evident within his practice. The lack of knowledge and problem-solving around spiritual care in John's first year meant that he had difficulty living his personal values within his professional life. As John reflected on the incident, and was challenged about his action, it offered him new insights about ways to cope and make decisions in the situation. Toofany (2008) felt that student nurses have difficulty prioritising and decision-making early in their career and opportunities to reflect, such as clinical supervision, helps develop those skills (Stacey et al 2017).

John was more proactive when he encountered a patient at the end of life by planning, making decisions and leading the team to provide spiritual care. John showed development of virtues because he was more courageous and committed to ensure that spiritual needs were addressed and communicated to the team. Sadooghi et al's (2016) concept analysis highlights the linkage of moral courage with spiritual beliefs and using spiritual intelligence as a framework in nurse education would be a method of refining this virtue by promoting debate about moral dilemmas. John became proactive in addressing the spiritual need, problem-solved in liaison with family and communicated decisions with the team. This proactive approach had a positive effect on the spiritual need of the patient and John said that he felt he had '*done a decent job*' and nursing has been noted as having a moral imperative which influences caring and compassion (NHS England 2016b, Sellman 2011, Newham et al 2017). John had reflected and embedded changes within his practice which would reinforce future decision-making to meet the goals he aspired to achieve.

The whole process involved all aspects of spiritual intelligence that is outlined in the diagram 7.1 above. John started at a personal level thinking about his own purpose and beliefs, developed transcendence as he was aware of his own spiritual perspective, knew what his goal as a nurse was and he displayed the key caring values to respect others. However, the incident he encountered had made him reflect at a deeper level which included more around the professional enactment of his

spiritual intelligence. John realised that his purpose as a nurse had not been fulfilled and the challenge made him consider how to implement his purpose in professional practice, his transcendent self was expanded professionally by gaining knowledge and perspectives about patients' spiritual needs, this then allowed him to become more adept at problem-solving for spiritual care which enabled him to cope with complex situations and, as a result, his moral character grew as he felt fulfilled personally and professionally. For John the spiritual intelligence seemed to have two aspects, one at a personal level and one that developed the professional level. However, there was a flow between the elements and close interaction amongst them, so the elements are important in the development process rather than being sequential. John showed courage in implementing spiritual care and I will discuss how the framework could be used for virtue development.

Learning courage using the Spiritual Intelligence in Nurse Education framework

Courage will be outlined as an example of how the Spiritual Intelligence in Nurse Education framework (Diagram 7.1) could be used to enhance nursing's desired virtues. Courage is often impulsive and sometimes reckless but in the sense of wishing to achieve something positive for another person without concern for yourself (Leuon Lloyd 2014). Courage in healthcare is described as doing the right thing, speaking up about concerns and embracing new ways of working (NHS England 2016b). This study highlighted that student nurses were fearful when dealing with spiritual care, particularly about saying or doing the wrong thing. The feeling of fear is associated with courage but there is a balance between fear that stimulates action and excessive fear that can lead to cowardice (Anthanassoulis 2013 p64). Nursing has numerous situations that create fear, such as making a mistake or not being competent with a clinical activity (Cowan 2016).

Courage is promoted as a virtue within United Kingdom healthcare as one of the '6 Cs' (NHS England 2016a) and involves risk-taking that is underpinned by integrity, personal sacrifice and commitment (Numminen et al 2017). Price-Dowd (2017) talked about three elements of courage in nursing as extending the craft of nursing, doing what is right and dealing with difficult situations. Sellman

(2011), however, sees courage as acting in a way which not everyone would, without concern for oneself; all these aspects were evident in this study as students wanted to do the best for the individual patient within challenging situations.

Courage is founded on a person's underlying meaning and purpose because you need to be willing to stand-up for what is important to you. To develop courage student nurses can reflect on their personal values and beliefs and compare them with professional expectations, as outlined in the spiritual intelligence framework above. Sellman (2011 p205) notes that courage is not explicitly stated in nursing codes of conduct but it is implied. Nurse education needs to enable the learner to consider their values and beliefs as '*values determine what people think ought to be done*' (Manley 2004 p55 – emphasis in original) and these are closely linked with the professional codes (McCance & McCormack 2017 p46). Nurses are expected professionally to be open and honest about mistakes (NMC 2015 p13) and act quickly if there is a risk to patients (NMC 2015 page14) which Sellman (2011 p206) says requires courage. Courage is needed in situations of poor practice and Francis reported in 2015 that staff did not feel listened too or were treated negatively for raising concerns (Francis 2015), thus courage is needed to persevere (Numminen et al 2017). Courage is linked to self-awareness about the right course of action in particular situations and gaining inner strength to do this.

Nursing students may find it hard to voice concerns and meet professional standards whilst realising the consequences of failing to do this, so courage needs to be developed early in their career (Bickhoff et al 2016). There are various teaching tools aimed at exploring values and beliefs such as developing shared vision, understanding core values and promoting an attitude of high challenge and high support (McCance & McCormack 2017 p46). In nursing, being courageous is associated with being a patient advocate and is seen as an everyday event that can be learnt (MacDonald et al 2018). In this study the participants either demonstrated, were supported with or witnessed courage as part of spiritual care activities. Participants' demonstrated courage by instigating spiritual care for a patient, even though they felt it was not valued by colleagues. Participants made

a special effort to meet individual needs; for example, the student who went to another ward to find the patient a bible. Moral courage and patient advocacy were also evident in Bickhoff et al's (2016) study on student nurses who were concerned about meeting individual needs.

Other staff can promote courage in students through example and actions. Participants were encouraged by their mentors to be courageous and go beyond normal expectations when undertaking care activities (MacDonald et al 2018); for example, when a student shaved a patient despite being chided by the healthcare assistant. Participants witnessed staff demonstrating courage by taking an intensive care patient outside to connect with nature. Intensive care patients can be unstable when moved so there is a risk involved which requires problem-solving and commitment for the patient benefit, and resonates with a concept analysis on moral courage (Numminen et al 2017).

Courage is an aspect that is needed throughout a nurse's working life to extend clinical skills, make decisions in difficult situations and stand up for what is right (Price-Dowd 2017), however Gibson (2018) thinks that courage is not fully achieved until nurses complete their training. Developing courage needs a number of antecedents according to concept analyses (Numminen et al 2017, Gibson 2018, Sadooghiasi et al 2016) including gaining competence, self-confidence, self-advocacy and persistence. The Spiritual Intelligence in Nurse Education framework (Diagram 7.1) identifies transcendence as the personal (or inner) self-awareness and awareness of professional (or other) perspectives. Self-awareness of one's personal perspective but knowledge about other people's viewpoints is needed to consider the best course of action for a patient (Keller 2015). In spiritual care situations students need to explore their own spiritual perspective and develop interpersonal skills for effective communication, which Numminen et al (2017) called true presence and was part of the moral courage concept. However, student nurses also need self-awareness about where they lack understanding and self-advocacy to voice their views; these are key skills for courage (Gibson 2018).

The Spiritual Intelligence in Nurse Education framework outlines transcendence to focus on self-awareness and awareness of others. This could be used to consider thoughts and approaches to courage using strategies such as self-awareness tools, unconscious bias training, visualisation, meditation or mindfulness activities (Dewing 2014; Metheny 2017; van der Riet et al 2017). Rasheed et al (2018) found that there was little evidence about the most effective ways to develop self-awareness in nurses and this needs further exploration. Spiritual intelligence tools have been developed (King 2008; Amram & Dryer 2008) to examine individual position, although these have mainly been used in research and their usefulness for student learning would need evaluating. More formal education resources, such as lectures, reading material, simulation or use of chaplains, could be used to explore the use of courage in spiritual care. Knowledge is considered powerful as it provides students with key information to adhere to but, in spiritual care delivery, listening to the individual patient is also vital (So & Shin 2011 Purdie et al 2008). Students may develop an awareness of themselves and understanding of the issues but courage is needed to put this into practice when tasks can dominate (Bickhoff et al 2016; Sharp et al 2018).

Goals and problem solving within the Spiritual Intelligence in Nurse Education framework (Diagram 7.1) is the area where courage may be most obvious as many of the moral dilemmas are related to doing good in practical terms (Athanasoulis 2013; Bickhoff et al 2016). Courage benefits the receiving person but can benefit the giver as they are often seen as a hero (MacDonald et al 2018). A nurse who displays courage can develop their self-confidence and resilience (Nummenin et al 2017) which is beneficial for patient advocacy. A positive result from a courageous act is likely to lead the person to repeat similar activities; in nursing a positive outcome may mean that the patient need is met, the nurse may feel sense of achievement and that they have provided the best, evidence-based care possible. Courage leads to professional excellence (Sadooghias et al 2016), promoting empowerment and trust (Gibson 2018) but student nurses need to be able to identify the goal for individuals to achieve person-centred care.

Taking risks is seen by Sellman (2011) as an aspect of courage but students' nurses need to develop competency to deal with dilemmas (Bickhoff et al 2016) and the courage to implement action.

Problem-solving and clinical decision-making are key skills in nursing (Standing 2017; Alfaro-LeFevre 2013) but, when dealing with spiritual care, there are many dilemmas and opposing priorities, such as taking time from a busy work day to address a spiritual need for a patient.

The Nursing and Midwifery Council Code (NMC 2015, NMC 2018d) tasks nurses to prioritise people and this can take courage when the patients' needs, whether spiritual or other, contrasts with the clinical area culture or work pressures. Students have reported needing support from mentors to deliver spiritual care (Porteous & Machin 2018) and when this is not forthcoming it leads to anxiety about addressing a patient need that is important to the students. Students need opportunities to discuss these dilemmas, and consider the coping strategies they use, so that they can develop decision-making skills that will inform and strengthen their courage to adhere to their purpose. It takes courage to reflect on experiences that were seen as difficult or ineffective as it is easy to push these to one side and ignore them.

Nurse education can use strategies, such as clinical supervision (Stacey et al 2017) and critical-creative companionship (Titchen 2018), to enable discussion of difficult issues and group discussions can enable sharing of experiences and strategies (Mezirow 2009). Simulation has been recommended as a method of practising difficult situations within a safe space and allows for feedback to aid learning (Fink et al 2014). Examining mentor feedback from practice may also be useful to enable the learner to identify how they can improve decision-making and develop their spiritual care competency over time (Ross et al 2016). Challenge and lateral thinking exercises could help students to think differently about problems and unpick all the elements so that they can approach a similar issue with an understanding of underlying aspects (Standing 2017). The goals of care delivery need to be clear but based within the person-centred approach (McCance & McCormack 2017) where courage is needed for nurses to act as an advocate (Nummenin et al 2017; MacDonald et al 2018) and implement patient wishes. Keeping the patient goals at the centred of

care delivery can enable innovation, risk-taking and problem-solving (McCance & McCormack 2017) where courage is required to implement the decisions made.

The final aspect of the Spiritual Intelligence in Nurse Education framework (Diagram 7.1) focuses on the development of character. Character is something that distinguishes each individual person and the virtues are integral to this (Sellman 2011). Each person has particular virtues that they are more adept at using and others that may need honing. Hawkins & Morse (2014) believe courage can be learnt, therefore virtues are not static but can develop over time. This is important in nurse education as students may need to consider their morals and virtues to become a good nurse, providing high quality safe and effective care as required by the profession (NMC 2015). Practising some of the virtues, such as courage, can embed these into the students' character so that it becomes a natural part of their nursing practice. Engraining professional virtues means that the nurse is more likely to act as the profession requires and, as they develop these traits, they should hold close to their purpose and values. Student nurses are tasked with becoming autonomous practitioners during their training (NMC 2018c) which requires the professional virtues as outlined in the '6 Cs' (NHS England 2016a) to be achieved.

Nurse education can foster the development of character in supportive ways, such as having mentors that promote and role model professional virtues, teaching about moral issues facing nursing and the synthesis of complex concepts when dealing with difficult situations. Courage may be one of the hardest virtues for nurses to develop because of the requirement, in some cases, to stand up and deal with opposing positions, which is stressful and can be intimidating (Bickhoff et al 2016). Nurses need resilience to deal with opposition (Stacey et al 2017) and resilience strategies may be useful at this stage to develop students' courage for practice.

Courage is a complex concept and I had tried to show how the framework I propose could be used to develop one virtue. The areas within the framework are fluid and overlap, such as growing in decision-making is informed by the nurses' purpose and can lead to development of character.

Further research to explore the usefulness of this approach to develop student nurse's self-awareness, decision-making and virtues is recommended.

Where Next?

This thesis has proposed that spiritual intelligence can be used to develop student nurses within the nursing education curriculum. Spiritual intelligence within a nurse education framework has been suggested as an approach to consider students' personal and professional development in the areas of meaning & purpose, self-awareness, goals & decision making, and character. Spiritual intelligence is different to emotional and cognitive intelligence but closely entwined. These insights developed from the original research aim to *explore undergraduate nursing students' lived experiences that develop their understanding of spiritual care*. I have found that spiritual intelligence is an element that needs focusing on during nurse education to enable students to develop understanding and application to spiritual care. However, this framework needs to be embedded within nurse education for it to be useful and the question is where next?

Cutcliffe & McKenna (1999) suggest that deductive studies can be used after a qualitative study to explore the findings further and it may be appropriate for this work to consider if using a Spiritual Intelligence in Nurse Education framework is beneficial to learning. A variety of research approaches could be undertaken such as a longitudinal study could be used to follow students over the three-year programme. However, nurse education is constantly changing and it might be difficult to confirm if the framework was the influencing factor.

Within my university the framework is being incorporated into curriculum at different stages of nurse education in a purposeful and structured way. At present the areas within the framework are covered ad hoc rather than systematically and the framework will focus educational experiences to cover all spiritual intelligence areas. The aim is to consider aspects of meaning and purpose in the first year, linking to the professional code of conduct (NMC 2015, NMC 2018d) and including strategies to develop self-awareness. Self-awareness in the framework is linked to knowledge, so building specific sessions around professional awareness, such as spiritual care, can be used here. As

students become more confident and competent in their skills several dilemmas will be introduced, such as in simulation activities or problem-based learning, for them to explore. It is envisaged that in the final year students will return to the virtues of nursing and consider how they reflect these and areas they still need to refine.

The Spiritual Intelligence in Nurse Education Framework could be used for other topics where values can create dilemmas. I have given the example of courage and spiritual care but items of conscientious objection (e.g. abortion) or other professional expectations (e.g. compassion) could be explored. Many topics need awareness of personal preferences in relation to professional expectations. Thus, this framework could be used to structure educational experiences to increase awareness about the impact of our values, aid understanding of key components of a topic, discuss dilemmas that challenge our beliefs and lead to us change the way we act (virtues). This could be a pragmatic approach to ensuring complex issues are explored at a deeper level to embed in nursing.

It is important to disseminate this research further and discuss the ideas around spiritual intelligence as it is a rarely used concept in nurse education. Van Manen (2014) said that the vocative writing of a phenomenological work was key, particularly if it resonated with the reader. I have had a concurrent session paper accepted to present the framework at a nurse education conference (see Appendix 12- Conference presentations) and I intend to write some publications about the thesis findings. This dissemination will be important to see the utility in other organisations and to critique and refine the work.

I plan to do further post-doctoral research on the topic to explore where spiritual intelligence can be developed in nursing students by using this framework considering the impact on decision-making or personal virtues. It would be important to gain a wider participant group for this work so that benefits and problems with the framework and topic can be explored more deeply. The third-year student in this study, John, demonstrated all areas of the framework and it may be helpful to

sample other final year students to see if this is replicated or there are other factor influencing development of spiritual intelligence.

Chapter 8

Conclusion

I have found this research project challenging but rewarding. It has made me a more confident and competent researcher, developed my creative thinking skills and enabled me to consider the variety of research approaches available to me. The work into spiritual care in nurse education has grown during the process of this thesis (particularly Lewinson 2016, Ali 2017, Ross et al 2018, Attard et al 2019 a & b) so the landscape is developing. Therefore, I see this thesis as the beginning of a journey rather than the end of one, but I need to conclude by summarising the implications, recommendations and acknowledging limitations of this work.

The main finding of this research is to reiterate the complexity of learning for student nurses when learning about spiritual care. It is a mixture of personal factors, values and beliefs, knowledge and skills development, and professional expectations. This study interpreted this in a novel way by relating these issues to spiritual intelligence and the aspects of purpose & meaning, transcendence, goals & problem solving and character within the Spiritual Intelligence for Nurse Education framework (Figure 7.1).

Implications

Since the original development and data collection of this thesis a spiritual care competency framework for pre-registration nurses and midwives has been published (Attard et al 2019a & b) and Ali (2017) thesis proposed an educational area. All the competencies outlined within the spiritual care competency framework echo the aspects student nurses discussed within this thesis, but Attard et al (2019a) framework does not refer to the area of spiritual intelligence. Similarly, Ali (2017) proposed SOPHIE (Self-exploration through Ontological, Phenomenological, Humanistic, Ideological, and Existential expressions) but does not include spiritual intelligence. However, I see the term spiritual intelligence as an overarching aspect which is evident within the framework that I have proposed as outlined above (Figure 7.1). Attard et al's (2019b) paper robustly evidences the aspects

of spiritual care that need to be learnt to achieve competency. My thesis complements Attard et al's (2019 a & b) work by suggesting areas to plan into educational activities to facilitate the learning process around spiritual care. This thesis offers a structure through the Spiritual Intelligence in Nurse Education framework to ensure that all the aspects to achieve competency (Attard et al 2019 a & b) are included within teaching and learning strategies. This thesis has highlighted that a variety of teaching and learning strategies, particularly using participatory approaches, are valuable but there also needs to be incorporation of this into the practice setting. Practitioners who role model within the clinical setting are vital to dealing with the complex and scary topic of spiritual care, to demonstrate how to approach this in an inclusive and person-centred way. Thus, a wide variety of teaching activities should be used to support the development of knowledge, skills, attitudes and values to promote person-centred spiritual care.

I have argued that spiritual intelligence is under-recognised and valued within nurse education, but I acknowledge that the complexity of spiritual care may mean that adding another term may confuse, rather than enhance, understanding of the topic. Intelligence as a concept is controversial because of the implication around cognitive function whereas nursing is a practical profession requiring complex skills and knowledge. However, nursing is a synthesis of skills, values, beliefs, emotions, knowledge and competency which may mean that using a different term, such as spiritual intelligence, could emphasise the spiritual component heightening its relevance to nurse education.

This thesis noted the importance of person-centred holistic practice where individual patients are listened to and respected, this enables the persons' spiritual needs to be heard rather than assumed. The student nurse needs to recognise their own biases so that they can be open to other perspectives whilst adhering to professional boundaries needs exploration; this will enable the student to discuss their fears and dilemmas which were evident within this work. A key aspect is that students still do not feel prepared for spiritual care, it is part of the nursing educational expectation and educators need to address the topic area thoroughly.

Recommendations

This study has utilised some novel approaches to both researching the topic and strategies to improve incorporation into nurse education practice. However, further research and implementation processes are needed to improve spiritual care education. Recommendations include:

- Explore the links between this thesis and the spiritual care competency framework to enable education strategies that translate into practice experience
- Designing curricula so that the components of the spiritual intelligence in nurse education framework is included, utilising a variety of teaching and learning approaches
- Portraiture as a descriptive narrative to 'paint a picture' could be utilised to build spiritual care exemplars for use in nursing education
- Further research is needed into mentors as role models, to understand the factors that help or hinder incorporation of spiritual care within the practice setting
- Further research into nurse lecturers' beliefs and attitudes towards spiritual care education
- Further research to understand student nurses learning about spiritual care from different faith perspectives

Limitations

Several limitations have been outlined throughout the thesis and this section offers a summary. As a novice researcher the skills I brought were limited and could have affected the design and implementation of the study procedures. Analysis processes, even in qualitative research, are more dependable if a team is utilised but I have acknowledged my potential preferences in chapter 3 and Van Manen (2014) recognises that interpretation may vary if other people looked at the data.

The context of this study was a single site, in a Church of England foundation university, which gives a unique perspective, but other institutions could have been included to see if experiences were different. The participants religious beliefs were not explicitly explored but the conversations demonstrated that most had a Christian influence or faith, even if they now considered themselves non-religious. Exploring experiences of student nurses from other faith positions would be informative to consider whether additional concerns or learning needs are evident. Practical difficulties meant that the findings and framework were not returned to participants for comment and this may have enhanced the understanding of the topic.

Van Manen (2014) talks about the vocative writing of the phenomenology and this study has been presented at conferences and resonated with attendees (see Appendix 12). However, to date, this work has not been published and so has only been scrutinised by supervisors and examiners; a wider audience could illicit important insights to develop this work.

Conclusion

I commenced this thesis with the aim to *explore undergraduate nursing students' lived experiences that develop their understanding of spiritual care*. I have found similar results to other authors showing that education of nursing students on the topic of spiritual care is complex with similar difficulties continuing over time. My interpretation has led to considering developing educational strategies that are underpinned by spiritual intelligence to incorporate a person-centered approach. This work should focus the debate about not only 'what' student should learn on the topic of spiritual care but 'how' they learn can embrace the topic in a holistic and person-centered way.

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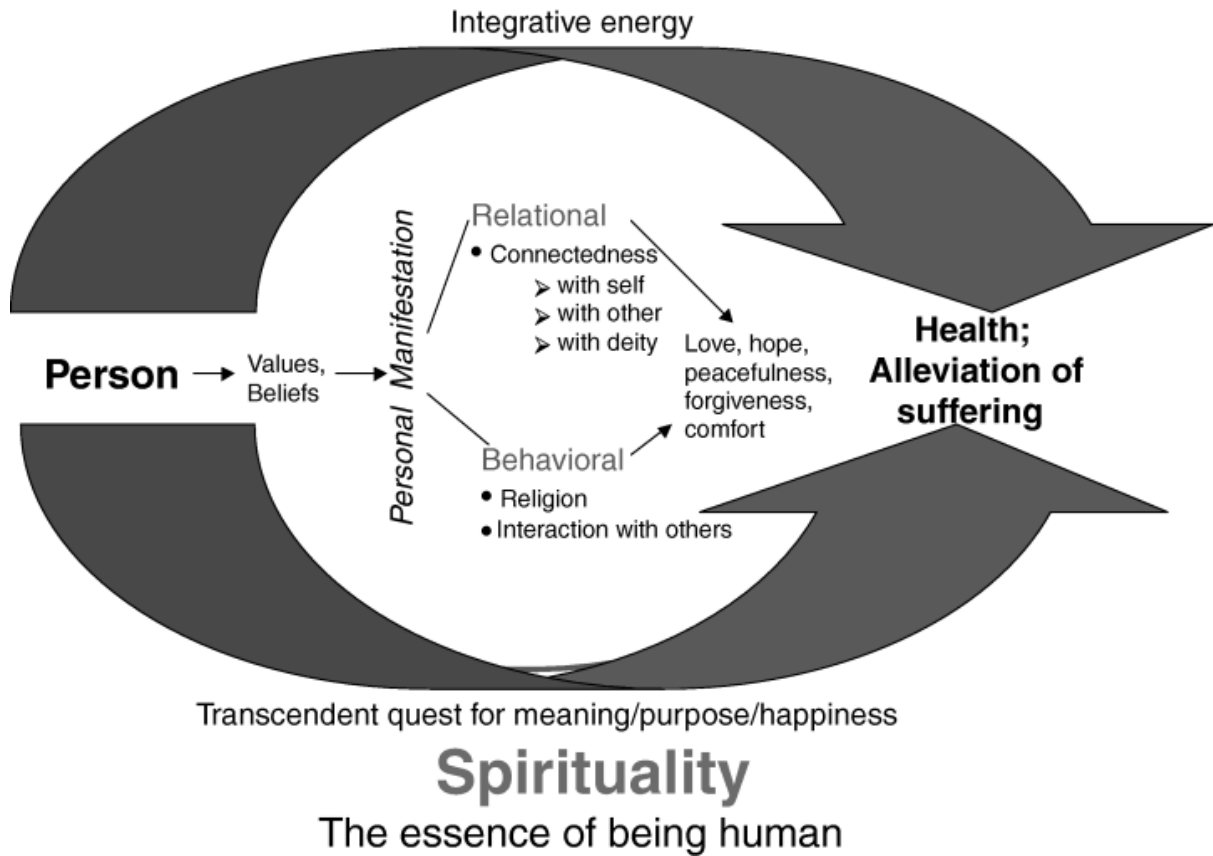
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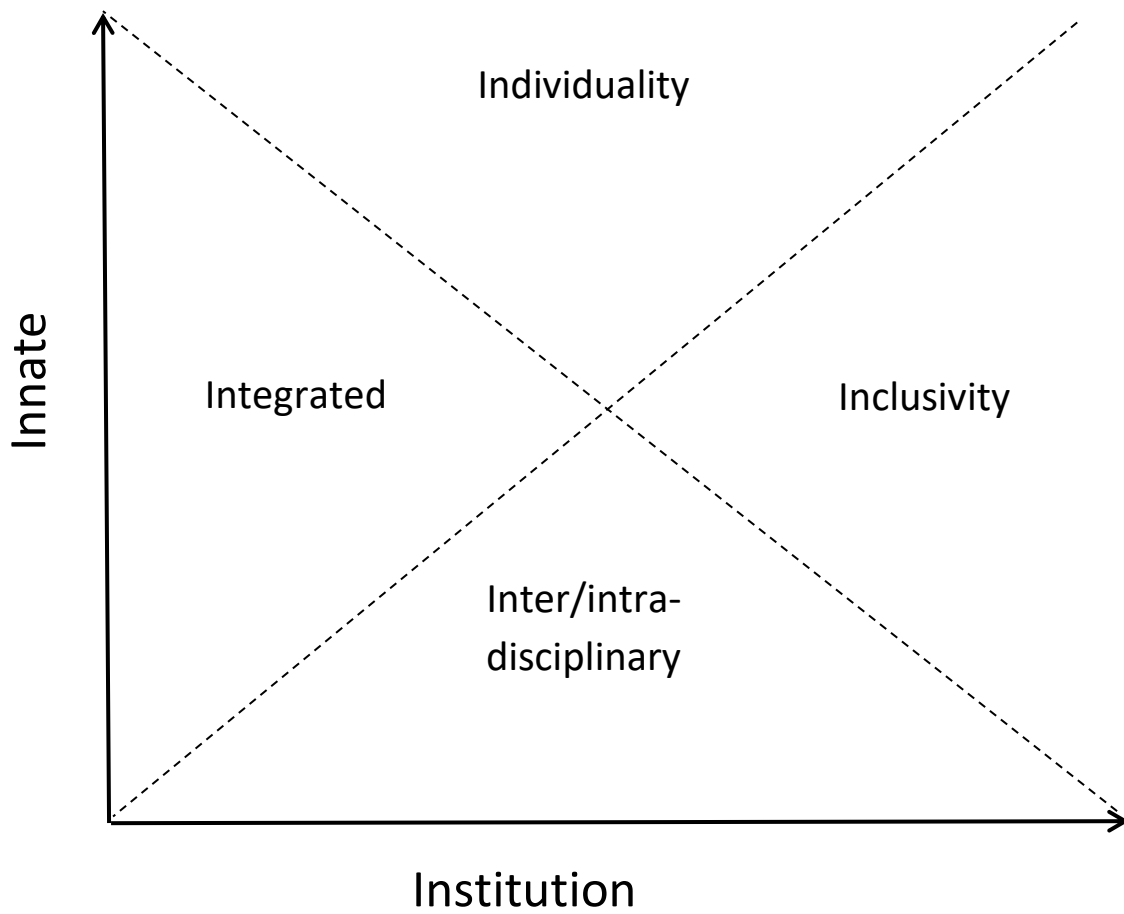
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APPENDICES

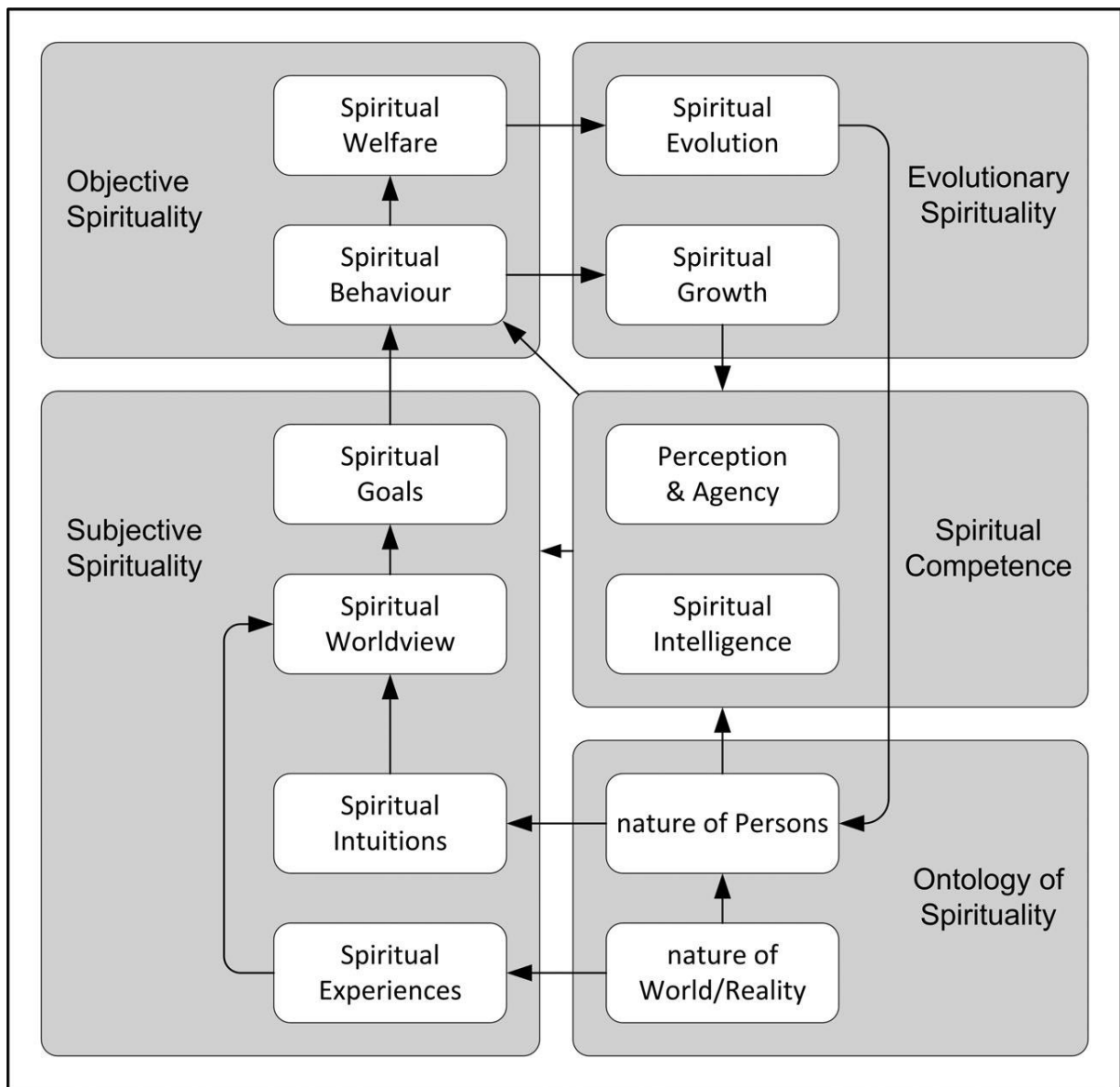
Appendix 1 - Model of Spirituality by Miner-Williams (2006 p817)



Appendix 2 - The Principal Components Model for the Advancement of
Spirituality and Spiritual Care within Health Care
McSherry (2007 p 259)



Appendix 3– A Systems Model of Sprituality by Rousseau (2014 p498)



Appendix 4 - Table of included studies and theming

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
Attard et al (1)	2014	Journal – peer reviewed	Quantitative Descriptive (part of bigger Delphi study)	Survey using Spiritual care competency scale post a taught module on spiritual care	Malta. Pre and post reg nurses and midwives (not clear how many were pre/post) 212 consented but response rate from this: 89% nurses 75% midwives	Inferential statistics by SPSS v18. Parametric statistics of profession against education on spiritual care	Findings confusing as compares those who did and did not undertake study unit but only seems to have invited those who DID participate! Nurses scored higher than midwives but not significant. Those who undertook study unit scored higher in all areas	Personal spirituality strong predictor to provide spiritual care Recommend further research on life events that may impact on nurses providing spiritual care Recommend integrating spiritual care into curricula Suggest need further research into various religions and cultures and education on spiritual care	not pre/post module test. Not compared with people who did not undertake the module. Sample does not match what is said in the findings. Spiritual experiences may be different for nurses and midwives as child birth is seen as positive event	Theories guiding this was Benner (novice to expert/ skills acquisition) and Schön (Reflective practitioner) Malta strongly Roman Catholic which the authors recognise. They recommend reflective teaching style but not clear if the module used this format.	Benefit of education on spiritual care. Integrate spiritual care into curricula
Baldacchino, D.R. (2)	2008	Journal peer reviewed NET 28: 501-512	Evaluation	Post study unit students sent in a self-reflection about the impact of the study unit. Anonymised by students on submission with assignment	Malta, diploma nurses. 63 participated (97%). Their final study unit. All the students were Christians	Thematic analysis using Burnard 1991 Author plus research assistant. Not gone back to students as they had finished	Personal impact - becoming more aware about one's own spirituality and health. -Learning to count one's blessing in life Academic impact – enhancing self development. -gaining more knowledge on spirituality and spiritual	Increased self-awareness of students which helps them be empathetic to patients. Integrate spirituality into the whole course – not just at the end. Self-reflection may help critical thinking. Case studies discussed in groups helped application to practice.	Study unit had Judeo-Christian focus as dominant in Malta . ?students felt not submitting the reflection would affect their marks	Conceptual approach ASSET module (Actioning Spirituality and Spiritual care Education and Training in nursing) Malta strongly	Self-awareness of own spirituality Integrate spirituality into curricula Knowledge of spiritual care

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							care Professional impact -- becoming more sensitive to patients' needs -giving priority to holistic care -being coherent with patients' coping methods	<u>Lack of research on the impact of education on spiritual care in students</u>	as submitted at the same time although anonymising seemed good. Only evaluated POST course – may have been influenced by personal life events or teacher enthusiasm (author recognised this)	Roman Catholic which the authors recognise.	Awareness of patient spiritual needs Part of holistic care
Beavers, T.T. (3)	2014	PhD Thesis – (only got abstract and preview)	Quantitative Descriptive	Religio-spiritual Demographic questionnaire (RSDQ) and Spiritual Care Competency Scale (SCCS) completed	18 freshers (nurses starting course) and 12 seniors (finishing nursing course). Catholic university in USA	Descriptive statistics and two-tailed T-tests.	No statistical significance capture between demographic data and SCCS scores. Potential influence of student age, time in university and number of religious courses completed	New students had higher self-scores of competency whereas seniors were more reserved about their abilities. Recommend larger more varied sample to investigate students perceptions and attitudes regarding spiritual care to their patients	Only able to get abstract. Recognised that the sample was very homogenous which could affect results. ?as catholic university will again have a dominant Judeo-Christian perspective.	Parson's Human Becoming Theory as theoretical frame	Development of self-awareness of spiritual care skills
Blesch, P.S. (4)	2013	PhD Thesis	Qualitative – grounded theory	Interviews in-depth face-to-face focus	20 Senior student nurses (and 16 Faculty	NVivo 9 Coding. Inductive	Three themes emerged from the student interviews:	Emphasises importance of including spirituality within the curriculum	One university setting,	Capella university in USA has a	Lack of clear definition Integral spiritual

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				groups, Observed during interviews and researcher took field notes	staff but only looking at students here) Convenience sample	process to produce themes	students cannot clearly define spirituality versus culture versus religion, they are not equipped to do a spiritual assessment, and there is a lack of role models by both nursing faculty and staff in the clinical setting demonstrating how to address the spiritual needs of clients. There are two sub-categories that support how to define spirituality and how to better equip students to address the spiritual needs of clients.	P175 suggests spiritual needs model where define by having self-assessment and difference between religious/spiritual; equip students by integrating into curriculum and teaching spiritual assessment; finally role modelling in university and practice	convenience sample	secular curriculum focus. Note questions asked are similar to mine! Comments – lack of role modelling about spiritual care and assessment	care into curricula Developing self-awareness Lack of spiritual assessment skills Role modelling needed Lack of clear definition Developing student awareness of patient spiritual needs
Boswell, C.; Cannon, S.B.; Miller, J. (5)	2013	Journal	Qualitative - narrative	Elective course on holistic care. nursing students required to do reflective writing	Convenience sample – 15 BSN students 15 RN-BSN students 15 graduate nurse practitioners. Undertaken in USA	3 researchers reviewing, Coding, analytical memoing, audit trial (triangulation)	Key concepts of the undergraduate students: Confusion: spirituality does not equate to religion. Responsibility. Communication. Value lead to respect. Trust/openness. Desire to learn is coupled with fear. Mind/ body/ spirit. Simple concept yet difficult t based on fears. Methods. Listening .	Need more educational opportunities about spirituality concepts. Spiritual care not equal to religion and needs to be 'put to rest' Emphasises the connection of mind, body spirit to enhance holistic care/healing.	Unclear if the reflective writings were part of the final assignment mark. They only took a set number of sections from each journal across the sample so may have missed important aspects, also	Theory focus Benner's novice to expert related to holistic care. Author said marks not affected by research.	Confusion about concept of spirituality Attributes to provide spiritual care Concerns about providing spiritual care Holistic approach

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							(critique – these areas are not fully addressed in the article)		makes it hard to see any differences between qualified staff and students.		
Burkhart, L. Schmidt, W. (6)	2012	journal	Quantitative – RCT.	2 sequential cohorts randomly assigned to normal education or normal plus a 'spiritual care educational and reflective program'. Demographics and 2 spiritual care plus spiritual wellbeing surveys pre and post interventions.	59 'traditional' students – 13 intervention, 14 control. 32 'accelerated' BSN students – 15 intervention, 17 control	Statistics (not clear which package), t test	No statistical differences in groups pre intervention. Post intervention no differences in spiritual/religious wellbeing. Statistically significant differences in the intervention group increased ability to provide spiritual care and doing assessments of patient spiritual needs.	Suggest that retreats and discussion boards offer a good opportunity to share perspectives. Increasing reflective practices whilst analysing spiritual care practices useful.	Risk of interaction between the intervention and normal group – not discussed. Self-reported questionnaire. Authors aware of possible selection bias as those participating may be more interested in spiritual care. Also recognised this was undertaken in faith based nursing school	Theoretical framework Burkhart/Hogan Spiritual Care in Nursing Practice theory. Funded by a Catholic organisation. Retreats and online discussion boards used in the intervention. Sample sample that would be under powered	Applying self-reflection to practice setting Education programme improves spiritual care

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Cobb, B.J. (7)	2004	PhD thesis	Phenomenology – aim to look at how students with high faith maturity provide spiritual care to patients	but did demographic survey and faith scale first, picked 27 students who were Christian and high faith scores and volunteered to do semi structured interview. Also looked at curriculum documents	Students from 2 faith based universities. 27 students interviewed. All Christians with high faith score. Students all in the final three semesters of nursing programme	Thematic, reducing using Creswell way	Three patterns of care were evident in the stories the students recounted of how they provided care to patients: Holism, presence (being with people, time, touch), and witness (acting as a good Christian, praying with people). two areas of enabling to provide spiritual care were personal faith and preparation (ie what taught and role model). (Also looked at the students own faith formation but not relevant for this review). Their own personal faith a key aspect of providing holistic spiritual care	Recommended that students need to develop their own personal faith. Thought developing relationship with other students needed. Learning about spiritual care in curriculum. Using struggles as personal spiritual growth. Teaching include holistic care, reflection on spiritual situations, explore Christian witness in pluralistic society, sensitive discussion, tutors need to feel comfortable with discussions,	Only looked at Christians and wider perspective would be useful. Samples from 2 Christian faith institutions	USA university. Says that this is phenomenology but looks more like ethnography as various methods used. She 'bracketed' own views explicitly. Students related praying with patients and families in this study; permission asked, might be cultural difference. Recognised she came from a particular world view and wondered if similar results would be gained in other institutions.	Holistic approach Presence Living beliefs Integrating spiritual care into curricula Personal belief system Knowledge Role models Reflection on spiritual situations Tutors ability to engage

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Cooper & Chang (8)	2016	Journal NET	Qualitative	Indepth semi structured interviews	6 undergraduate nursing students in Australia . After a spiritual care course. First semester in second year	Thematic analysis using Colaizzi method	2 themes: Seeing the person as a whole. Being with the person. Students felt more prepared for holistic care if spiritual care included.	Spiritual care education for students has positive effect on them providing this. Thought having subjects on difference religions and competencies important. Education on spiritual helped with open mind to different cultures, recognised the broad nature of spirituality. Enabled students to be prepared and assess spiritual needs	All participants female. They didn't state any limitations.	Institution (in Sydney) had Christian orientation. Focus on acute hospital setting. 3 hr sessions for 13 weeks	Holistic approach Presence Integrating spiritual care into curricula Knowledge of different religions. Competency in spiritual care Opening the mind to spirituality Assessment of spiritual needs
Coscrato & Villela Bueno (9)	2015	Journal in Portugal (only abstractEnglish)	Qualitative – action research	Observation, field diary, interviews, questionnaires.	Brazil (says nursing undergraduates but not sure how many)	Interpretation categorisation	Predominance of technical-procedure observed. Educational action, they felt, helped constructivism and problematization of knowledge	Suggest the education of nurse educators to include spirituality and humanization. Also suggest use of competencies to help individualisation for clients	As only abstract difficult to see how procedures followed and how action research enacted. ?number taking part	State owned teaching institution . Seems to confirm other studies so appears to be a global issue	Technical dominates Constructivism approach Educate the educators Competency needed
De Souza, Maftum, de Azevedo Mazza (10)	2009	Brazilian online Journal in Portuguese (abstract only in English)	Exploratory descriptive	Semi-structured interviews	10 undergraduate nursing students	Not stated	Recognised difficulty in apprehending a person's spiritual dimension but thought it was significant for caring. Unknowing makes students feel insecure	Not evident in abstract	As only abstract difficult to see how procedures followed and how descriptive research enacted.	Not stated if this was a religious affiliated education setting. Seems to confirm other studies so appears to be a global issue	Difficult to know others spiritual dimension Lack of Knowledge

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Du Plessis, Koen, Bester (11)	2013	Journal NET	Qualitative, Phenomenological	Reflection from students using 'world café' and interviews with families	South African. 18 final year (4 th) undergraduate nursing students, grouped to visit 7 families at home in faith communities. Aim to aid mental health as part of psychiatric module	Thematic process	Initially feeling overwhelmed and challenged but then felt more competent, student's awareness of religious and cultural factors, students perception of their role.	Mutual benefit to students and families, aids emotional competence as well as spiritual/ cultural awareness. Recommends more practice placements in faith communities to heighten spiritual / cultural awareness. Recommends more teaching via reflection and realistic opportunities	The students and families were of the same faith – Christianity. didn't say much about spiritual aspect but more about cultural. Recognises that being of the same faith may mean things were overlooked or assumed	Students were mixed ethnicity (black/white/ coloured) but the families were all white within a lower socio economic class. ? reflective of south African culture which has lots of diverse faiths (eg Zulu), often strongly shamanistic tradition even among Xians	Feeling overwhelmed Emotional competence Understanding religious and cultural factors Role perception Practice Placements in Faith communities Teaching needs to include reflection
Espinha et al (12)	2013	Journal Portuguese (translated into English)	Quantitative	Cross sectional exploratory, descriptive. Self-administered questionnaire	Brazil 120 nursing students (response rate 75%) all years. 90% women	SPSS 17.0	87.9% claimed some religious affiliation. Spirituality as belief in God (61.7%) whereas meaning of life (40.8%) Most students felt moderately or slightly prepared (83.3%) to approach spiritual aspects. 91.6% believed information on spiritual aspects insufficient. Wanted more participation in activities	Lack of understanding affects competency. Suggests need a more evidence-based approach to teaching spirituality that shows positives and negatives.	Translated from Portuguese so ? accuracy. Recognises limitation of one university setting.	Religious affiliation higher than UK and so ? results might be different here.	Feeling unprepared Lack of competency in spiritual care Evidence base for teaching spiritual care Lack of Knowledge Teaching to include participation

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Fink et al (13)	2014	Journal	Quasi experimental	Spiritual care at the end of life questionnaire , demographics, evaluation of learning. administered one week before intervention and one week after for both groups	Bacclearate nursing students. 30 in treatment group (first semester) had simulation and 24 (second semester) in control group.	SPSS 17 Descriptive and inferential statistics.	Variety of religions of students (predominately Christian). 9 males. Knowledge improved in the treatment group after the simulation. However, knowledge for treatment group was also better BEFORE the intervention. Confidence increased in intervention group post. Students liked doing the simulation.	Suggested that simulations or work experience may help this area needs more research. Involved clergy and allowed for discussion and application to other religions – could include other professionals. Ideally needed true experiment. Felt it was an authentic experience for students and should be used for spiritual aspects	Treatment group was older than control so may have had more experience prior to starting nursing to affect scores. Treatment group was also more diverse in gender and religious identity. Convenience sample who knew the investigator.	Funded by Catholic Nurses fund ? other aspects of the training had changed between the semester 1 and 2 students to give the bigger differences pre intervention. Confidence not a predictor of competence.	Use of simulation Involvement of clergy in teaching Improving self confidence
Frouzandeh, Fereshteh & Noorian (14)	2015	Journal	Pre-post intervention	Pre did holistic nursing process for chronic patient and self-efficacy questionnaire. 5 sessions on spiritual care/ practical spiritual assessment in before post questionnaire on self efficacy	30 students in semester 8 of studies. 21 female and 6 males. Took place in Iran	SPSS v16 and descriptive statistics	Self-efficacy increased post intervention for providing spiritual care (increased from low/moderate to high)	Felt that the opportunity to discuss their performance during the intervention about providing spiritual care was key to self-efficacy (but this not supported in results as not stated which part of programme was most helpful)	Says 30 took part but only 27 reported on. Discussion states things that are not clearly supported in the results.	?quality of the methodology is quite poor. Need to comment on attrition	Improving self confidence

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Giske & Cone (15)	2012	Journal	Glaserian Grounded theory	Semi structured interviews	3 Norwegian university colleges. 8 focus groups including 42 student nurses. Had to speak English. Groups covered all 3 years	Constant comparative analysis	Main category "How to create a professional relationship with patients and maintain rapport when spiritual concerns recognised" resolved by "opening up to learning spiritual care". 3 iterative phases - 'preparing for connection' - connecting with and supporting patients' - 'reflecting on experiences' Few role models in practice, fear of offending patients,	Respectful and sensitive communication needed. Need visible spiritual assessment and interventions in clinical practice. Discussions around spiritual concerns need to be part of holistic care. Personal background can be a help or hindrance. Suggest need scenarios to work through. Importance of reflection and teachers to raise issues	They didn't state any but People who's English was weak may have been excluded. 2 of the institutions were Christian based	Some similar ideas to what I'm finding, no role models and don't know what to say.	Professional relationship Attributes to provide spiritual care Spiritual assessment Opening up to spiritual care Incorporate into holistic care Personal beliefs Connection Use of scenarios Reflection on experience Role of teachers to raise issues Lack of role models
Graham (16)	2008	Thesis - EdD	Mixed methods	4 hour session on spirituality Quantitative assessment using spirituality assessment scale (SAS). Phenomenology interviews using open questions	24 students did pre/post intervention SAS scale. 12 students undertook the interviews. Christian nursing School in USA		Five themes: -Nursing students' personal spiritual beliefs -spiritual interventions -assessing patients' spiritual needs -personal beliefs impacting nursing care -spirituality in nursing education No difference in pre and post scores on SAS – no difference in feeling prepared	Suggests more emphasis needed on spiritual domain in nursing education. Highlights Fowlers 4 th stage of faith development occurs 21-30 so these students may not have fully developed their own views. Holistic model not reinforced in practice. Recommend workshop to address competency and education on assessment , more emphasis in practice setting	Only 'senior' nursing students invited to participate. All female, all white. Limit may be the methods of teaching which was DVD, PP, small group discussion and reading. Age range 21-40 Average 23 yrs.	Used Watsons theory of human caring as theoretical framework. Linking body, mind, spirit with spirituality at centre p9	Personal beliefs Spiritual care interventions Spiritual care assessment Lack of role models Clarify concepts of spirituality in nurse education Feeling unprepared Use of participatory methods

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Graham (16) continued									Notes SAS assumes a belief in deity.		Living spiritual care in practice
Hoffert, Henshaw, Mvududu (17)	2007	Journal	Quasi experimental	90 minute seminar that introduced client spiritual assessment tool (CSAT) followed by self-assessment questionnaire	Convenience sample of 38 First year nursing students completed survey. Administered pre and post at 4 week interval	SPSS (?version)	Results showed that there was a statistical difference between pre and post test scores not affected by age, ethnicity, religious affiliation, previous education level	Spiritual care complex and requires education and experience to aid confidence and competence. Need commitment to develop content, experience and reflection on spiritual care. Vital to holistic practice. Organised programme helpful	35 students female. 76.9% white, 12.8% Asian, 7.7% Hispanic. 71.8% identified as a Christian denomination. This was at religious private affiliated university	Watsons Theory of caring as theoretical framework	Seminar effective Holistic care
Iranmanesh, Tirgari, Cheraghi (18)	2012	journal	Development and testing of questionnaire validity and reliability	questionnaire	200 questionnaires to nursing students – 98% response rate. 80% female. All aged 20-29yrs	SPSS v17	96.6% said experience God daily in their lives. 79.9% had daily religious activities such as pray. Spiritual care is about meaning and hope. Spiritual care is about connection, presence, support, listening and relationship. Meeting patients as religious being – should place prayer book near patient and inform patients how to worship.	notes in Iran that many patients believe illness is a test from God and 99% of the population say they are religious. Thus the significance of spiritual care is very high and linked to coping with disease. Need to take note of each person's unique spiritual needs. Recommends students have opportunity to reflect on perceptions, experiences and attitudes	Performed in Iran where Islam dominates and religion seen as important. Very different to UK/ Western culture where spiritual needs as seen in the private domain - ?transferable	?need to look at western culture and eastern cultures separately when studying education but we may be able to learn from each other and might need more cross over of ideas	Connection and presence Personal religiosity Meaning of illness Meaning of spiritual care Coping with disease Unique spiritual needs Reflection

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Iranmanesh, Tirgari, Cheraghi (18) continued							Meeting patients as being with autonomy – so they could decide what spiritual care and whether from nurse or family				Patient autonomy
Kenny & Ashley (19)	2005	Journal (child)	Not specifically stated - Survey	Questionnaire based from adult literature. Space for comments. Left with cohorts after teaching	Undergraduate child nursing students in UK university. Not first or last semester. 21 responses (21%)	SPSS descriptive statistics. Qualitative comments themed	Students with religious affiliation more aware of spiritual needs. Family main driver in child nursing for spiritual care. Identified that education important and practice experience.	Important insights from adult but need to develop child focus understanding to inform educational approaches. Family often inform spiritual care in the child. Need self-awareness, reflection and communication skills. Child development of spirituality may not be accurately reflected in models available. Thinks reflexivity important as children constantly changing.	Recognised poor response rate. Demographics of respondents not stated. Themes from comments not clearly stated.	Only research found so far on child pathway. Highlights the role of family centred care (again a way of holistic care for children)	Personal spirituality affects awareness Family centred Education needed Needs practice experience Reflection Self-awareness needed
Lovanio, Wallace (20)	2007	journal	Quantitative	Pre/post-test design Used spirituality and spiritual care rating scale (SSCRS). Intervention included ½ day education, prayer, presence, chapel visit, reminiscence	10 second year student nurses (pilot study) USA 1 male, 9 Caucasian, 1 Hispanic. Pair with residents from faith based long term home.	Paired t tests	Agreed that spirituality does not only apply to religion. Students changed their views about spirituality particularly around connecting with people, morals and being at peace.	Focused on holistic needs of clients when addressing spiritual needs. Involved students in spiritual care giving.	The pre and post test scores are not hugely different to me but recorded as significant. As such a small sample difficult to say this isn't just chance (state as limitation).	This study tries to put theory into practice – not sure how achievable this is in reality and how much support needed from mentors to do this.	Spirituality applies to all Holistic approach Connection Moral development Being at peace

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Lovanio, Wallace (20) continued					Students encouraged to implement strategies with residents				Not clear the faith of the students but comments suggest that they did believe in God. Done with older adults so may not be generalizable to other patient groups		
McSherry et al (21)	2008	journal	Exploratory longitudinal design	Tracked students through a 3 year pre-reg course. All branches, adult, child MH and LD included Spirituality and spiritual care rating scale (SSCRS) used. Added questions about ethics	135 took part (76.7% response rate). Largest was adult. 16 males. 37.3% aged 18-20 yrs	SPSS v14.0 t-tests, Pearson correlation	Majority see spirituality as associated with existential. suggests that nursing students were opposed to religiosity (but I think the comment more says that they don't associate spirituality with only the religious rather than being opposed to it – need to review scale!). Most thought spirituality should be taught as part of nursing course.	Suggests women less tolerant of religiosity than men but small number of men in sample. Suggests the more educated you are the less concerned about spiritual matters. Students seems to think its OK to share views (not to keep to themselves) but should be able to hold their own views even if others disagree with them. Won't disclose to client if will cause upset	Only one cohort of students and not clear why people did not respond. Moral issues are much wider than this paper addresses.	Based on the old NMC 2004 statement. Exaggerated effect as few men in sample. Looks like this was undertaken in Hull	Spirituality as existential phenomena Education on spirituality needed Respecting personal beliefs Professional values

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Mooney & Timmins (22)	2007	Journal NET	Qualitative – looking at learning about spirituality through art	Visit art gallery and select one picture they perceived as spiritual and give subjective reasons. Focus group to discuss this using open questions. Notes taken by researcher re non-verbal aspects	2 nd year nursing students in Ireland- 21 took part in 4 focus groups. Recorded and transcribed.	Thematic	5 themes -recognising spiritual dimensions of everyday life -a snapshot of spirituality through others' impressions of art -developing a deeper awareness of the meaning of spirituality -spirituality transcends traditional religions -spirituality enhancing the nurses' role	Recognised that from a country entrenched in Catholicism. Noted that lectures had broadened understanding of spirituality. New awareness of spirituality through art so thinks this should be further explored.	Small sample, subjective view recognised.	Doesn't state the nurses religious beliefs and, as Ireland, Catholic does dominant. However, not clear if the nurses were practising the religion and an assumption that Ireland entrenched in religion as attitudes may be changing	Every day spiritual dimensions Art to explore spirituality Meaning of spirituality Existential spirituality Enhancing professional role
Moss (23)	2007	Thesis – abstract only	Qualitative - interpretative phenomenology	Semi-structured interviews	16 nursing students in USA one institution	Van Marten analysis approach	3 themes: -difficulty articulating perceptions of spirituality -lack of preparation to recognise and/or intervene with clients spiritual needs -permission sought by concerned nursing students to include spirituality in their study nursing practice	Need education of spirituality, spiritual awareness,, spiritual care in curricula as a first step to providing competent spiritual care		Unable to get a full text copy of thesis but felt important to include as reflects other literature	Articulating spirituality Lack of education Causes student concern

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Nardi, & Rooda (24)	2011	journal	Exploratory mixed methods	questionnaire	2 Schools in USA – one faith based and one not. Final semester students – 86 in total (50 from the faith school)	SPSS v 16.0 T test to determine differences between the 2 schools	89.5% female. 43% Roman Catholic, 36% protestant. 68.6% Caucasian, 11.6% African American. Faith based group said spiritual care emphasised in their training but only a third said this for public school. However, little difference in understanding. Almost all agreed human life is sacred but only half felt it was linked to a deity. Connecting, comfort, patient prayers all thought to help healing. Few use spirituality based therapeutic in their practice. Factor analysis found 5 dimensions: -valuing and supporting others -use of spirituality based nursing process -use of the metaphysical self -individual spiritual based actions -spirituality based outcomes	Used this to develop a spirituality based nursing practice theory. See p262 for diagram Areas – nurse spiritual awareness and spiritual actions, patient spiritual need and acceptance of actions. Nurse needs awareness of the patients spiritual needs thought N_P interaction. Thought theory could inform curriculum design	Limitations that it was senior students and needed a more diverse group. Need to test the theory	One of the few studies with some differing ethnic input.	Education affected by institution philosophy Connection Comfort Variety of spiritual interventions help healing Lack on implementation in practice Support Valuing others Spiritual nursing process Use of self Individualised Spiritual actions and outcomes

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Purdie, Sheward, Gifford (25)	2008	Journal NEP	Qualitative	Reflective diaries and focus groups about a placement taking sick/disabled people to Lourdes	6 third year students UK	Thematic	4 themes: -Perceptions of caring. -Interpersonal skills. -Spirituality (personal). -Trust Noted that students self-awareness increased	Recommend that pre reg programmes should consider such placements as boosted confidence, listening, ability to develop relationships. they felt it increased caring and compassion.	Placement took place in 2005	Aim was to develop holistic skills. Seems that alternative placements are a good way to develop awareness. ?students had an particular interest in going to Lourdes (selection bias) How the theme of 'spirituality' developed is vague in the article.	Perception of caring Interpersonal skills Trust Awareness of spirituality Increased self-awareness and confidence Value of spiritual placements Increased interpersonal skills Increased caring and compassion
Riklikiene et al (26)	2016	Journal NET	Descriptive Cross sectional study National survey	Questionnaire around professional values and spiritual care. Open ended responses included	6 colleges and 3 universities in Lithuania that train nurses included. 316 nursing students 3 rd /4 th year (80%) and 92 nurse educators (69.7%) 148 students completed open ended question on spiritual care (46.8%)	SPSS 13.0 Qualitative data using thematic content analysis	Students who considered themselves religious also valued it more within professional aspects. Themes from students: -attributes of spiritual care -advantages of spiritual care -religiousness in spiritual care -nurse-patient collaboration & communication	Recognises complexity of spiritual care with character, behaviour and social skills, values and attitudes. Felt that younger students grew up in non-Soviet environment and may explain the differing view of older educators in the study.	Noted that Lithuania had restrictions on spiritual expression during soviet occupation. Survey translated into Lithuanian. Most students female, age 24yrs	The attributes that this paper talks about are often associated with nursing or expected in nursing. Quite an existential view of spiritual care expressed in the paper.	Personal beliefs Spiritual care attributes Benefits of spiritual care Religiousness Relationship

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Riklikiene et al (26) continued										Hints that self-awareness and personal faith important but needed more detail	
Ross et al (27)	2016	Journal NET	Cross sectional, multinational , correlational survey	Questionnaires looking at perceived competence in spiritual care. Self-assessed demographics, spiritual wellbeing, spiritual attitude, spiritual care rating scale and competency scale.	Convenience sample. Undergraduate nurses/midwives . 531 (86%) response in 6 universities across 4 countries Netherlands, Norway, Wales, Malta. institutions 3secular, 3 religious	PSAW v18	Those who saw themselves as competent had a broader view of spirituality/spiritual care. Students who were religious, undertook religious activities and had high spiritual wellbeing score perceived themselves to be more competent.	How do educators enhance spiritual care competency in students who are not religious and encourage those with narrow view to have broader perspective. Students who had broad view, were involved in art/nature/ meditation had more perceived competency. How to develop that view in nursing – is it taught or caught? Suggests personal factors , values/beliefs, may be significant	85% were female, 95% in the first year so will they feel less competent anyway. All less than 20 yrs old! 87% said Christian, As first years not much teaching on spirituality so not much difference between the universities	My study is trying to look at what changes students understanding (so might widen their view). Malta is seen a RC dominated others are not.	Competency widens spiritual view Challenge to widen student view Personal spiritual beliefs adds competency Influence of personal values

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
Seymour (28)	2006	Thesis (via EThOS)	Qualitative case study – exploratory and descriptive	Nominal group technique, reflective journals or reflective group interviews, evaluative questionnaire. Pre-reg in 3 rd year given short course in one day. Pre-reg in 4 th year, MSc students and staff given short course over 2 weeks	54 participants: 38 –pre reg in 3 rd year. 6 pre reg in 4 th year 5 on MSc 5 were staff	Constant comparative analysis	Four themes: (i) Beliefs and values about spirituality and attitudes towards spiritual care, (ii) The language of spirituality and spiritual care, (iii) Telling spiritual stories: Biographical and autobiographical accounts, and (iv) Learning about spirituality and spiritual care. These areas were represented as uncovering the spiritual dimension through spiritual education.	Notes spiritual dimension is hidden and lacking in answers, has individual and collective aspects, links emotional to spiritual. Spiritual beliefs challenged by suffering and need embedding in ethical principles. Communication for confidence and reassurance. Spiritual practices form of therapeutic healing, spiritual needs of staff. Teaching widened understanding but not reflected in practice to discuss spiritual care. Learnt from other student experiences. Reflection aided self-awareness. Recommends setting up similar course and educating lecturers to teach the subject area.	Very homogenous group as taught differently and different prior experiences. Undertaken in Scotland. Small sample and poor response rate to evaluative questionnaire about programme (61%). Notes reluctance to share spiritual care issues in practice although does happen in classroom.	She saw spiritual knowing as part of holistic care (?an assumption)	Beliefs about spiritual care Language of spiritual care Spiritual stories Emotional and spiritual linked Education on spiritual care Ethical principles Communication Peer learning Spiritual care not discussed in practice Reflection
So & Shin (29)	2011	Journal of Christian nursing	Phenomenology	Student did practicum which chaplains led and participated in-depth interviews. Open ended question	12 students in Korea. Was a Christian nursing school with mixture of faiths. All 12 were Christians.	Colaizzi's method	(p231 has full diagram of categories and themes) 1 – Burden – unfamiliarity, perplexity 2 – helplessness – limitedness, scepticism, emptiness	Think educating in spiritual care and giving practicum helped change them from passive to active in providing spiritual care. Also felt it was important for holistic care.		A lot in the paper about praying with patients which would not be culturally acceptable in UK	Chaplain led practicum Uncomfortable about response to spiritual care Unsure if they make a difference

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
So & Shin (29) continued							3 – improvement of coping skills – empathy, removal of prejudice, cordial communication, distinctive approach 4 – self-reflection – insight, forming a network of mentors, self-development 5 – spiritual growth – service, spiritual experience				Aids holistic care Opportunities for reflection Build relationship with client
Taylor et al (30)	2009	Journal	Pre-experimental design	Pre/post-test questionnaire and administration of self-study learning package (DVD & workbook) around spiritual care Collected June 2006-Jan 2007	Included Baccalaureate nursing students and registered nurses. Mostly from one religious USA university. Total 201 participants	Descriptive statistics and repeated measures of analysis variance (RMANOVA)	Students perceptions and attitudes increased more than RN. No other significant changes. Prior education on spiritual care meant that there was less difference in pre and post scores.	Felt that the programme supported the increased ability to talk to patients about spiritual care. Particularly helped with attitude and empathy. Frequency of attendance at religious activities / spiritual experience contribute to their attitude.	Self-reported. \$100 incentive for students to participate! Questionnaires posted back. Majority female, white American. Was difficult to determine which group people were in so not separated into RN and student.	Again, seems to support the need for self-awareness about own spirituality position.	Teaching changes students attitudes

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
Tiew & Drury (31)	2012	journal	Qualitative – around perceptions and attitudes to spiritual care in practice	In depth interviews – guided open questions- 1:1 Reflective notes post interview by researcher	Final year nursing students in Singapore. 3 nursing schools. 16 participants – 6 males	Miles and Huberman inductive analysis method.	themes: -Students perceptions of spirituality -spiritual care -factors influencing spiritual care in practice Spirituality linked to holism. Students felt inadequate to provide spiritual care. Noted lack of education as focus on biomedical aspects. Ward staff influenced whether spiritual care seen as important.	Highlights the complex nature of spirituality which is highly individual and influenced by upbringing/ culture. Noted the importance of self-reflection (time and space) for the students. The importance of spiritual assessment to aid spiritual care mentioned. Suggests employing chaplains to teach about spiritual care	Mainly Christian participants – don't state numbers that were atheist, Buddhist and Muslim (although say there were some). Risk of giving socially desirable responses.	Need for reflection and education again highlighted. Findings similar to Western cultures.	Perceptions Complexity of spiritual care Factors influencing practice Self-reflection needed Part of holism Spiritual assessment needed Education focused on biomedical Role models in practice needed Role of chaplains to educate
Tiew, Creedy, Chan (32)	2013	Journal NET	Quantitative -Descriptive Cross sectional survey	Data collected, demographic and spiritual care giving scale which has 35 items on 5 areas: attributes, perspectives, defining, attitudes, values	Final year pre-reg nursing students in Singapore from 3 institutions. 745 responses (61.9%). 86.4% were female. Convenience sample. Submitted anonymously	SPSS v 17.0 Descriptive statistics, Pearsons correlation, t-test, ANOVA	High agreement that trusting nurse patient relationship needed for spiritual care; thus spiritual care is relational. Spiritual care seen by most as a process. Spirituality important part of being human. No real differences between age, gender etc but was a difference between diploma/degree and institution.	High level of spiritual awareness not affected by age. Importance of spiritual assessment to address spiritual needs. Spiritual values embeds caring, compassion,, engagement with people. Importance of developing spiritual awareness (they felt these students had good awareness despite age being median 21yr).	Recommends using comparative studies across different countries. This study had roughly 20% for each religion.	This study drew on the Tiew & Drury 2012 study to develop scale.	Nurse patient relationship Spiritual assessment Values important Spiritual awareness Spiritual part of being human

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
Tiew, Creedy, Chan (32) continued								Existential view dominates. Suggests that spiritual care not enforced in one institution so explaining differences.	Stating Christian, Muslim or Buddhist so a better range of affiliation present . Also good ethnocultural mix in this study		Institution affects embedding of spiritual care
Tomasso, Beltrame, Lucchetti (33)	2011	Journal (translated)	Quantitative – cross sectional	Self-applied questionnaire. Included demographic, religious/spiritual of participants, clinical practice experience and education received on topic	One university in Brazil in 2010. 30 professors and 118 students (all years) included. Says mainly women but % not stated.	SPSS v17.0 Chi squared	Mainly Caucasian in all groups. 'Most' have religious affiliation (doesn't say % or which religion). Most felt comfortable to ask about spiritual needs but did not feel prepared educationally to meet needs. 45% said never been taught it . God/religious came top of concept of spiritual with meaning & significance close second. Biggest fear was about imposing their own beliefs (46.6%) and time (23%).	Sees spiritual care as important for holistic care. Thinks spirituality lacking in curriculum. Participants did not address spirituality in practice although studies show important to patients. Notes that the students had a 'religiosity' view rather than a more 'spirituality' view as God top, they felt that was related to lack of education about the topic incorporating holistic care.	Doesn't state dominant religion/s (?RC as Brazil) . As spread of students may have been taught later in course causing high 'not taught' answer. One point in time – didn't follow students to see if views changed with education.	God being top of spiritual concept may reflect religious culture of Brazil	Part of holistic care Feeling unprepared to meet spiritual needs Spiritual care not seen in practice Poor understanding leads to limited conceptual view Concept is religious focus Fear of imposing beliefs Lack of time

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
Valizadeh et al (34)	2012	Journal	Qualitative – descriptive, exploratory	Semi-structured interview	18 Iranian nursing 2 nd year students from different universities in 3 cities (unclear how many). Looking at teaching spiritual care in Islamic culture by Muslim students. Iran has 4 year BSN (11 students included) and 2 year associate degree (7 students included) for nursing.	Thematic – constant comparative analysis	2 Themes: -religious beliefs about humanity, nursing and caring...Nurses very open that their beliefs influence the way they care for patients; their caring is due to there beliefs. Presence, communication, prayer, companionship, peace are key -cultural barriers to spiritual care – notes the cultural that women can't touch men and visa versa so limits ability to comfort and support	Notes cultural barriers to spiritual actions. Wanted to recognise their patients' spiritual needs but felt providing such care was difficult. Religion and spirituality entwined in Iran nursing profession. Need sex appropriate training programmes on spiritual care. Suggests following Quran teaching to guide education	Difficult to understand analysis process. Why only 2 nd years – does not state how many men/women in sample but obviously included both from transcripts included.	Notes that literature dominated by Western and Christian view and this looks from Muslim stance. No difference between religion and spirituality in Muslim beliefs	Beliefs affect personal approach to care Relationship attributes Incorporate Cultural issues into education Cultural barriers to spiritual care (note lack of literature from Muslim perspective)
Van Leeuwen et al (35) NOTE papers 35 & 36 report on the same study/ intervention	2008	Journal	Quasi-experimental cross over design (pre-post-test) .	Students assigned intervention or control group. Intervention group given 6 weeks programme on spiritual care whilst on placement; control group did education programme later.	97 nursing students from two Christian nursing school in Netherlands . 49 intervention: 48 control Only 2 males 99% members of church or faith community.	Statistical - regression	Showed little difference but those on clinical placement showed increased scores on assessment, professionalism and communication aspects of SCCS and they did increased score in one of the vignettes	Felt that the effects take a long time to be incorporated into the student competency. Suggests education should focus on the professional aspects of spiritual care as other areas are already covered (such as communication). Felt that students still poor at recognising implicit spiritual aspects rather than religious ones (explicit).	Intervention and control group may have some intermixing and sharing ideas but having one on placement might minimise this (they recognise risk of contamination).	Education included about spiritual care, communication skills and self-reflection. Says place for spiritual care education needs debate within nurse education	Placement aids assessment Placement aids communication Difficulty recognising range of spirituality Placement helps learning spiritual care Systematic approach to education needed

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
Van Leeuwen et al (35) continued				Tested at various points using spiritual care competency scale (SCCS) and assessing using vignettes				Felt that clinical placement offered richness to learning spiritual care. Felt needs to be systematically covered in curriculum.	These students seem quite committed Christian and not reflective of secular nursing students		
Van Leeuwen et al (36) NOTE papers 35 & 36 report on the same study/ intervention	2009	Journal NET	Qualitative	Review of reflective journals written for guided thematic peer-review sessions.	Part of an educational programme used in 2 Christian nursing schools in Netherlands. 3 rd year students took part. 39 students utilising 203 written journals. Students were committed Christians with most having weekly church attendance	Key labels & dimensions identified using Baarda et al method and Kwalitan software.	Key labels: -use of self-respect in relation to personal and contrasting spirituality -handlings ones' own spirituality -coping with feelings of uncertainty -role of personal life experiences -dealing with contrasting faiths -provision of spiritual care -recognitions of spiritual issues (small things important) -attitudinal aspects (attentive/ respect) -nursing interventions -nursing responsibilities for spiritual care -organisational aspects of spiritual care -attention to spiritual care in the nursing process -colleagues	Felt that reflection was important to gain self-awareness and to embed the concepts of spiritual care from a course of education. Felt that nurses who were not spiritual were less likely to address spiritual needs or be aware of them (but ? where this came from as most in the study had a spiritual side).	Recognised that the sample could be bias and not reflecting the country which is multicultural and multi ethnic.	Based on experiential learning theory. Looking mainly at whether the peer review of journal process aided understanding of spiritual care and seemed positive. Talks of Cone's (1997) 3 stage model of spiritual care and that stage 1/ 2 is professional responsibility and stage 3 not for all nurses.	Self-respect/awareness Dealing with own spirituality Reflection Emotional aspect Personal experiences Dealing with contrasting faiths Provision of spiritual care Little things make a difference Professional responsibility Organisational factors Developing personal attributes

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/Recommendations	Limitations	Comments	THEME
Van Leeuwen et al (36) continued							-the learning effect of guided thematic peer-review -gaining awareness -developing confidence -change orientated attitude				
Wallace, Campbell, Grossman et al (37)	2008	Journal	Quantitative	Pre and post-test after integration of spiritual curriculum. Used spirituality and spiritual care rating scale. 13 junior nurses did qualitative questions too	Junior (n33) and senior (n34) undergraduate nursing students	Paired t-tests for pre and post scores	Significant differences for the senior students only. Juniors showed some development of different ideas around what is seen as spirituality.	Study supports the inclusion of spiritual issues within the curriculum. Suggests should be included as part of holistic care.	Not clear who was seen as junior or senior students. Small sample size and senior had more complex clinical exposure which may explain differences	Study from USA	Need for spirituality in curriculum Part of holistic care Experience affects spiritual understanding
Wigley (38)	2013	Thesis (via EThOS)	Glasarian grounded theory	2 phases: Focus groups and then individual interviews; theoretical sampling of literature and media	8 pre-registration nurses	Constant comparative analysis – identifying core concepts	pre-registration nursing students' awareness of spirituality can be explained in three main Basic Social Processes [BSPs]: struggling, safeguarding and seeking. theory that emerged from the findings: a theory of <i>carrying hope</i>	Recommendations from this study include the identification of role models in clinical practice and the implementation of a model of pastoral care for tutors supporting pre-registration nursing students.	Data collected between 2008-2013 2 focus groups with only 2 people in each. Poor response rate. Only from one intake diploma/degree.	Not clear whether these were a particular pathway or only common foundation.	Role models in practice needed Support for tutors Social processes to deal with spiritual care

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/ Recommendations	Limitations	Comments	THEME
Williams, Voss, Vahle et al (39)	2016	journal	Quantitative – pre-experimental design	Start and end of semester completed spirituality and spiritual care rating scale after using FICA spiritual history tool in practice	31 nursing students- convenience sample of first year students – 2 males. Age 18-45 Collected demographics and knowledge of FICA	SPSS v21 T tests	Vast majority were Christian/Catholic students. 97% were white. Not statistically significant differences in pre/post FICA or SSCRS scores	Recognised that first year students did not improve in spiritual care using tool but suggest that might need to focus on self-reflection to make students consider the ‘uncomfortable’ situations in spiritual care. Recommend more structured teaching on communication/ spiritual care. Suggests longitudinal study at start and end of course	Did not state if any male participants. Most students had a religious affiliation but the students were from a Catholic and Christian college	Study from USA FICA – Faith 7 belief, Importance & influence, Community, Address in care	No change when using history tool Opportunities to deal with uncomfortable spiritual issues Structured teaching approach
Wu, Liao, Yeh (40)	2012	journal	Cross sectional descriptive design	Survey questionnaire	Final year or Senior nursing students in 22 schools in Taiwan. 239 (91.9%) response rate. 114 men: 125 women	ANOVA	45.6% no belief, 20.5% Buddhist 34.3% taken a course is spiritual care in nursing school. 46.4% had been taught about spirituality. Spirituality does not only apply to religious people. Agree there is existential aspect to spiritual care. More training increased the students perception level about spiritual care.	Found uncertainty about aspects such as listening, respect, kindness but the students had very little clinical experience. Gender impacted on spiritual care scores (don’t clearly explain how). Students did not feel prepared to deal with spiritual care. Recommends importance of teaching this aspect. Perception of spiritual care higher if person had interest in nursing career. Need to address attitudes to spiritual care too.	Used Chinese version of Spirituality and spiritual care rating scale. Age range 19-22yrs so all very young! Noted small sample size for this type of study.	Why such as high response rate? One of the few studies where Christianity does not predominate. As young may not have developed spiritual awareness. Would clinical experience increase awareness?	Feeling unprepared Spirituality is existential Training to increase awareness Spiritual care attitudes

Author (number)	Year	Publication type	Methodology	Methods	Sample	Analysis	Key findings	Discussion/Recommendations	Limitations	Comments	THEME
Yilmaz & Gurler (41)	2014	Journal	Quasi-experimental post intervention two groups design	Spirituality and spiritual care rating scale (SSCRS) used. Intervention group had more interactive methods such as discussion, case study, observation.	130 volunteer senior students (85% response rate)– assigned to control or intervention group (one cohort followed by next). In Turkey. All women but similar age, gender and culture/ beliefs in the two groups	SPSS v14	Intervention group had higher scores than control, particularly knowledge improved. Suggests that spiritual care not translated into practice. Intervention group better at diagnosing spiritual distress. Control group had higher scores on religious aspect but not clear if intervention group saw a more encompassing view of spirituality to explain this difference.	Spirituality should be more widely included in curriculum and use an integrated approach throughout the curriculum. Notes hard to learn from role models in clinical practice as isn't many for spiritual care. Difficult for students to understand as abstract concept.	Conducted in 2009-10/ 2010-11. Students completed forms in class time (may feel coerced) Mean age 21.8 yrs (young). Not clear what a 'senior' student was.	Notes that Turkey seen as secular country with many ethnic groups. Islam is common religion and spirituality often related to religious belief. Used Gordons Functional Health Patterns (FHPs) to integrate spirituality into curriculums (see p931 for explanation)	Participatory teaching methods helps understanding Theory practice divide Integrated approach to teaching spiritual care Lack of role models in practice Difficulty grasping abstract concept

Appendix 5 - Thematic Analysis of Literature

Theme	Sub themes	Paper number relates to Appendix 4 list
Integrating spiritual care into curriculum (structured and systematic)		1,2,4,7,8,19, 21, 23, 28, 31, 35, 37, 39, 41
	Benefits of spiritual care	1, 6, 26
	Knowledge development (EBP to wider view, religious focus, T-P divide) Use of seminars	2,8,10, 12, 17, 24, 28, 33, 41
	Definition and meaning of spiritual care (and meaning within education, language)	4,5, 16, 21, 22, 23, 26, 28, 40, 41
	Assessment skills	4,8, 15, 16, 31, 32
	Role modelling in university (challenge)	4,7,9, 15, 27
	Constructionist approach needed (participatory, peer Use of simulation Use of art/stories)	9, 12, 13,, 16, 22, 28 , 41
	Institutional philosophy affects incorporation (support of tutors, faith perspective)	24, 32, 38
Self-awareness around spirituality issues (in every day life, education helps)		2, 3,4, 8, 15, 19, 22, 25, 30, 32, 36, 40
	Attributes required for spiritual care (presence, self confidence, connection, communication, morals, comfort, trust, interpersonal, peace, social processes, attitude	5,7,8, 13, 14, 15, 18, 20, 24, 25, 26, 33, 34, 36, 38, 40
	Concerns about providing spiritual care (overwhelmed, role perception, unprepared, helpless, burden, time, imposing beliefs)	5, 11, 12, 16, 23, 29, 33, 39, 40
	Reflection needed	6,7, 11, 15, 18, 19, 28, 29, 31, 35
	Personal beliefs (Respecting, aids competency, personal values, experiences)	7, 15, 16, 18, 19, 21, 25, 26, 27, 28,34, 35
	Involve chaplains in teaching	13, 29, 31
Spiritual as part of holistic care		2, 5, 7, 8, 15, 17, 20, 29, 31, 33, 37
	Awareness of patient individual spiritual needs	2, 4 ,10, 18, 24
	Living spiritual care in practice setting (patient autonomy place of prayer, interventions, use of self, not seen, little things may a difference, role of experience)	16, 18, 24, 31, 33, 35, 36, 37
Competency in spiritual care		9, 12, 16, 27, 35

Theme	Sub themes	Paper number relates to Appendix 4 list
	Emotional competency (peace)	11, 20, 28, 35
	Understanding religious/cultural factors /placement in faith community, contrasting faiths)	11, 19, 25, 34, 36
	Professional role (relationships , values, caring)	15, 21, 22, 24, 25, 26, 29, 32, 36
	role models needed in practice	15, 16, 28, 31, 38

Appendix 6– Semi-structured Interview Guide

Practical aspects

Welcome the student. Gain consent for interview/recording.

Remind student that it is their experience, no right/wrong answers. The student will be reminded to adhere to the NMC Code and Student Code of Conduct e.g. confidentiality

The following questions and prompts would be used to trigger discussion around experiences that are important to the student.

1. Demographic –

Thank you for agreeing to participate in this study. For the purposes of the recording could you start by saying which nursing pathway you are studying and what year you are in please?

2. Preunderstanding

I wanted to start by asking about any terms you have heard related to spiritual care. Prompts: spirituality, religiosity, religious needs, spiritual needs.

What does the phrase 'spiritual care' mean to you? (explore their answer)

3. Lived Experiences

I would like to know your experiences about spiritual care you have had during your nurse education. Prompts: in lectures, in practice, how developed their learning/practice, role models, attitudes.

4. Factors affecting learning

I'd like to know about any aspects that have helped or hindered you around spiritual care. Prompts: lecturers, mentors, patients, practice issues, context,

5. Transformation

Finally, would you like to outline what the most important experiences that developed your learning about spiritual care. Prompts: personal awareness, peer/family factors, any personal spiritual/religious preferences, beliefs about its importance for clients

6. Conclusion

Those are all the questions I have for you but is there anything that you think is important that we have not covered about learning spiritual care as a student nurse?

Thank you for taking part.

Appendix 7 - Ethical Approval Letter



24th August 2016

Ref: 16/FHW/16 003

A Price
School of Nursing
Canterbury Christ Church University

Email: ann.price@canterbury.ac.uk

Dear Ann

Project Title: Exploring how undergraduate student nurses develop their understanding of spiritual care

Your application was reviewed by the Faculty of Health and Wellbeing Research Ethics Committee panel on 27th July 2016. The Committee agreed that the conditions set out in my email of 5th August 2016 should be met before final approval could be given.

As Chair of the Committee, I am content that these conditions have now been met in full, and I am writing to give formal confirmation that you can commence your research. Any significant change in the question, design or conduct of the study over its course should be notified to me as Chair, and may require a new application for ethics approval. You are also required to inform me once your research has been completed.

With best wishes for a successful project.

Yours sincerely

A handwritten signature in black ink that reads "J.A.E. Melville - Wiseman".

Dr Janet Melville-Wiseman
Chair, Faculty of Health and Wellbeing Research Ethics Committee
Tel: 01227 782116
Email: janet.melville-wiseman@canterbury.ac.uk

cc: Joanna Candler, Research and Innovation Assistant

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Professor Rama Thirunamachandran, Vice Chancellor and Principal

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Appendix 8 -Invitation to Participate in Research Study
(for blackboard and email)

**Title of Research: Exploring how undergraduate student nurses develop their
understanding of spiritual care**

All nursing students, from all pathways (Adult, Child and Mental Health) and years (1st,2nd and 3rd), are invited to participate in a research study to explore experiences that developed understanding of spiritual care. These experiences may be part of university time, practice activities or personal understanding.

If you agree to take part, you will be asked to attend an individual meeting to discuss your experiences and explore these. Please see the attached participant information sheet for more details.

You will not be required to disclose any personal information about your spiritual/religious preferences or beliefs.

If you wish to know more about the study please contact Ann Price (Researcher) on 01227 782608 or email ann.price@canterbury.ac.uk.

Appendix 9 – Participant Information Sheet

Exploring how undergraduate student nurses develop their understanding of spiritual care

PARTICIPANT INFORMATION SHEET

A research study is being conducted at Canterbury Christ Church University (CCCU) by Ann Price as part of a Doctorate in Education programme.

Background

Spiritual care is seen as integral to holistic nursing practice. However, it is unclear which experiences assist students to learn about spiritual care during their nurse education. This study will explore experiences that you may have had which has influenced your understanding of spiritual care.

What will you be required to do?

If you agree to take part in this study you will be invited for an individual interview which will be recorded and transcribed with your permission.

To participate in this research you should be:

- an undergraduate student from the following pathways - Adult, Child or Mental Health nursing, at Canterbury Christ Church University at the time you are interviewed
- willing, of your own free will, to be interviewed at an agreed time convenient to you and your studies
- willing for me to record the interview for ease of transcription.

Procedures

You will be asked to undertake the interview at a mutually convenient time agreed with the researcher. This will be undertaken at a venue agreed with you, normally on campus, and will be arranged to fit around your study commitments. Interviews are expected to last about 1 hour and will be held in a private room.

Feedback

You are welcome to have a copy of my report, and/or abbreviated summary, which will be available via Blackboard at the end of the study. If you have left the university before the study's completion, you can leave a contact email address to receive information if you wish.

Confidentiality

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by Ann Price, Stephen O'Connor (supervisor), Trevor Cooling (second supervisor). Data will be made anonymous (i.e. all personal information associated with the data will be removed) at the time of transcription and an approved person may be used to transcribe recordings.

You are expected to adhere to the NMC Code (2015) and Code of Student Professional Conduct (2015) during the interviews and asked to give any information about patients, staff or work places anonymously.

Dissemination of results

Results will be made available to all students via Blackboard. Results will also be submitted for inclusion in conference proceedings and for publication in journal/s.

Deciding whether to participate

You are not required to share any personal, spiritual or religious preferences/beliefs in this study. The focus of the study is around your experiences of learning that has affected the spiritual care you might provide to patients/clients.

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me. Should you decide to participate, you will be free to withdraw at any time without having to give a reason.

Participating in, or withdrawing from, the study will not affect your course and will not be recorded on your personal file.

Please contact Ann Price (details below) if you are interested in participating in this study. Please note that recruitment of students is on a 'first come' basis and will cease once enough information has been collected.

Any questions?

Please contact Ann Price on 01227 782608 or ann.price@canterbury.ac.uk or write to Ann Price, School of Nursing, Canterbury Christ Church University if you have any questions or are interested in participating in this study

Ethics Approval Number 16/FHW/16 003

Appendix 10 – Consent Form

Title of Project: Exploring how undergraduate student nurses develop their understanding of spiritual care (Ethics Approval 16/FHW/16 003)

Name of Researcher: Ann Price

Contact details:

Address: School of Nursing, Canterbury Christ Church University, North Holmes Road, Canterbury Kent CT1 1QU

Tel: 01227 782608

Email: ann.price@canterbury.ac.uk

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and this will not affect my academic record.
3. I agree for the interview to be audio recorded to enable ease of transcription
4. I understand that any personal information that I provide to the researchers will be kept strictly confidential and recordings will be anonymised during transcription process to enable this
5. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Copies: 1 for participant 1 for researcher

Appendix 11 - Extracts of Personal Reflections

Example 1 – 26.6.2016

I had not ever thought about Jesus as a teacher affecting me as a Christian teacher. The speaker at this conference talked about Jesus principles and practice of teaching and I realised that it mirrored my own values in teaching around constructivism. Jesus linked his teaching to background and experience:

- He used parables (scenarios) to unpick complex situations
- He used examples to develop understanding
- He challenged and came alongside people
- His message was designed to transform people
- He taught with authority and knew his subject well
- He was humble and relied on God

Reminded me that we express our faith through our actions rather than words and needs sensitivity in a secular society.

Example 2 – Participant 1 interview reflection 28.9.2016

This participant was open about being a Christian believer. It struck me that she emphasised the values of spiritual care such as dignity, feelings. She told me after the tape had stopped about a personal experience where she had needed surgery, and someone had visited her early on a Sunday (although they were not religious themselves) to remove her stitches so that she could go to chapel.

Example 3 – Participant 2 interview reflection 10.10.2016

This participant was a mental health nursing student and it fascinated me that she had not received any obvious teaching around spiritual care. The student said that my study had made her think about the topic area. It made me wonder why it is not evident within mental health nursing; were the lecturers afraid to mention it as might be considered deranged in the medicalised model?

Her interview made me wonder about how people categorise spiritual experiences and what tips an experience from being acceptable or seen as certifiable. Who makes that judgement? Is this culturally related in that what is allowed in one country is not acceptable, or even criminal, in another? Where are the boundaries and who draws them? Is spiritual care different in diverse contexts and cultures? I felt yes because some cultures encourage prayer and outpouring of spiritual fervour and some discourage it. I wondered whether spiritual care is much more entwined in our secular culture than we realise and the issue of private versus public spiritual expression came to mind.

Example 4 – Participant 6 interview reflection 9.2.2017

I thought, after today's interview, how significant experiences are, particularly practice related ones. Often these experiences are related to end-of-life or palliative care and transform the students' understanding. However, if the students don't see spiritual care delivered effectively, they may become stuck and unable to integrate into holistic care. I wondered how we, as educators, enable that learning transformation? Practice experiences are very individual and, therefore, impossible to replicate so how do educators achieve this understanding? Simulation activities seemed an obvious choice to me.

Example 5 – Participant 7 interview reflection 21.3.2017

I found this an interesting interview because her understanding of spirituality had changed as a result of teaching towards a more existential, wide view. She emphasised that each person was an individual and the *uniqueness* struck me! The spiritual is part of your unique identity – this uniqueness related to spiritual identity was, I felt, a hermeneutic insight but unsure how this will develop at the moment.

Example 6 - Reflection on my researcher skills

This reflection was recorded after completing the seventh interview for the study

I wonder whether my inexperience means that I'm not getting enough depth in the interviews as they are shorter than I expected. However, I am getting real experiences that are important to the students and they are explaining how this affected them. Maybe it is just that they do not have many experiences to draw on, they have not seen spiritual care or have not been able to relate it to themselves. Is there something here about being open to spiritual care in their learning experiences? Is this a reason why they feel fearful about dealing with spiritual issues because lack examples? Is spiritual care the "elephant in the room" because it is not addressed openly?

Example 7 – Participant 9 interview reflection 28.3.2017

I was interested that her personal history had influenced her perceptions so much. It had made her very fearful of religion imposing itself on healthcare although mindfulness and self-awareness were key to her understanding and incorporation. This interview emphasised the importance of having awareness of your own preferences and biases; that nurses need to bracket them whilst still providing holistic and inclusive care.

It made me feel that our culture is mixed up because it is acceptable to be religious but not acceptable to bring it into your job. I wondered how you can separate them? How does that affect our own being and personhood? Participant said about looking after ourselves as care givers, but I wondered how we do that if not true to yourself and personal beliefs? A conundrum!

Example 8 – Participant 10 interview reflection 2.5.2017

This student was very open about the influence of her faith on the way in which she practiced nursing but also showed the complexity about what she can/ cannot say to patients. This seemed to create some dilemmas for her about how to address spiritual needs in an honest and holistic way.

I was annoyed with myself as, despite checking the recorder battery before starting, it died in the interview and I had to change the battery. However, the participant did not seem phased by this and gave clear examples about what she had seen in practice, both good and poor.

It struck me that there are similar issues coming across the interviews although they are articulated very differently considering a persons' personal perspective and experiences. A lot of uncertainty and anxiety about dealing with issues but much eagerness to meet holistic patient needs, including the spiritual.

Example 9 – Reflection on Analysis 5.11.2017

I am feeling overwhelmed with analysis and wondering how I make this into something that is relevant and readable! However, as I was searching for information I realised that some people talk of 'spiritual intelligence' along with other intelligences. This feels relevant as the images I have found show the links with other intelligences. I am struggling with the complex web of essences in

the data to link in a meaningful way. The spiritual intelligence information I have found seems too resonant with my own data and I feel that this is missing in nurse education curricula, or barely touched on. This may give me a framework or view to discuss my findings so that they can be incorporated into nurse education. Something to explore further!

Example 10 – Reflection on spiritual intelligence ideas 18.11.2017

I was thinking that certain activities would aid learning for students about spiritual care BUT now I am thinking it is more about developing student attributes around spiritual intelligence. The students in my study all came from different positions of faith or not, but still expressed that they saw the importance of spiritual care related to experiences or wanted to understand spirituality better. So there is possibly something about seeking to develop spiritual intelligence as an indirect way to help patients with spiritual needs. This is something educators could focus on through a variety of activities, including simulation, to aid students development of spiritual intelligence and could link to emotional intelligence to aid their own personal development. Future studies could measure effects of learning activities on spiritual intelligence aspects, possibly linking with emotional intelligence or caring attributes

Appendix 12 - Conference Presentations

These are conference presentations that had been presented or accepted at time of submitting thesis.

Price, A.M. (2019) 'Spiritual intelligence as a method to improve spiritual care in nursing students'. Concurrent session. NET conference. 3-5th Sept 2019. UK: Cambridge (accepted)

Price, A.M. (2018) 'Spiritual care: can student nurses learning contribute to leading person-centred practice?' Concurrent session: Enhancing Practice Conference 22nd - 24th August 2018. Basel, Switzerland

Price A.M. (2017) 'Using phenomenology to explore student nurses experiences of spiritual care'. Concurrent session: British Association of Critical Care Nursing Conference. 4th-7th Sept 2017. UK: London

Price, A.M. (2017) 'Exploring spiritual care in nurse education: is Phenomenology the right tool for the job?' Concurrent Session: Christianity, Education and Contemporary Culture International Conference. 7th-9th July 2017. UK: Canterbury

Appendix 13 - Transcript of Participant 6 Interview

INT:

OK Thank you for agreeing to do this for me. Just to start off with and for the purpose of the recording can you just tell me what pathway are you on and what year of study you're in.

Participant 6:

I'm a third year adult nursing student.

INT:

Lovely, thank you. Now I wanted to ask you and start by just asking you what terms you've heard around spiritual care, so things like spirituality, religiosity, what do you understand by those sorts of things?

Participant 6:

Well again the concepts I've heard put around are as you say religion and culture, spirituality, even philosophical beliefs and ethics and morals. My understanding, are you asking for my personal understanding or what the word means?

INT:

Yes well both.

Participant 6:

My personal understanding of the word is that spirituality covers any of those intangible forces behind an individual's belief system and their own personal kind of code of conduct and behaviour. When I say intangible I mean for example people will not step out onto the road because they have objective evidence that they will probably be run over by a car. People won't put their hands in hot water because they have objective evidence that they will get burnt. When I say ephemeral, I mean that there is no objective evidence for it. It's a belief that's essentially a construct one way or another regardless of whether that happens to be a construct based on religion or culture or philosophical writings or code of conduct.

INT:

Lovely. So what do you understand by the terms like religious needs or spiritual needs?

Participant 6:

Well I think, in accordance with person-centred care, those things vary from person to person and just like spirituality is a very nebulous term. The terms like religious needs or spiritual needs are very nebulous as well. Really I think with the spiritual needs or religious needs are essentially comes down to what the patient says they are. Especially on the wards considering that even if the patient considers themselves religious that's a wide spectrum. When they say they are religious do they mean they are regular church goers or if they were Muslims do they pray the required 5 times a day? They might not but they may still consider themselves religious based on their own perceptions. So, really the only, I think the only way to anticipate patient's actual spiritual care and needs is to ask them what they are.

INT:

And you said that spirituality was a nebulous term, so what do you see as that encompassing?

Participant 6:

Well it encompasses so many different things. I think it really is, the spirituality really encompasses

again what the patient says and it encompasses from our own personal perceptives that we've incurred. It would encompass religious beliefs, esoteric beliefs. For example, there are people that believe in magic and spirit animals and so on. Those animistic beliefs that don't particularly identify with any one particular Deity. For example there are people who live their lives based on a philosophy for example, you have people who identify themselves as stoics or confusions. So really, it's a very wide encompassing term and it's very difficult to pin down. It's probably easier to define spirituality by what it is not rather than what it actually is.

INT:

That's an interesting thought actually. So lovely thank you. So what does based in spiritual care mean to you?

Participant 6:

Well spiritual care to me means meeting that person's spiritual needs whatever they may express those needs to be. For example if we have a Muslim patient for example then it's, who is very religious and prays times a day then it's the responsibility of the people who care for him to ensure that he is able to meet those needs whether that is something as simple as providing a basin with some water and a mat and a compass if they need it or even just knowing the particular compass direction towards Mecca and point him towards a particular wall. Or it could be something, it could be something more complex. For example, arranging for a priest to come to provide final offices for a person who believes themselves to be dying. Or it could be something as simple as someone wanting to have a, to have a religious confessor attend so they can make a confession as part of their regular every day experience. But certainly, there is no reason why people's spiritual life should come to a halt just because they move into an environment like a hospital which is very reason based in a sense, almost everything is based on evidence and research. But just because it is a very scientific environment doesn't mean there isn't room for spirituality. They have to accommodate a patient's needs.

INT:

So why do you think, why do you think that?

Participant 6:

Why do I think that?

INT:

Mmm

Participant 6:

I would love to be able to say it was because it was an aspect of nursing training but I think it was just an accumulation of life experience and being open to being a person who is naturally been shaped by their experiences to be open to all sorts of esoteric beliefs. For example, my wife is a witch. She knows she's pagan. I myself have been a member of a Christian faith in adulthood and abandoned that and eventually found that in my particular case that stoicism is a really the sort of code of conduct, not that I choose to fit my life more the opposite case that it is the particular philosophy, the code of conduct that best fits with the world we have developed over the years

INT:

So and why do you think then spiritual care is important in say a hospital environment because you sort of implied that you didn't think it was given enough credence or thought?

Participant 6:

I think in a hospital environment especially, people are most vulnerable. It's the most time in life

when people who do have a spiritual source of comfort are most likely to want to call upon it and need it. But at the same time a hospital is a very busy environment. By its very nature the people who are employed there and who work there are primarily concerned with bodily health and second to that, mental health, emotion health perhaps. Only tertiary to that would spiritual health be a priority for most health care providers. On top of that we often find that for, it's very rare in my experience to find a member of a clergy for any organisation regardless of their religion to be actually present in the hospital. Normally it's a case of making contact with the chaplain or with the volunteer. And then the volunteer then coming out. Which in itself suggests to me that is not a great deal of demand for spiritual care in a hospital which strikes me as odd. And I think perhaps that that has come about more because people's perceptions are that it is not a thing that is readily available when in fact I could be made readily available if there was sufficient demand it. So perhaps it is the case that care givers, whether they are nurses, doctors, physiotherapists, perhaps it's a case of being a little bit perceptive, perhaps noticing if a patient has anything in the environment that suggests they may have spiritual needs. For example if they were wearing a crucifix around their neck or if you notice a bible on their table then it may be worthwhile broaching the subject with the patient. It might be that many healthcare providers are uncomfortable with the notion of doing that but I rather expect that many patients would be grateful for the subject to be raised.

INT:

So why do you think people might be uncomfortable about raising it?

Participant 6:

It's one of those topics you're always taught never to mention at the dinner table. Never discuss politics, sport or religion. I often find that those are three topics that generally speaking that healthcare providers tend to avoid mentioning when they're interacting with the patients, purely because they can be a culturally engrained source of discomfort when you're speaking with someone who's a stranger. On the other hand if we come across a patient who is wearing a football top and they are lying on their bed we are usually quite happy to strike up a conversation about football even if we know nothing about it, yet it's strange we have a like contrast and dichotomy where patients who are wearing, who are obviously wearing items of religious or spiritual significance don't receive that same interest.

INT:

That's interesting. Now I'd like to know that your experience of spiritual care you've had during your nurse education. So what things have you?

Participant 6:

I've come across a couple of things. Probably one of the most difficult experiences I ever had, as a student on my very first placement. We had a gentleman who was very very poorly ill. He was in fact a pastor. He'd fallen, obviously because of reasons of confidentiality I can't go into specific details but he's fallen ill on the Saturday, been told on the Saturday evening he had perhaps a week, two weeks to live. And this gentleman had been married for less than two years and had an 18 month old child and he was very young and very very religious. And it was very difficult to watch. When his family or when members of his congregation were visiting him he was very very keen to put on a brave face and he did very well. But a tonight, especially when there was no one around to watch and he didn't have to be strong any more he really struggled. And it was a very very difficult experience to see a man in so much pain and torment, fuelled by his particular position in life. He was unable to express it. He very much needed someone to be strong for him but because of his spirituality and his spiritual beliefs he felt he had to be strong for everyone else around him. A

consequence of that, I don't think he has the death that his loved ones and himself would have preferred that he had.

INT:

Did the staff do anything or did you?

Participant 6:

Well the staff did do what they could. At the time I didn't think to suggest to him that perhaps he's want a visit from another pastor from his particular faith because at that point my experience of death and palliative care and spiritual care was really very limited. This was the first kind of scenario if you like that I'd come across where that had been a factor. In retrospect now I'm very disappointed that I didn't have the awareness to suggest that perhaps that night when he was alone and he was struggling when he didn't have the people around him that he would have to be strong for, even to offer to pass him the ward phone so that he could call a colleague and have the sort of spiritual chat, express his doubts and his concerns that he couldn't do in front of his congregation or his family. In that respect I feel that not just myself but the other staff I felt let him down in that regard.

INT:

That must have been very hard for you.

Participant 6:

It was very hard, especially more so I think because I realised that we weren't doing everything that we could without quite being able to put a finger on why. So it left me feeling very very confused and very frustrated as well.

INT:

Did you, afterwards have you reflected on that, talked through with anybody? You've obviously mentioned a couple of things that you would do differently but have you had anything in the university or anything you.... "can I would have done this?"

Participant 6:

Well funnily enough in 2nd year we did have a short module on spirituality and spiritual care but it was encompassed as part of a larger module so it really only consisted of a few lectures, a few seminars and very very useful and informative presentation from the university chaplain. And in the course of that experience an opportunity arose to discuss it. And that was when another student suggested to me "why didn't you just pass the phone?" And that, yeah that was, that felt like a kick in the stomach. Something so obvious hadn't occurred to me. And that led to some moments of doubt in the sense of well, am I really giving spiritual care the attention and the time that he needs.

INT:

So has that moved, has that experience or those experiences with him and the other student has that now moved you on in some way?

Participant 6:

Very much so. I'm much more aware of spiritual needs. On my last placement of 2nd year for example, we had a gentleman with palliative care. Again I can't go into too many details but he was a very very devout Muslim. And we knew he was going to die in hospital. We were doing our best for the family and for the gentleman to make sure he'd die at home but it was one of those situations where if we had attempted to return him home he would probably have died in the ambulance which would have been even more distressing for the family and he was certainly not the way that he wished to go. And I was very very much aware that there are certain, of the particular customs

regarding the final offices for a Muslim who had died. In particular the fact that the body has to be washed and prepared by a member of their own faith and we did not have a single Muslim member of staff on the ward. And this caused me quite a bit of concern to the extent that I made a particular point of getting myself in touch with the local Imam chaplain at the hospital and I spoke with him, got some advice from him that was very useful and the next time the family attended I made a point of taking them into the family room and discussing what their wishes were because their father was unable to communicate his wishes by this point. And at that point to my relief I found out that several members of the extended support network if you like, friends of the family, who were male and therefore were able to perform the final offices had already come forward to discuss with the family that they would attend. Because we knew nothing this so I made a point of making sure that all the ward sisters and the ward staff were aware that when the time came the final offices, we were to contact certain friends of the family and certain members of the family and that they would come. And that we would just quietly close the door and await their arrival and not do anything to disturb the body.

INT:

And did that actually happen?

Participant 6:

That did actually happen.

INT:

So how did that make you feel?

Participant 6:

Well I would hate to say it gave me a sense of satisfaction because it really didn't. But what I can say is that I felt as though I had done everything I possibly could for the gentleman and for his family especially. So rather than feeling that I had, rather than the feelings that I had in that first instance we discussed, where I had let down the patient and the patient's family by not doing everything I could, I felt that I'd been able to give the patient and the family proper holistic care by encompassing all of their needs. So I felt that I had done a decent job.

INT:

Ok lovely, thank you. I just wonder if there is any particular aspect that has helped or hindered you learning around spiritual care?

Participant 6:

No I don't think so. Do you mean with the context of university setting or outside the university setting?

INT:

Both, it could be the university, it could be you know something that's happened in practice?

Participant 6:

you know I honestly can't think of anything that would have become a barrier to that. I'm very lucky that I grew up in a very open minded household. All the more considering that some of my near relatives, cousins and nephews for example, did not grow up in particularly open minded households. So no, I don't think there has been any kind of hindrance. If anything I think my previous history, my previous background has facilitated openness towards spirituality.

INT:

Do you think, you've mentioned that you've had a little bit of spiritual care training within the university. So you think that's been enough or?

Participant 6:

No. No really not. I think the emphasis on the university is that they've got, the spiritual training, the training of having spiritual care has been of quite a good quality but I think this is insufficient in terms of quantity. I don't think that the modern nursing culture places enough emphasis on spiritual needs. It seems odd to me to say that because as someone who conveniently fits into the stoic philosophy of looking at things I am modern stoic in that I am an atheist and an agnostic so although I personally have no spiritual needs as such that most people would recognise as spiritual needs, I'm still very aware and very conscious of people that do. And from the perspective of an outsider looking in I really don't think that care is, that spiritual care is given sufficient evidence in our modern evidence based, research based, scientific. health care culture

INT:

Is there anything you'd like to see?

Participant 6:

I would love to see healthcare practitioners actively promoting spiritual care rather than passively promoting it the sense that, or waiting for the patient to approach them regarding their spiritual needs. I would love to see that. I think that if there internal culture can change so that people in particular nursing staff because we have so much contact with patients, are more, to become more proactive about addressing a patient's spiritual needs, then we may be able to seechaplains in hospitals. Maybe we would see people, patients in particular, dealing with trauma, considerably better than we do, especially families, patients and their families. So I would very much like to see that. I think it would require a complete see-saw culture change because we have such a ...society even outside of healthcare when it comes to religious and spiritual matters. They sound like there is an issue. I do think it is a problem at the moment.

INT:

So it sounds like you are saying it's wrapped in our culture why we don't address it.

Participant 6:

Exactly. I don't think it just comes, I don't think it's entirely down to being healthcare providers. I think discussing spirituality is something that we as a culture in Britain just do not do and it carried over into healthcare. But as with so many things there are certain, healthcare professionals have to break beyond that taboo in the same way we broke beyond, when we are discussing bodily functions the same way we broke beyond the taboo of male nurses washing female patients and vice versa. We've broken through those taboos. We just need to break through the spiritual taboo as well.

INT:

Interesting. OK. The final sort of question is what do you think is the most important experiences that have developed your learning about spiritual care? So I was thinking is there any sort of personal awareness or like family. You've mentioned some of your own spiritual practices etc. but I was just wondering if there was anything else that?

Participant 6:

It's been ...part of care. This made me very very aware of spirituality, very aware. I think quite often because nurses don't bring up the prospect of spiritual needs unless there is obviously a need to for for example, in the case of the two gentleman we discussed earlier. We quite often by the time

Appendix 14 - Interpretative Phenomenological Existential Themes for Each Participant

Van Manen existential themes	Interpretive phenomenological insights from participants
Relationality (lived relations)	<p>Participant 1 - McCance & McCormack (2017) person centred framework emphasises the need to work with patients beliefs and have a sympathetic presence, which Emily displayed in her approach with patients. Emily shows the importance of working with patients beliefs and having a sympathetic presence that McCance & McCormack (2017 p37) think are key to achieving person-centred outcomes in health care.</p> <p>Building a relationship between client and nurse is vital according to Bach & Grant (2011) as this develops trust. The skills of listening, empathy and respect are important to establish interpersonal relationships and Emily demonstrates her keenness to develop these skills. Emily recognises that each individual has particular views and preferences to consider and the transactional model of communication (Arnold 2016) explores the internal and external factors that influence interactions. The Nursing and Midwifery Council Code (2015) also records the need for nurses to show good and individualised communication within professional practice. Therefore, Emily was applying a range of communication and interpersonal skills within her nursing practice, including when she was dealing with spiritual issues. Narayanasamy (1999) proposed a model to aid education about spiritual care and highlighted the areas of communication, building trust and giving hope; Emily displayed all these areas within her interactions on spiritual care. Giving hope, according to Narayansamy (1999), included interpersonal connectedness and light-heartedness, which Emily incorporated into her practice.</p> <p>However, Emily also acknowledged the difficulty of some communications and the need to draw on expertise, particularly in relation to dying patients. Collins et al (2018) noted that euphemises are used to avoid speaking about death and patients interpret these in different but Emily drew on the mentors' expertise to deal with this in a positive way.</p> <p>Participant 2 – relationships in mental health nursing are complex, influenced by illness trajectory and personal context. Tee et al (2012 p11) showed how mental health nurses have a discourse related to the medicalisation of psychiatry rather than a person centred approach, which Sarah also noted. However, building therapeutic relationships is important and Clifton & Banks (2014) note that a change to a recovery model for mental health promotes social inclusion; Sarah's experience of the singing group highlights the benefits of this form of support.</p> <p>Participant 3 - Minnie did outline a person centred approach to spiritual care as she was keen to work with patient beliefs which is key to person centred practice (McCance & McCormack 2017). Sharp et al (2018) have noted that acute hospital settings tend to focus on efficiency and this can lead to task rather than person-centred care; as Minnie's experiences seem</p>

<p>Relationality (lived relations) continued</p>	<p>to have been hospital based this may have influenced her ability to integrate spiritual care within the setting, relying on patients or family to highlight needs. However, despite this Minnie recognised the need to respect and incorporate individual preferences when expressed by patients which is part of the NMC code (2015) expectations.</p> <p>Participant 4 - – Joanne’s conversation demonstrated many aspects of person centred framework showing some of the pre-requisites and care environment elements to achieve a sense of well-being for patients (McCance & McCormack 2017). McCance and McCormack (2017 p 46) talk about ‘commitment to the job’ and this sense of dedication and, as Joanne describes, the little things making a difference to patients. There was evidence of supportive work cultures that enabled the staff to be innovative by exercising professional accountability (McCance & McCormack 2017 p 53); this was demonstrated in Joanne’s experiences of taking a critically ill patients outside to achieve holistic care. The person centred outcomes was evident in Joanne’s experiences as the patients had a sense of well-being (McCance & McCormack 2017 p59) which Joanne could see enhanced their care. There was clear team working to achieve the outcomes as the teams were supportive and facilitative in meeting individual needs and Baillie & Black (2015) highlight the importance of collaborative working to achieve holistic outcomes. Joanne’s experiences showed how the team and herself, worked with the patients values to incorporate their individual perspective and needs, this is also consistent with person-centred practice (McCance & McCormack 2017 p 54) and listening to patient and family was important in this process. NHS England (2016b) report on ‘Compassion in Practice – one year on’ emphasises the importance of compassion, caring, communication, competency, courage and commitment (the ‘6 Cs’) to provide person centred care and Joanne’s examples displayed many of these features when providing spiritual care.</p> <p>Participant 5 - Communicating with patients was important to understand their spiritual concerns for Zena, however, she was fearful of offending people and Brown (2017) found similar concerns in mental health nursing students. Ellington et al (2017) found that nurses lacked confidence in discussing spiritual needs with patients so Zena’s experience is not unique. Zena was keen to find out individuals needs and listen to their preferences so she demonstrated adherence to the NMC Code (2015) for professional practice.</p> <p>Participant 6 - – John demonstrated many of the aspects of McCance & McCormack (2017) person centred framework because he wanted to engage with patients authentically, recognising the uniqueness of the individual to provide holistic care. John recognised individual personal beliefs and wanted to work with these values (McCance & McCormack 2017) but he also communicated with the team which NMC (2015) and Baillie & Black (2015) both advocate to provide holistic care. Communication is a complex process (Arnold 2016) and John demonstrates a variety of communication skills, such as listening and asking, within his practice.</p>
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<p>Relationality (lived relations) continued</p>	<p>Participant 7 - Aspects of the person centred Framework (McCance & McCormack 2017) were evident in Sonia's conversation; she emphasised about respecting the patients wishes by asking them which is 'working with the patients' beliefs and values within the framework (p54). The framework also talks about 'sharing decision making' (McCance & McCormack 2017 p54) with patients by focusing on their concerns and Sonia was keen to find the meaning for the individual through relationship building. Giske (2015) talks about the importance of nurses tuning into spiritual concerns and uncovering deep concerns through relationship building which involves interpersonal skills and commitment to the job in McCance & McCormack (2017) framework. Sonia identified relevant experiences where the team had made an effort to meet the spiritual needs of patients, therefore, showing a commitment to providing holistic care (McCance & McCormack 2017).</p> <p>Participant 8 - Jane talked about the importance of being person-centred and giving holistic care which resonates with the Person Centred Framework (McCance & McCormack 2017). Spiritual care was related to the wider wellbeing more explicitly for Jane and Holmes (2018) article says that more research into the link between wellbeing and spiritual care is needed. Clarke (2013) book emphasises that spiritual care is a way to see the person behind the disease and Jane wanted to include this aspect in practice but this element could improve other aspects of the patients healthcare experience.</p> <p>Participant 9 - beliefs are what people think is true whereas values guide people to the right action (McCance & McCormack 2017 p46). Tuckett (2015) found that the important values for nurses have remained similar over time with a focus on person centred care, which was evident in Amanda's portrait. Although healthcare is seen as secular, Knott & Franks (2007) study found that there were religious aspects embedded within it, and this is similar to Amanda's experience. Amanda saw disparity between staff language and actions and McCance & McCormack (2017) discuss the importance of beliefs and values for both staff and patients. However, the relational aspect still followed the professional codes (NMC 2015) based on respect and equity of care delivery but underlying personal beliefs could be different to those which were espoused. Relational reciprocity was discussed by Pesut & Throne (2007) saying that nurses need to focus on the patient in a pluralistic society and this will minimise, what they describe, as ethical risks if nurses take on a stance of being expert on spiritual care. Amanda drew on her experience in relationships with patients but did not consider herself an expert suggesting that reciprocity happening.</p> <p>Having a holistic view of care delivery seems to be embedded within nursing practice (www.nursing-theory.org 2016) with many theories of nursing including the need to care or heal the whole person as part of nursing practice. The person centred framework (McCance & McCormack 2017) include the aspects of 'providing holistic care' and "being sympathetically present' which were both highlighted in Amanda's conversation. Several authors (Hoffert et al 2007, Giske & Cone 2012, Cobb 2004, Lovanio & Wallace 2007, So & Shin 2011) agree that spiritual care is integral to holistic practice and, even though Amanda struggled with some elements, she agreed that it was an element of nursing care that was</p>
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<p>Relationality (lived relations) continued</p>	<p>needed.</p> <p>Participant 10 - Professional integrity is discussed by Blowers (2018) research noting that students needed understanding of professional boundaries and ability to speak up for patients. Lyn had a heightened awareness of the need to keep to professional boundaries and this caused her some anxiety about how she should communicate about religious matters to patients. Lyn was eager to listen to patients and showed relational reciprocity (Pesut & Thorne 2007) by enabling them to discuss spiritual concerns in a non-judgemental way. Lyn demonstrated interpersonal skills which McCance & McCormack (2017 p44) think is essential to build positive relationships with patients. Lyn demonstrated a variety of communication skills to listen, ask questions and understand the patient spiritual needs (Arnold 2016) but used a person centred focus by trying to engage with the patient authentically (McCance & McCormack 2017 p56). Acting on the findings of patient encounters was important to Lyn which ensured that the holistic needs of the patient were met, not just the physical needs, and another indication of person centred approach (McCance & McCormack 2017 p58).</p> <p>The equity and fairness within patient relationships was important to Lyn and this reflects the professional code of conduct (NMC 2015). Lyn had a commitment to the job and desire to maintain professional expectations, again, these are relevant to person centred practice to meet individual needs and support colleagues (McCance & McCormack 2017). Respecting the patients' beliefs and values within the relationship, even though this was sometimes very different to her own, was central to Lyn's approach and is cognisant with professional code (NMC 2015) and a person centred approach (McCance & McCormack 2017). Lyn recognised that she could learn from patients, so did not act as an expert in spiritual matters which Pesut & Thorne (2007) felt would be unhelpful.</p> <p>Effective staff relationships are consider vital to person centred practice according to McCance & McCormack (2017) and Lyn outlined the role staff had played in role modelling spiritual care. Strand et al (2017) highlighted the importance of effective role models to aid student learning about spiritual care and Lyn demonstrated that this was important for her development in practice. Role models are also considered important to develop courage (Ieun Lloyd 2014 p113) and this may help Lyn overcome some of the fears she had in dealing with spiritual matters openly.</p>
<p>Corporeality (lived body) Corporeality</p>	<p>Participant 1 - Emily highlighted that the spiritual is part of every person and this links with the concept of a person as "<i>the recipient of nursing care, having unique biopsychosocial and spiritual dimensions</i>" (Arnold 2016 p2). Emily's belief that the spiritual is the 'inner' person and physical the 'outer' person and that the whole person needs to be incorporated holistically for best spiritual care delivery resonates with a number of nursing theories, which have moved away from an illness focus towards a caring focus over time (Hickman 2014). Emily had self-awareness about her own spiritual dimension and McCance & McCormack (2017 p 45) identified 'Knowing self' aids ability to embody another persons' perspective. Emily</p>

<p>(lived body) continued</p> <p>Corporeality</p>	<p>was able to recognise and moderate her own emotions when dealing with a patient, despite the age difference. This suggests Emily displayed emotional intelligence (Foster et al 2017) about the wide variety of factors influencing a relationship and differing perceptions involved. McCance & McCormack (2017 p57) describe 'being sympathetically present' which aligns with empathy, by valuing the uniqueness of the individual and responding to client cues; Emily demonstrated this in a number of her interactions by trying to address spiritual needs.</p> <p>Participant 2 – There was a recognition that the physical and spiritual overlapped and people had needs in both aspects (McCance & McCormack 2017). The therapeutic use of self (Brown 2012) is a key concept within mental health practice and the skills of listening and self-reflection were evident in the portrait. Sarah expressed fear about discussing spiritual care and confusion between the boundary of illness or spiritual concern; Brown's (2017) thesis highlights similar issues for mental health nurses in her study on spiritual care. Although an individualistic approach to patient care is evident within the portrait the implementation of this, when confronted with spiritual needs, is difficult for students.</p> <p>Participant 3 - – Minnie had a religious focus to her understanding of spirituality but was not religious herself which the National Secular Society (2018) promotes as a secular view of society. This may mean that Minnie is less aware of different spiritual perspectives or may not consider it as part of professional practice which some authors agree with (Paley 2009). Minnie was keen to refer people's spiritual needs to spiritual advisors which may reflect her discomfort or lack of knowledge about spiritual matters. Naber & Markley (2017) suggest that reflective writing during placement may help students to be more self-aware and analytical, as Minnie was focused on the examinations this might help her to develop other aspects of nursing practice, particularly to develop her understanding of spiritual needs.</p> <p>Participant 4 - Joanne found that a session on spirituality had stimulated her interest in the subject and Aksoy & Cobarn (2017) felt that integrating spirituality into sessions was important for increasing students' awareness of the topic. Sharing stories was a helpful strategy for Joanne to understand spiritual concerns and research suggests this is one method to increase students awareness of caring practices (Adamski et al 2009). Recognising and assessing spiritual needs is important but Austin et al's (2018) systematic review showed that there was a lack of robust tools for this purpose within healthcare; Joanne relied on listening to the patients preferences for spiritual needs which is important for person centred practice (McCance & McCormack 2017). Mindfulness was a strategy that Joanne found beneficial and there is emerging evidence that this may reduce stress and increase compassion in nursing students (van der Riet et al 2018). A sense of achievement was important for Joanne, which she saw in the teams' commitment, and ten Hoeve et al (2017) found that disappointments in providing nursing care could lead to attrition in students and the nursing team played a key role in preventing this. McCance and McCormack (2017 p 49) also highlight the importance of effective teams.</p>
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<p>(lived body) continued</p> <p>Corporeality</p>	<p>Participant 5 - Aksoy & Cobarn (2017) felt that integrating spirituality into taught sessions was valuable; Zena found the teaching positive but struggled about translating this knowledge into practice. Monaghan (2015) systematic review highlighted that newly qualified nurses feel that they do not possess the practical skills needed and Zena suggested simulated activities to address this which Monaghan (2015) agrees may help to bridge the theory-practice gap. Carson (2013) lists the benefits of simulation including the opportunity to relate theory to practice and practising complex interactions, such as spiritual conversations. Emotions of making the patient happy and comfortable were important to Zena which suggests some degree of emotional intelligence which develops over the course according to Foster et al (2017). Kaur et al (2015) suggest that the reflection and self-awareness required in spiritual intelligence had a positive effect on caring behaviours in nurses and Zena demonstrated some self-awareness in her conversation. Kaur et al (2015) believed that spiritual intelligence and emotional intelligence had a significant impact on nurses caring behaviours and should be developed.</p> <p>Zena demonstrated commitment to the job (McCance & McCormack 2017) by undertaking reading around spiritual matters and Tuckett (2015) found that students were motivated to provide person centred care.</p> <p>Participant 6 - Chan (2010) talked about factors that affected staff incorporating spiritual care into practice and noted that nurses who had higher perception levels towards spiritual care were more likely to include this into their care delivery. Although John did not follow a specific religion he demonstrated self-awareness about his personal meaning and beliefs which Zohar & Marshall (2000) conclude is fundamental to spiritual intelligence. Spiritual intelligence is seen as a way to combine cognitive and emotional aspects of intelligence according to Zohar & Marshall (2000) to enable a person to transform their understanding of a situation. John's developed a more proactive approach to spiritual care as his experience developed and this concurs with Ross et al (2018) research findings demonstrating that student competency in spiritual care improved over the three year nursing programme. Wu et al (2016) found that the majority of nurses did not feel they had enough education on the topic of spiritual care and this affected their willingness to provide spiritual care. John similarly felt there was not enough education on the topic which Rushton (2014) also supports while Zamanzadeh et al (2015) noted that education tended to prioritise physical disease processes.</p> <p>John articulated his stoic beliefs and this is a philosophy that focuses on virtues and character (Gill 2013). The relationship between virtue ethics, character and morals has been discussed within nursing literature but concern raised about whether it is possible to change a person's character although Sellman's (2011) book argues that virtues are important to make someone a 'good' nurse. John particularly demonstrated his desire to 'do good' and the person centred framework (McCance & McCormack 2017) talks about the moral, ethical and values clarity needed to work towards individual patient goals and be committed to the job. The pride John felt when he achieved holistic care is something that Cook (2017) refers to as 'human flourishing' seeing it as an important aspect to develop caring attributes within student nurses. Tuckett (2015) noted that the important values for nursing have not significantly changed over time and, thus, are still an area to consider</p>
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<p>(lived body) continued</p>	<p>in education practice.</p> <p>John changed from a passive onlooker to an active participant when delivering spiritual care and this reflects Ross et al (2018) research that says students competence in spiritual care delivery improves over the course. Transformative learning theory (Mezirow 2009) highlights the importance of experience, challenge and reflection to change students understanding and John's experiences with a peer and in practice is evidence of this process.</p> <p>Participant 7 - Education had a transforming effect on Sonia (Mezirow 2009) where she described a teaching session as a 'turning point' in her understanding. Sonia demonstrated that she had developed her personal understanding of spirituality which shows a level of self-awareness in her learning that is important for professional practice (NMC 2015) and shows some spiritual intelligence (Zohar & Marshall 2000).</p> <p>Participant 8 - Jane demonstrated an internal locus of control as she was proactive about learning spiritual care which Mert et al (2012) says helps motivation for learning in nursing students. Jane showed awareness of the emotional impact on clients of illness and Milliken's (2018) integrative review calls this 'ethical sensitivity' to others predicaments. Knowing self is also important to deliver person centred care (McCance & McCormack 2017) including an understanding of your own beliefs and values; which Jane also relayed. The NMC Code (2015) outlines a number of key aspects that nurses need to follow and Janes conversation showed that the issues of respect and meeting individual needs was important to her practice. Transformative learning (Mezirow 2009) is evident within Jane's experiences because they shaped the ways she approached spiritual care in future encounters, showing her how it aided holistic care provision.</p> <p>Participant 9 - Amanda talked about being '<i>in the moment</i>' and this is an aspect of mindfulness to help people cope with stressors. Jenaabadi's (2018) study linked the concepts of spiritual intelligence and mindfulness to demonstrate how it reduced anxiety about death within nursing students. Zohar and Marshall (2000 p 14) discuss spiritual intelligence including elements of self-awareness considering personal beliefs and wrestling with question, Amanda was dealing with all these elements within her experience and back ground which Amanda. Amanda's experience made me wonder how easy or difficult it may be to separate your personal beliefs and values from your professional side; she talked about her values being formed at a young age and Carr (2014) emphasises the importance learning virtues. Amanda struggled with the interlinking of secular and spiritual within UK practice and felt uncomfortable with this aspect which she had not resolved.</p> <p>Participant 10 - Lyn demonstrated a high self-awareness of her own values and beliefs which is ability to know self (McCance & McCormack 2017) but also relates to spiritual intelligence (Zohar & Marshall 2000). Lyn acknowledged that her religious values, which were developed from childhood, informed the way she worked and Carr (2014) described the relevance of developing virtues early in life. Lyn showed commitment by noticing that little things made a difference to patients and</p>
<p>Corporeality</p>	

<p>(lived body) continued</p>	<p>ensuring those needs were addressed (McCance & McCormack 2017). However, there was a reticence in Lyn about saying or doing the wrong thing and being reprimanded, which Brown (2017) also found. Lyn was very honest about the importance of her religious life and activities but she could reconcile these beliefs and had developed a clarity that McCance & McCormack (2017 p45) describe as being beneficial for person centred care. However, Lyn wanted to provide individualistic care but seemed able to understand Christianity more clearly and Timmins et al (2018) found that student nurses felt more competent when dealing with patients from their own religion. Kay (2014) talks about rules that are followed in families, religion and society and Lyn had learnt much of her moral code from her background. Lyn showed a 'distributive justice' moral framework (Kay 2014 p105) because she talked about the importance of equity but also treating people individualistically. These elements influenced her professional identity and she faced dilemmas in practice relating to her religious views; Timmins et al (2018) also notes some of the challenges that are faced by students between their professional values and religious ideals meaning that students do not share their religious beliefs in practice. The values of Lyn's religion and profession were important and Blowers (2017) notes the importance of developing values and integrity in nurse education to be able to cope with the challenges. Lyn recognised an emotional effect of some of her experiences and Foster et al (2015) outline the importance of emotional intelligence in student nurses. Zohar and Marshall (2000) believe that spiritual intelligence links emotional and cognitive intelligence into a more holistic frame and Lyn seemed to combine her religious, professional and emotional identities to provide quality patient care. These emotions and experiences promoted reflection within Lyn and this is an expectation for nurses throughout their career to learn from the past (NMC 2017).</p>
<p>Spatiality (lived space)</p>	<p>Participant 1 - Opportunities to observe others (such as mentor) allowed Emily to see key competencies and skills in developing therapeutic relationships (McCance & McCormack 2017) which demonstrated concern and commitment for another. Experiential learning of spiritual care is recommended by Narayansamy (1999) as a way to embed skills and is viewed as an effective strategy if the care displayed is re-enforcing good quality care (James et al 2016); Emily encountered a few practice experiences that challenged her and others, and Martin & Manley (2017) highlight the importance of a facilitative workplace culture to enable change to occur. A workplace culture, where staff do not display the espoused values, can lead to dissonance for the student where power is not shared but hierarchy dominates (McCance & McCormack 2017), Emily was distressed by some of the attitudes she saw when dealing with patients in practice.</p> <p>Participant 2 – Sparking an interest in the topic area is helpful to develop student interest in spiritual care; Sarah interest was lit by the research study but a learning environment that promotes exploration of concepts is needed for spiritual care. The culture of mental health nursing seems to continue to be medicalised (Clifton & Banks 2014) but there are several approaches to mental health practice (Stickley & Wright 2014), such as cognitive behavioural and psychodynamic approaches. Sarah's portrait leant towards a humanistic approach (Cassedy 2014), that emphasises building esteem and</p>

<p>(lived space) continued</p> <p>Spatiality</p>	<p>empathy, which were evident within her responses.</p> <p>Sarah said that she would take someone to chapel if asked too; there was a recognition that a place may be important to the person but the emphasis was on the person asking which requires empowerment for the individual. In a medicalised mental health setting patients can feel disempowered and follow advice (Clarke et al 2018) rather than feeling emancipated; the emancipation of patients was not clear in this portrait.</p> <p>Teaching around spiritual issues within university and by mentors was not evident in this portrait so the student has little opportunity to develop their competency and knowledge in this area.</p> <p>Participant 3 - The importance of mentors to role model spiritual care is noted by (Strand et al 2017). However, as referred to above (Sharp et al 2018), it may be the organisational setting that is focused on efficiency and having a variety of placement experiences may help Minnie to gain experience of spiritual care. McCance and McCormack (2017) highlights that the care environment is key in delivering person centred care and considering placement experiences may be important to provide students with experiential learning opportunities around spiritual care.</p> <p>Participant 4 - McCance & McCormack (2017 p 47) discuss the importance of the care environment to provide person centred care, including the skill mix within the team, the decision making processes and supportive setting, Joanne seemed to experience this with team and mentors demonstrating holistic practice to achieve spiritual care goals. The workplace culture is important, according to McCance & McCormack (2017), to promote innovation which was demonstrated in Joanne's conversation.</p> <p>Joanne noted the patients' needs for social interaction as supporting spiritually is described by Adams et al (2016) who found that loneliness was a factor in patients care and needed to be incorporated into care plans to avoid social isolation. The hospital space can be very busy yet socially isolating for patients which can disengage them from their normal support mechanisms, such as religious or family affiliations.</p> <p>Participant 5 - Zena had not seen spiritual care incorporated into practice and Strand et al (2017) noted the importance of role models to enable students to implement this aspect of care. Zena valued the taught sessions but thought there needed to be more emphasis on this aspect of nursing care; Baldacchino in 2008 recommended a teaching strategy which promoted use of a variety of teaching methods to address the topic.</p> <p>Participant 6 - The healthcare setting as a place where spiritual matters were avoided was evident in John's conversation and this may be due to historical context of uncoupling religion from state as well as the secularisation of healthcare (Swatos & Christiano 1999). NHS chaplaincy guidelines (NHS England 2015) notes the vulnerability of patients during illness and John highlighted the poor resourcing for chaplaincy services. A review by Roze des Ordons et al (2018) found that</p>
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<p>(lived space) continued</p>	<p>patients thought wards were too focused on the biomedical and spiritual distress was not tackled. Thus, conversations tended to focus on culturally acceptable topics but Strang et al (2014) highlight the importance of communicating about spiritual matters within a supportive context.</p> <p>Participant 7 - Sonia assertion that patients feel trapped in hospital suggests a loss of autonomy for the patient and Huddle (2016) felt that decisions were often made by medical staff and followed by the patients. The person centred framework (McCance & McCormack 2017 p59) says that patients feeling involved in care is important to ensure patients embrace their health decisions. Sonia noted, as many of the participants have, that the busyness of ward environment detracted from spiritual care but the palliative care setting facilitated this area; the literature highlights that wards can focus on tasks (Sharp et al 2018) whereas a recent systematic review demonstrates the of spiritual care in palliative care work (Chen et al 2018).</p> <p>Participant 8 - – Learning spiritual care from a role model was important for Jane as also outlined by Strand et al (2017). The mentor demonstrated competency in considering spiritual care which McCance & McCormack (2017) incorporate as a pre-requisite for person-centred care. The ‘care environment’ in the person centred framework (McCance & McCormack 2017) is about the systems in place within the setting, the staff skill mix, the ability to share power as well as the physical environment. These aspects contribute to a placement experience that enables a student to be involved and learn from the team.</p> <p>Participant 9 - Amanda found some of the situations in the practice setting unsettling and this may lead to stress. Mindfulness, according to Kelly & Tyson (2017), is a useful strategy for students to deal with stress and may explain why Amanda found this helpful. The French secular culture had influenced Amanda and Tveit et al (2015) note the change from faith based nursing to a more secular approach across Europe citing the difficulties this can bring. The changing landscape of European nursing towards a pluralist post-modern view (Tveit et al 2015) may be particularly important for someone transitioning to a different cultural perspective.</p> <p>Participant 10 - Lyn struggled to know what was permissible within the healthcare setting and Cole (2017) discusses cultural competency and how staff wish to address sensitive issues but do not know how to do this. Gallagher & Polanin (2015) undertook a meta-analysis about interventions to improve cultural competency but no one strategy was effective. Lyn was the only student who specifically mentioned the university’s Christian foundation (www.cathedralsgroup.ac.uk) who’s values echo those of Lyn. Porteous & Machin (2018) note the difficult transition that students face into university life but it is unclear whether a particular focus, such as a Christian foundation university, impacts on these experiences.</p>
<p>Temporality</p>	<p>Participant 1 - Emily noticed different persons and their needs which showed a subjective focus on time and attentiveness</p>

(lived time)	<p>which is an aspect of nursing presence (Mohammadipour et al 2017). Student nurses, within the UK, are supernumerary members of the team and Emily seemed to have more time to be attentive and talk with patients although evidence suggests that students can be used to fill staffing gaps promoting professional guidance on the issue (RCN 2018). An objective view of time is the development of Emily as a second year nursing student where her skills and abilities are being established and looking forward expectantly to learn more about spiritual care; Ross et al (2018) have recently demonstrated that students self-perceived competency in spiritual care develops over the period of nurse training due to the experiences that they encounter.</p> <p>Participant 2 – Historical time was explored by Sarah as she related how historical figures would be viewed within the current social context relating to mental health practice. Historical time is not mentioned by Van Manen (2014) but shows how past events can influence current understandings. This highlights that time is a multidimensional concept that is influenced by other factors; something that was seen as positive is now viewed negatively. Mental health conditions can lead to confusion and altered perception in patients (Smith & Rylance 2016) leading to irrational behaviour where the use of assessment tools and legislation is required to consider the safety of the patient and others. The therapeutic use of self (Brown 2012) requires a person do devote time to another and taking time with someone was referred to in the portrait.</p> <p>Participant 3 - Time is seen as precious (Van Manen 2014) and Minnie was focused on achieving results as she had an examination approaching. Wray et al (2017) discusses the multiply factors that influence student nurse progression with the emphasise on academic success to progress in nurse education. Group clinical supervision (Sheppard et al 2018) has been shown to assist students to embed non-judgemental values and enable them to question their assumptions around practice.</p> <p>Participant 4 - Time here is critical as a terminal diagnosis means that time is limited both objectively and potentially can be a subjective feeling of needing to address the concern. Objective time to move a patient from ICU needs staff to be available, and Chuang et al (2016) noted that workload pressure can lead to burnout in ICU nurses which reduces their ability to care. Kim & Yeom (2018) demonstrated that the nurses own spiritual well-being can reduce burnout and Joanne showed how staff had used their own religious knowledge to inform good quality spiritual care. Incorporating the staff knowledge and spiritual beliefs into patient care may support staff to and feel valued. Subjectively the time spent on meeting spiritual needs helped to lift a patient’s mood and there is evidence that ICU patients particularly suffer depressive symptoms many months after ICU discharge (Wintemann et al 2018). Meeting spiritual needs may draw on a different inner patient resource to deal with an illness.</p>
Temporality	Participant 5 - Zena noted the lack of time in practice to address spiritual care and Sharp et al (2018) highlighted how tasks

<p>(lived time) continued</p>	<p>in certain nursing settings could be prioritised because of time pressures.</p> <p>Participant 6 - Sharp et al (2018) found that busy wards could detract from person centred care and John found this detracted from spiritual care. Roze des Ordons et al (2018) review found that time was a factor meaning that spiritual distress was not dealt with by staff. Zamazadeh et al (2015) noted that education tended to prioritise physical disease processes, and John concurred that spiritual care teaching was lacking and needed more time devoted to it.</p> <p>Participant 7 - Sonia assertion that patients feel trapped in hospital suggests a loss of autonomy for the patient and Huddle (2016) felt that decisions were often made by medical staff and followed by the patients. The person centred framework (McCance & McCormack 2017 p59) says that patients feeling involved in care is important to ensure patients embrace their health decisions. Sonia noted, as many of the participants have, that the busyness of ward environment detracted from spiritual care but the palliative care setting facilitated this area; the literature highlights that wards can focus on tasks (Sharp et al 2018) whereas a recent systematic review demonstrates the of spiritual care in palliative care work (Chen et al 2018).</p> <p>Participant 8 - Jane's practice experience was incomplete in the example she gave as she finished the placement before knew outcome and this might disrupt her learning, particularly as a first year student. Birks et al (2017) found that a block of time on placement was seen as a more positive learning experience by student nurses and helped them integrate into the team. Whether it would be possible for Jane to follow up the patient and find the outcome at the end of placement is something to consider to aid learning. This highlights that placement experience, although key, can be disjointed so may not help to put the pieces together for spiritual care.</p> <p>Participant 9 - Amanda's focus on 'being present in the moment' involves spending time with the patients (McCance & McCormack 2014 p27). Amanda saw practice as '<i>work time</i>', a subjective time to focus on presence with the patient (Mohammadipour et al 2017). Time that is spent not focusing on patients, such as the nurses talking about religious aspects, may lead to Amanda feeling uncomfortable. James et al (2016) discuss how socialisation of students is needed to help them feel confident doing practical aspects but if they do not feel comfortable in the setting this may impeded learning.</p> <p>Participant 10 - Lyn noted that the research being undertaken had highlighted the issue of spiritual care to her. Ross et al (2018) found that student nurses competency in spiritual care increased over their pre-registration course but does not discuss aspects transform their understanding. However, Lyn gave an example related to cancer care and conditions that may be life-limiting in objective time heighten both religious and spiritual awareness in cancer patients (Lazenby 2018).</p>
<p>Materiality</p>	<p>Participant 1 - engagement with physical material things promote identity as a person and Emily noted the importance of</p>

<p>(lived things) continued</p>	<p>However, there is a debate in the nursing literature about the role of spiritual symbols within nursing practice (Nambiar-Greenwood & Timmins 2015; Pesut 2015) and, although this is related to nurses attire, might affect the perception patients gain about whether religious items are acceptable, or not, within the healthcare setting.</p> <p>Participant 8 - Jane recognised that certain rites, such as food, were important in some religions and needed to be respected. Van Manen (2014) notes that material aspects are quite personal and, even within Judaism, different subdivisions adhere to differing rites (BBC 2014). Therefore, it is important to acknowledge that there may be a spiritual need but awareness that this might be different, even within the same tradition.</p> <p>Participant 9 - Amanda was focused on values in her conversation and did not mention any material things that might influence spiritual care. Again, this may reflect her desire to focus on presence and the individual, listening to their needs rather than predicting them (McCance & McCormack 2017).</p> <p>Participant 10 - Lyn had an awareness of the importance of the material to express religious needs as demonstrated in her endeavours to find a bible. Van Manen (2014) highlights the importance of things in our lives and McCance & McCormack (2017) note that the physical and aesthetic environment need consideration to provide person centred care.</p>
<p>Technology (lived cyborg relations)</p> <p>Technology (lived cyborg</p>	<p>Participant 1 - there were no evident technological issues within this encounter.</p> <p>Participant 2 – - neither of these aspects were evident within Sarah’s conversation. Smith & Rylance (2016 p140) say that the importance of spiritual and religious practices can be underestimated in mental health nursing believing that it aids recovery, particularly in certain ethnic groups. However, patients may not express spiritual preferences for fear that if will be interpreted as illness related.</p> <p>Participant 3 - Technology related aspects were not evident in Minnie’s conversation. This is surprising as the expansion of social media and some evidence of its use to teach spirituality (Hasanhahi et al 2016), but this might reflect the ‘private’ nature of spirituality for someone with no religious inclination personally and, as Paley (2009) argues, might consider healthcare as secular.</p> <p>Participant 4 - - Physical safety of the ICU patient was needed in transporting outside because he was reliant on a respiratory mechanical ventilator. The Intensive Care Society (2011) guidelines provide information about transport of critically ill patients to prevent complications during transfers. Thus, allowing the patient to connect with nature seemed straightforward but is difficult for an ICU patient due to their physical reliance on technology. Van Manen (2014 p 310)</p>

<p>relations) continued</p>	<p>noted the increased use of technology within medicine and that this could lead to ethical dilemmas.</p> <p>Participant 5 - similar to previous students there was no evidence in Zena's conversation about the role of technology within spiritual care delivery.</p> <p>Participant 6 - John demonstrated ability to observe and assess for signs of religious activity in patients such as noting a crucifix around someone's neck and a bible on the patient table; spiritual assessment is integral to history taking according to Hogan-Quigley et al (2012). The importance of things in our lives is supported by Van Manen (2014) and the meanings and values are very individualistic.</p> <p>Participant 7 - Sonia did not overtly talk about any technological aspects that might affect spiritual care.</p> <p>Participant 8 - Patience (2016) outlines the differences in religions and dietary choices that might impact on patients; Jane particularly noted this related to treatment options when considering drugs to use. However, other technologies are not evident but Stokel-Walker (2017) thinks that smartphones are changing religion and gives examples from a Christian perspective, particularly around the use of social media. This suggests that the 'taken for granted' aspect of technology that Van Manen (2014) maintains may be pervading spiritual care in practice but is not recognised.</p> <p>Participant 9 - Amanda did not mention any technological areas related to spiritual care.</p> <p>Participant 10 - -- The potential negative impact of social media on student nurses was evident from Lyn and Price et al (2017) found that a small proportion of student nurses were concerned about the effects of social media in teaching. The use of technology, such as smartphones (Stokel-Walker 2017), is changing formats of spiritual expression so incorporating it in a positive way is vital.</p>
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