

# Moving beyond clarity: towards a thin, vague, and useful understanding of spirituality in nursing care

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## Abstract

Spirituality is a highly contested concept. Within the nursing literature, there are a huge range and diversity of definitions, some of which appear coherent whereas others seem quite disparate and unconnected. This vagueness within the nursing literature has led some to suggest that spirituality is so diverse as to be meaningless. Are the critics correct in asserting that the vagueness that surrounds spirituality invalidates it as a significant aspect of care? We think not. It is in fact the vagueness of the concept that is its strength and value. In this paper, we offer a critique of the general apologetic that surrounds the use of the language of spirituality in nursing. With the critics, we agree that the term 'spirituality' is used in endlessly different and loose ways. Similarly, we agree that these varied definitions may not refer to constant essences or objects within people or in the world. However, we fundamentally disagree that this makes spirituality irrelevant or of little practical utility. Quite the opposite; properly understood, the vagueness and lack of clarity around the term spirituality is actually a strength that has powerful political, social, and clinical implications. We develop an understanding of spirituality as a way of naming absences and recognizing gaps in healthcare provision as well as a prophetic challenge to some of the ways in which we practise health care within a secular and sometimes secularizing context such as the National Health Service.

*Keywords:* spirituality, language, epistemology, nursing, spiritual care.

## Introduction

Spirituality within health care in general and nursing in particular has rightly attracted a degree of sceptical criticism in some quarters (Sloan *et al.*, 1999, 2008; Pattison, 2001; Bash, 2004; Paley, 2008a). At the heart of many critical discussions about the validity and

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reality of 'spirituality' and 'spiritual care' often lie three main argumentational moves. First, it is argued that terms like these are used in endlessly different and loose ways. Second, this is then taken to be the evidence that, they cannot, and do not, refer to constant essences or objects within people or in the world. Third, from which it is then deduced, that because the usages of spirituality are emergent, changing, pluriform, diffuse, and non-referential, they really have no legitimate use or value; spirituality does not exist. The inference of this is that, within evidence-based, cash-strapped healthcare services, spirituality has no substantive place and should be excluded as a category of understanding and provision (Paley, 2008a; National Secular Society, 2009).

This paper starts from a position of entirely agreeing with steps one and two of the critique advanced by spirituality's intellectual critics. We recognize and affirm the loose, pluriform uses of terms like spirituality and spiritual care. Furthermore, we do not believe that there is any kind of unitary, universal essence to spirituality, spiritual need, or spiritual care that all can come to agree on as the definitive and universally acceptable ontology of 'the spirit'. But we dispute the view that just because the language of spirituality as it is presented within the nursing literature may not refer to any single essence or 'substance' within people or the world that this means that it is therefore meaningless and valueless. Despite its vagueness, the language of spirituality remains useful.

### Words change things

Presumably, hard positivists would argue that if concepts in language do not correspond in some sense to events or things in the material world, they should not be attended to. However, not all languages or concepts are directly or simply referential and they are still accorded value within the social world. It cannot then be a knock down argument that rational people should immediately try to extinguish all talk of spirituality simply because it does not fit in with a rather narrow empiricist view of reality. Languages are performative and expressive as well as referential. In this

paper, we want to examine the utility of the language of spirituality for the practise of nursing and health care.

Life is messy and chaotic. Illness and death are even more messy and chaotic. It is, then, unreasonable to expect that the practises and concepts associated with the emergent term, spirituality, will be lapidary, coherent, and universally valid. But that does not mean that the languages that deploy spirituality and its theoretical and practical cognates are without significance in nursing. Indeed, their value lies precisely in their contingent, evolutionary, and contextual usage. We therefore assume, with Wittgenstein (1961), that words are not essentialist in their meaning, but rather performative. If hitherto much of the intellectual controversy about the reality or otherwise of spirituality has focussed on the *definition* of words, it is our intention here to focus on the *function* of those words in practise, the languages in which they are situated, and the people and contexts in which they are used. This will lead to a different and less lexicographical discussion about meanings as the language of spirituality is situated much more firmly in the socio-political context of nursing practise. We suggest that instead of arguing about whether or not spirituality can exist in any realist, essential sense – a line of argument that has proven to be somewhat circular, controversial, and unhelpful – it is more useful to develop a thin, vague, and functional understanding of what this word and its cognates might connote and do in the world of health care. As will be seen, such a thin, pluralist, and functional understanding may have profound social and political implications for the ways in which health care is delivered and experienced by patients, carers, and staff alike.

One thing that it is important to note throughout is that when we use the term 'spirituality' in this paper we are referring to the diffuse and controversial meanings of this term that has come into play with its relatively recent conceptual separation from religion (spirituality includes but is not defined by religion). Our argument is not that God does not exist or that religions are nothing but socially constructed systems. Likewise, we do not intend to argue that spirituality as a human phenomenon does not exist. It may well exist. It is when we attempt to name and tie it down

that the problems emerge. Our target is the apparently substantive 'new spirituality' that is frequently referred to in the nursing and healthcare literature and that claims to be universally available to human beings and conceptually to stand apart from religion or formal religious traditions. It is this mode of spirituality that sits at the heart of the National Health Service which claims to serve people of all faiths and none (Mowat & Swinton, 2007; Scottish Government, 2009). We will argue that this mode of spirituality names a series of absences. Although it may not denote things or essences within the world or persons, similar to the symbolic system of money, it can denote areas, absences, and quests that have real and appropriate effects upon societies, institutions, and individuals. Minimally, it is performative and expressive, denoting at the very least, sites of resistance, void, and absence in health care. For this reason, it has an important and legitimate critical role to play in publicly funded institutions.

### Spirituality and its critics

The relevant nursing literature reveals a rich diversity of perspectives and meanings, as people attempt to articulate what is meant in practical and theoretical terms when they use terms like 'spirituality' and 'spiritual care'. Some, as has been suggested, see this diversity as a fatal flaw in the credibility of the enterprise that has come to be known as 'spiritual care'. These critics urge nurses and other healthcare professionals, to reject the term spirituality and move towards a more naturalistic perspective that has no need for spirituality or religion (Paley, 2008a). They believe that the tasks ostensibly performed through 'spiritual care' can be reconstrued and discharged purely through naturalistic and secular means (Paley, 2008a; Sloane, 2008). The lack of clarity and looseness of definition within the area of spirituality, particularly spirituality in nursing, it is argued, nullifies or at least significantly reduces its practical utility (Bash, 2005a, 2005b; Clarke, 2006). The rising prominence of spirituality is regarded as indicative of political and socializing processes within nursing whereby it is being marked out as an area of professional expertise that

draws it in to an ongoing discussion around issues of professionalization (Walter, 2002; Gilliat-Ray, 2003).

The concerns raised by the critics of spirituality in health care have highlighted important issues. The breadth of the 'spiritual' as it is laid out within the nursing literature often appears to be overly inclusive; the precise reasons for prefixing the term 'care' with the term 'spiritual' are not always clear. If everything is spiritual care then why bother calling it spiritual care rather than simply good person-centred care? Precisely how would such a broad discourse differ from a discourse on values (Pattison, 2004)? As we move on we will present an argument that takes seriously the concerns of the critics of spirituality in healthcare contexts, but which opens up a slightly different conversation that does not focus on conceptual clarity, but rather begins by asking a series of practical questions:

- 1 Does the area of human experience marked out by the terms 'spirituality', 'spiritual care', and their cognates, have practical utility?
- 2 Can patients benefit from healthcare professionals' adoption and usage of such language?
- 3 If the language of 'spirituality' does have practical utility, and if patients can and do benefit from the use of terms like 'spiritual' and 'spiritual care', then how might the language of spirituality play out in the development of better ways of caring for individuals who are experiencing illness and facing death?

In this vein, an important place to start is by pointing up some of the limits and exclusions to the evidence that has been adduced by the kinds of criticisms we have been considering above. In so doing, we hope to open up a conversation that will redress perhaps the most important exclusion: people who are actually sick and needy.

### Missing voices and perceptions in the debate about spirituality

Amidst the theoretical and professional debates about the existence or non-existence of spirituality, the fact that ordinary people, patients, carers, and professional healthcare workers seem to find the language of spirituality both unexceptional and helpful is

often ignored (Hay & Hunt, 2000). Indeed, many people are skilful performers in this language and appear to find it essential and meaningful, despite it is not having clear definitions as to what spirituality might mean in referential terms (Hay & Hunt, 2000; Hay & Nye, 2006). This is an important precursor observation to our main argument, because we would like to contend that there is evidence to suggest that the voices, habits, and perceptions of ordinary people should be closely attended to in thinking about any aspect of health care, and especially when it appears to relate closely to issues of purpose, identity, and the self, as the language of spirituality often does. It seems to be the case that many people find this language functional and helpful, particularly during times of illness and duress (Nathan, 1997; World Health Organization, 1998; Gilbert & Nicholls, 2003).

Perhaps not surprisingly, spirituality is a language that might be particularly helpful in times of chaos, struggle, and distress, i.e. in situations where people are ill or under pressure (Williams & Faulconer, 1994; Breitbart & Heller, 2003). One of the major problems with much of the statistical and other evidence that has been assembled in the controversy about the reality or non-reality of spirituality and spiritual needs is that it has drawn upon the views of samples of the 'general population' (Paley, 2008b). There are two significant issues with this approach. First, most of these people are not ill, or experiencing the kinds of crises that might cause them to think hard about the deeper questions of meaning and identity that have come to be named as 'spiritual needs'. It seems, however, that in times of illness, what might loosely be called spiritual, meaning, and identity issues come to the fore even when religion and spirituality formally defined have not previously been of significance (Breitbart, 2002; Breitbart & Heller, 2003). So much so that a therapeutic focus on such issues has been shown to be preventative against depression, loss of self-value, and the desire for suicide among people with terminal illness (Gibson *et al.*, 2004). It is in such situations, rather than in answering broad and general survey questions in the context of the everydayness of their lives, that people are most likely to think about 'spiritual' issues or to have 'spiritual needs', however inchoate or ill-articulated.

Second, and equally as important, the methodology that lies behind quantitative general surveys tends to exclude the voices of people who are less articulate such as people with significant intellectual disabilities, dementia, stroke, or other cognitive difficulties. Yet, there is evidence that people with such life experiences express interests and desires within the area of experience that has been framed as 'spirituality' (Post, 2000; Swinton, 2002, 2004; Kalra, 2007). The picture provided by sociological approaches that omit such experiences is far from complete.

In any talk about the value of spirituality perhaps the most important thing to do is to think about who is using the language and for what purpose. If ill people or people with particular cognitive difficulties and people offering care and support are using it, and using it with earnestness and serious intent, *prima facie*, their views should be taken seriously by academics and healthcare providers. The task is to listen and to understand the function and direction of the language of spirituality, not to question its validity or right to exist and be used.

### Spirituality as a social construction

In making a case for the functional utility and validity of spiritual discourse within nursing theories and practises, it must be owned that it has clearly been constructed by healthcare professionals in particular ways. We have seen the language of spirituality (in its generic forms) enter the social and healthcare worlds and ramify itself in many ways over the last 40 years, so it is quite clearly a discourse that has come into existence, not something that was always there. The social and contextual construction of spirituality is neither unique to health care nor alien to the history of the term spirituality itself. Spirituality has *always* been and *inevitably* will be a social construction. But that is not to say that it is *nothing but* a social construct. Spirituality may well have an ontology (Swinton, 2001; Hay & Nye, 2006). However, whatever that ontology may or may look like, it is clear that it has been interpreted in various ways and that the context within which these interpretative actions take place are significant. Our point is that under-

standings of spirituality are inevitably influenced, and to an extent constructed, by the social context within which they are developed.

Spirituality is constructed in different ways by various religious traditions, spiritual movements, belief systems, cultures, and contexts, and not least by particular individuals in specific circumstances. All may use the term 'spirituality', but each may well be using it in quite different ways. Even within apparently stable formal religions, there is development and diversity of understandings with regard to what spirituality may or may not be (Sheldrake, 2007). This is not intended to be a reductionist view. Our point is not that spirituality is *nothing but* a social or cultural construct. Likewise, the question of whether there are natural (Hay & Nye, 2006) or supernatural roots (Anderson, 2003) to our understandings of spirituality is not the issue here. The point is that spirituality is never given to us as some sort of neatly wrapped gift, which we then unpack and can apply to all places at all times and in all circumstances. Rather, the meaning of spirituality is necessarily emergent and dialectical; it is shaped and formed by the context within which spiritual language is expressed.

### **Spirituality as emergent, responsive, and contested language**

The suggestion that spirituality is socially constructed is not new or radical. One of the errors often made within the literature is that people seem to assume that spirituality has a single, original core meaning reflecting some kind of essence; if we could just trace back to that meaning, the debates and confusions would be over. However, as we have noted, historically, the term spirituality has taken on a variety of meanings depending on context, culture religion, and historical period (Sheldrake, 2007). In the context of health care, the search for the 'original meaning' of the term 'spirituality' (what might be described as lexicographical fundamentalism or literalism), is not particularly helpful. Carrette & King (2004) make this point well:

Those who make an explicit appeal to etymology and the so-called 'original meaning' of terms are often concerned with masking their own political intentions through an

appeal to 'authenticity'. Such approaches are guilty of the 'genetic fallacy', . . . the mistaken belief that the 'original meaning' (however one might determine that) is the definitive or true meaning of a term. . . . (p. 3)

They go on to point out that many important concepts derive their significance and value precisely from their ability to evolve and develop, sometimes in very different, even contradictory ways:

Why privilege original meanings? Language and culture evolve throughout history and terms take on a variety of semantic registers in accordance with the changing social, cultural and political contexts in which they operate. It would be a mistake then to appeal to some 'authentic' meaning for the term 'spirituality', as if such concepts were not embedded in a rich and contested history of usage that shifts according to changing conditions and social agendas.

The meaning of the term spirituality is thus found to be *emergent* from certain circumstances, contexts, and particular epistemological considerations, *responsive* to particular needs in specific situations and circumstances, and *contested*, in that its meanings may change and multiply so that there is no one understanding of what it might mean. Rather, there is a constellation of meanings some of which might even contradict and modify others. Even a brief glance at the nursing literature that tries to define spirituality illustrates and perhaps makes this point quite well. It is right to ask that people should be as specific as they can be about what they think are talking about when using the term 'spirituality' in particular contexts so that confusion and misunderstanding can be avoided as far as possible. But it is not right to suggest that words with more than one set of meanings or associations should be banned from public usage.

Some might argue that such a constructionist perspective on spirituality merely confirms the fact that 'spirituality' is simply too vague and slippery to have practical utility. If spirituality is not an identifiable 'thing' (like an aspirin, a chart, or a thermometer), then how can it be used within a nursing context? However, it should be remembered that many of the key terms that are used within health care (including health care itself!) are similarly emergent, constructed, and changing. They are the product of

complex and often political construction and modification. It is wrong to suggest that just because a concept is new, unclear, or fragile that it is more or less automatically suspect. Words come from all kinds of places and times and, as part of living human language and experience, they change and transmute. 'Holism', for example, was first used by General Smuts in relation to his participation in the colonization of Africa (Smuts, 1927). Its association with apartheid and the separatist perspective of sphere sovereignty do not immediately bring the waves of warmth and comfort that are associated with contemporary usage of the term! But that does not mean that it cannot have valid meanings for today. It has grown beyond its original context and acquired different and secondary meanings. The terms 'community' and 'care' are similarly vague concepts, but that does not mean that these words can be dispensed with: we need to be able to talk about our relations with groups of people, and to explain what it means to be concerned about others, albeit in rather general and ill-defined terms. Other commonplace words such as leadership, person, values, religion, art, love, and friendship are equally vague, contested, multi-, or poly-valent, but nonetheless important and necessary. That being so, spirituality as it is emerging within nursing may not be monolithic or unambiguously clear, but it is not alone in this. There is no inherent reason why a lack of clarity should necessarily denote a lack of significance. Indeed, it can be suggested that it is precisely where things are difficult to grasp and indistinct, but important, that polyvalent, unstable, and contested concepts are most likely to emerge. Multiple definitions may be indicative of the necessity and the flexibility of the term to meet particular needs that would otherwise go unmet. That is why such concepts exist.

### **Spirituality as 'limit language'**

In this connection it is worth introducing the idea of 'limit language'. Some important language is in fact limit language. That is to say, it does not denote something that is necessarily concrete so much as it designates an area of limit beyond which it may not be clear what can and cannot intelligibly be said. So for example, we know that a field is not a tortoise.

However, we may be happy to assume that a park is a form of field. Why? Because the terms 'field' and 'park' belong to similar semantic universes. The term 'tortoise' falls out with the limit language of the term 'field'. There is a huge diversity of meaning ascribed to the terms 'field' and 'park', but there is enough continuity of meaning to enable us to distinguish them as separate and to recognize the areas of experience that they designate.

The word God functions in a similar manner. It is not unintelligible or unimportant, but it denotes an area where positive assertion of characteristics or ideas may be limited or inappropriate because of the subject matter concerned. The word 'God' in theological language represents and preserves an intellectual space that is useful for some kinds of discourse. But the necessary incoherence, imprecision, and paradox that may be found in this kind of usage, although it may occasionally denote laziness and dogmatism, does not mean that the language being used is completely misplaced or useless. Just because we cannot clearly characterize God does not necessarily mean that God cannot in any way be characterized – it just means that we recognize the limits of language and so we should not overemphasize any notion of positive knowledge. Just because I do not quite know what I am talking about does not mean that I am talking about nothing; that what I am trying to talk about is not worth talking about, or that it is not worth trying to understand it better. So, it may be that treating spirituality as a similar kind of limit concept preserves an important space for exploration.

### **Spirituality as absence**

Having suggested that spirituality might appropriately be seen as limit language, it is possible to amplify this designation to argue that it tends to function as a way of naming *absences* rather than *presences*. It is not inconsequential that a number of nurse researchers contrast spirituality with the biomedical approach and argue that the latter has come to dominate healthcare provisions and that we need to develop a focus on the former (Swinton, 2001; McSherry, 2004; Pesut, 2010). Spirituality is related to issues of meaning, hope, purpose, connectedness, love, and so

forth, the implication being that these things are perceived as missing or downplayed within current approaches to care and treatment (Murray & Zentner, 1989; McSherry & Draper, 1998; Tanyi, 2002). Although these researchers may intend to introduce spirituality as a 'thing' that we need to reclaim (Swinton, 2001), the way in which they do this is by pointing towards particularly significant *absences* within current healthcare provision.

At one level this seems unproblematic. Until that is, it is asked whether and why one might choose to call the identified absent dimensions of experience 'spirituality'. At a practical level it seems plausible that people are often not, in fact, describing 'spirituality' as any kind of coherent entity when they talk about such issues. Rather, what they are describing is their (often personal) perception of spiritual well-being, i.e. what they intuitively perceive as being the effects of a person's spirituality on their life and well-being. Such experiences and qualities of human experience – meaning, hope, purpose, relatedness, transcendence, etc. – do not actually describe what spirituality is as an identifiable, discrete entity. (Hope is not a thing, it is a disposition; the search for meaning is not a thing, it is a process, a multifaceted human quest (Frankl, 1963; Pargament, 2007).) Rather, they describe a series of human desires or inclinations, or perhaps better, *quests* that are perceived as beneficial to people when they face the uncertainty of illness. Put slightly differently, they describe what spirituality *does*, not what spirituality *is*. The term 'spirituality' viewed from this perspective thus relates to the various quests that human beings engage in for the purpose of gaining a sense of well-being, and which take on particular significance in times of ill-health. Recognition of this dimension of experience and how healthcare professionals should respond to it appears to be missing from the ways in which health care is currently conceptualized and delivered. That being so, spirituality may well point towards a presence, but its primary task seems to be to name and highlight the importance of an *absence*.

### **Spirituality as a point of resistance**

The observation that spirituality names a process to do with recognizing an absence is crucially important.

In highlighting a possible presence (spirituality) and naming a perceived absence, spirituality in all of its diverse forms and meanings names a *point of resistance* against particular inadequacies that have been, albeit inchoately, perceived or sensed within health care and that people wish to resist.

In a Western context, an emphasis on the spiritual attempts to capture something of the phenomenology of illness (the lived experience of being ill) that has been underplayed by highly medicalized modes of healthcare strategy and delivery. In a highly secularized healthcare context, it seeks to recapture those dimensions of the human person that were once expressed in religious language and that are not captured effectively by biomedical discourse. So, by raising the importance of meaning, purpose, hope, love, God, relatedness, issues that often come to vital prominence during the experience of being ill, the language of spirituality points critically towards the gap between experience and current practises and becomes a point of socio-political resistance and protest against the absence of some kinds of language, significance, and modes of care. Because the absences are different in different contexts, understandings, and constructions, the emphases of 'the spiritual' and 'spirituality' will tend to shift and change sometimes quite radically across contexts and situations. Such variance will inevitably be encapsulated in the ways in which people define the spiritual.

### **Developing a thin and vague description of spirituality**

With all of the previous in mind, we would like to argue for a description of spirituality that does not assume spirituality to be a rich, thick theoretical concept, but rather assumes it to be a thin and vague construction that, within a nursing context, is defined by its practical utility rather than its conceptual clarity.

#### **A thin description**

A thin description (Geertz, 1973; Neville, 1995) of spirituality assumes it to be a mode of contextual language with practical intent, used in this case, as a

means of highlighting and expressing deficits and absences within healthcare provision and initiating positive change. We therefore will not assume that people *have* spirituality; rather we will go looking for those traits that we know have come to be represented by the term 'spirituality' in healthcare discourse and that are omitted from common medical parlance (pointing towards the absence); traits that both nurses and patients will respond to in a range of ways. The vital point here is that when we are speaking about spirituality we do not simply have an ethereal idea in mind that requires to be honed and defined; rather we have a social and political context in view that requires transformation and change. In other words, the content of the language of spirituality is characterized and motivated by what is lacking or absent within that social and political context. In this perspective, it is the practical content and function of the term spirituality as denoting absences that are dimly discerned and missed and protesting their exclusion from the healthcare arena rather than its conceptual structure that is of primary importance. So we might characterize the practical usage of the term spirituality as referring to the discomfort and resistance of people in the face of the exclusion and narrowing of quests (e.g. for meaning, hope, value, love, purpose, relationality and God) that they engage in as they try to live their lives.

### A vague description

Spirituality is not only thin, it is also vague. Although this designation sounds pejorative, it is used here to define precisely what can be most useful about categorization. As the philosopher Robert Cummings Neville explains it, theoretical vagueness allows for a broad field of comparison that is nevertheless meaningful in the minimal level of similarity that it identifies. He illustrates this through the metaphor of translation: 'Translation has to do with expressing the relatively specific in terms of the relatively vague, and then doing the same with some other relatively specific category, so that both specific things are expressed in the language of the vague level of categories that function as their unifying context'

(Neville, 1995, p. 61). In contrast to the current search for *the* specific meaning of spirituality, Neville argues that:

*[v]ague categories can counterbalance the distorting tendencies of specificity.* They assert the significance of foundational similarity between specific incidences that have been elaborated in diverse directions, they provide a perspective within which given differences can be seen according to their actual proportions and significance, and *they help theorists to see much much more than they otherwise might.* (Shantz, 2009, pp. 10–11, Italics added.)

Understood in this way, the thinness and vagueness of spirituality reveals it to be a deeply practical, revelatory, and important term, even if it does primarily denote uncomfortable absences and hoped-for presences that patients and carers seek after, but often do not find.

Seen from this perspective, the term spirituality relates to the way people perceive and *actually* respond to all aspects of the context of contemporary health care. It is that practical perception and response that service providers should be interested in knowing about and helping to foster. Thus, the activity of 'spiritual care' or responding to 'spiritual need' becomes a matter of recognizing what people fail to receive in healthcare contexts and trying to ensure that they are, as far as possible, assisted on their multiple quests to make that which may be absent present. For some people, this kind of quest may be an overtly religious one and they may require and seek religious care to meet religious needs. For others, their 'spiritual quests' may be human or even material.

Significant absences come in many diverse forms and are met through any number of significant mediations. Although understandings of spirituality may be thin, vague, and functional, the meeting of spiritual needs and the fostering of spiritual quests may require a very thick, complex, and nuanced understanding and response. Understanding and nurturing these quests will require interdisciplinary approaches that draw on a variety of perspectives – psychology, sociology, philosophy, anthropology, religious studies, theology, and medicine – to enable people to attain the fulfilment of their quests (Swinton, 2006).

### **Spirituality as a point of resistance: the politics of time**

We have argued that spirituality can be seen to have come to represent a point of resistance or protest that reveals and addresses significant omissions in the ways in which health care is currently conceived of and delivered. A good example of this emerges around the apparently simple issue of time.

If the quests of spirituality include such things as enabling people to discover meaning, purpose, hope, and connectedness in the midst of situations that often appear profoundly meaningless and hopeless, then these quests will require practitioners to take time with patients; to come close and to listen. And yet a primary complaint 'from the ground' with regard to spiritual care is that people do not have time to spend time with patients. In the context of health care, 'I don't have time' is not a politically neutral statement. Not having time to do something relates to priorities and the ways in which we choose to prioritize our time. Within Western culture, time is considered to be a commodity. We 'waste time'; 'spend time well'; 'lose time'; 'sell our time'; and so forth. Within health care, time is a recognizable commodity that forms an important dimension of the politics, structure, and economics of the system. If we do not have time to do good care, then it may well be that the system is forcing us to spend time in the wrong places. A focus on the quests of spirituality understood as the attempt to make the absent present, immediately brings us to a point of resistance wherein we are forced to notice the politics of time and their implications for the type of care that we are allowed to deliver at a personal and at a systemic level. In pointing towards the space and revealing the nature, meaning, and significance of time, a focus on spirituality reveals a significant flaw in the way in which we are expected to deliver care and offers us a series of questions that we can engage in that will challenge us to fill that space in a different way. In this way, those who wish to offer spiritual care become champions of a different understanding of time – they have to begin to tell the time differently!

### **Spirituality as sensitizing language**

If what we have argued thus far is apposite, then the space that spirituality has come to point towards within healthcare practises represents a cluster of often inchoate and inarticulate, but nonetheless important quests, needs, and absences. These, when brought together within the term 'spirituality', offer a metaphorical container for a field of enquiry intended to enhance human well-being in ways that are currently unavailable within models and configurations of healthcare provision. The term spirituality and the discourse that surrounds it, at least at its best, functions as a sensitizing concept that draws our attention to issues such as meaning, purpose, relationality, hope, value, love, God, and transcendence; areas of experience that may well be overlooked without this sensitizing function. Despite its vagueness and lack of conceptual clarity (or perhaps because of these things), the use of the term spirituality underscores particular areas of human experience that are vital for genuinely patient centred care.

### **Conclusion**

If a thin and vague understanding of spirituality is an important part of functional, performative, and expressive language that denotes inchoate, ill-defined absence and the quest to relieve that absence is adopted, the area of care that the term spirituality has come to represent is seen to be much more concrete, radical, political, and important than is often assumed. If our arguments are correct, we might think of spirituality as functioning like a string or a rope placed around a space in which real absences in health care are acknowledged in order to provide the opportunity for the quests for making good these absences to be undertaken. We might use the image of putting a rope around an area of deserted land in order to allow wildlife to develop and flourish. This understanding has some empirical pull, insofar as it allows the identification, naming, and fulfilling of absences in quite concrete ways – but it is also vague and open enough to admit that we may not always coherently be able to identify and express what we have not quite got. It allows and preserves spaces for both the concrete and

external, e.g. better bed baths, and also for the inward and imaginative – I do not quite know what I have not got, but I sense there is something missing here.

### Spiritual care

Spiritual care then has to do, *inter alia*, with recognizing the points of resistance within the ways in which care is delivered and responding, sometimes in quite simple and basic ways. Such spiritual care might both resist current practises and model new ways of caring that recognize and respect the quests of spirituality as central to the delivery of care. In this context, spiritual care is not to be understood as a single thing, a single task, or even a discrete series of tasks. It denotes the multifarious, disparate, and pluriform skills and perspectives that carers need to learn in order to cater well for certain aspects of the experience of illness as it is lived out within particular contexts.

Thus, if one aspect of functional spirituality is the human search for meaning then carers will need to develop approaches and methods to enable them to deal with the existential quests of people in times of illness (Breitbart & Heller, 2003). If spirituality denotes a quest for hope, the desire for relationships, or the construction of purpose, then, again, various approaches and techniques will be required to enable nurses to care well for this aspect of people's lived experience of illness (Lopez *et al.*, 2000). If spirituality is a search for God and the transcendent, then facilitating that quest requires a particular set of skills and knowledge of religious traditions, theology, religious practises, or at least an ability to recognize the need and refer to appropriate persons (Koenig, 1998).

### Nurse education

This of course raises the issue as to precisely how nurses can be taught spiritual care and, more importantly, precisely what they should be taught. If the concept is as vast as we have suggested, then does it not become almost impossible to train nurses to help in this area? We think not. If spiritual care is not perceived as a single thing, but rather as a response to a variety of human quests, then the key seems to lie in enabling nurses to identify and respond effectively to

the particular spiritual quests that they encounter within whatever situation the nurse finds herself in. What is called for in terms of nurse education is therefore flexibility and consciousness raising. This will mean teaching nurses the significance of spirituality in ways that are flexible and contextually workable and raising nurses' consciousness to dimensions of their caring practises that are often hidden or forgotten (Swinton, 2001). What is needed is an interdisciplinary (or multidisciplinary) approach that recognizes the general area of spirituality as it has been identified in the literature and notices and takes heed of the family resemblance between the various definitions and perspectives. What we mean here is that although there is much diversity over definition and a good deal of contextual construction of spirituality, there remains nonetheless a family resemblance between the various definitions. In other words, there are enough similarities between the various definitions that mean that the concept has limits. Likewise, there are certain common ideas that run through the literature and that can be used as points of orientation. Thus, for example, there is a recognized body of literature focusing on the significance of meaning along with established models education and practise (Breitbart, 2002). Similarly, there are established bodies of literature that can be used to teach nurses on issues of hope, religious issues, connectedness, and so forth (Brown, 2002; Stanton *et al.*, 2002; Chan & Chung, 2004; McSherry, 2004; Cobb, 2005). Introducing nurses to these bodies of literature would help them to identify in practical ways, with the established literature on spirituality and spiritual care, thus enabling the raising of nurses' consciousness to the field of enquiry currently named as 'spirituality'. This mode of spiritual education would seek not only to impart knowledge, but also to introduce nurses to a particular way of seeing the world and in so doing raising their consciousness to the possibility of the presence of spirituality and the absence that it names. As per our previous argument, the nurses' perception of spirituality will vary as will their practise. They would nonetheless be introduced in practical ways to a field of enquiry which has boundaries, but which remains flexible and to some extent indefinable.

If we are correct in the discussion we have presented in this paper, then it is clear that spirituality is a significant, functional, and useful reality within contemporary healthcare delivery even though its nature and existence (in ontological terms) necessarily remains contested. As a matter of fact, it is probably important that spirituality remains a contested and functional concept rather than becoming consolidated if it is usefully to denote the kinds of contextual absences that need to continue to be recognized and worked with. Some of the quests denoted by this thin understanding of spirituality are accessible and have positive implications for the delivery of health care. However, within a secular and often secularizing context such as the National Health Service, careful attention needs to be paid to precisely how and why spirituality is constructed in the ways that it is and exactly what role it might have within a social context that in a meaningful, but not derogatory sense is both post-Christian and post-religious.

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