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Identity and resistance: why spiritual care needs 'enemies'

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Aims. This paper explores certain key critiques of spirituality-in-nursing as they have been offered by people outside of the discipline. It argues that nurses have not taken seriously enough the recent criticism of the nature and role of spirituality in nursing. Not to listen to the 'enemies' of spirituality-in-nursing is to risk stagnation and a drift into obscurity.

Background. The area of spirituality has become a growing field of interest for nurses and has produced a burgeoning body of research literature. Yet, whilst much has been written about the positive aspects of spirituality, nurses have offered almost no critique of the ways in which spirituality and spiritual care are understood, despite the fact that there are clearly certain key issues that require robust critique and thoughtful reflection. Almost all of the major criticisms of spirituality-in-nursing have come from people outside of the discipline of nursing. The paper argues that nurses need to listen carefully to the criticisms of spirituality and spiritual care offered by the 'enemies' of spiritual care in nursing. When listened to constructively, they highlight issues that are vital for the development and forward movement of this important area of nursing practice.

Methods. Literature review and critical reflection on current critiques of spirituality in nursing practice.

Conclusions. The paper concludes that nurses need to begin to develop spirituality as a specific field of enquiry with its own bodies of knowledge, methodologies, assumptions and core disciplines.

Relevance to clinical practice. In listening to and taking seriously its 'enemies', nursing has the opportunity to establish spirituality as an important, creative and vibrant aspect of nursing practice that has the capacity to grow and respond constructively to its 'enemies', in ways that make whole-person-care a real possibility.

Key words: health, nursing, quality of life, religion, spirituality, well being

Introduction

It is clear from the burgeoning literature on spirituality and nursing that the area of spirituality and spiritual care is perceived by a growing number of nurses as a significant dimension of their practice. Nurses are called in many different ways, to recognize and respond to the subtle rhythms of the human spirit and to challenge practices, systems and policies, which threaten to blind them to the importance of this important dimension of human experience (Ross 1994).

There is little question that nurse academics, researchers and educators have helped us to recognize an important area of patient care. Within a highly technologized healthcare system that shapes its practices and assumptions under the ever-present shadow of scientific reductionism, it is easy to overlook subtle yet vital issues of humanness and well being which may 'slip under the radar' of accepted mainstream care strategies. A focus on spirituality enables us to remember dimensions of the experience of illness and, indeed, of being human which patients, in many different ways, express a

need and a desire for (Ross 1997a,b, Mental Health Foundation 1999, Swinton 2001).

However, while there has been progress within this area of nursing care, there remains a need for caution. There is a concerning lack of movement and growth within some of the spirituality literature and little evidence of there being a positive movement towards a new phase of development. The conversations that occur around the role of spirituality in nursing tend to be rather static (what is spirituality, what is spiritual care, etc.; Greasley *et al.* 2001, Coyle 2002, Tanyi 2002). It is rare for nurses to end up arguing over the validity or appropriateness of the ways spirituality is conceptualized and spiritual care practiced within nursing. On the rare occasions when this does happen, the conversation tends to be with people outside of nursing (McSherry 2005).

The lack of a rigorous internal critique of the validity of certain key assumptions about the nature and role of spirituality-in-nursing has created a situation wherein nurses now find themselves vulnerable to some convincing critiques from other disciplines. These critical voices have offered important challenges to the ways nurses conceptualize and use spirituality in their education and practice. However, nurses seem to be unprepared for such challenges. With one notable exception (Bash 2005a,b, McSherry 2005), nurses have not raised any serious responses to the emerging critique of the validity of spirituality-in-nursing. The 'enemies' of spirituality-in-nursing are beginning to surround the camp, yet there is little resistance being offered by nurses to their increasingly penetrating 'attacks'.

In this paper I will reflect constructively on some of the criticisms of spirituality-in-nursing that have recently been offered by voices from outside the discipline. I will argue that nurses should listen carefully (but not uncritically) to these external voices and allow their apparently negative observations to act as a stimulant for creativity and identity-formation. Like grit in an oyster, our 'enemies' hold the potential to function creatively and encourage the field of spirituality-in-nursing to move on to its next phase.

Identity and resistance

Nursing has a long history of incorporating spirituality into its practices (Carson 1994, Barnum 1995, Bradshaw 1996). However, it is only relatively recently that the term 'spirituality' has been assumed not to have a necessarily correlate in religion (Bradshaw 1994). This is an important observation. While some writers seem to assume that we are dealing with a long-standing issue within nursing, that is only partly true. In relation to models of spirituality that relate only to formal religion, nursing does indeed have deep historical roots and a long tradition (Bradshaw 1994, Barnum 2003). However, in relation to the more generic models of spirituality, which are not defined by specific religious traditions and which are assumed to apply to all human beings, the history of the debate is relatively recent (Davies 1994, Meador & Schuman 2004). This is an important point for our current discussion. The various debates that surround the definition and practical utility of spirituality – what it is, how it is to be understood in its religious and non-religious forms and precisely how nurses should best manage it within their clinical encounters – are, relatively speaking, in their infancy. Spirituality-in-nursing, (differentiated from religion-in-nursing) is thus seen to be an emerging field within the nursing profession, the parameters of which are currently being negotiated, challenged and developed. What the field of spirituality-in-nursing will become has yet to be fully negotiated and, indeed, similar to the definition of religion (Walter 2002), will probably never be fully defined in a way that is agreed upon by all. Viewed in this way, we can see that the various debates over the definition and clinical utility of spirituality in nursing practice could be viewed as part of the process of this particular field of enquiry moving away from its religious roots and seeking to develop an identity that will capture something of its new dynamics.

The question of identity

An analogy with human identity formation will help clarify the significance of this observation. Scottish philosopher John Macmurray (Macmurray 1961, 1991) offers a perspective on personhood and identity formation that is understood in terms of *relationship* and *resistance*. In distinction from Cartesian notions that the essential self is the isolated thinking self (Descartes 1984), Macmurray argues that we become who and what we are (develop our personhood and identity) not as we reflect on our own, but as we relate to and engage with others. It is as we encounter others in meaningful personal relationships, as we engage in actions with and towards one another, that we discover the limits of the self: our *identity* and personhood. Macmurray argues that the development of personhood and identity requires agency (agency being understood as a state wherein one person acts upon or exerts power over another); agency requires another person who will *resist* the Self. If there is no Other available to offer us resistance, as Anderson observes, 'the self as agent cannot experience itself, because there will be no ''other'' than self to constitute a limiting factor to the movement of the self. The opposition, which comes in the form of that which is Other than the self, constitutes the unity of the experience of the self as Agent' (Anderson 1975, p. 194). Put

slightly differently, in line with the argument of this paper, it is only as we (in this case spirituality-in-nursing) engage with the Other (our 'enemies') and encounter resistance-to-Self, that we discover the limits and boundaries of the Self, that is, our sense of identity.

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If we use this model of identity formation as an analogy for the current state of the field of spirituality-in-nursing, then the need for critical voices of resistance becomes apparent. It is my proposition that the field of spirituality-in-nursing is currently in a state of static equilibrium with no particularly new or radical thinking emerging and very little critical appraisal of the field coming from within nursing. I have also suggested that spirituality-in-nursing is an emerging field that is currently negotiating the nature of its identity. In order for this process of identity formation to develop creatively and effectively, there is a crucial need for voices-of-resistance that will challenge certain accepted assumptions about the nature and role of spirituality in nursing and engage in forms of debate that will move the field towards a clearer understanding of its identity and purpose.

Listening to our 'enemies'

It is for this reason that the recent critiques of spirituality-in-nursing should be welcomed by nurses as they provide important and necessary resistance and challenge. Such critiques, whilst not always accurate or fair, nonetheless provide an important source of resistance, which offers the field an opportunity to address some central issues that have not been fully addressed thus far. It is not possible here to address all of the points of critique that have been raised in relation to spirituality-in-nursing. It is, however, possible to open a debate by reflecting critically on some key issues relating to a central debate – the implications of the separation of spirituality from religion – and use that critical reflection to raise certain other vital issues. Such reflection will help make the point that nurses need to engage more critically with the theory and practice of spiritual care and with those who bring the problems to their attention.

The separation of religion and spirituality: universal definitions, indoctrination and the problem of internal conversations

As mentioned previously, one of the key features within the field of spirituality-in-nursing is the general assumption that spirituality and religion can and indeed should be separated from one another (Meehan & MacIntyre 1995, McSherry and Draper 1998, Swinton 2001, McSherry & Ross 2002). It is assumed that, while only some people are religious, all people have spirituality. Religion is understood as just one of many ways in which a person can express his or her spirituality. There are of course significant philosophical and theological problems with this distinction, which some critics of spirituality have been quick to highlight (Meador & Schuman 2004). These critics argue that the idea that spirituality is a generic, human universal downgrades the possible ultimate significance of the particular (religion) and opens the way for a commodification of spirituality which is very much in line with Western consumerist assumptions (Meador & Schuman 2004). Like cornflakes or blue jeans, we find a spirituality, which suits our personal taste and go with that until it ceases to fulfil our needs, then we move on to another form of spirituality. Such an approach to spirituality is very different from the approach of the major religious traditions. It is, therefore, debatable whether such understandings of spirituality are actually compatible with religious understandings (Markham 1998, Pattison 2001). These are important discussions that nurses need to engage in. However, my focus here is on a slightly different point of critique that relates to the way this 'generic spirituality' is often divided up.

There is no clarity as to the precise way the split between spirituality and religion should be understood. Roughly divided, the concept of 'spirituality' could be defined under three subdivisions: *religious*, *non-religious* and *amalgamist*. The religious definitions offer an understanding of spirituality, which relates directly to a specific religious tradition (Bradshaw 1997, O'Brien 1999, Shelly 1999, 2000), the non-religious definitions present their understanding of spirituality in secularist or humanistic terms (Burnard 1988, Emblem 1992, Carson 1993, Tanyi 2002). There may be an informal theistic dimension within these non-religious definitions in the sense that God or a higher power is not ruled out, but spirituality is not understood as relating to any kind of formal religious system. The final type is the amalgamist. The word 'amalgam' as used here relates directly to the blending of two or more meanings into a single name. Amalgamist definitions attempt to present understandings, which can be applied to all people, both religious and non-religious. The amalgamist definitions are perhaps the most vulnerable to critique as they can easily be accused of presenting a 'one size fits all' spirituality (McSherry 2005), a form of spirituality which assumes a homogeneity amongst human beings, even those who adhere to specific religious traditions, that is questionable (Augsberger 1986, Lartey 2003). Nevertheless, amalgamist definitions remain popular and form the essence of so-

called 'generic spiritual care'. Such an approach to spirituality can seem appealing within a healthcare context where an emphasis on political correctness tends to make people wary of the particularities of traditional religions. Nevertheless, appealing as it may appear to be, such an approach to spirituality is, as will become clear, problematic.

While a good deal of intellectual energy has been expended by nurse academics and researchers on developing and clarifying the religion/spirituality dichotomy, it is still not at all clear that nurses working in the field understand what the term 'spiritual' means when it is dislocated from religion (McSherry *et al.* 2004). Despite the emphasis on spirituality and spiritual care at a policy level, there is evidence that nurses tend to focus on the psychological and physical aspects of the patient's experience and are much less clear on what they should do with the spiritual dimensions (Oldnall 1996). Indeed, as Ross has pointed out and as much anecdotal evidence would suggest, nurses tend to see referral to the chaplain or other religious carer as a central aspect of spiritual care in nursing practice (Ross 1997).

None of this, of course, invalidates the importance of spirituality for nursing practice. It does, however, mean that nurses have to receive specific forms of education within this area of care, education designed to enable them to see the importance of spirituality and to understand the separation of spirituality from religion. And it is here, within the education of nurses for spiritual care, that some critics of spirituality-in-nursing have raised important issues.

Education in spiritual care: 'but whose model is correct?'

Walter (2002), in his interesting critique of the suggestion that all nurses should be expected to engage in spiritual care, observes that many nurses (particularly those who have no religious background) do not 'naturally' see the divide between spirituality and religion and 'have to be consciously taught both the newly approved meaning of the term ''spirituality,'' and that it is different from religion' (Walter 2002, p. 136). This, he argues, is precisely what workshops on spiritual care laid on for nurses do. The 'successful workshop takes non-religious nurses who are troubled by, or indifferent to, the requirement for them to provide spiritual care and persuades them that everyone has a spiritual search for meaning, that this is different from formal religion and that nurses can play a significant role in providing spiritual care' (Walter 2002, p. 136). Within the nursing literature, there does appear to be a sense in which education is perceived as raising nurses' consciousness to the importance of spirituality, particularly in its non-religious forms (Narayanasamy 1993, Sterling-Fisher 1996, Catanzaro & McMullen 2001). There is, however, no obvious self-reflection as to the potential dangers of this approach.

At one level, one could frame this desire to educate nurses in spirituality quite positively as an act of conscientization (consciousness raising) (Freire 1993). In developing the area of spirituality-in-nursing, nurse researchers have recognized that the story of illness can never be fully narrated by the disciplines of medicine and science alone. They recognize important 'forgotten' dimensions of patient care that patients often highlight as important (Ross 1997) and seek to offer an alternative to scientific reductionism (Swinton 2001). Viewed within this frame, such modes of education in spiritual care appear to be positive additions to the continuing professional development of nurses.

This, however, is not what Walter is pointing us towards. The implication of his reflection is that the education of nurses for spiritual care can actually function as a subtle (or not so subtle!) mode of indoctrination wherein narrowly defined understandings of spirituality worked out by nurse academics with their own particular agenda are put forward as *the only* understandings of spirituality that can have clinical utility for nurses. Part of his point is that the implicit or explicit function of certain definitions of spirituality that are available within the literature and taught by nurse educators, is not simply to bring clarification to the idea of spirituality and spiritual care, they actually function to put precise boundaries around what nurses think spirituality and spiritual care are. In so doing, nurses are prevented from seeing wider possibilities and developing different understandings of spirituality and spiritual care. This places nurse academics and educators working within the field of spirituality-in-nursing, and those who teach nurses spiritual care, in a very powerful position.

The power of nurse academics and educators to shape understandings of spirituality and spiritual care according to their particular agendas is highlighted in a different way by Gilliat-Ray (2003). In her important critique of spirituality-in-nursing, she argues against generic and general definitions and understandings of spirituality in nursing, suggesting that the developing interest in claiming spirituality as a field of enquiry for nurses is part of an arguably unconscious effort to professionalize nursing. 'The concerted efforts to define spirituality in relation to nursing and the stress placed upon the need for nurses to be trained in the delivery of such care stands out as an effective strategy for making professional claims. Spiritual care can thus become an area of work over which nurses have a clearly defined monopoly – especially in relation to doctors – based upon their own body of knowledge' (Gilliat-Ray 2003, p. 343). This criticism

suggests that the field of spirituality-in-nursing is being used by nurse academics with a professionalizing agenda as a tool in their quest to develop a discrete body of knowledge that will set them apart as a group of professionals with an identity that is clearly distinct from medicine. Spirituality thus becomes an area of exploration, research and expertise, which is deemed to be unique to nursing and which offers a sense of professional identity over and against medicine.

Taken together, Walter's and Gilliat Ray's critiques provide a powerful challenge to the validity of the ways in which spirituality and spiritual care are taught and practiced as well as to the assumed value-neutrality and presumed altruism of the field of spiritual care within nursing. But are they correct in their concerns?

Education or indoctrination?

Walter's and Gilliat-Ray's perspectives make those of us who wish to argue for the importance of spirituality in nursing more than a little uncomfortable. Are we really being indoctrinated? Or worse, is it we who are doing the indoctrination!? Are we really being manipulated by academics for purposes beyond our immediate ken? Could there be agenda at work, which reach beyond the compassion of the immediate act of spiritual care? However, if we reflect a little more closely on the way spirituality is defined and reflected on in the nursing literature, and the ways that nurse academics form and use their definitions of spirituality, these challenges take on more poignancy than we might desire them to. A critical reflection on one of the most frequently used definitions of spirituality within nursing literature will help raise our consciousness to some important issues.

Thinking critically

Murray and Zentner (1989) offer a definition of spirituality which is frequently cited by nurse researchers within the literature (McSherry 2000, Carroll 2001, Thomson 2002, Papadopoulos & Copp 2005) and has formed the basis of some healthcare policy in spiritual care (Harrogate Heath Care 2004). They describe spirituality thus:

> a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in any good. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes essentially into focus in times of emotional stress, physical (and mental) illness, loss, bereavement and death (Murray & Zentner 1989, p. 259).

This definition sits within the amalgamist camp. It claims to move beyond religion and God, whilst at the same time seeking to incorporate aspects of 'spiritual experience' – inspiration, reverence, awe, meaning and purpose, which find significant resonance with the forms of spiritual experience encountered within many forms of religion. It fits neatly with the generally accepted goal of providing spiritual care for people of 'all faiths and none'.

This definition is frequently quoted within the nursing literature as providing a sound and inclusive understanding of spirituality. However, the fact that it 'meets the bill' so neatly should raise our suspicions. If, for example, one were to ask the question of how the authors came to this definition, the initial apparent clarity begins to fade. On what basis should we be persuaded to take it seriously? Within which body of knowledge, religious tradition or philosophy is this definition rooted? What empirical evidence is used by the authors and those who quote them, to support the claims that this is what spirituality is for all people? Furthermore, what do the components of the definition actually mean? What might terms such as *inspiration* (a filling of the human spirit), reverence (towards what?), awe (in relation to what?), meaning and purpose mean without some form of clear epistemological, religious or moral context? This lack of moral clarity or ethical boundaries makes definitions such as this dangerous. Should nurses respect the patient who is inspired by the work of the paedophile ring with which he is currently engaging and who is in awe of the quality of the photography, his reverence towards the leader of this group of people and the meaning and purpose that his involvement brings to him should, presumably, be nurtured by nurses during his time of illness. Again, Wakefield (in Pattison 2001) observes that Hitler had a powerful spirituality, which fits with a good deal of the content of Murray and Zentner's definition. Should nurses respect this form of spirituality? When we begin to break down the content of the definitions further, it becomes even more odd. What might it mean to 'be in harmony with the universe?' What would that feel like and who could tell you? When such questions are asked, the criticism that such definitions of spirituality 'are diffuse, vague and contradictory' (Pattison 2001, p. 37) are difficult to refute! Amalgamist definitions like Murray and Zentner's do not really tell us much about spirituality as a universal human experience. They may, however, tell us much about the particular philosophical or theological leanings of the people who constructed the definition and how they want spirituality to be understood and spiritual care to be carried out.

The failure of definitions

The wide acceptance and uncritical usage of Murray and Zenter's definition (and others like it) opens nursing up to precisely the type of criticism that Walter and Gilliat-Ray offer. Nurse researchers and teachers have tended simply to use definitions such as this one to make their case regarding the importance of spirituality in nursing without thinking through its implications. Because we have not reflected critically on the implications of the definition and simply quoted it copiously as a 'good inclusive definition', nurses have ended up engaging in an ongoing internal conversation which has focused on a definition and a series of concepts which, it would appear, the original authors seem to have simply made up in order to make a point based on the need for inclusivity. Because this definition is deeply flawed and appears not to be based on any particular body of knowledge or research evidence, it is then easy for the critics of spirituality-in-nursing to make a case that suggests that definitions such as this function as modes of indoctrination wherein nursing academics (with their own particular agendas) create concepts for their own purposes which in turn shape practice, policy and the professional identity of nursing.

Truth, method and the problem with teaching narrow definitions of spirituality

In his book *Truth and Method*, Gadamer (1981) offers a critique of method that will illuminate the point being made here. For Gadamer, the problem with method is that it inevitably shapes and puts boundaries on the types of practices that emerge from it. Method has its questions and standpoint constructed prior to engagement with action. The person embarking on the enquiry simply substantiates or refutes the given theory. Methods create the 'plausibility structures' (Newbigin 1989) – the boundaries that mark out what appears plausible or implausible within a certain context or culture – within which people make sense of a phenomenon or indeed of their world. Method illuminates some aspects of a situation, but blinds us to other important aspects. The insight gained from Gadamer's critique of method can helpfully be applied to the current discussion.

In their research into the meaning of spirituality for nurses and patients, McSherry *et al.* (2004) discovered that the nurses within their sample *all* had an understanding of spirituality not dissimilar to Murray and Zentner's model. They interpreted this finding in terms of nurses having constructed a discourse around spirituality, which they argue, is incomprehensible to patients. This may be the case, although it is not at all clear that the language of spirituality is as alien to the general public as McSherry *et al.* (2004) seem to suggest (Hay & Hunt 2001). However, a more challenging interpretation of these authors' findings is offered by Bash (2004) in his critique of spirituality in nursing. Bash suggests that McSherry *et al.*'s findings confirm the suggestion that 'within health care, staff are educated to express their understanding of the term (spirituality)…according to only one of many possible definitions' McSherry *et al.* (2004) Weight is given to this suggestion by McSherry *et al*'s observation that 'nurses provided clear definitions of spirituality in line with Murray and Zentner (1989)'. This is rather odd, bearing in mind the fact that, as Bash (2004) points out, you would not get such unanimity over the definition of spirituality if one asked the same question to clergy in England; that is, those who are trained to consider the spiritual dimension as central to their occupation. From my position in Scotland I can confirm that a similar lack of unanimity over this issue is true of clergy on this side of the border! Walter's critique that nurses are educated into narrowly defined and restricted understandings of spirituality and spiritual care might be given some weight in the light of the findings of McSherry *et al.*'s (2004) study.

Bearing in mind the above critique of the questionable basis on which Murray and Zentner's definition of spirituality appears to be based, it is no surprise that in McSherry *et al.*'s study, Murray and Zentner's 'definition and its assumption that spirituality comes into focus at a time of illness or crisis was not reflected in the patient's view' (McSherry *et al.* 2004). The people interviewed may well have had deep spiritual experiences. However, if these experiences fell outside the spiritual worldview of the nurse whose understanding of spirituality has been shaped and confined by this definition, they simply would not see it or hear it. If true, this is a most unsatisfactory and deeply concerning situation.

It would seem that Walter's critical observations have alerted us to an important issue for nurses seeking to engage meaningfully in spiritual care in an authentically person-centred manner. Similarly, Gilliat-Ray's (2003) suggestion that spiritual care can easily become co-opted into academic agendas which reach beyond the simple desire to provide spiritual care, whilst not proven by this discussion, is certainly given some credibility and weight.

Some thoughts on a way forward: developing a field of enquiry

The previous discussion has highlighted my central point: that the field of spirituality-in-nursing needs to listen to its

'enemies' if it is to grow, develop and find a credible, sustainable identity. There are certain fundamental issues that are being raised by the critics of spirituality, which demand not defensive, apologetic argument for the status quo, but serious critical engagement that honestly acknowledges the difficulties and is prepared to wrestle seriously with the issues. In the final sections of this paper I would like to make some suggestions as to how we might move forward as we continue to develop this vital area of patient care.

Spirituality-in-nursing: marking the boundaries of a field of enquiry

It is clear that the field of spirituality-in-nursing is diverse and contains a wide variety of perceptions and understandings. This diffuseness is certainly problematic, but it does not necessarily mean that 'theorists and practitioners of spirituality are muddled about what actually constitutes their subject matter' (Pattison 2001, p. 37). True, some may be, but if the analysis offered above is correct, the diversity might best be understood in terms of a search for identity which is taking place within a general field of enquiry which is identifiable and which, at least in potential, has shared and recognizable aims and goals. By the term 'field of enquiry', I mean: *a recognized and recognizable field of knowledge, investigation and experience*. Of course the critics of spirituality-in-nursing will inform us that this is not possible. I would want politely to suggest that they are wrong!

The area of spirituality-in-nursing has the potential to become a recognizable, vital, empirically viable, multidisciplinary field of practical enquiry that has relevance at both academic and clinical levels of nursing practice. Within this 'field of enquiry' there is a diversity of definitions, methodologies and understandings, some that are in harmony with one another, others that are clearly challenging and even contradictory. The epistemological tension experienced around the area of spirituality is not unique to spirituality-in-nursing as a field of enquiry. Nevertheless, I would want to argue that, building on the criticisms offered by our 'enemies,' it is possible to develop a coherence and an identity within the field of spirituality-in-nursing that is not present at the moment.

Disability studies

The emerging discipline of disability studies offers a useful model for the type of approach I am advocating (Linton 1998, Albrecht *et al.* 2001). Disability studies attempt to reframe human disability by focusing attention on the fact that disability is as much a social problem as it is a biological or psychological one. This field of enquiry has emerged as people with disabilities have begun to notice the critical fact that disability is a social construct and that policies and practices, which appear 'normal' within society, can be deeply oppressive to people with disabilities. For example, why do people with the label of schizophrenia find it so hard to find employment? Is it their lack of ability or the power of the label of their diagnosis (Swinton 2000) Within disability studies, disabling aspects of society are uncovered and reflected on using a critical, multidisciplinary, dialectical approach that is designed to reveal ways in which the structures and values of society can be deeply oppressive for people with disabilities.

The field of disability studies draws together a variety of core disciplines – economics, politics, sociology, psychology, social theory – to examine the experiences of people with disabilities and to push for changes in attitudes, values, practices and policies. There are various ways the study of disability is carried out, and a range of contradictory approaches, responses, models and understandings have emerged from within this field of enquiry. Nevertheless, what holds them together is a shared focus on the oppressive experiences of people with disabilities and the suggestion that current practices need to be challenged and altered in order that people with disabilities can remain full citizens, perceived as whole persons in every aspect of their lives.

Spirituality-in-nursing

There are important similarities between the field of disability studies and the field of spirituality-in-nursing. Like disability studies, the definitions and perspectives that form the field of spirituality-in-nursing are diverse and various. However, one could argue that they have emerged from and are held together by a common desire to offer an alternative to scientific reductionism. Within a healthcare context that tends to be dominated by finance efficiency and the medical model, nurses have begun to notice that something important is missing within current strategies for patient care. They have also noticed that there is growing body of evidence to suggest that this omission can be detrimental to the health and well being of patients (Koenig *et al.* 2001). A focus on spirituality reminds nurses and, indeed, the healthcare system, of the importance of coming close and listening intently to the personal meaning of illness; unique, personal meaning which can easily become subsumed in the power of diagnostic categories. The need for healthcare practices to move from reduction-

ism to holism, from the universal to the particular, from diagnoses to persons-in-relationship, forms the common core of the field of enquiry called spirituality-in-nursing. It seems to me that there is enough shared focus with regard to purpose and intention for there to be justification in calling spirituality-in-nursing a discrete and recognizable field of enquiry.

A multidisciplinary field of enquiry

To begin to address the depth and breadth of human spiritual experience and to avoid the dangers of overly narrow (or overly broad) definitions that, as we have seen, can be highly problematic, we will have to learn how to be self-consciously *multidisciplinary* in our approach. I say multidisciplinary rather than *interdisciplinary* deliberately. Interdisciplinary work tends to look for synthesis and common ground between the disciplines. There are at least two dangers inherent in this approach. Firstly, there is a danger that the most powerful voice within the interdisciplinary conversation takes priority and overwhelms the other voices (e.g. the way in which implicit and explicit perspectives from existentialist philosophies have, in some cases, excluded or downgraded religion in the discussion of spirituality-in-nursing).

Secondly, interdisciplinary work can become a quest for the lowest common denominator: 'what is it that we can all agree on and how can we synthesize this between the disciplines?' Here much that is crucial can be neglected or discarded (e.g. the particularity of religious traditions or the uniqueness of an individuals' spiritual experiences) in a quest for *unity*, *agreement* and *synthesis*.

Multidisciplinary work approaches the table of dialogue assuming that each of the disciplines has something unique and sometimes creatively contradictory to offer to the discussion. The key features of this approach are *hospitality*, *dialogue* and *dialectic* – dialectic in the sense of two different and perhaps opposite entities coming together to 'create' something that might be radically different from either position. Of course both approaches can throw up radically new challenges, but there is a danger with *inter*disciplinary work that the search for synthesis actually prevents new growth.

Religious and non-religious spirituality

For such a multidisciplinary approach to work itself out effectively, it might be appropriate to narrow the models of spirituality used to two primary approaches. Rather than holding tenaciously to three models of spirituality – religious, non-religious and amalgamist – perhaps a useful way forward would be to stick with only two models: religious and non-religious. (The non-religious does not rule out a person having non-religious theistic beliefs, but it does not attempt to frame or understand these beliefs in terms of secularized religion (Markham 1998). One advantage in this dichotomy, in addition to conceptual clarity, would be that it would enable nurses to focus on the task of developing a meaningful evidence base to support the various definitions that are offered. There are certain key disciplines, such as ethics, sociology, theology, pastoral care, anthropology, psychology, which nurses could draw on to support their understandings of spirituality and spiritual care in ways which are both creative and rigorous.

Religious spirituality

The area of religious spirituality encompasses a wealth of data and a rich history relating to the religious traditions that can help nurses clarify and develop our understanding of what spirituality is (and is not) and what it might mean for those who practise within certain religious traditions. *I am not* suggesting a tick box approach wherein the nurse simply learns some basic information about a religion and then assumes that she knows how to deal with a Christian, a Jew or a Muslim. Our critics have convincingly pointed out the failure of this approach and the ways it fails either to understand, respect and value religious traditions or the particularities of human experience. There is, nonetheless, a wealth of material within, for example, the psychology of religion, chaplaincy, anthropology and pastoral care which, when brought into dialogue with the religious traditions, shows how nurses might respect the reality that people experience their religion:

1 In ways that are common to all within the tradition;
2 In ways that are particular to specific communities;
3 In ways that are unique to the individual (Augsberger 1986).

There is also a burgeoning body of literature which indicates positive (and negative) correlations between a person's religious beliefs and involvement with religious communities and their health and well being, which nurses can draw upon as they begin to consolidate and clarify their understanding of spirituality and how it relates to their clinical practice. Serious multidisciplinary engagement with these disciplines opens up the possibility of developing clarity and a credible evidence base to support the clinical utility of religious spirituality for nursing practice and expose nurses to a wide range of approaches and understandings of religious spirituality.

Non-religious spirituality

One of the issues with the 'new spirituality' is that when it moves away from its religious roots it becomes very difficult to define and to support empirically. I have argued above that the amalgamist model of spirituality is deeply flawed and so vague and unsupported as to be unusable. However, the clinical utility of the central features of a number of definitions, which fall into the category of non-religious, secular or humanistic are, in principle, verifiable. Central features such as inherent relationality (Hay 2006), the need for forgiveness (McCullough *et al.* 2000), the search for meaning and purpose (Frankl 1963), the necessity of hope (Burns 1998) and the need for value (Swinton 2001) all have correlates in empirical data. As such, an evidence-based case can, in principal be made for the validity of definitions of spirituality, which base themselves on criteria such as these.

Within the non-religious understandings of spirituality a trenchant engagement with ethics would prevent the type of ethical absurdities highlighted previously. Few (if any) nurses would be comfortable with paedophilia or fascism as meaningful forms of spiritual expression, which should be nurtured and encouraged. However, many non-religious definitions of spirituality would appear to be quite comfortable with *all* forms of spirituality. A rigorous engagement with ethics would prevent non-religious spirituality from becoming morally neutered or even dangerous.

Of course, critics could, quite justifiably still ask the question: 'why would nurses want to call these non-religious features of the patient's experience ''spirituality''?' This is an important conceptual question. Perhaps it is the next pressing question that nurses should turn their attention to? Here the point I want to make is that, if nurses are prepared to do the intellectual work and not simply uncritically accept received knowledge as immovable truth, the field of spirituality-in-nursing *can* be developed as a rigorous field of enquiry with a common goal and a verifiable set of conceptual tools. Of course, critics from within and outside nursing may well argue that such an approach is far too 'clinical' and 'academic' and that it strips spirituality of its necessary mystery and indefinability. And they may well be right. But if they are, then they need to make a rigorous defence of such a position and show clearly how it could be sustained within an evidence-based culture where mystery and wonder are not budgetary priorities! I look forward to engaging with them in developing that defence.

Conclusion

The key thing that should be taken from this paper is this: *nurses need to be more reflective, critical and aware of the complexities of defining and using the concept of spirituality and more rigorous in the ways in which they use it and seek to develop 'spiritual care' as a credible academic and practical field of enquiry*. A more rigorous and critical approach to spirituality in nursing practice offers nurse academics and educators the opportunity to develop innovative modes of research and education, which move beyond narrow definitions of spirituality and glib assumptions about religion. In so doing they can enable students and fellow nurses to become acquainted with something of the width and breadth of the human experience of spirituality in all of its diverse forms. By inviting students and the consumers of research reports to enter into a process of critical enquiry within the field of spirituality-in-nursing, nurses will be given the opportunity to engage with the rich diversity of fragments and insights available in the many definitions of 'the spiritual,' and thereby have their horizons expanded in ways which bring both enlightenment and genuinely person-centred forms of spiritual care.

Nurses working within the field of spirituality-in-nursing need to recognize that they have 'enemies' and that these 'enemies' may actually be able to see things that nurses simply cannot see if they enter into dialogue only among themselves. However, if we engage constructively with our 'enemies' and listen carefully to the challenges that they bring, we might discover that our 'enemies' turn out to be friends who bring us important gifts that, whilst often heavily disguised, offer the promise of growth and development for the emerging field of spirituality-in-nursing.

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