A PHILOSOPHIC ANALYSIS OF THE SPIRITUAL IN NURSING LITERATURE

By

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In every sphere, in every relational act, through everything that becomes present to us, we gaze toward the train of the eternal You; in each we perceive a breath of it; in every You we address the eternal You, in every sphere according to its manner. All spheres are included in it, while it is included in none.

Through all of them shines the one presence.

But we can take each out of the presence.

Out of life with nature we can take the “physical” world, that of consistency; out of life with men, the “psychical” world, that of affectability; out of life with spiritual beings, the “noetic” world, that of validity. Now they have been deprived of their transparency and thus of sense; each has become usable and murky, and remains murky even if we endow it with shining names: cosmos, eros, logos. For in truth there is a cosmos for man only when the universe becomes a home for him with a holy hearth where he sacrifices; and there is eros for him only when beings become for him images of the eternal, and community with them becomes revelation; and there is logos for him only when he addresses the mystery with works and service of the spirit (Buber, 1970/1996, p. 150).
Abstract

Over the past several decades an impressive body of theoretical and empirical literature has been published on the spiritual in nursing. Members of the profession are increasingly claiming an ethical responsibility to pay attention to the spiritual in the context of care. Yet, various, and often contradictory, positions are being taken on the conceptualization of the spiritual. The purpose of this work is to investigate and clarify the various conceptualizations of the spiritual and spiritual care in nursing literature; to discuss the implications of these conceptualizations for nursing’s ontology, epistemology and ethics; and to argue for a particular approach based upon the moral and pragmatic nature of nursing. I survey key literature on the spiritual in nursing and organize this literature using the philosophic categories of theism, humanism and monism. Through a hypothetical dialogue, I ask questions about these various perspectives, exploring the implications for nursing’s ontology, epistemology and ethics. I then make arguments for how the spiritual should be approached. First, I argue that nurses should not expect agreement on the conceptualization of the spiritual. Rather, the focus should be on understanding and incorporating the worldviews that characterize spirituality in society and promoting dialogue among those worldviews. Second, I challenge the assumption that a normative body of knowledge about the spiritual should be part of nursing’s disciplinary expertise. The nursing role in relation to spirituality should not be characterized as one whereby nurses assess and intervene in the spiritual lives of patients. Instead, nurses seek to understand and create a space for the expression and development of patient’s spirituality. Nurses enter into a spiritual relational space where the spiritual “work” is often characterized by mystery and where the benefits of the encounter flow just as readily from patient to nurse as from nurse to patient. Finally, I use the Canadian Nurses Association’s Code of Ethics for Registered Nurses to illustrate how the ethical conduct of spiritual nursing care can be evaluated. Responsibilities of guarding against coercion, ensuring patient confidentiality, promoting reflection about nurse’s own positioning in relation to the spiritual and serving the needs of a diverse society provide a foundational starting point for providing ethical spiritual care.
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Preface

Philosophy is a journey. It starts with a compelling question for which you must have the answer. As you engage the question, you never fully know where it will take you until you have arrived. And even then, you realize your arrival is only a rest stop on the journey, because inevitably life presents you with new perspectives, and carefully thought out answers produce new questions. Such is the case with this work on the spiritual in nursing.

Having experienced the centrality of the spiritual in my own life, it was with great delight that I began to see the burgeoning interest in the spiritual in nursing literature several decades ago. I watched as the theoretical and empirical literature on the spiritual in nursing grew. However, my initial enthusiasm was soon replaced by a growing sense of dis-ease. Referents of the spiritual expanded to the point where it was difficult to see what was not spiritual. Spiritual interventions abounded, some of which had real ethical implications for the nurse patient relationship. The nature of nursing itself was being reframed in light of these perspectives. Theory was outdistancing research, and the research seemed to suggest that patients were seeing our role in relation to the spiritual differently than we were.

Two decades ago I could have articulated my view of the spiritual and spiritual care unproblematically. Now questions plagued me. How could I reconcile the many perspectives being put forward about the spiritual in nursing? What were the implications of these perspectives for our profession? How could we engage the spiritual in nursing in a coherent way while maintaining an essential respect for the diversity of viewpoints? Such began my journey, and this work is really a chronicle of that journey to date.

Chapter 1 provides the background to this philosophic analysis. I briefly discuss the reasons for this interest in the spiritual, the nature of the literature that is emerging in nursing, and the types of questions we must grapple with once we engage the spiritual as part of our disciplinary dialogue.

Chapter 2 provides a literature review that sets the context for this work. This review starts broadly with an overview of the types of questions that philosophers have debated in relation to the spiritual. I then provide a brief overview of the spiritual and religion within a Canadian context. As nursing is a discipline with a public trust, it is important to understand the nature of the spiritual in Canadian society. I follow this with a brief overview of the development of the spiritual in nursing and conclude with a review of the conceptualizations and controversies that characterize the current debates on the spiritual in nursing.

Chapter 3 provides a description of the methodology for this work. The philosophic method is discussed generally. The problem, purpose and questions of this work are presented. I explain how I chose the nursing theorists whose work I analyzed and what methods I used to distill their ideas.
Chapter 4 provides a distillation of the works of nine theorists who have written on the spiritual in nursing. These theorists are categorized according to three basic philosophic positions one can take in relation to the spiritual: theism, monism and humanism. For each theorist, I answer a set of questions to help us understand how the spiritual and spiritual care are being conceptualized and how these conceptualizations influence nursing epistemology and ethics in relation to the spiritual. I conclude the chapter by summarizing the three positions and posing some questions that highlight the dilemmas that occur by adopting these positions.

Chapter 5 provides an imaginary dialogue between a narrator and theorists representing the three positions on the spiritual in nursing: theism, monism and humanism. The participants respond to, and dialogue about, a series of questions designed to help us explore these worldview approaches to the spiritual and the implications of these approaches for nursing’s ontology epistemology and ethics. I conclude the chapter with a series of fundamental questions that can be used to help understand and analyze the work of any theorist writing on the spiritual in nursing.

Chapter 6 poses a series of questions designed to make recommendations for how the spiritual should be conceptualized and acted upon in nursing, given the moral and pragmatic nature of the profession. A series of arguments addresses the conceptualization, integration, and epistemological and ethical approaches that should be taken to the spiritual in nursing. I conclude this chapter with an explanation of how the concept of inter-relational space may help to guide our research, practice and education in the realm of the spiritual.

Chapter 7, the final chapter, summarizes the work and, like all good philosophy, concludes with a set of questions arising from this work. I conclude with the practical guidance, or wisdom, I take away from this particular journey in the spiritual in nursing.

And so the journey begins.
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Chapter 1
Background

A more reasonable estimate of human costs and values will lead us to think that no labour is better expended than that which explores the way to the treasure-houses of the spirit, and shows mankind where to find those goods which are increased by being shared, and which none can take from us.

William Ralph Inge

Over the past several decades an impressive body of theoretical and empirical literature in nursing has sought to explore the treasure-houses of the spirit. In fully embracing a holistic view of the person, nurses have recognized the need for a spiritual dimension of care. Indeed, it is now a common argument that attention to the spiritual domain is a primary ethical responsibility for nurses. Even national policy documents such as the Romanow (2002) report have included the spiritual dimension of persons as one that should be attended to within the context of healthcare. The spiritual is in vogue.

Inquiry into the spiritual has been extensive. What started as a trickle of literature in the early eighties has burgeoned into a relatively large and comprehensive body of literature. A number of primary concept analyses have been published (e.g., Burkhardt, 1989; Goddard, 1995; Meraviglia, 1999). Review articles and meta-analyses have explored definitions of spirituality, spiritual care interventions, and the relationship of spirituality to health and quality of life (e.g., Chiu, Emblen, Van Hofwegen, Sawatzky, & Meyerhoff, 2004; Sawatzky, 2002). Models of spiritual nursing care and ways to educate nurses to deliver spiritual care have been proposed (e.g., Bradshaw, 1994; Bradshaw, 1997; Narayanasamy, 1999a). Researchers have explored both nurse’s and patient’s perspectives of spiritual care-giving (e.g., Harrison & Burnard, 1993; Johnston Taylor, 2003a; Johnston Taylor & Mamier, 2005; McSherry, 1998; Reed, 1991). The concept of the spiritual has been explored within various ethnic groups (e.g., Newline, Knafl, & Melkus, 2002).

Nursing is not the only discipline for whom the spiritual has become a topic of debate and interest. Increasingly, the medical literature is exploring topics such as the beliefs, attitudes and practices of physicians in relation to spiritual care (Ellis, Vinson, & Ewigman, 1999); patient expectations of spiritual care from physicians (MacLean et al., 2003); and ethical questions related to spirituality and religion (Hall, 2003; Post, Puchalski, & Larson, 2000). Similar topics are being discussed in all the allied health disciplines. However, it is important to point out that this phenomenon is not entirely new. There is a substantial body of empirical literature that explores the relationship between religion and health (Koenig, McCullough, & Larson, 2001). What is new is the mainstream acceptance of this as a legitimate focus of inquiry and care for the health disciplines, and the adoption of the term spirituality rather than religion.

For many nurses this attention to the spiritual has been like a fresh wind blowing through the profession. Nurses, for whom the spiritual has been a significant part of their
own being, have had greater freedom to express this aspect within a professional context. Whereas overt religious interventions with patients have frequently been discouraged within the public healthcare system, nurses now have permission (at least theoretically) to intervene openly in the spiritual needs of their patients. Along with the attractiveness of being able to express one's own spirituality in the context of practice, there is an added attraction of being able to implement independent spiritually based nursing interventions such as therapeutic touch, mindfulness, and prayer.

An additional incentive to more fully explore the realm of the spiritual has come from an acknowledgement of the importance of diversity. Mainstream Western society, until relatively recently, has been content with secularism in public life, and in particular within healthcare with its scientific biomedical emphasis. Religious and spiritual issues were suppressed as the material aspects of the person were emphasized. Although nurses have consistently confronted issues of meaning and purpose in the context of practice, attention to these issues has often been invisible work. However, those from diverse cultures may not be satisfied with our Western secularism. I attended a presentation recently by a woman who was responsible for educating a group of First Nations students. She spoke poignantly and humorously of the student’s expectations that their education, like their culture, needed to be grounded within a sacred perspective of life. She shared her feelings of inadequacy as she sought to meet those expectations in the classroom. Many immigrants come from cultures where religious traditions and the spiritual are a fundamental part of daily life. The spiritual is not a hidden and private part of their existence, but rather a part of their daily routine that is enacted publicly. Celebrating diversity means we need to support these visible aspects of the spiritual within healthcare.

Truly, most could agree that the spiritual is an important dimension of the person, and hence, an important dimension to attend to in any profession that cares for persons. One could argue that attention to this dimension is even more compelling for professions such as nursing that deal with persons during life transitions and illness. However, agreement on a conceptual definition of this dimension is difficult to obtain. Spirituality in the literature is typically defined by broad and varied concepts such as transcendence, energy, connectedness, meaning, purpose, hope and love. Not that we should be surprised by this lack of consensus. The spiritual has been a point of debate for philosophers for centuries. These diverse conceptualization of the spiritual have led to a large number of potential spiritual care interventions; the Nursing Interventions Classification system proposes over 40 broad categories of intervention commonly used in providing spiritual care. Spiritual care has become so broad that at times it is difficult to distinguish it from other dimensions of care.

What is somewhat troubling is the relative dearth of critical analysis of this evolving body of work. Although some scholars have questioned the evolution of spirituality in nursing, one wonders why there are not more voices engaging in constructive debate. Perhaps there is a reluctance to challenge something as sacred and personal as the spiritual, even in a theoretical sense. Perhaps this body of literature is primarily speaking to the “converted”, those already convinced of the importance of this
domain. I have at times been surprised by the responses of audiences when I have spoken on issues of the spiritual in nursing practice. For many, the idea that it should become a part of nursing practice is new, and greeted with varying levels of enthusiasm. Perhaps the lack of critique is simply one more example of the relativism engendered by postmodern thought. The spiritual is the quintessential expression of individual truth, and as such, may not be subject to analysis from a postmodern perspective. A woman recently asked about my dissertation topic. When I explained my topic her curt reply was, “It’s all true. There is no right or wrong.” I was summarily dismissed. I pondered her reply for some time afterward.

Although, I can sympathize with the importance of not treading on sacred ground, it seems there is something fundamentally different about allowing individuals the freedom to develop on their own personal spiritual journey, and integrating a concept such as this within a professional discipline. Certainly, if we choose to integrate it from a disciplinary perspective we have a responsibility to grapple with some of the ontological, epistemological and ethical issues that arise from our conceptualizations. Some of the questions related to the spiritual that philosophers have grappled with for centuries become ours. How will we define the spiritual in relation to the other domains of the person? What is its relationship to the rational? What is its relationship to the material? What is its relationship to ethics and morality? Is it primarily human, divine or some mysterious combination of both? These fundamental questions are not simply a stimulating philosophic exercise. Rather, the answers that we choose to these questions have moral and pragmatic implications for practice. Further, we have a responsibility to analyze our conceptualizations in relation to the current social and cultural milieu. The knowledge generated by disciplines is both political and powerful. In generating that knowledge there is a potential tension between what serves the discipline well and what serves the public well. We have a responsibility to question our emerging understandings in light of that tension.

So how can we grapple with such extensive questions? If philosophers have been unable to agree upon such fundamental questions of the spiritual, what can we hope to accomplish within the context of a professional disciplinary inquiry? Like all good philosophy, our goal may not be to find the right answers, but rather to ask the right questions and to consider possible alternatives in light of those questions. It seems that even problematizing some of our understandings at this point would be useful. Further, from a professional perspective our goals may be somewhat less ambitious than those of the philosopher. Rather than asking the question of what is the spiritual, we question the implications of our conceptualizations of the spiritual on the discipline as it seeks to fulfill its social mandate. Hence, the purpose of this work will be to investigate and clarify the various conceptualizations of the spiritual and spiritual care in nursing literature; to discuss the implications of these conceptualizations for nursing’s ontology, epistemology and ethics; and to argue for a particular approach based upon the moral and pragmatic nature of nursing.
The power of mere ideas is a matter about which intellectuals commonly deceive themselves and, intentionally or not, also mislead the public. They constantly take in hand the most powerful factors in human life, ideas, and, most importantly, ideas about what is good and right. And how they handle and live them thoroughly pervades our world in its every aspect (Willard, 1998, p. 6)

Prior to presenting the nursing literature on the spiritual that will be analyzed in this work, some historical and sociological groundwork must be laid. I will begin by providing a brief overview of some of the questions that have characterized the debate over the spiritual within Western philosophy. The spiritual has been a point of debate for philosophers for centuries, and although a review of this is beyond the scope of this work, it may be useful to start with some of the questions in relation to the spiritual that will naturally become a part of the debate of the spiritual in nursing. Next, I will explore some of the contextual factors driving the societal interest in the spiritual. This contextual background is particularly relevant for understanding some of the emerging trends we see in conceptualizations of the spiritual in nursing. Finally, I will turn to the development of conceptualizations of the spiritual within nursing. I will first present a brief overview that will trace transitions from religious to scientific to postmodern understandings of the spiritual. I will then explore some of the current definitions of the spiritual within nursing literature, and I will conclude by highlighting three controversies that confront us as we consider the nature of the spiritual within nursing.

Philosophic Questions of the Spiritual

Smith (1988) has suggested there are seven points of debate that characterize the philosophical positions in relation to the spirit. What is the definition of the spiritual? How does the spiritual determine the meaning of a personal life? What is the relationship of the spiritual to the concrete, the rational, the material, causality, and judgments of validity and worth? (p. 46-48). What follows is a brief discussion of these questions proposed by Smith. Please note that I am simply attempting to give a concise, and lamentably simplistic, summary of his questions and considerations. His book is a first philosophy of the spiritual, devoted entirely to addressing each of these questions in detail. My intent here is not to address these fundamental philosophical questions, but rather to lay the groundwork for understanding how similar debates have informed the developments of our conceptualizations of the spiritual in nursing.

First, what is the definition of the spiritual? Smith (1988) has suggested that “Spirit is, by consensus, an invisible suprapersonal reality that decisively affects the perceptions, intentions and actions of persons” (p. 44). However, his subsequent questions suggest that even this consensus is somewhat suspect. Can it be defined? Is it being or something other than being? Is it a higher way of being toward which we aspire? Is it transcendent or totalizing, whole or part, divine or human, suprapersonal or “I”? Is it
expressed through the mind, the will, or the emotions? The fact that philosophers for
centuries have grappled with these questions suggests that this thing we call spiritual
undoubtedly exists. But gaining consensus on a definition of that existence is highly
problematic. All of the positions taken by various philosophers have been adopted within
various conceptualizations of the spiritual in nursing. Like the philosophers, I anticipate
that we will be unable to come to consensus; however, we can grapple with the
implications of our definitions within a professional discipline that serves a diverse
population.

Second, how does the spiritual determine the meaning of a personal life? Smith
(1988) has suggested that the meaning of self is contingent upon the meaning of the
spiritual. Are our lives meaningful because we engage in a universal consciousness or
community? Or, are our lives meaningful as we actualize the power of self? These
positions may not be mutually exclusive, but they encourage us to reflect on the roles of
individual and other as we consider the effect of the spiritual on the meaning of our lives.
The debate becomes particularly important in the context of nursing, as meaning has been
adopted as a primary descriptor of the spiritual and the focus of nursing interventions.

Third, what is the relationship of the spiritual to the concrete? When we ask this
question we are really asking about the starting point of the spiritual. Is it the mind as put
forward by Hegel, or is it a relationship with other as suggested by Buber (Smith, 1988)?
Our position on this issue will determine whether we adopt a purely humanistic
spirituality or one that involves a divine other.

Fourth, what is the relationship of the spiritual to the rational? Is spirit equated
with the mind or reason, or is reason subordinate to spirit? This question becomes
particularly important for the nursing profession as we grapple with the epistemological
implications of our conceptualizations of the spiritual. Is the domain of the spiritual
something that should be subject to our critical faculties, or should it remain mysterious
and somewhat unknowable? Are spiritual claims challengeable and upon what basis?
What risks do we run by removing the spiritual dimension from reason or by making it
subordinate to reason? If we make the spiritual a legitimate focus of the discipline, we
have an ethical responsibility to grapple with these questions.

Fifth, what is the relationship of the spiritual to the material? Smith (1988)
proposed that a fundamental consensus among the philosophers is that spirit is to some
extent opposed to matter. Given this assumption, the question then becomes how we
negotiate the presence of spirit within matter, for as Smith has argued, the spiritual must
always be dealt with to some extent in terms of its inhabitation of the material. It only
becomes accessible to us as it is “dealt with here or there, animating this or that” (p. 47).
These questions become fundamental ones for nursing as we are being charged with
caring for both the spiritual and material aspects of the person. How do we see these
relating in the context of our care, and what are the consequences of giving pre-eminence
to one over the other should we choose to do so?
Sixth, what is the relationship of the spiritual to causality? Most will agree that spirit has some causal effect; however, the degree and nature of that effect is a point of debate. How does it affect a course of events? From a pragmatic disciplinary perspective one of the fundamental questions lies around the ability to intervene in this realm. To assume that we can institute spiritual interventions is to assume that we can influence some underlying spiritual realm that will provide a causal effect in some direction to which we aspire. This has been a point of debate within the spirituality literature and requires careful consideration.

Seventh, what is the relationship of the spiritual to judgments of validity and worth? The spiritual is often equated with connotations of goodness. For the Greek thinkers it was an excellence of mind. For early Christian thinkers such as Paul and Augustine it was the yielding of self toward justice, goodness, love and ultimately God. For Hegel, it was the overcoming of self-alienation (Smith, 1988). Does spirituality transcend considerations of value, or is there a reality of values to which spirit must subscribe? Once again, these are fundamental ethical questions for the discipline of nursing. Does the rubric of spirituality imply some framework of values or does it transcend consideration of ethics and morality?

What will become apparent throughout the course of this work is that these same questions, in some form or other, are evident in the literature on the spiritual in nursing. By taking on the responsibility for the spiritual in nursing practice, we inevitably come up against these questions that have concerned philosophers for centuries. Although nursing theorists are not always explicit about their particular answers in relation to these questions, the approach they adopt inevitably portrays their assumptions in relation to at least some of these questions. These broad questions concerning the nature of the spiritual will inform some of the more specific questions I will use in this work to investigate and clarify the different conceptualizations of the spiritual in nursing literature and to discuss the implications of those conceptualizations for nursing.

Religion and Spirituality in the Canadian Context

No discussion of the spiritual within the context of nursing would be complete without considering the broader social world within which these developments have occurred. Analysis of the social context enables us to understand why particular ideological positions have taken hold and to bring an informed critique to those positions. Only when we understand the context can we start to discriminate between possibly unhelpful, reactionary positions and those that contribute to the social service that is nursing. Indeed, a moral understanding of practice cannot be extricated from the social world within which it is enacted (Urban Walker, 1998). There is also a pragmatic advantage to understanding societal context. Understanding context enables us to position ourselves strategically as a profession, both to support the development of the profession and to support clients in their health transitions and challenges.
Three societal trends are most relevant to this work. First, is the changing role of religion in society and the tensions surrounding religious pluralism and fundamentalism. Second, is the emergence of new spiritualities. Society, rather than becoming more secular as many sociologists predicted, seems to have simply changed the nature of religion to various spiritualities. Third, is the changing epistemological landscape. The transcendence, and in some cases outright rejection, of scientific empiricism, has opened the door for alternative ways of knowing, potentially leading to new understandings of religion and spirituality within the academy.

Reginald Bibby (1993), a sociologist of religion who has extensively surveyed Canadian society, found that although Canadians associate less with institutionalized religion, they retain a religious memory whereby they continue to identify themselves with certain traditions and return to those traditions for momentous life events such as birth and death. Although many believe that Canada supports and consists of a religious mosaic, census data indicates that Christianity remains the dominant religion (Bibby, 2000). Further, Canadian society may not be particularly supportive of religious diversity. Bibby (1993) has suggested that while Canadians have espoused values of pluralism, their relativistic philosophies have contributed to the marginalization of religion. By adopting the position that religion is socially constructed, all positions have been uncritically accepted as equally valid. The irony is that rather than making way for religious diversity, this philosophy has produced an ethnocentric marginalization of beliefs.

These concerns of religious marginalization have been echoed by Beaman (2002, 2003) who illustrated through case law how judgments involving religious rituals often go against the less dominant traditions. For example, Aboriginal peoples may be restricted from fishing or hunting out of season, even when these actions may be a form of sacred ritual. She concluded that freedom of religion is always constricted by some societal baseline. Although he agreed with Beaman's basic premise, Beyer (2003) argued that Canada is not unique in this regard. This is a characteristic of every culture and could be seen as a way of encouraging pluralism by limiting the claims of certain groups. However, certain religious groups in Canada continue to seek religious authority in the public realm. For example, recently Muslim groups in BC and Ontario requested the government sanction Islamic Shariah law in family related matters (Todd & Bisetty, 2004). This request has already raised concerns within Canadian Islamic women's groups because of the perceived oppressiveness of Shariah law. Many women came to Canada to escape such laws. How these diverse religious claims will be negotiated in Canadian society remains to be seen. Accepting all religious positions as equally valid may no

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1 I want to acknowledge the risk I feel by trying to articulate societal trends. To some extent, to speak in these terms brings a marginalization of the segment of society for whom these trends would not hold true. To speak of the decline of religion and the emergence of new spiritualities would only hold true for a segment of the population. Indeed, what is most concerning is how often the elite of a society will make their lives most visible through the mass media, thus creating an artificial perception that their lives are the norm for society. In discussing these trends I am simply trying to make visible societal forces that have influenced the dialogue around spirituality in nursing, however elitist this dialogue may be.
longer be an option as the government will be forced to choose between potentially antithetical value positions.

The rise of religious fundamentalism is a worldwide concern. Armstrong (2000), in an eerily pre-sentient warning of the terrorist attacks of 9/11, published a book tracing the rise of fundamentalism in the theistic world religions and warning of the threat that it posed to modern society. She described religious fundamentalism as militant piety concerned more with doctrinal correctness than with values such as freedom, love and social justice. A recent census indicated that potential religious tensions have replaced language as an area of primary concern for Canadians (Montgomery, 2004). Writing from an American perspective, Sherkat and Ellison (1999) have suggested that America is experiencing a culture war where religion is informing political values and behaviours with far reaching consequences. One has only to follow the war on terror, and the use of religious images and ideology to justify that war, to realize how potentially far reaching those consequences are. Mitri (2003) has claimed that whereas there used to be an interest in the similarities among religions, there is now a tendency to see differences and to stereotype all within a particular religious tradition. Hence, those from the Muslim world characterize those from the West as “selfish, materialistic and dominating” and those from the West characterize those from the Muslim world as “irrational, fanatical and expansionist” (p. 26). Although the religious cultural war within the political landscape of Canada might not be quite so blatant, there is little doubt that it exists. Understanding the potential tensions and violence that arise out of a specific form of religion helps us to understand why religion has become a somewhat distasteful concept to many Canadians.

Although many Canadians are dissociating themselves from formal religion, others are becoming increasingly spiritual. A vast majority still claim that God is important to them. Many are intensely interested in the mysterious and paranormal, and continue to ask the existential questions that have traditionally been the concern of religion, questions about the meaning of life and life after death (Bibby, 1993). Bibby has claimed that while religion is declining, personal belief is flourishing. The origins of the burgeoning interest in the spiritual are multi-factorial. One of the primary reasons is a reaction to the extreme secularism, empiricism and materialism of modernity. When science became god, the world became devoid of meaning. Only that which could be observed had legitimacy. As society realizes that science cannot solve our most existential problems, there has been an intense and enduring search to recover that meaning. Materialism is rampant in modern culture. Economic prosperity results in pressure on individuals to have the right possessions and appearance, and to pursue achievement and prominence, values that have traditionally been considered antithetical to spiritual values. This excessive societal materialism has driven many to reconsider alternate spiritual values as a balance.

Other philosophies of modernity have contributed substantially to this new spirituality. Charles Taylor (2002), a Canadian philosopher, revisited William James’ classic work on the varieties of religious experiences to illustrate how religious understandings have evolved to our current emphasis on individual spirituality. He traced
how modernity's focus on individualism served to equate any sort of collective activity with mindless conformity. A culture of authenticity developed where expressing individual humanity became more important than participating in the collective. Individual feeling took preeminence over the object of that feeling. As such, perceptions of the sacred evolved from belonging to an institution, to the importance of individual choice, to the expectation that the perspective presented to us would be both meaningful and comfortable.

Fenn (2003) suggested that the sacred has become so diverse and individualistic that it can no longer be contained within religious institutions. He referred to this as a form of secularism because inspiration and authority lies with individuals rather than religion. Of interest for the nursing profession is Fenn’s theory that in this form of secularization, institutions and professions take over the responsibility for the sacred. “The arts and crafts of teaching, healing, judging, predicting the future, and pastoral care have been transferred from the church to educators, doctors, an independent judiciary, social scientists and social workers and therapists”(p. 5). This helps us to understand the claims being made within nursing that nurses have a moral obligation to pay attention to the spiritual dimension. Nursing is simply one of the social institutions upon whom the responsibility for the sacred is being laid.

This new spirituality can take on interesting forms. Douglas Todd (2004), in a recent article in the Vancouver Sun, explored what he calls a secular but spiritual cohort, suggesting that this is one of the fastest growing religious groups in North America and the wave of the future. These socially elite individuals seek a peaceful lifestyle in harmony with nature. Their search for divinity is highly personal, freedom loving, and sometimes difficult to apprehend. Some adopt forms of mysticism that entail believing in the power of certain inanimate objects or in the existence of unseen cultures on earth. This new spirituality, although widely popular has also been the subject of much criticism. Wheen (2004) has argued that movements such as this are indicative that we have entered the “age of unenlightenment”, an age where “reason, secularism and empiricism” have been supplanted by “deconstructionists, mystics and fundamentalists” in favour of “cults, quackery, gurus, irrational panic, moral confusion and an epidemic of gibberish”(p. A11).

Wheen’s (2004) critique of the irrationalism of much of what has been considered spiritual thinking is an excellent indication of why the changing epistemological landscape is so important to conceptualizations of the spiritual. Over the history of academia some forms of knowledge have carried legitimacy over others. In the Greek and Roman times, philosophy was considered the ultimate field of study for it led to wisdom for the path of life. During the middle ages, theology became the pre-eminent discipline as religion provided the primary authoritative basis for society (Hadot, 1995). However, with the rise of positivism and empiricism, knowledge, and hence authority, was transferred from religion to science. Many who argued for a continuing pre-eminence of theology fought this battle by subjecting theology to science, understanding it as the science of God (Pannenberg, 1976). Armstrong (2000) has claimed that this inversion of science into theology and theology into science is what provided fertile
ground for the religious fundamentalism that is currently on the rise. By turning science into theology, the important knowledge of purpose, meaning and mystery was lost. By turning theology into science, a literal perspective of sacred texts was adopted that led to violence. Townes (2003) has pointed out that we are moving to an increasing convergence of science and religion in that we are realizing that both require “all our human abilities to understand – faith or postulate; experiments or observations, intuition, revelation, esthetic; and logic or reason” (p. 158). However, despite their similarities they serve different but mutually compatible goals. One is meant to provide knowledge about the world, the other wisdom about how to live well within that world. To confuse the two has potentially devastating consequences.

Nursing has been at the forefront of championing varied ways of knowing and of using other disciplinary knowledge when it contributes something useful. And so it would seem fitting for nursing to consider the potential usefulness of theological knowledge when considering conceptualizations of the spiritual. After all, this has been the concern of theologians for centuries. However, using this type of knowledge has some inherent challenges. First, is the issue of dealing with sacred text. Often sacred texts are considered infallible without an appreciation that an infallible text is always interpreted through a fallible person. This sometimes prohibits the healthy critique that is so essential to the use of other disciplinary knowledge. Second, is the issue of what constitutes adequate preparation for a nurse to use this knowledge. If we accept the potential use of theological knowledge as it relates to the spiritual in nursing, do we then assume that all nurses should have some exposure to theological knowledge? A valid critique of nursing’s adoption of the spiritual as part of its ethical mandate has been the lack of basic preparation of nurses in this area. Speaking from the discipline of psychology, Belzen (2003) argued that for psychologists to intervene competently in this area they require sufficient knowledge in morality, ethics, religion and spirituality. Intervening without this knowledge would be unprofessional.

This brief discussion of context highlighted three key factors: the changing role of religion in society and the tensions that have arisen as a result of religious fundamentalism and a commitment to religious pluralism; the emergence of a new spirituality that is highly diverse and individual; and the changing epistemological landscape that opens the door for the potential use of theological knowledge but brings some inherent challenges for the use of that knowledge within a disciplinary perspective.

Overview of the Development of the Spiritual Dimension of Care in Nursing.

The array of conceptualizations of the spiritual that exist today in nursing reflect changing historical understandings. McSherry and Cash (2004) have divided current understandings of the spiritual into two major categories: the old, characterized by religious and theocentric perspectives, and the new, characterized by postmodern secular perspectives. A colleague and I (Sawatzky & Pesut, 2005) have proposed that current understandings of spiritual nursing care are the product of three primary eras: religious, scientific and existential. These eras reflect the changing societal understandings of who
is the bearer of truth: from religion, to science, to the individual. Each era was characterized by a unique perspective that has contributed to the diversity we see today.

Many authors have written about the religious roots of the spiritual in nursing (e.g. Bradshaw, 1994; O'Brien, 2003). Although the Christian tradition is often discussed most extensively, the concept of the priest-healer is a common one that spans many faith traditions (Dawson, 1997). Within these traditions, the gap between the divine and the suffering state of humanity is bridged through priest healers who heal and speak truth out of divine authority. However, the most commonly cited examples of the religious roots of nursing seem to be found in the examples of the military nursing orders associated with the crusades, the monastic nursing orders, and the mystics such as Hildegard of Bingen, St. Clare of Assisi (Mauk & Schmidt, 2004) and Florence Nightingale (Dossey, 2000).

Bradshaw (1994) has provided an overview of what she calls the historic tradition of care, one that she locates within a religious and theological context. The purpose of her historical inquiry was to show how religious perspectives provided the essential motivation for nursing. She explored spiritual care within the early Christian church where care was enacted through a spirit of compassion motivated by the love of Christ. The physical and the spiritual were a unity, to love in the realm of the spiritual meant that one must also care in the realm of the physical. This translated naturally into the care of the sick being a primary concern of the church. Elizabeth Fry, Josephine Butler, Octavia Hill and Florence Nightingale are examples of women who initiated their social reforms in response to a religious calling. Nightingale, a passionate theologian, revived and popularized “the concept of nursing as a service to God at a time when in an increasingly secular society the care of the sick was considered both a patronizing charity and a commercially-based interest” (p. 134). Bradshaw's primary argument was that the historical religious context must be considered when talking about the spiritual within nursing practice.

This historical perspective is therefore important in contextualizing the contemporary debate on the definition of the spiritual dimension as an aspect of patient care. Without an objectively valid historical perspective nursing is in danger of regarding itself, its beliefs and values, and its own time, as both normative and absolute (p. 98).

Bradshaw was really arguing against the societal trend discussed previously to secularize the sacred and to place it within the realm of professional authority without consideration of its religious roots.

The religious perspective was marginalized when science replaced religion as the primary authority in society during the age of Enlightenment. Science, and specifically empiricism, limited knowledge claims to what could be seen and observed. Further, Descarte's proposition that the world, and persons, could be conceived of as material and immaterial components allowed a focused attention on the visible material aspect of persons to the neglect of the less credible, immaterial aspects. Goddard (2000) has provided a discussion of the impact of science, and particularly medicine, on the
understandings of the spiritual. The view of the person as both material and immaterial opened the door for invasive postmortem procedures. The discovery of physical manifestations of disease, and the understanding of causal attribution, shifted the understandings of health and illness from the supernatural to the natural. Medicine became responsible for the health of the body, while clergy became responsible for the health of the soul. However, Goddard credited nursing for managing to maintain a holistic perspective of persons. Nursing theorists Levine, Roy, Leninger, and Rogers included spirituality as part of their model, and nursing theorists Neuman, Newman, Parse, and Watson used spirituality as the central concept of their models (Martsolf & Mickley, 1998).

The scientific era was exemplified by the use of the nursing process in spiritual care. The spiritual domain of the person became a legitimate focus of assessment, intervention and evaluation. Potential nursing diagnoses related to the spiritual were formulated, along with interventions that could help the patient to achieve spiritual well-being. The drawbacks related to the empirical nature of this process are readily apparent. Considerations of the spiritual became naturally limited to what could be observed by the nurse. Further, a process of this nature rests upon some key assumptions: that we can assess aspects of the spiritual, that there is the potential to influence the spirituality of another, and that there are some agreed upon outcomes that would characterize spiritual well-being. Mayer (1992) has questioned whether spirituality can be classified and controlled, quantified and written up in nursing notes, and processed in such a way that questions about ultimate values and intimate areas of relationship can be asked, answered, and recorded in the same way as questions about fluid balances, bowel functions and body chemistry (p.33).

Bradshaw (1994) echoed a similar critique to what she has termed the empiricist or structural/functional approach to spiritual care. One of her major critiques concerns the externalization of religion, and its relegation to a socio-cultural understanding. She has criticized nurses for trying to intervene within a religious and cultural context of which they have only outsider knowledge. Further, by allowing the nurse to make judgments about the spiritual or religious understandings of another, the nurse is placed in a potentially controlling and manipulative role. She has called this the “bolt-on” approach to spiritual care because it tends to compartmentalize the spiritual domain rather than having it as a natural extension of the physical and psychosocial aspects of care.

The third era that has profoundly influenced conceptualizations of the spiritual in nursing is that of postmodernism. The nature of postmodernism, although widely debated, can probably best be understood as a reaction to modernism, an age that was characterized by an unfailing commitment to human reason and science as the answer to

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2 The use of the nursing process became popular in the 1960s, already well into the postmodern period. However, the popularity of this process, and the scientific credibility it provided for nursing, made it a popular vehicle through which to write about spirituality. The more existential literature on spirituality did not emerge in nursing until several decades later.
the challenges of human existence. However, with the rise and consequences of capitalism, industrialization and world war, this unflagging optimism began to be overshadowed by increasing societal critique. Confidence in reason and science was replaced by a profound skepticism about the nature of knowledge and reason. Crotty (1998) has described the transition well, “Instead of espousing clarity, certitude, wholeness and continuity, postmodernism commits itself to ambiguity, relativity, fragmentation, particularity and discontinuity” (p. 185). Although the consequences of this skepticism were manifold, one of the distinctives of the postmodern reaction was the deconstruction of truth claims through the understanding that reality does not exist independent of the knower. The recognition that much of the knowledge that we had enshrined as truth was actually constructed and influenced by social and political structures led to a profound distrust of all meta-narratives. The acceptance of multiple co-existing truths became a new source of human optimism. Authority had effectively been transferred from science to the individual.

The impact of this type of thinking on the spiritual was predictable. Theological and scientific constructions of the spiritual were replaced by more subjective, interpersonal and inclusive approaches (Sawatzky & Pesut, 2005). McSherry and Cash (2004) have provided a definition of this postmodern or existential form of the spiritual.

This type is very subjective reflecting society’s and individual’s preoccupation with the material, sectarianised aspects of life. This form of spirituality contains an infinite number of descriptors that may be phenomenological and existentially determined such as meaning and purpose in life, creativity and relationships (p. 157).

This new secular form of spirituality is characterized by existentialism, transcendence (although not necessarily related to a divine being), and a rejection of the reductionistic, scientific worldview. This is the same individualistic spirituality described by sociologists of religion such as Bibby (1993) and Fenn (2003).

Another characteristic of this era has been the blending of Eastern philosophical and religious perspectives into the understandings of spiritual care. Theorists such as Martha Rogers and Rosemary Parse have drawn upon Eastern philosophies to propose a unitary view of the world that results in an emphasis on the non-material, or spiritual, aspects of the person. Their work is particularly interesting in this debate because it transcends the reductionist notions of spiritual care and embeds spirituality as the central focus of the profession, but primarily within an Eastern religious and philosophical perspective. This perspective is not significantly different from the earlier embodiment of spiritual nursing care within a Christian religious perspective, but the underlying philosophy is now from the East rather than the West.

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3 Crotty makes it clear that the lines between modernism and postmodernism are not as simplistic as he is trying to describe. Postmodern critique existed long before a recognized age of postmodernism and much of modern thought still prevails in society.
Critiques of the postmodern perspective of the spiritual dimension abound, and although one might expect opposition from those holding traditional theistic perspectives, opposition has also arisen from others. Dawson (1997), a self-proclaimed atheist, has criticized Goddard’s (1995) definition of spirituality as “integrative energy” as historically bankrupt and stripped of meaning. He has provided a brief review of historical understandings of science and spirituality within faith traditions to illustrate the impoverishment of Goddard’s definition. Goddard (2000), in reply, supplied a historical context of her own stressing the tradition of holism as a moral imperative, defending her definition as dynamic and unifying.

Salladay (2000) and Bradshaw (1994), writing from traditional theistic perspectives, have put forth a number of arguments against the postmodern approach to spiritual nursing care. Salladay, focusing specifically on some of the healing techniques associated with postmodern spiritual care, has accused this worldview approach of being philosophically incompatible with traditional worldviews of theism and modern science. She has argued against a syncretistic perspective that ignores underlying differences and historical roots. Bradshaw has taken aim at what she calls the existential approach to spiritual care citing problems of coherence, individualism, irrationalism and morality. She uses examples from existential nursing theorists to illustrate how they have deviated from the philosophical perspective they claim to be deriving their theories from, and in particular, how they have ignored many underlying theistic assumptions in these philosophies. This leaves their theories somewhat incoherent and without the normative assumptions found within the philosophies upon which they draw. The excessive individualism of these theories tends to overemphasize the role of the nurse in the nurse patient relationship, leading to a form of professional narcissism. The emphasis on individualism also prohibits the generalizability of knowledge in this area. As these theories are typically put forward in opposition to science, they tend to neglect the material body. Finally, she argued that existential perspectives provide no normative ethic, and hence leave room for nursing care to be at the whim of the nurse’s subjective values. Stripped of traditional theological perspectives, these perspectives on spiritual care provide no allowance for the existence of human fallenness.

In summary, conceptualizations of the spiritual have emerged from three primary eras: the religious, the scientific, and the postmodern. However, two important points should be emphasized. First, this should not be viewed as an evolutionary process whereby one form of understanding has evolved into something more enlightened. All of these particular perspectives continue in the understandings of the spiritual today. Second, this is a highly politicized debate. Far from being a neutral consideration of which perspective is best, these represent perspectives toward which individuals and groups are passionately committed. The same divide that has characterized society over religious issues is operating similarly within this debate in nursing. This will become apparent as I turn to a discussion of the current conceptualizations of the spiritual in nursing.
Spiritual Dimension in Nursing: Conceptualizations and Quagmires

Few ideas are more difficult to define than the spiritual. The array of definitions in the nursing literature testify to this complexity. The term has become everything and nothing. Everything in the sense that it covers most of what it means to be human, and nothing because it has become so generic and all encompassing. McSherry and Cash (2004) have referred to this as the blanket approach to spirituality. They criticize this approach for creating a meaningless and insignificant spirituality. Draper and McSherry (2002) have suggested that we already have an adequate language within nursing to support the human search for meaning without reverting to a language of spirituality. In contrast, Narayanasamy (2004a) has been a vocal advocate of not allowing the lack of clarity around spirituality to discourage us from inquiring about this important phenomenon. He has taken issue with the belief that we have to understand it to help others with spiritual issues such as meaning, hope, and connectedness. “In my view, spirituality is spirituality: we know intuitively that it is within us, and that is the end of the matter, as G.E. Moore would put it” (p. 463). The complexity of this idea of the spiritual has created a number of positions. There are some who argue for a concrete definition related to traditional theistic and religious understandings. There are some who argue for a broadly inclusive definition. There are some who advocate for a withdrawal from these murky waters.

Appendix A provides an overview of some of the key definitions and themes from the nursing literature on the spiritual. This list is not comprehensive. Rather, it compiles what I consider key, often cited works, and several reviews of spirituality in the literature. From this table, one can appreciate the definitional blanketing effect described by McSherry and Cash (2004). Spirituality captures everything from a relationship with a higher being, to the existential aspects of existence, to connection and integration, to energy. Truly, there is no aspect of existence, human, natural or divine, exempt from this definition. Even the material aspects, if viewed within a framework of holistic energy, are included within these definitional characteristics. If it exists, it is spiritual.

McSherry and Cash (2004) have proposed a useful seven category taxonomy for the various definitions of spirituality: theistic; religious; language; cultural, political, social ideologies; phenomenological; existential; quality of life; and mystical. Further, they have proposed that the descriptors of these categories could be equated with the various branches of philosophy such as cosmology, mind/body, language, religion and science. The categories are considered fluid in that a particular individual may view several of these aspects as essential to their spirituality, and they may choose to modify their perceptions of what constitutes their spirituality over a lifetime.

As appealing as it may be to have such broad and diverse definitions of spirituality co-existing, it has created some quagmires from a professional perspective. First, is that of inclusivity versus hegemony. By broadening our definitions to achieve inclusivity, are we creating a new hegemony that marginalizes certain groups? Second, is the relationship of spirituality to science. How do our definitions of spirituality fit with traditional positions of science and empiricism? Third, is the relationship of spirituality to
religion. How important is religion to spirituality, and what do we potentially lose or gain by marginalizing it? I will touch on each of these controversies just briefly, as each of these dilemmas will be addressed in detail under the philosophic questions that are the focus of this work.

**Inclusiveness and Hegemony.**

One of the most prevalent arguments for having such broad definitions of spirituality is that of inclusiveness. There has been a determined attempt to broaden spirituality beyond religion and to make it a fundamental aspect of human existence. An inclusive spirituality is meant to account for the experience of the sacred that transcends religious experience (Thomason & Brody, 1999), and to acknowledge that it is not only within the context of a belief in God that individuals experience spiritual needs (Burnard, 1988). One of the challenges of traditional religious definitions has been the value ladenness of various perspectives. Broader definitions discourage judgments over the beliefs of others (Burnard) and may facilitate the enactment of spiritual care between patients and nurses who hold different philosophical or religious positions (Goddard, 1995). Finally, a broadly inclusive definition holds the promise of a starting point for scientific investigation (Goddard, 2000). As in so many areas of nursing scholarship, an agreed upon starting point is felt to be necessary for knowledge development. Presumably, a definition that provides little offense, while encompassing as many perspectives as possible, could provide that starting point.

However, there are just as many arguments against these broadly inclusive definitions. First, vague definitions hold the risk of making a concept meaningless and stripping it of its historical context (Dawson, 1997). As history is collective memory, we lose many of the significant contributions of those who have gone before. Such is Bradshaw’s (1994) argument against defining spirituality apart from its religious traditions. Second, this broadly inclusive spirituality presumes that the public we serve will understand what spirituality is and will agree that it is a dimension of their lives (Draper & McSherry, 2002). This assumption has not always been born out through research (Draper & McSherry, 2002; Swinton & Narayanasamy, 2002). Third, we run the risk of producing an unintended hegemony. “We argue that universalizing the concept of spirituality may have the paradoxical effect of ascribing to people values they may not share” (Draper & McSherry, p. 1). An excellent example of this unintended hegemony has been provided by MacLaren (2004). She discusses how the descriptors of spirituality related to meaning and purpose are formulated primarily from a Christian perspective and may not be appropriate for someone who is a Buddhist. For the Buddhist, the journey may not be about discovering meaning and purpose but about living the experience. So, even terms as innocuous as meaning and purpose may support a particular worldview. Henery (2003) has suggested that many of the definitions that are supposed to be inclusive and universal simply disguise value positions that may not be immediately apparent.

Various authors writing from a Christian perspective have discussed the hegemonizing impact of a universal definition of spirituality on their practice. Salladay
and Shelly (1997) have claimed that many of the new definitions of spirituality represent an Eastern worldview that is incompatible with the Christian worldview. Rather than leaving room for both worldviews, the universal definition charges those who hold to a particular worldview with dogmatism. Fawcett and Noble (2004) have echoed this struggle as they believe in objective truth related to spirituality. They question how one reconciles a belief in one right way with a spirituality that legitimates all ways as acceptable? A spirituality that claims to have universal answers ends up being the only unacceptable form (O'Mathuna, 2004). The challenge is that a universal definition, rather than making room for diverse voices, may paradoxically end up suppressing them. This is essentially the same argument that Bibby (1993) has made about the hegemonizing tendency to relativize religious beliefs in Canadian society.

**Relationship to Science.**

Two questions surface repeatedly in the literature on the spiritual in nursing. First, is inquiry into spirituality amenable to the methodologies of science? Second, can the knowledge be considered universal, and hence, generalizable. Reed (1992), in an early and classic work on spirituality, proposed a scientific paradigm for the investigation of spirituality in nursing. “Central to the paradigm is the epistemological assumption that spirituality can be empirically investigated and ultimately applied in practice, using methods of science and praxis accepted by the nursing community” (p. 351). However, she qualified this by stating that spirituality itself is not measurable, rather we should be attempting to measure the observable outcomes of spirituality related to connectedness and transcendence. This argument is reminiscent of Smith’s (1988) argument that the spiritual only becomes meaningful as it is expressed through the material aspects of existence. Goddard (1995) argued for a precise operational definition of spirituality as the basis for a body of knowledge. However, unlike Reed, she did not fall back to outcomes of spirituality but rather presented a “real” definition of spirituality (integrative energy) that described its essential nature as the starting point for research. This acceptance of spirituality as suitable to scientific inquiry using either traditional or alternate research methods is common in the literature.

Yet, there are others who have argued that spirituality should not be reconstructed within the language of science, but rather that it represents an alternate way of knowing about the world. Henery (2003) discussed the potentially alienating effects on patients of considering spirituality within the instrumental, reductionistic, controlling and interventionist construct of science. Dawson (1997), in a similar critique, criticized Goddard (1995) for defining spirituality as integrative energy, an expression that he believed simply paraded spirituality in the language of science. Indeed, he suggested that such a definition trivializes spirituality and opens the door for it to be medicalized and pathologized like the material aspects of human existence. His argument is based primarily on the assumption that spirituality has no objective truth, but rather is characterized by individual subjectivity.

This issue of objective truth versus individual subjectivity is the foundation for the second question of whether or not the knowledge related to spirituality is universal,
and hence, generalizable. Again, scholars can be found on both sides of this divide. MacLaren (2004) argued for a postmodern rejection of the spirituality meta-narrative in favour of a form of spiritual nursing care that encourages nurses to use practice situations to inquire about fundamental aspects of the human condition. Fawcett and Noble (2004), on the other hand, believed that this tolerance of multiple individual spiritualities could only be ethically defended if there was an absence of universal truth. They firmly located themselves within the belief of an objective and universal truth related to spirituality.

McSherry has shown an interesting evolution in his ideas related to spirituality and science over the years. In a 1998 article with Draper, he outlined a challenge for the nursing profession “to develop a definition of spirituality which is broad enough to accommodate the uniqueness of all individuals, patients and nurses, and indeed the whole of humanity irrespective of beliefs, values, or religious orientation” (p. 690). He called for a body of conceptual and empirical knowledge in the area of spirituality. However, by 2002, again writing with Draper, he questioned the validity of assessing spirituality because it rests on the assumption that it is a relatively universal and homogenous experience. He went so far as to suggest that we need to move away from the language of spirituality in nursing if we are talking about the existential dimensions of human life. In his 2004 work, writing with Cash this time, he stated that there are no universals in spirituality. Rather, they are embedded within particular worldviews. He also made a compelling point that while many of the definitions make a claim to inclusivity they depend on a functioning intellect. He then questioned how spirituality applies to individuals who are cognitively impaired. Are they excluded from developing or possessing spirituality?

Perhaps the question lies not so much with spirituality’s relationship to science but with our understandings of science. Many authors would agree that the traditional positivistic assumptions of science may not be suitable to the study of spirituality. However, as we broaden our views of science to encompass multiple paradigms of inquiry (Lincoln & Guba, 2000) science may indeed find a closer relationship with spirituality. Again, this harkens back to Townes (2003) belief that religion and science are converging in their approaches to inquiry. As we broaden our understandings of knowledge within nursing, we may also find room for a unique way of spiritual knowing.

Relationship to Religion

In the late 1980s, nursing authors began to distinguish spirituality from religion as separate, albeit related, concepts. This movement in nursing paralleled the societal disenchantment with organized religion in favour of a more individualized spirituality. Lane (1987), in her article on the care of the human spirit, identified two types of spiritual care; one that is shaped by the beliefs and faith traditions of the nurse and the patient, and one that transcends particular belief systems to care for more fundamental spiritual needs such as connecting and transcending. Burkhardt (1989), in an early concept analysis of spirituality, characterized religion as a collective understanding of spirituality and placed religion as a subtext of spirituality. Emblen (1992) sampled the nursing literature to differentiate between definitions of religion and spirituality. She also concluded that
religion was a part of spirituality but identified key differences: religion was characterized by organized beliefs and worship, and spirituality by a personal and transcendent life principle. Almost without exception, nursing authors have continued to make this distinction between religion and spirituality and have assigned religion as an optional subcategory of spirituality. The extent to which the separation is made varies, some see the two concepts intimately tied, others, relatively unrelated. A pervasive theme in the literature is to characterize religion as institutionalized, socially constructed, and a potentially negative aspect of spirituality.

The reasons for separating these two concepts are many. Some have suggested that the differentiation must be made because when emphasizing religion nurses may fail to see the greater universal needs related to spirituality (Dyson, Cobb, & Forman, 1997). Others have suggested that equating spirituality with religion has too much potential for promoting bias in care (Long, 1997). Still others have characterized religion as "cookbook" morality, whereas, true spirituality has no inherent right or wrong (Burkhardt & Nagai-Jacobson, 2002). Focusing on spirituality instead of religion allows us to transcend the difficulties of providing specialist religious care, and to provide spiritual care for those who have rejected religion but not God (MacLaren, 2004). As nurses cannot hope to provide expert care within the wide array of diverse religious worldviews, a more secular spirituality provides a simpler starting point, appropriate to those who may or may not consider themselves religious. Presumably, by adhering to a definition that transcends the divisive potential of religion nurses can engage in care more equitably.

There are a few lone voices that have opposed this marginalization of religion within spirituality. As discussed previously, Bradshaw (1994) has been an advocate of maintaining a religious essence to spirituality. She argued for the historical tradition of care where theology provides both a motivation for care and a normative standard by which to deliver that care. Salladay and Shelly (1997) have suggested that reducing religion to ideology is a politicized movement that marginalizes those who hold a particular worldview. Even Dawson, (1997) a self proclaimed atheist, argued against any definition of spirituality that strips it of its historical faith based roots. He supported maintaining the religious element that views humankind in terms of a body, soul and spirit that exists in relation with nature, religion, state and God.

Henery (2003) has pointed out that even though many authors are claiming to present a more inclusive and generic spirituality, religious constructions remain in many of these writings. He proposed that two main purposes of religious discourses are to define the limits of humanity and to suggest the presence of external subjective forms. Using a number of illustrations from the nursing literature he demonstrated how much of the new spirituality still contains inherent value positions and references to an external subjectivity that needs to be satisfied. He criticized these works for simply “smuggling” in new value systems and creating new religions that are perhaps far less developed than the old. However, even though there are a few voices speaking against this trend of separating religion from spirituality, there is generally broad consensus within the nursing literature that the two are conceptually distinct. In a recent literature review of the
differences between religion and spirituality Burkhart and Solari Twuadell (2001) found that religious writers were arguing for religion being the broader concept while spirituality writers were arguing for spirituality being the broader concept.

A similar debate on the relationship of spirituality to religion has been occurring within the social science literature. Some of the points being raised by these authors have not been discussed well within the nursing literature, and yet, are key to this work. I will introduce several of the most pertinent here. Pargament (1999), writing from the discipline of psychology, discussed how religion is being characterized by ideology, organization and ritual, whereas, spirituality is being characterized by the personal, affective, and experiential in the psychological literature. Increasingly, the spiritual is being viewed positively and religion negatively. He criticized these new constructions of spirituality as having the potential to produce ungrounded research and theory and to create polarities such as individuals versus institutions and good versus bad. He argued that most of the population does not make a distinction between the two, and that when examined critically, the new spirituality scales look very much like the old religious scales. Further, he suggested that it is a fallacy to think in terms of individual versus institutional when spiritual expression occurs in a social context and institutional form also embraces an individualistic mandate. Finally, he believed that the stereotyping of good and bad simply distracts us from more interesting questions.

Beyond the risks of ungrounded and polarized definitions, there is also the risk of not doing justice to the depth and complexity of religion. Hill and colleagues (2000) used examples from the work of theologians such as Heschel and Tillich to illustrate the depth of the religious thinking that is broad enough to encompass contemporary understandings of spirituality. Further, there is the risk of instrumentalizing religion, making it subservient to disciplinary concerns. Belzen (2003) used the example of depression to illustrate this risk. Whereas psychologists might try to pathologize depression and cure it, from a religious perspective, it may be seen as an important spiritual journey of growth, often referred to in the classic spirituality literature as the dark night of the soul. By limiting religion to institutional forms, there is the risk of marginalizing the role it plays in the lives of individuals and not appreciating the resource it supplies for health.

Many of the psychologists writing in this area are supporting the position that spirituality, while having a broader reference than religion, is really a narrower concept. They argue this on the basis that religion always requires some form of spirituality, whereas spirituality can be entirely secular. This issue of broader versus narrower is a fascinating one. If one takes the standpoint that it is the concept that has the most inclusive nature, then spirituality would be considered broader. However, if you consider all the potential definitional aspects of spirituality, only those who would also consider themselves religious would fulfill all the requirements, thus making it the broader term. This really becomes an issue of language. Because language is always fluent, these terms
may need to be re-defined for each generation (Hill et al., 2000). It is that re-definition that is providing such intense parlay within the disciplines.\(^4\)

Hill and colleagues (2000) have suggested a rather unique solution to the debate. They have argued for a combined definition of spirituality and religion with added referents for each one. The combined definition is the following:

The feelings, thoughts, experience, and behaviors that arise from a search for the sacred. The term ‘search’ refers to attempts to identify, articulate, maintain, or transform. The term ‘sacred’ refers to a divine being, divine object, Ultimate Reality, or Ultimate truth as perceived by the individual (p. 66).

The added referents may include components of searching for non-sacred goals or the rituals and prescribed behaviours of more formal groups (i.e. religious). This way a common definition is the starting point, and criteria may be added to characterize the more secular or religious aspects of spirituality.

In summary, this literature review has presented a number of key issues foundational to a further discussion of the conceptualization of the spiritual in nursing. I began with a brief overview of key questions that Smith (1988) has suggested have characterized the debate among philosophers about the nature of the spiritual. These questions inform the more concrete questions that will be asked in this work. A brief analysis of the Canadian context was presented that focused on the changing understandings of religion, spirituality and epistemology. This context is important for understanding the factors that are shaping the current literature on the spiritual in nursing. Next, I provided an overview of how the concept of spiritual nursing care has been influenced by religious, scientific and postmodern understandings. Many authors writing in the area of the spiritual today continue to position themselves within one of these influences, which at times creates a highly politicized debate. This diversity was illustrated in the next section where current conceptualizations of the spiritual in nursing were presented. I concluded by presenting three controversies presented by our current conceptualizations, that of hegemony versus inclusiveness, the relationship of the spiritual to science, and the relationship of the spiritual to religion. These three controversies will be explored in more detail in this work as I investigate the various conceptualizations of the spiritual and spiritual care in nursing literature, discuss the implications of these conceptualizations and argue for a particular approach based upon the moral and pragmatic nature of nursing.

\(^4\) For the remainder of this work, when I use the term religion I am defining it as “an answer to man’s ultimate questions” (Heschel, 1955, p. 3).
Chapter 3
Method

"Philosophy may be defined as the art of asking the right questions"
(Heschel, 1955, p. 4).

Nursing theory and research is inevitably linked to philosophy (Silva, 1977/2004). Nursing’s focus on human experience within health and illness means that many of the questions we grapple with from a disciplinary perspective are ones that philosophers have struggled with for centuries. What does it mean to live a human life? How does one find growth and well-being in a world that is often characterized by suffering? What represents goodness in the context of a human life? These questions are an integral part of the theory base of nursing. Indeed, some have argued that philosophy is so important to the discipline that if we do not pay more attention to nursing’s philosophic questions, the discipline will be in jeopardy (Kikuchi & Simmons, 1992). When we refer to nursing’s philosophic questions we are typically referring to three areas of concern: ontology (the nature, object and scope of the discipline), epistemology and ethics.

Philosophic analysis is essential for a topic like the spiritual. The nature of the spiritual will always remain somewhat ineffable, but within the context of a professional discipline, not reasoning through the implications of positions is morally indefensible. Although the theoretical and empirical literature on this topic has burgeoned, there are relatively few voices questioning this emerging body of theory. Philosophy has long played a role within religion, a role that it should also play with the emerging understandings of spirituality. Heschel (1955) has suggested that while religion provides the answers to the ultimate questions in life, philosophy rediscovers the questions. Philosophy enables us to reflect upon and question our religious understandings in a way that strengthens and sharpens those understandings. It serves to help anchor religion within reason. This in no way implies that religion should merely be limited by reason, but rather that “without reason faith becomes blind” (Heschel, p. 20). Similarly, the use of philosophy can help to anchor our understandings of the spiritual within reason. We can take the many answers that have been provided about the spiritual in nursing, reframe the questions that may have led to those particular answers, and explore and evaluate those answers in light of the nature of the profession.

Having stressed the importance of reason in relation to the spiritual, I think it is also important to emphasize that the nature of this topic does not lend itself to detached analysis. For many, spirituality is an inner life spring out of which all else flows—a sacred, inviolable core that rebels against exterior scrutiny. And so, to do this analysis I engaged in a form of thinking that Heschel (1955) has called situational. Conceptual thinking brings useful knowledge about the world, but situational thinking brings understanding about things that have far reaching implications for human existence (see Appendix B for further details on how I engaged this type of thinking). Because the stakes are so high, this form of thinking should be characterized by “amazement, awe, and involvement” (p. 5). We seek for answers because we suspect those answers provide
the key to existential angst. As I grappled with these questions, I tried to do so in a way that involved amazement of the rich work that is being done in this area, awe of the ineffable that I will never truly comprehend, and involvement with a critical analysis of these ideas that hold such potential power for human health and healing.

Philosophic method problematizes, reveals assumptions or potential distortions, clarifies views, and argues for some positions over others (Sarvimaki, 1999). Philosophic analysis should bring clarity to an issue (Rosenberg, 1978) and reveal illogical or unreflective ideas (Martinich, 1996). Unlike scientific inquiry that produces knowledge, or what Simmons (1992) has termed productive power, philosophical inquiry leads to insight and direction for social conduct. Philosophers from ancient times have pursued their craft as a search for wisdom. Philosophic method is particularly useful at this stage of the development of the conceptualizations of the spiritual within nursing. A large body of theoretical and empirical literature has been published over the last two decades. The healthy diversity that characterizes much of nursing's philosophical thinking is apparent in this literature. But, what is somewhat ominous is the lack of critical reflection on some of the positions being taken, positions that have consequences both for the discipline and for our healthcare partners. This is the time to clarify the different positions, to make explicit some of the claims being made, to consider the implications of the various positions, and to argue for some alternatives over others.

Problem Statement

Members of the profession of nursing, and the healthcare community, are increasingly claiming an ethical responsibility to pay attention to the spiritual in the context of care. Yet, various, and often contradictory, positions are being taken on the conceptualization of the spiritual. There is a need to investigate and to clarify the various positions being taken within the nursing literature; to analyze the implications of those positions for nursing's ontology, epistemology, and ethics; and to make recommendations for how the spiritual should be enacted in nursing.

Purpose

The purpose of this work is to investigate and clarify the various conceptualizations of the spiritual and spiritual care in nursing literature; to discuss the implications of these conceptualizations for nursing's ontology, epistemology and ethics; and to argue for a particular approach based upon the moral and pragmatic nature of nursing.

5 In using philosophic method to analyze the literature on the spiritual in nursing I am also recognizing that some aspects of the spiritual are not subject to rational analysis. There will always remain an ineffable dimension to the spiritual.

6 I am assuming here that nursing is a discipline with its own epistemology and ethics. Some might argue that because of nursing's vocational and practical emphasis it is not a discipline. For a discussion of this debate see Donaldson & Crowley (1978/2004) and Bishop and Scudder (1997/2004). Further, in this work I will focus primarily on nursing in the context of the patient as client. Although nursing legitimately focuses on family and community as client, and necessarily extends its expertise to education, research and policy,
Questions

1. What are the various conceptualizations of the spiritual and spiritual care in the nursing literature?

2. What implications do these conceptualizations of the spiritual have for nursing's ontology, epistemology and ethics?

3. What approach should we take to the spiritual in nursing?

To answer these questions, I first survey key literature on the spiritual in nursing and organize this literature using the philosophical categories of theism, humanism and monism. I then ask philosophic questions about these various perspectives, drawing out the implications for nursing's ontology, epistemology and ethics. Based on these answers, and upon the moral and pragmatic nature of nursing, I then make recommendations for how the spiritual should be approached.

Many questions are asked in this work, and not all of them are answered. Although they all in some way address the primary question of how we should incorporate the spiritual in nursing, different sets of questions are posed to explore facets of this question. In some cases, a concrete set of questions, such as those found in the beginning of Chapter 4 and throughout Chapter 5, are used to help elucidate various positions. These questions help to lead the reader logically through the literature and through the various philosophic positions of theism, monism and humanism. In other cases, questions are used to reveal some of the potentially problematic issues in relation to the various perspectives. Such is the nature of the questions found at the end of Chapter 4 where works of various theorists are categorized, presented and then problematized in terms of the implications for nursing. One set of questions, found at the end of Chapter 5, is primarily analytic. These questions could be used as a framework of analysis for any theoretical work on the spiritual in nursing. Finally, the questions found in Chapters 6 and 7 allow me to put forward my own recommendations regarding the spiritual in nursing and to identify questions that could be the focus of future research. Although this approach may seem to entail an unwieldy number of questions, they all relate back to the central questions of how the spiritual is being conceptualized, the implications of these conceptualizations and, ultimately, how it should be incorporated into nursing.

Literature Selection and Analysis

Various nursing theorists who have written extensively about spiritual nursing care were selected for analysis. Theorists were chosen based upon the following criteria: having published a text within the last decade, having written extensively enough to fully understand the implications of their position for nursing's ontology, epistemology and

my primary concern in relation to the spiritual is how it works out in its primary application, within the context of the nurse patient relationship.
ethics, and having taken a somewhat unique approach to the conceptualization of the spiritual. Theorists were identified through a search strategy that began with my familiarity with the topic. As I had been studying in the area of the spiritual for a number of years, I was already familiar with many of the leading nurse theorists. But beyond that, I checked the reference lists of theoretical articles on spirituality, searched the catalogues of Universities and Colleges, and had a reference librarian conduct a search on WorldCat. This WorldCat search yielded 180 records. Most of these works were inappropriate because they were edited volumes, multi-disciplinary works or were only distantly related to the topic. As a result of this search, I selected the works of the following theorists: Jean Watson, Ann Bradshaw, Judith Allen Shelly, Mary Elizabeth O’Brien, Rosemary Parse, Barbara Barnum, Elizabeth Johnston Taylor, Aru Narayanasamy, and Margaret Burkhardt. The work of Wilfred McSherry was originally included because he has published both a book and a number of articles. However, the evolution of his ideas in relation to the spiritual has been such that it was difficult to characterize his work in a way that does justice to his ideas. His book reflects a somewhat different approach than his most recent articles. Instead, I chose to draw upon his work in my analysis and critique.

Published books were the primary source of data, but related journal articles were included as part of the data set. I included all articles that might have relevance to the topic, even if the title did not explicitly identify spirituality. For example, Bradshaw’s work on nursing competency is a reflection of her overall theological approach to nursing care, and so I included those articles as part of the review. Articles were obtained through a computerized search of Academic Search Premier (which includes the Computerized Index for Nursing and Allied Health Literature) and through a manual search of the reference lists of the authors themselves. I assumed most authors would make reference to their other bodies of work. If texts had multiple editions, only the most recent edition was analyzed.

Data were collected using the questions located in Appendix C. Extensive notes were taken from the work of each theorist in answer to these questions. I then created a series of tables to compare and contrast the different perspectives. This process enabled me to take a large amount of primary data and condense it in such a way as to better understand, organize and categorize the different positions being taken on the spiritual in nursing. As I compared and contrasted the various perspectives, I searched for the most logical commonalities by which to group the works of the theorists. The distinctions seemed to arise from the fundamental assumptions about the ontological origins and nature of the spiritual. Therefore, the philosophic categories of theism, monism and humanism evolved out of this analysis of the literature7 and were then used to organize and critically review this literature.

7 Finding terms to adequately reflect the fundamental philosophic differences was a challenging process, particularly in the case of the monistic perspective. Theism and humanism seemed to adequately represent the differences I was seeing in perspectives. However, monism is not as readily understood. Indeed, with theorists such as Parse, the concept of unitary was a more appropriate label. But, monism seemed to best represent the fundamental assumption of an underlying unity of spiritual substance that best characterizes these theorists.
In Chapter 5, the hypothetical dialogue, it became necessary to go beyond the nursing literature to the theological and philosophical literature to better articulate the theistic, monistic and humanistic perspectives. The question arises then of how I chose the philosophers and theologians to draw from. In the case of the theistic perspective, I selected recent Christian and Jewish thinkers who have addressed the areas of interest and who would be recognized as credible sources within these traditions. These included Martin Buber, Abraham Heschel, C.S. Lewis, Dallas Willard and Pierre Teilhard de Chardin. The theistic nursing theorists tend to draw upon scriptural references, and Ann Bradshaw, in particular, referenced C.S. Lewis, Martin Buber, and Karl Barth in her work. The monistic perspective was more problematic, because these nursing theorists do not necessarily locate themselves within an organized, easily nameable movement. For example, Barnum makes little attempt to anchor her New Age spirituality. Parse makes reference to A.J. Bahm and J.L. Mehta to support her unitary view of the human but builds her theory primarily on the work of Martha Rogers. I had to find a source that would explain this particular way of viewing the world. I selected the work of Neale Donald Walsch whose books “Conversations with God” have been on the New York Times Bestseller List. His book “Tomorrow’s God: Our Greatest Spiritual Challenge” (2004) comprehensively lays out a vision of spirituality that has much in common with the monistic view. These commonalities include a vision of the world as an interconnected unity, a god that does not exist apart from humanity, the presence of a powerful universal consciousness, a reluctance to view the world in terms of dichotomies such as right/wrong, a view of humans as essentially autonomous and good, and an emphasis on human choice. Walsch’s writings have gained widespread acceptance in North American society as indicated by the enormous popularity of his books. It is not surprising then that this understanding of the spiritual will also be evident in the nursing disciplinary discussions. In general, the humanist arguments have been so well represented in the work of theorists writing on the spiritual in nursing, and in the popular press, that it was unnecessary to consult outside of this literature. In the context of this work, the humanistic perspective regards spirituality as a subjectively defined, universal human dimension, and so the best source of authority in understanding those ideas are the works of the nursing theorists themselves.

8 However, she does cite a number of theorists that Roger’s work is rooted in: Teilhard de Chardin, Michael Polanyi, Kurt Lewin, Soren Kierkegaard, Edmund Husserl. She makes is clear however that though her work is consistent with Rogers work it is a “new product” (1998, p. 4)
Chapter 4
A Distillation of the Works of Selected Theorists

All functions of man's spiritual life are based on man's power to speak vocally or silently. Language is the expression of man's freedom from the given situation and its concrete demands. It gives him universals in whose power he can create worlds above the given world of technical civilization and spiritual content.

(Tillich, 1959, p. 47)

This chapter will provide an overview of the works of nine nursing theorists who have written extensively on the spiritual in nursing. My purpose in this chapter is to begin to address the research questions: What are the various conceptualizations of the spiritual and spiritual care in nursing literature, and what are the implications of these positions for nursing's ontology, epistemology and ethics? This overview will provide the theoretical foundation from the literature for the next chapter where the implications of various positions will be discussed in more depth. The work of the following theorists will be reviewed: Ann Bradshaw, Judith Allen Shelly, Mary Elizabeth O'Brien, Aru Narayanasamy, Elizabeth Johnston Taylor, Margaret Burkhardt, Barbara Barnum, Jean Watson, and Rosemary Parse. These theorists have written at least one book on the spiritual in nursing and most have published a number of articles.\footnote{You will note that the texts of Shelly and Burkhardt were co-authored. I have chosen to focus only on the works of these primary authors because their writing in this area is more extensive than their co-authors.}

I have chosen to group these theorists into three categories based on their ontological starting point for understanding the spiritual: theism, monism and humanism. Bradshaw, O'Brien and Shelly have been placed in the theistic category. The theistic perspective begins with the assumption that God is the beginning point for understanding the spiritual. All three theorists come from a Christian theistic perspective. I am not aware of any nurse theorists writing from the Judaic or Islamic perspective. Narayanasamy, Johnston Taylor and Burkhardt have been placed in the humanistic category. Although they acknowledge God within their work on the spiritual, their fundamental assumption rests upon existential experiences such as meaning, connectedness and transcendence. The spiritual is a universal human experience that may or may not be related to a belief in God. Barnum, Watson and Parse have been placed in the monistic category. Monism assumes that only one substance exists, and the substance is usually characterized as universal psychic energy. Unlike theistic perspectives, within monism there is no distinction between humanity and god, rather humanity and god are merged within a universal cosmic consciousness.\footnote{Some might refer to this position as pantheism rather than monism. I have chosen to not use the term pantheism because it implies that god is inherent in all things. These theorists do not necessarily bring in the concept of god to understandings of the spiritual. They do, however, hold to a fundamental unity of all things.}

Assigning labels is a difficult process because it often fails to do justice to the complicated nature of ideas or to account for the overlap that occurs in positions. It is
important to note that I am not attempting to make a judgment on the worldview perspective of the nurse theorist. Rather, I am trying to assign their work based on the fundamental assumption of the nature of the spiritual implicit in their writings.\textsuperscript{11} This is an important distinction, because some of the theorists combine perspectives in a syncretistic manner and might resist having their work placed within a particular view.\textsuperscript{12} In assigning theorists to a category I tried to discern the fundamental reference point for the origin of the spiritual. In most cases it was fairly clear. In other cases it was not so clear, primarily because the theorist would locate himself or herself within multiple positions. The question then became what assumption could be excluded without losing the viability of the position? For example, some theorists blend positions of theism and humanism. But in the enactment of the position it was clear that theistic assumptions were optional, whereas the human right to define the nature of their individual spirituality was not. This then allowed me to place them within humanism. If one holds to the position that these are mutually incompatible ontological positions, then in trying to combine them, a theorist will always locate one as most fundamental.

It is also important at this point to acknowledge the limitations of typologies of this nature. I have chosen to use the philosophic organizing categories of theism, humanism and monism, but other typologies are potentially as useful and valid. But beyond that, any typology is limited by its inability to capture fully the diversity of human thought and experience. This limitation is expressed well by Paul Tillich (1963a) in his book on Christianity and world religions.

The establishment of types, however, is always a dubious enterprise. Types are logical ideals for the sake of a discerning understanding; they do not exist in time and space, and in reality we find only a mixture of types in every particular example. But it is not this fact alone which makes typologies questionable. It is above all the spatial character of typological thinking; types stand beside each other and seem to have no interrelation. They seem to be static, leaving the dynamics to the individual things, and the individual things, movements, situations, persons (e.g., each of us) resist the attempt to be subordinated to a definite type. Yet types are not necessarily static; there are tensions in every type which drive it beyond itself (p. 54-55).

And so, I am using these typologies to help explicate and understand the various expressions of the spiritual in nursing literature, knowing fully well that they are limited

\textsuperscript{11} In keeping with this assumption, I am going to write about this literature in the present tense. However, I recognize that ideas evolve and that what I am presenting here may not represent the most current thinking of these theorists – it is simply the ideas represented in their most current publications.

\textsuperscript{12} This in itself is an interesting question and one that has pervaded the nursing science discussion. Are some worldviews logically incompatible or can they be combined without losing the essential integrity of the underlying assumptions? The theorists writing in the area of the spiritual differ in their response to this question as evidenced by their willingness, or unwillingness, to combine the various worldview perspectives in their work. This is why this categorization is potentially problematic. Some might argue that assigning them to a particular worldview contradicts their view that these perspectives can be combined. A good example would be Jean Watson who explicitly states that all of these are simply one way of viewing a unified reality.
in their capacity to express the diversity that exists in reality and the interrelation and overlap that occurs between these positions.

In keeping with the purpose of this chapter, the questions are designed to help us understand how leading nurse theorists are conceptualizing the spiritual and spiritual care in nursing, and how their conceptualizations influence nursing ontology, epistemology and ethics in relation to the spiritual. In some cases, it was difficult to answer all of the questions because theorists choose to emphasize different areas in their work. For example, some write extensively on the preparation of practitioners to provide spiritual care, while others only mention it briefly. Similarly, some explicitly address the link between the spiritual and nursing ethics; whereas, with others the link is implied. In describing the work of each theorist I will answer the following questions:

- **Who is this theorist, and how extensive is his or her body of work in relation to the spiritual in nursing?**
- **What characterizes his or her particular understanding of the spiritual in nursing?**
- **How is spiritual care enacted, and how is a nurse prepared to engage in spiritual care from this perspective?**
- **What characterizes knowledge about the spiritual, and how is it discovered or constructed?**
- **What is the relationship of the spiritual to nursing ethics, and what ethical values are central?**

By the end of this chapter the reader should have a broad overview of the various perspectives developing around the spiritual in the nursing literature and a beginning familiarity with the implications of these positions. The implications will be explored further in the next chapter where the various positions will be compared and contrasted.

**Theistic Perspectives**

The theistic perspectives are characterized by a foundational assumption that God is the beginning point for understanding the spiritual. However, although they start from this common assumption, the implications for nursing are quite different as will be demonstrated in the following overview. The theorists in this category are Ann Bradshaw, Judith Allen Shelly and Mary Elizabeth O’Brien.

**Ann Bradshaw – Covenantal Caring.**

Bradshaw is a Lecturer and Clinical Fellow in ethics and palliative nursing of the Royal College of Nursing Institute of the Radcliffe Infirmary at Oxford in the United Kingdom. She authored a relatively early book on the spiritual entitled “Lighting the Lamp: The Spiritual Dimension of Nursing Care” (1994). This extensive work provides a historical review that lays the foundation for a religious definition of spiritual care, critiques various nursing theoretical perspectives in light of her definition, and presents a meta-theory of nursing grounded in theology. Bradshaw has also published six articles
that re-iterate and further develop ideas from her book (1995a, 1995b, 1996a, 1996b, 1996c, 1999), and an article that describes the implications of her perspective for teaching spiritual care (1997). Bradshaw has also published several articles on competency in nursing, and I have included these as part of this review because they logically extend her ideas related to spiritual nursing care. She argues that physical care is inseparable from spiritual care and that the heavy emphasis on psychosocial care within nursing theory has led to a neglect of the technical knowledge and skill so necessary to care of the body (1998, 2000).

Bradshaw’s understanding of the spiritual is based upon the premise that humankind was created by, and lives in covenental relationship with, God. Understanding of covenant is key to her work. As God has covenanted to be faithful to humanity, so nurses are called to be faithful to their patients in a spirit of love, freedom, trust and sacrificial service. This is in opposition to a contractual model of care that seeks personal or career achievement and satisfaction. Humans are tri-dimensional beings of body, mind and spirit, and she emphasizes the inseparability of these three dimensions in the context of care.

Bradshaw does not support the notion of spiritual care as an added dimension of care as it is commonly described in the literature. She refers to this as a “bolt-on” approach that belies the essential nature of the spiritual. In other words, to think of spiritual care as another dimension of care is to deny the interconnected dimensions of the person. From her perspective, spiritual care refers to how the nurse engages in the relational aspects of nursing, a motivation and the ethic by which the work of nursing is done. The nurse is not required to assess the spiritual needs of patients, because when care is enacted through this ethic, the Holy Spirit is able to meet the needs of patients without any need for the nurse to be consciously aware of what is happening. There is no need for nursing techniques or therapeutic encounters directed toward particular outcomes. Rather, the nurse engages with the patient in a way that acknowledges a shared humanity. She differentiates her approach from other theistic theorists as “not the giving of doctrine but the sharing of love” (1994, p. 294).

From her perspective, learning to provide spiritual care is “not taught so much as caught” (1997, p. 51). As the primary goal is the character development of the nurse within a particular moral ethos, this is best done through modeling care. However, it is not necessary for the nurse to embrace her theistic assumptions to enact this ethos of care.

The covenant role provides a paradigm for all nurses whether they know the roots of the paradigm personally or not. Yet the nurse who knows the inspiration behind the covenant can take hold of its power through prayer. This is the silent gift she can bring to each nursing relationship (1994, p. 329).
Revelatory, or theological knowledge, is the foundational aspect of knowing within Bradshaw's perspective. Nursing practice draws upon scientific, rational and intuitive knowledge, but it is theological knowledge that provides the moral knowledge for care. Based upon her belief that God has created a universe with laws and principles, she argues for a predictable framework for understanding human existence. That is, we know who we are and what our purpose is based upon unchangeable theological certainties. This universe of laws and principles means that knowledge is not so much constructed as discovered. She considers empiricism as a way to discover knowledge, and she criticizes holistic interventions that cannot be empirically tested. Although she acknowledges the importance of both qualitative and quantitative research as legitimate methods of inquiry, she places limits on the knowledge obtained. “Thus, the understandings of academic knowledge, whether biological, psychological or sociological, are limited descriptions of the human being that cannot give rise to prescriptions for human behaviour and human life” (1994, p. 301). Rather, the products of these endeavours provide “tools, insight, and method” rather than “direction, goal or foundation” (p. 301). She also cautions against generalizability in the enactment of spiritual nursing care.

The principles of covenant relationality warn against defining standards of nursing care that are based on generalizations which ignore the mutuality and freedom of the heart implicit in the caring relationship... the standard of care is derived from the quality of a relationship and the moral character of the nurse. And this, by its nature, is not open to arbitrary judgment or systematic evaluation because it is dependent on the freedom of the heart (1994, p. 320-1).

So, though she acknowledges the importance of various types of knowledge and methods of inquiry for practice, theological knowledge provides the ethic and ethos by which the work of nursing is done.

For Bradshaw, the spiritual and nursing ethics are inextricably joined. Theological knowledge provides the moral ideal for the enactment of care. Although God is inherently good, humans have the choice to either express that goodness or to yield to their own nature that is inherently fallen or sinful. She does not believe in the unrestricted autonomy of the nurse, which she characterizes as the breaking of the lamp tradition in nursing. Rather, nurses are accountable to God for the way their life is lived and the way they perform their service of nursing.

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13 Theological knowledge generally implies a scholarly endeavour whereby one grapples with the meaning of revelatory knowledge. The term revelatory knowledge emphasizes the infallible nature of sacred writings as revelation of God to humankind.

14 I think what Bradshaw is suggesting here is not that humanity can be understood completely in a cause effect type of model, but rather that there does exist a framework, primarily moral, for understanding human existence. “As God’s nature is faithfulness and dependability, so the universe rests in objective and universal laws and principles, which provide a framework not only for creation but also for the manner of human existence” (1994, p. 3).

15 The use of the phrase “Lighting the Lamp” in the title of her text is a response to what she has called breaking the lamp, the removal of the ethic of care from its religious foundations.
Her theory espouses a number of values. Her concept of health and well-being is the image of God in humankind which is characterized by the valuing of human life, freedom, love, relationality, hope and peace. She emphasizes that nurses are to be with patients in a spirit of love and relationality, and that patients must be free from ideological pressure from nurses. She argues against theorists who try to control patients or who view them as autonomous and independent. Instead, she advocates for a mutuality that emerges from, and is clarified by, “the partnership of companions involved” (1994, p. 317). She further argues against theorists who suggest that effective care is promoted through the powerful consciousness of the nurse, instead characterizing the relationship as an authentic encounter that is relatively unselfconscious. Bradshaw provides a clear and extensive articulation of the need for ethical relationships between nurses and patients, based upon their mutual humanity and the potential vulnerability of patients.

*Judith Allen Shelly – Kingdoms in Conflict.*

Shelly has worked extensively with Nurses Christian Fellowship and was, until recently, the editor of the Journal of Christian Nursing. She holds an adjunct Professorship at North Park University in Chicago. Shelly has written a number of books in the area of spiritual care, many of them dating to the late seventies and eighties. One of her most recent books “Called to Care: A Christian Theology of Nursing” (Shelly & Miller, 1999) is the one I have drawn on for this analysis. I have also included a journal article co-authored with Salladay that examines current conceptualizations of the spiritual in nursing in light of Christian nursing ethics (Salladay & Shelly, 1997).

Like Bradshaw, Shelly draws upon the work of Christian theologians to describe the spiritual based upon an understanding of a covenantal relationship between God and his people. Central to Shelly’s view is a spirituality characterized by co-existing good and evil kingdoms. Spiritual existence is a battleground between these kingdoms that are trying to lay claim to humanity. Humankind is seen as created in the image of God, fallen, and redeemed through Jesus Christ. They are characterized as physically, psychosocially and spiritually integrated sexual, moral and mortal beings.

Shelly’s characterization of the spiritual as kingdoms in conflict has implications for how spiritual care is enacted. Unlike Bradshaw who believes patients should be free of ideological pressure from nurses, Shelly takes an evangelical approach. Health is defined as a restored, harmonious relationship to God, and so a key part of the nursing role is to facilitate the restoration of that relationship.

Nursing cannot work toward the goal of health without including a clear proclamation of the gospel, as well as providing physical care with a servant attitude. Nursing, as a vocation, or calling, from God, must return to its roots in the church and Christian faith in order to work toward the goal of true health (1999, p. 25).

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16 Nurses’ Christian fellowship is an international organization whose purpose is to promote Christian values and principles in nursing and to bring Jesus Christ to nurses.
This perspective of kingdoms in conflict informs her perspectives of illness and appropriate nursing interventions. She suggests that many social diseases have spiritual roots and notes the tendency in society to view some behaviours as sick rather than evil. Although she believes in the importance of spiritual assessment, the enactment of care consists of a way of being with patients rather than a mechanistic interventional approach. Further, because both good and occult spiritual forces coexist, she cautions nurses against certain spiritual interventions. She describes many of the New Age energy based healing therapies as cultic, particularly those where practitioners have to suspend their judgment and engage with an unseen reality. She believes these interventions, rather than being beneficial, may open the door to influence by evil spirits.

Practitioners are prepared to engage in spiritual care by learning both a theology of nursing and a practical theology. Like Bradshaw, Shelly sees theology as providing both the motivation for practice and the moral ethos of care. She also suggests that nurses need to understand the nursing metaparadigm (i.e. health, humans, nursing) from a theological perspective, partly so they can avoid harmful approaches to the spiritual. Practical theology includes competencies of "knowing how to share their faith, how to pray with patients and read Scripture appropriately, how to listen to the Spirit as well as the patient, and how to participate as colleagues in ministry along with the clergy and the body of Christ" (1999, p. 253).

Shelly also positions revelatory knowledge as key to understanding the spiritual. Revelation occurs both through scripture and through a personal revealing of God to people. Scriptural knowledge is foundational to this perspective because of the importance of sharing doctrine. Shelly clearly positions herself within a realist ontology and argues against a purely subjective view of reality. All knowledge, theory and instruments of inquiry should be tested against scriptural knowledge. For example, she cites the use of spiritual needs surveys that do not include the need for repentance from sin as described by Christian doctrine. In essence, all knowledge is discovered from a real world that exists and must be tested by the truth of scriptural revelation.

Shelly’s conceptualization of the spiritual, like Bradshaw’s is inextricably related to nursing ethics. Evil and good have origins in a spiritual realm with material consequences. She locates morality within the character of God and moral behaviour as guided by theHoly Spirit. This moral ideal governs interpersonal ways of being, views of sickness and health, acceptable interventions and desirable patient outcomes. While acknowledging that the Bible fails to provide direction on some ethical issues, she believes that it does provide some absolutes. 17

A primary value of Shelly’s perspective is the restoration of humanity to a relationship with God. As a result of her belief that humans proceed to either heaven or hell after death, she suggests that nurses have a moral responsibility to share the good

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17 There is a bit of confusion here about what is absolute and what is not. For example, she suggests that protecting life is an absolute but then goes on to discuss the ethical issue of when it is appropriate to remove a patient from a ventilator. This suggests that there is some negotiation of these absolute ethical principles.
news of salvation. She acknowledges that this may not always be comfortable for patients and discusses how this topic can be approached sensitively and graciously. A fundamental ethical dilemma from her perspective is that there is no allowance for Christian orthodoxy in nursing theory on spirituality. That is, there is no allowance for proselytizing based on an understanding of the sinful nature of humankind and the need for reconciliation. She sees this as an example of the discipline creating its own orthodoxy that is antithetical to Christian beliefs (Salladay & Shelly, 1997).

Mary Elizabeth O’Brien – On Holy Ground.

O’Brien is a Catholic sister and Faculty member at the Catholic University of America School of Nursing. She brings the unique perspective of being a nurse, a Catholic sister and a Chaplain. She has authored several books on spirituality; however, a couple of them have significant overlap in content. Her primary text is entitled “Spirituality in Nursing: Standing on Holy Ground” (2003). Her book “A Nurse’s Handbook of Spiritual Care” (2004) is primarily a reiteration of this material in condensed format. The other book that was used for this analysis was “The Nurse’s Calling: A Christian Spirituality of Caring for the Sick” (2001).

O’Brien’s work differs somewhat from the two other theorists in this category as she makes a fundamental distinction between religion and spirituality. Whereas the other two theorists view the spiritual as inseparable from religion, O’Brien characterizes it as a fundamental human need related to transcendence, ultimate ends, and values. O’Brien has characterized spiritual care as standing on holy ground because she believes the nurse encounters God when serving others. Although she agrees that the Christian message is one of evangelism, or good news, like Bradshaw, she views this primarily as service to those in need rather than the sharing of doctrine.

Unlike the other two theistic theorists, O’Brien advocates for enacting spiritual care through the use of the nursing process. Spirituality is conceptualized as a dimension of the person that can be approached using a systematic method. She advocates for comprehensive assessment of this dimension and presents her own quantitative assessment tool that she suggests can be used for either research or practice (2003, p. 65-66). The nursing diagnoses she discusses are described in relationship to God from a Christian perspective. She draws upon an impressive array of research to propose a variety of interventions but emphasizes that the individualistic nature of spirituality does not permit a rule book approach.

18 I have chosen to include her in this category because in the introduction to her work she clearly locates herself within a Judeo-Christian tradition. Also, although she separates religion from spirituality in her definition, the working out of her conceptualization centers around a relationship with God. For example, even though she acknowledges that transcendence and valuing can happen apart from a relationship with God, all of her spiritual diagnoses are defined in relation to God (2003, p. 67-69), and she bases spiritual nursing care within what she calls a theology of caring. Hence, I have chosen to group her with the theistic theorists.
O’Brien believes nurses do not require religious training to intervene in the area of the spiritual, only an understanding of their own spirituality. Based on her research, she characterizes the nursing role as that of an anonymous minister. The nurse prepares for and fulfills this role by acknowledging a sacred calling, enacting a nonverbalized theology and practicing nursing liturgy (2003, p. 89). She encourages nurses to judge their own competency in this area and to make referrals to chaplains when the issues extend beyond their competency.

Although O’Brien does not refer explicitly to epistemological issues she does call for well validated nursing theory about spirituality. She believes that spirituality develops and can be measured quantitatively. Her text presents an overview of research related to spirituality in different contexts and populations. This research review includes a broad range of methods of inquiry, tools and conceptualizations of the spiritual. Her text reflects a blend of revelatory, empirical, personal and intuitional knowledge as it relates to the spiritual in nursing.

O’Brien does not draw an explicit link between the spiritual and nursing ethics like the other theistic theorists. The ethical implications arise out of her particular definition of spirituality. By definition, spirituality is a fundamental human need that allows one to transcend the realm of the material (2004, p. 50). So, whereas the other theorists in this category focus on service to humanity, and well-being as a restored relationship with God, O’Brien takes a more eclectic approach. The ethically desirable outcomes are those that enable individuals to transcend the realm of the material. Hence, the spiritual is by nature something good and self defined.

The ethical values of spiritual health and relationality are fundamental to her perspective. Spiritual health is described as understanding and valuing the role of spirit in life, and a number of descriptors such a hope, joy and love are used to characterize the outcomes. An ethical nurse patient relationship is characterized by loyalty, responsibility, mutual obligations, no conditions on faithfulness and no expectation of a return for the nurse’s services (2003, p. 85).

In summary, Bradshaw, Shelly and O’Brien conceptualize the spiritual through a Christian theological lens. However, the focus they take through that lens is quite different. Bradshaw advocates for a religious perspective that brings both a motivation and an ethic to nursing care. Shelly’s view of spiritual kingdoms in conflict results in a decidedly evangelical approach to care. O’Brien, adopting a needs based perspective of spirituality, advocates for an eclectic, nursing process approach to spiritual care.
Humanistic Perspectives

The fundamental assumption of the humanistic perspective is that the spiritual is a universal, innate, subjectively defined human dimension. These theorists, while acknowledging the existence of the sacred and divine, resist adopting any particular characterization of what those concepts mean. Whatever the individual finds meaningful and values as supreme becomes their individualized expression of spirituality. The theorists included in this category are Aru Narayanasamy, Elizabeth Johnston Taylor and Margaret Burkhardt.

Aru Narayanasamy – A Biological Basis.

Narayanasamy is a senior health Lecturer in the School of Nursing at the University of Nottingham in the United Kingdom. His work in the area of spirituality has been prolific including a book entitled “Spiritual Care: A Practical Guide for Nurses and Health Care Practitioners” (2001), four theoretical pieces or responses (1999c, 2004a, 2004b; Swinton & Narayanasamy, 2002), three articles on spirituality in nursing education (1999a, 1999b; Narayanasamy & Andrews, 2000), and three articles on nurse’s spiritual care abilities (1993; Narayanasamy & Owens, 2001; Narayanasamy et al., 2004). His body of work also includes a number of studies of spirituality in various populations (1995, 2002, 2004c; Narayanasamy, Gates, & Swinton, 2002).

The key distinguisher of Narayanasamy’s perspective on the spiritual is his belief in a biological basis for spirituality (1999c). In essence, this means that humanity has an innate biological capacity for spiritual awareness or a “direct awareness of a sacred or divine presence” (1999c, p. 121). He places this biological model in contrast to the theological model which limits spirituality to Christianity. Further, the biological model is characterized by perception rather than belief. Although he draws upon existentialism to support spirituality as a universal phenomenon, he claims that it is an insufficient base and that “any description of spirituality cannot be comprehensive enough without its biological root” (1999c, p. 279).

Spirituality is treated as a dimension of the person that is subject to a needs based, problem solving approach as embodied in the nursing process. In his book he claims to focus on meeting the spiritual needs of Christians but states that these needs could be considered universal (2001, p. 25). He presents a broadly based qualitative approach to assessment and recommends interventions that reflect the skills of the nurse, namely self-awareness, communication, trust building and giving hope. Patient outcomes include things such as improvement in physical functioning, appropriate behaviour and a clearer self concept. In the enactment of spiritual care, the nurse acts as challenger, counsellor and teacher (2001, p 80), while unconditionally accepting the patient without judgment, reservation or criticism (2001, p. 77).

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19 I am not quite sure what to make of this claim, particularly in light of his critique of Christianity as being too limiting in the context of spirituality.
Narayanasamy suggests that nurses can become competent to intervene in the realm of the spiritual through appropriate education. He has published a curricular map for the teaching of spirituality. This curriculum includes content in self awareness training, in understanding spirituality and in how to address the spiritual dimension using the nursing process (1999a).

Narayanasamy believes that spirituality is a discipline with its own developing epistemology and theories (2001, p. 2). He suggests that in nursing there is a lack of clarity around the understandings of spirituality primarily because of nursing theorist's ignorance of epistemology, namely theology, philosophy, and existentialism (2004a, p. 462). Although he acknowledges that spirituality is highly individualized, difficult to define and measure, and mysterious to the point that it may be beyond even subjective explanation, he advocates for a scientific approach to study (2004a). He believes that our understandings of science may need to change to accommodate the study of this phenomenon. He emphasizes understanding the lived experience of spirituality, and uses primarily qualitative methods in his own research. In opposition to those who might question the legitimacy of spirituality in nursing, he argues for the inclusion of spiritual care based upon the research evidence that suggests that it is an important consideration in patient care. This use of the word evidence, his discussion of the generalizability of the findings of his research, and his advocacy of the nursing process in practice suggests that he views spirituality as a somewhat universal phenomenon that can be generalized. However, he also emphasizes the existential and somewhat mysterious nature of the concept.

The link between the spiritual and ethics is not explicitly articulated. Spiritual integrity is considered a desirable endpoint for care, a central value. “The person who has attained spiritual integrity demonstrates this through a reality-based tranquility or peace, or through the development of meaningful, purposeful behaviour, and a restored sense of integrity” (2004b, p. 1144). Another key value apparent in his work is an emphasis on the importance of nurses developing spiritual and cultural sensitivity and awareness. His article with Andrews (2000) emphasizes the need to make nursing education more sensitive to Islamic spirituality.

Elizabeth Johnston Taylor — Unification and Healing

Johnston Taylor characterizes the spiritual as an innate, universal, intangible, and somewhat inexpressible dimension of the person that seeks meaning, often through connectedness or relatedness (2002a, p. 3-5). Although in her book she presents a number of nursing definitions of the spiritual, she does not explicitly adopt one definition for her own work. In her work with Highfield and Amenta she defines spirituality in the following way: “A unifying and healing force of the whole person, spirituality centers on relationships, development, wholeness, integration, and individual empowerment. It is not private, but communal, and can be studied only by examining its reflection in human behaviour and experiences” (2000, p. 54). Spirituality is characterized as non religious, although religion may be a “bridge to spirituality” (2002a, p. 10).

Johnston Taylor uses a nursing process approach to address the spiritual dimension of persons. She claims that spirituality becomes manifest in needs—needs related to self, others, groups and transcendence. These needs include usefulness, dignity, forgiveness and understanding duties and responsibilities (2002a, pp. 17-20). She includes a number of qualitative and quantitative assessment tools in her book. She suggests that assessment tools should be “free of religiously biased language” (p. 117) so that non-religious clients will not be offended. Johnston Taylor uses the North American Nursing Diagnosis Association (NANDA) diagnostic categories and stresses the importance of accurate assessment so that interventions are not wrong or possibly harmful. She advocates for standardized terminology for communication, documentation and quality assurance purposes. She presents a standardized care plan for spirituality that presents a list of expected outcomes that nurses can tick as appropriate with the rationale that it can save nursing time. A variety of nursing interventions are proposed, the most important being nursing presence. She claims that moving a client toward spiritual well-being may “depend on the nurse’s ability to practice presencing” (p. 148). She quotes Dossey as believing that “a nurse who harbors negative thoughts towards a client can be harmful to that client” (p. 204).

Academic preparation can prepare nurses for this role in spiritual care; however, she suggests that personal spirituality seems to be the greatest predictor of the delivery of spiritual care in practice (2000). To be prepared to deliver spiritual care, nurses should develop self-awareness, their own spirituality, knowledge of different religious traditions, and the ability to assess and intervene in the area of spiritual care.

Although Johnston Taylor does not provide a discussion of epistemological issues, in the quote provided earlier she makes it clear that the spiritual can only be studied through its reflection in humanity. She uses both qualitative and quantitative methods in her research on the spiritual. Further, her description of the spiritual as a communal phenomenon suggests that the knowledge obtained through inquiry is somewhat generalizable. She proposes that spiritual self-awareness and intuition are important forms of knowledge as it relates to the spiritual in nursing (Johnston Taylor et al., 1995).

Johnston Taylor draws a direct correlation between ethics and spirituality on the basis that spirituality is concerned about supreme values, and ethics entails using those
values to make decisions about what is good and right. “When one asks ethical questions (e.g. ‘What is right in this situation? What ought I to do?’), one is also inevitably raising spiritual questions (e.g. ‘What is the source of truth for me?’)” (2002a, p. 13). Spiritual well-being is a concept that she believes should have specific and measurable outcomes. She provides examples such as “expresses movement toward satisfactory answers or meanings, renews participation in religious practices or community, identifies healthy ways for expressing the soul, joy or creativity” (p. 154). She also provides an extensive discussion of some of the ethical implications of spiritual caregiving in the context of the nurse patient relationship. This includes how to share ones own beliefs, how to engage in prayer with patients and how to avoid an interventionist perspective whereby the nurse is perceived as more powerful and knowledgeable. She believes that an ethical approach entails ensuring that the interventions reflect the perspectives of the client without violating those of the nurse. Another ethical value is helping patients to overcome “harmful religiosity”. Although she states that “Ethical care requires the nurse to respect the client’s religiosity and the needs that arise from it even when doing so may contribute to an outcome that the nurse may consider detrimental” (2002a, p. 256), she provides a number of descriptors of what she would consider harmful religiosity and supports the view that a nurse can help patients to think of God differently.

Margaret Burkhardt - Connectedness.

Burkhardt is a Faculty member in the West Virginia School of Nursing. She published a book “Spirituality: Living our Connectedness” in 2002 (Burkhardt & Nagai-Jacobson). Her body of work includes a seminal concept analysis of spirituality (1989), two articles on spirituality in Appalachian women (1993, 1994) and one article on the application of spirituality in community (Burkhardt & Nagai-Jacobson, 1985).

Burkhardt’s conceptualization of the spiritual is based upon connectedness. She describes spirituality as an inherent aspect of being human and the essence through which we know our connectedness. Spirituality is “an expression of soul, is awareness of who we are and how to be our most authentic Selves. As embodied souls, there is no way to behave or act outside our spiritual selves, although we can act outside of our personal religious perspective” (2002, p. 10). Further, she characterizes the spiritual core as the place where we “discover life’s meaning, our purpose in being, and our inner resources” (p. 21). Spirituality is “the search for right relationship more than it is the search for right answers” (p. 21). She distinguishes between masculine and feminine spirituality likening women’s spirituality to the Eastern (or Western mystical) tradition, and characterizing it as “relational, intuitive, earthy, compassionate, sensuous, and mystical” (p. 15).

Spiritual care in nursing has two foci, the spiritual self development of the nurse and the enactment of an energetic healing presence in the context of the nurse patient relationship.²⁰ Burkhardt discusses spiritual care through the nursing process including

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²⁰ Burkhardt was one of the more difficult theorists to categorize. Her emphasis on energetic connectedness, and wholeness that cannot be measured against objective criteria, would seem to place her within a monistic perspective. However, her use of the nursing process, nursing diagnoses, and fairly
the use of assessment tools, diagnoses, interventions and outcomes, although she cautions against viewing this as a linear process. Rather, she suggests that it might better be viewed as an integrative process whereby assessment might also be intervention.

The structure of her book reveals the importance she places on the spiritual development of the nurse. After spending the initial three chapters introducing spirituality, healing and meaning, she devotes the next six chapters to healing presence and the spiritual self-nurturing of the nurse. The final three chapters discuss connecting, attending to spirit and the use of story in spiritual care-giving. She believes that as healers, nurses have a professional responsibility to develop their own spiritual natures, for it is through who nurses are, not what they do, that healing occurs. This includes living out of a center that allows nurses to attune to others and create sacred space (2002, p. 39).

Burkhardt proposes that intuitive and cognitive ways of knowing are essential for understanding the spiritual. However, cognitive knowing seems the less important of the two as she suggests the following:

The goal of the spiritual journey is to enter more deeply in the Mystery, where we let go of our usual way of ‘knowing’ in the cognitive sense and move instead into the knowing of our heart…Entering into the mystery means letting go of our need to control and to know in the cognitive sense and trusting that we, as the wave, are fully part of the ocean (2002, p. 57).

Spirituality is a legitimate focus of research in nursing and is complementary to scientific perspectives. She supports the use of both qualitative and quantitative methods but cautions against quantifying spirituality, primarily on the basis that clinicians may be inclined to substitute judgment and clinical reasoning for intentional presence.

Spirituality is not explicitly linked to ethics in Burkhardt’s view. She suggests that spirituality is not subject to choice, it is simply an expression of our nature. However, she does imply that it is a source of ethics when she describes the spiritual as “openness to and trust of our own inner knowing of the imperatives of absolute love and justice and personal experiences of a transcendent actuality that is inclusive of all” (2002, p. 9). The ethical values are healing and harmonious and connected relationships as evidenced by “unity, peace, reconciliation, and connection” (2002, p. 27). Healing is a spiritual process that “attends to the wholeness of a person” (2002, p. 25), but wholeness is not open to judgment. “Wholeness cannot be measured against a set of objective criteria, nor does it look or act any particular way. As nurses, we do not necessarily know what wholeness looks like for another” (p. 26).

Narayanasamy, Johnston Taylor and Burkhardt envision spirituality as an innate, individualized, inherently good human dimension that seeks for meaning, connectedness and transcendence. Spiritual care is enacted through the nursing process, and with

explicit outcomes would seem to place her with the humanistic theorists. Indeed, she probably could have gone into either category.
sufficient preparation nurses can become competent to deliver spiritual care. Knowledge of the spiritual is derived from the human experience using a variety of methods of inquiry. The spiritual is not necessarily related to ethics; although, the two may be related in that the spiritual is about supreme values, values that may be used in the context of ethical decision making.

Monistic Perspectives

Monism rests upon the assumption that reality consists of one unified substance (Honderich, 1994). From the perspective of the monistic spiritual nursing theorists this universal substance is energetic consciousness. Nurses are viewed as agents of an energetic connection, and engagement with the patient in this connection facilitates growth into a universal consciousness or becoming. Biomedically based nursing interventions are de-emphasized in favour of interventions that provide healing through energy or consciousness. Three theorists fall into this category: Barbara Barnum, Jean Watson and Rosemary Parse.

Barbara Barnum – New Age.

Barnum is an Adjunct Professor in the Columbia University School of Nursing in New York. She has written a book, now in its second edition, entitled “Spirituality in Nursing: From Traditional to New Age” (2003). This book provides an extensive discussion of New Age spirituality. She states that she has chosen to focus on New Age Spirituality because of the dearth of religious based theories.21

Barnum (2003) uses the term spirituality to mean the following:

A persons’ search for, or expression of, his connection to a greater and meaningful context. For some people, that will be seen as a connection with God; for others it may be finding their place in the universe, and that may involve in-depth search for a greater sense of self (p. 1).

She emphasizes that her definition of spirituality concerns context rather than content. Spirituality “may be reflected in humanitarian acts, in religion, or in many different ways. Alternately, it is possible to have humanitarian acts and religious practices that stem from non spiritual motives” (p. 2). Spirituality is also characterized as a search, one that she claims has “for many, successfully concluded”. She bases this upon the understanding that we can come to a place of knowing about spirituality. Humans within New Age thinking are viewed primarily as energy and light. In essence, they extend beyond their physical bodies, and both personal and universal energy can be manipulated through levels of consciousness to produce effects. The ultimate end point entails soul growth or expanding consciousness.

21 I was somewhat confused by how she came to this conclusion in light of the number of theorists who have written from the Christian theological perspective. She makes no mention of the works covered in this review. Perhaps they did not meet her definition of a nursing theory.
Barnum claims that the nature of nursing practice changes in accordance with this new understanding of the nature of persons. She divides nursing paradigms into new and old and uses Nurse Practitioner programs based “entirely on the older scientific model” (p.10) as an example of the old. In contrast, within the new paradigm, nurses are envisioned as healers that utilize the universal energy. Barnum is not averse to using the language of the nursing process to speak of nursing care within this new paradigm. Indeed, she acknowledges that spirituality can manifest in nursing theory as content, process, context or goal. Although she does not provide an explicit discussion of assessment, she does use the language of diagnosis when considering the enactment of spiritual care. A large part of her discussion focuses on explicating therapies within the New Age worldview. Indeed, she claims that one of the key distinctions between religious and New Age theories is that New Age theories have clear interventions; whereas, religious theories tend to set process goals with little explication of what the nurse actually does. Interventions within the New Age paradigm fall into two categories, those that target the soul, and those that arise from nursing theories that could also include attention to the body. Interventions include therapeutic touch, meditation, sound therapy, hypnotism, Reiki, yoga, chakras, auras, prayer and bioenergetics. Typically, these therapies entail altered states of consciousness on the part of the patient and/or practitioner and the movement of some form of energy. She believes that these therapies are simply logical extensions of things that we have become quite comfortable with in nursing. For example, she cites the energy restorative effects of cardiac bedrest and likens psychiatry to the soul retrieval work of Shamans.

Barnum acknowledges some of the role and preparational challenges inherent with this new view of nursing. She cites the difficulties that can arise if the patient expects bodily care and the nurse envisions his or her role as a soul healer. Likewise, she acknowledges that there is little distinction between what nurses do and what other “healers” do within the New Age paradigm. This creates some overlap between disciplines and confusion over what constitutes preparation. Indeed, she considers the preparation of nurses to deliver this type of care somewhat problematic because the nurse must be in a state of advanced spiritual development, particularly if “soul” work rather than “body” work is the primary emphasis of care. She acknowledges that not all nurses will be spiritually mature enough to operate within this paradigm; however, she suggests that even understanding the stages of spiritual development would help to prepare practitioners.

Barnum’s foundational epistemological premise is that we cannot know anything directly. She collapses ontology with epistemology, and epistemology becomes located within the knower. Physics, philosophy and psychology are all legitimate ways of discovering the spiritual because they search for meaning through the physical universe, through wisdom, and through the human mind. Religion, however, does not qualify as an avenue of discovery because it claims to have found the answers.22 She suggests that

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22 I find her approach to epistemology somewhat difficult to understand. In essence, I think she is trying to show how all the disciplinary perspectives actually converge into one worldview and that this worldview is understood and accessible through the individual. In following this rationale she suggests that mystics and physicists are beginning to converge in their worldviews.
although the spiritual can be understood through inquiry, its tone is not scholarly. Rather it is characterized by words such as awe and reverence. She uses the language of science, such as when speaking of the need for scientific validation, but the methods of inquiry are less than traditional. She considers channeling as a method of inquiry; although, she acknowledges that it cannot be validated scientifically. Channeled information is scrutinized by considering whether it is useful, whether it feels right and whether it is internally consistent. Another mode of inquiry is through mystical experiences, an experience that she believes provides a more direct means of validation than the more traditional religious ways of knowing. She uses the example of out of body experiences to illustrate how we can access a universal mind; although, she acknowledges that this can be risky because it provides an opening for possession by outside undesirable entities (p. 74).

The distinction Barnum makes between new and old perspectives within nursing is extended to nursing values and ethics. She draws a fundamental distinction between humanistic and spiritual values and ethics. Humanistic values, such as justice, liberty, equality and service are those that can exist independent of any spiritual explanation. In contrast, spiritual values are those that enable a human spirit to transcend to a higher power, however that higher power is defined. She claims that traditionally ethics have been more concerned with regulating relationships between people than with relationships between people and higher powers. Ethics within the old paradigm focuses on decision making, whereas ethics in the new paradigm focuses on context, the context that lifts the human spirit. Ethics in the old paradigm entails “problems and vulnerabilities” but in the new paradigm of spirituality entails a “joyous experience of soul growth and connection with a higher good” (2003, p. 185). To illustrate this distinction, she uses the ethical dilemma of prolonging life. Within the old paradigm, the discussion concerns rights, responsibilities and the distribution of scarce resources. In the new paradigm, the importance of prolonging life may be irrelevant in light of the understanding that a soul is reincarnated and developed over a number of lifetimes. Hence, she suggests that while both the old and new understandings are value based, spirituality might be the larger consideration, with ethics being the more “limited and practical one” (p. 185).

Jean Watson - Love as Healing Energy.

Watson is a Professor and Chair in Caring Science at the University of Colorado School of Nursing. Her most recent book “Caring Science as Sacred Science” (2005) proposes caring as the moral and philosophic foundation for practice. Her emphasis on love as the universal healing energy suggests that spirituality is a foundational consideration of her model. The appendices of her book contain a number of articles which were previously published in other journals that expand upon and reiterate her theory (2000, 2002a, 2002b, 2003, Watson & Smith, 2002). I also reviewed an article in which she envisions a new role for nursing in the healthcare system (2001).

This is essentially the same argument that Shelly is making when she critiques New Age therapies as being potentially risky.
Watson reconciles both the monistic and theistic views within one underlying ontology. Like the monistic theorists, she believes in a “unitary field of consciousness and energy that transcend time, space and physicality” (2005, p. 2). She views all things as having spirit and life including “rivers, oceans, rocks, earth, air, fire, water, sky, plants and animals” (p. 111). However, in reconciling this monistic ontology with other perspectives, she suggests there may be multiple centers of spiritual consciousness, some physical, some transcendent, and so argues for ontological unity. She bases her caring science on a “new” assumption that “makes explicit an expanding unitary, energetic worldview with a relational human caring ethic and ontology as its starting point; once energy is incorporated into a unitary caring science perspective we can affirm a deep relational ethic, spirit and science that transcends all duality” (p. 28). She identifies the most primal and universal energy as caring and love. From her perspective, spirit is “evoked” when one integrates the moral, the metaphysical and science (p. 28). Her emphasis on ethical caring and love is similar to that of the theistic theorists.

Watson believes that the survival of nursing as a discipline is at risk. She views the profession as generally broken and its participants as suffering from a loss of meaning. She believes that our “jobs have been too small for the nature of our work and the needs of those whom we serve as well as too small for the evolution of our individual and collective humanity” (2005, p. 180). On this basis, she argues for a cosmic perspective that re-integrates soul and spirit into the basis of our lives and work. The fundamental basis of nursing then becomes a transpersonal caring encounter, one that she believes is a “spirit-to-spirit unitary connection” (p. 6). The more caring the encounter, the higher the energy frequency, and the greater potential there is for healing.

“Transpersonal caring is communicated via the practitioner’s energetic patterns of consciousness, intentionality, and authentic presence in a caring relationship” (p. 6). A key part of this encounter is recognizing that consciousness and thoughts can positively or negatively affect this energetic field, and hence, patients. She describes healing interventions such as visualization, relaxation and imagery. Watson identifies what she calls empirical outcomes of this encounter both for the nurse and the patient. For the nurse, these outcomes include an emotional-spiritual sense of accomplishment, purpose, self-esteem, gratitude, fulfillment and ultimately a love for nursing. For the patient, these outcomes include emotional-spiritual well-being, self-control, personhood, safety, energy, comfort and enhanced physical healing.

Nurses are prepared for this role by devoting time and energy to the divine love in their own lives. Indeed, nursing changes significantly within this model. Watson envisions a new role for nursing in the healthcare system as “transdisciplinary” professionals. This entails developing a different type of nurse, one who will be required to be more grounded in who they are and who and what they bring to their practices. They will be required to bring to their practices and teaching, and

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24 Watson was another theorist that was difficult to categorize because of her explicit combination of both monistic and theistic ideas. I placed her within the monistic category primarily because theists would strongly resist any suggestion that this form of monism is compatible with theism and because central to her work is the concept of love as universal psychic energy.
perhaps even their research, a different consciousness and a mindful intentionality about their values, theories, and fundamental philosophy for caring-healing work (2001, p. 80).

Watson's epistemological approach is eclectic. She characterizes her work as "caring science" that is grounded in a "relational ontology of unity within the universe, which in turn informs the epistemology, methodology, pedagogy, and praxis of caring" (2005, p. 29). She argues for multiple epistemologies and methodologies and for forms of evidence that include empirical, aesthetic, noetic, poetic, personal, intuitive, ethical, mystical and spiritual (p. 28). Drawing upon Kierkegaard's idea of a leap of faith, Watson argues for a reuniting of science and metaphysics, claiming that metaphysics provides the moral and ontological grounding for humanity. She favours noetic ways of knowing and suggests that we need to apply conventional scientific methods to exploring aspects of mind, consciousness and spirit. She uses examples such as distant healing, distant intentionality and prayer as manifestations of the movement of a hidden reality.

Watson's fundamental ethical stance is that of caring which is characterized by a way of being with others. Using Logstrup's work, she contrasts sovereign (loving and caring) expressions with ego-centric ones (e.g. hatred, envy, self-righteousness, greed). Drawing upon Levinas, she describes the ethical stance we should take with patients.

When we gaze into the eyes of another, we gaze into Infinity. This is a fundamental ethical stance. And to turn away from another, to refuse to face another, is to turn away from Infinity of life itself. And this, therefore, leads to an appropriation or a totalizing, an objectifying of Other and ultimately, in turn, an objectifying of self (2005, p.47).

Using this perspective she suggests that when encountering ethical challenges our answers may be as simple as asking what the kind thing to do would be. By transcending our own personal and professional egos to care for others, we contribute to the healing of humanity during "a time of its threat of survival in the world" (p. 41). Thus, the spiritual is expressed or made manifest through an ethical relationship of caring.

Rosemary Parse – Human Becoming.

Rosemary Parse is a Professor in the Loyola University Chicago School of Nursing and the editor of Nursing Science Quarterly. The body of work under consideration here includes a second edition book entitled "The Human Becoming School of Thought: A Perspective for Nurses and other Health Care Professionals" (1998) and a number of theoretical articles and editorials that further explicate her position (1999a, 1999b, 2000, 2002, 2003, 2004).

Parse does not suggest that her work is a conceptualization of the spiritual. She might even resist using the language of the spiritual in her model primarily because she views the world as an underlying unity where the spiritual cannot be considered apart from anything else. She suggests that the traditional biomedical approach to nursing
viewed humans as mechanistic bio-psycho-socio-spiritual beings. In contrast, her view is that humans are unitary, indivisible, unpredictable, mysterious and pandimensional, meaning they exist outside of spatial or temporal attributes (2002, p. 47-48). The three major themes of her philosophical assumptions about human becoming are meaning, rhythmicity and transcendence. Meaning refers to ultimate meaning and purpose in life however an individual chooses to define that. Rhythmicity refers to patterns of change and connecting that arise as a result of choices. Transcendence refers to reaching beyond ourselves to hope and dreams. So one can see that although Parse does not use the word spiritual, her language and concepts echo the themes in the nursing literature on the spiritual.25

Nursing, according to Parse, is a scientific discipline. She distinguishes between an applied nursing science that uses an interventional approach to diagnose, treat, cure and control and a basic nursing science that focuses on quality of life. Her human becoming theory is a basic nursing science that focuses on human becoming within the context of the human-universe health process. Nursing practice entails supporting quality of life as defined by the patient. This self defined quality of life is an integral part of her model because humans are characterized as mysterious, unrepeatable and unpredictable. Humans co-create their lives with the universe through their various choices. Like all of the theorists writing on the spiritual in nursing, emphasis is placed upon the nurse’s ability to engage with patients using true presence. Nurses who enact true presence with their patients have the capacity to influence health value priorities by “creative imagining, affirming personal becoming and glimpsing the paradoxical” (1998, p. 74-75). However, nurses are discouraged from an interventional approach, even to the point of not providing health teaching unless it is requested by the patient.

Parse (1998) provides a model curriculum for a Masters in Nursing program meant to prepare nurses to practice within the Human Becoming school of thought. The assumptions are formally integrated into the courses. She believes that her approach to nursing has the potential to make a significant difference for patients and recommends doing applied research, which she defines as evaluating the outcomes for patients of using the Human Becoming approach in practice.

Knowledge from Parse’s perspective is inherent to the knower. That is, there are no implicate and explicative orders of knowledge. The nurse cannot choose to stand outside or to enter into the world of the patient. Because existence is indivisible, the nurse lives his or her beliefs, and therein lies the knowledge for practice. She proposes her own phenomenological-hermeneutic method for understanding universal-human-health experiences. This method is different from other qualitative methods primarily in that all

25 Parse is representative of a group of theorists whose work is based upon that of Martha Rogers. Parse was chosen because her work is relatively recent and her language so closely resembles the spirituality discourse. I felt that Parse’s work was particularly important to include because her work is an excellent example of a form of spirituality that is becoming increasingly popular within North American society (see Walsch, 2004). This spirituality emphasizes the following: the world as an interconnected unity, the presence of a powerful universal consciousness, a reluctance to view behaviour in terms of dichotomies such as such as good/bad, and individuals as autonomous choice makers who have the ability to construct a preferred future.
interpretation is grounded within the Human Becoming assumptions. Data are gathered through dialogical engagement using true presence as opposed to an interview in the traditional sense. In essence, this perspective is so specialized that there is no allowance for the epistemological and methodological diversity promoted by the other monistic theorists.

Parse makes no explicit link to ethics. Her primary value is human becoming. Health and well-being, something that she refers to as quality of life, is a value that is constructed and defined by each patient. There is no allowance for standardized plans of care or for intervention by the nurse in accordance with any sort of societal norm. The program goals and indicators for her sample curriculum include ethical themes of accountability, comparing value priorities, and collaboration.

In summary, Barnum, Watson and Parse hold some common views in relation to conceptualizations of the spiritual. Ontologically, humanity is part of the universal energy that characterizes all of existence. Nurses are capable of acting as vehicles through which that energy can evolve to a higher state of existence, thus making a significant difference in the lives of patients. However, this inevitably leads to a different role for nurses in the healthcare system whereby their focus switches from bodily care to that of care for the soul or spirit.

Summary and Questions

At this point it may be useful to summarize the commonalities within each of the theistic, humanistic and monistic conceptualizations of the spiritual. What will become apparent from these summaries is that each position brings to light key questions or dilemmas related to the implications of these positions for nursing. I will introduce these questions briefly, but they will be dealt with in detail in the next two chapters.

The theistic approach starts from the assumption that God is the origin of the conceptualization of the spiritual. God is seen as living in covenantal relationship with humanity. Humans have a multi-dimensional interconnected nature whereby ultimate health and well-being is embodied in a restored relationship to God. The natural consequence of this belief in the context of nursing is the need for service to humankind as a response to the goodness of God. Two of the three theorists in this category suggest that the interventionist perspective of the nursing process is not an appropriate way to engage in spiritual care. Rather, spiritual care consists of an ethical and caring way of being with patients. Nurses are prepared to care in this area through attention to character development and practical theology. Revelatory knowledge is adopted as a foundational way of knowing about the spiritual, providing a source of truth by which other knowledge must be tested. Ethics are inextricably related to the spiritual because the spiritual is God, God has a moral nature, and humans are called to live in accordance with that nature. From this perspective several questions arise:

• Can this concept of the spiritual do justice to the needs of a diverse population?

The theistic theorists hold to a view of absolute truth about the world that
invariably excludes other positions, both religious and secular. The challenge arises then of how one reconciles this position with the needs of nurses and patients who hold to a variety of different worldviews. As a professional discipline with a public trust can we embrace a worldview position that naturally excludes others, and if so, how?

- **How does one critique revelatory knowledge?** Revelatory knowledge is typically drawn from sources that would be considered both sacred and infallible. If we use this knowledge as part of our disciplinary knowledge base how can it be critiqued, and how can we reconcile competing revelations characteristic of the varying perspectives of the sacred?

- **What effect might an evangelical moral imperative have on patient’s choice, dignity and well-being?** Nurses typically interact with patients during times of suffering and need where there is an inherent vulnerability and power imbalance. This is exacerbated by the institutional nature of much of nursing practice where patients are “guests in our houses”. How might the practices of nurses who feel their ultimate responsibility is to share the doctrine of salvation affect patients?

The humanistic approach to the spiritual is characterized by a universal, subjectively defined dimension of the person. Common spiritual needs are connectedness, meaning and transcendence. No particular religious perspective is required; the spiritual is just as pertinent for atheists and agnostics as it is for religious individuals. Spiritual care can be enacted through the nursing process, and nurses can be prepared for this role with appropriate education. The ways of knowing about this dimension are embodied in common ways of knowing in nursing, and the methods of inquiry are eclectic. Ethics may be tied to the spiritual in the sense that spirituality entails grappling with ultimate values and hence will influence decisions about what is good and right. From this perspective several questions arise:

- **Can this concept of the spiritual do justice to the needs of a diverse population?** One of the greatest appeals of this perspective is that because it is universal and subjective, and does not start from any particular religious base, it promises to meet the needs of a diverse population. However, the question arises as to whether this understanding of the spiritual is one that is familiar to patients and does justice to their needs. Draper and McSherry (2002) suggest that this undifferentiated approach to the spiritual may end up assigning to individuals values they do not share. For example, Johnston Taylor recommends using tools that are free of religiously biased language in assessment (2002a p. 117). And yet, this may exclude those who see their religious traditions as the source of their spirituality. Further, some research in this area suggests that the way that the spiritual is being constructed and prioritized in nursing may not be congruent with patient’s views (McSherry & Watson, 2002; McSherry, Cash, & Ross, 2004).

- **How do we reconcile a subjectively defined spirituality with the generalizable perspective necessary for the nursing process?** This challenge becomes apparent
when one looks at the tensions in some of the following statements. “The person who has attained spiritual integrity demonstrates this through a reality-based tranquil or peace, or through the development of meaningful, purposeful behaviour, and a restored sense of integrity” (Narayanasamy, 2004b, p. 1144). The question that comes to mind is whose reality if this is a subjective experience? In Narayanasamy’s approach, the nurse is called to challenge, counsel and teach (2001, p 80), but is also supposed to unconditionally accept the patient without judgment, reservation or criticism (2001, p. 77). How does the nurse suspend judgment while acting as a challenger or teacher? To challenge one must make some judgments. Also, the nurse is called upon to suspend personal values and beliefs at the same time as being genuine. A similar dilemma arises when Burkhardt makes the statement that healing is a spiritual process that “attends to the wholeness of a person” (2002, p. 25), but wholeness is not open to judgment. “Wholeness cannot be measured against a set of objective criteria, nor does it look or act any particular way. As nurses, we do not necessarily know what wholeness looks like for another” (p. 26). Finally, Johnston Taylor illustrates the same dilemma when she cites patient’s belief in divine healing as an example of harmful religiosity. Here we have the challenge of the normative religious worldview of the nurse (i.e. divine intervention never suspends the laws of nature) being imposed upon the normative religious worldview of the client (miracles can and do happen). How can we approach spiritual care from an interventionist perspective if there is no common agreement about things such as wholeness or harmful religiosity? In the event of a conflict between the ideas of nurses and patients, whose ideas should take precedence, particularly if the nursing role is to counsel and teach?

• **What are the risks of the interventionist approach in this sensitive and personal area?** The nursing process assumes that we can assess, diagnose and intervene toward some agreed upon outcome. Further, we typically document and share this plan of care with other healthcare workers. This process, while seemingly well suited to physical care, may be experienced as oppressively intrusive when we attempt to address ultimate issues of meaning, connectedness and transcendence.

The monistic approach starts from the assumption that humanity is part of the indivisible universal consciousness and as such extends beyond the space, time restrictions of the physical body. Spiritual care entails attention to an energy that transcends the physical body. This includes utilizing the power of consciousness that connects the nurse and the patient, and sometimes entails the implementation of energy based forms of healing. Nurses can only be effective in this realm to the degree that they have appropriated and developed this higher consciousness. Knowledge is inherent to the knower and methods of inquiry may be unique such as Parse’s phenomenological/ hermeneutic method or Barnum’s channeling. The spiritual does not rest upon any particular ethical framework. Right and wrong is replaced by the enactment of choices toward a self-defined preferred endpoint. From this perspective several questions arise:

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26 Again I think it is important to point out that Watson’s work would not fit these last two criteria. Her methods of inquiry are fairly traditional and her view of the spiritual is a moral one.
• **Can this concept of the spiritual do justice to the needs of a diverse population?**
  The difficulty here is similar to that of the theistic perspective in that this is a particular way of viewing the nature of reality that might be considered exclusive of other worldviews. As a professional discipline with a public trust can we embrace a worldview position that naturally excludes others, and if so, how?

• **Does this view of nursing fulfill its social responsibility?** The heavy emphasis on the development of soul or consciousness within this worldview has the potential to conflict with the social contract of nursing that includes attention to bodily care. Can we adopt a view that potentially diminishes the importance of the physical body and still fulfill our social responsibility as a discipline? Further, can nursing fulfill a social responsibility when the nature of the outcome is entirely self-defined, either in terms of soul healing or quality of life?

• **What are the potential consequences for patient choice and well-being?** A particular emphasis in this worldview is the manipulation of a powerful consciousness, both on the part of the nurse and the patient. Are there risks inherent in this manipulation, and what are they? What are the implications of a therapeutic nursing encounter being dependent upon a “good” consciousness on the part of the nurse?

• **Can nurses be considered competent to enact spiritual care from this perspective?** If one takes the position that the expanded consciousness is fundamental to spiritual care and the success of energy based healing interventions, then the question logically follows of whether or not we are capable of preparing nurses to care in this area. If not, then are we integrating an aspect of practice for which they are not competent?

• **How would one critique these sources of knowledge?** Like revelatory knowledge, integration of new types of knowledge into the discipline require some standard of evidence or critique. How does one go about critiquing knowledge that comes through channeling, or knowledge that is entirely inherent to the knower?

These questions arising from the various conceptualizations of the spiritual will be discussed further in the next chapter as we now turn to an imaginary dialogue between three participants who represent the theistic, humanistic and monistic approaches to the spiritual in nursing.
Chapter 5
A Dialogue Between Perspectives

We must learn to feel addressed by a book, by the human being behind it, as if a person spoke directly to us. A good book or essay or poem is not primarily an object to be put to use, or an object of experience: it is the voice of You speaking to me requiring a response.

Kaufmann, 1996, p. 39

My purpose in this chapter is to further answer the questions, what are the various positions being taken on the conceptualizations of the spiritual and spiritual care in the nursing literature, and what are the implications of these positions for nursing? The questions of this chapter are designed to help us understand the different worldview approaches to the spiritual in nursing, and the implications of these approaches for nursing’s ontology, epistemology and ethics.

What follows is a dialogue between a narrator and three participants who represent three different positions taken on the conceptualization of the spiritual in nursing: theist, monist and humanist. As mentioned in the previous chapter, this is one typology of the approaches to the spiritual, there may be others. These participants are hypothetical and not meant to characterize any one particular theorist; although, the reader will recognize shades of arguments and positions put forward by the theorists discussed in the previous chapter. I have chosen to present this material as a dialogue for a couple of reasons. First, this is the type of dialogue that needs to occur around the spiritual in nursing, and indeed in society. The spiritual is a point of polarization in society, a polarization that is often fed by misinformation and stereotypes rather than by authentic dialogue over commonalities and differences among the positions. Dialogue enables us to transcend our preconceived notions and to appreciate the subtleties and rationale of another view. Healthy plurality is best negotiated through a sympathetic understanding of difference.

Second, a dialogue among hypothetical participants allows me to go beyond the position of any one particular theorist to show the potential implications of various worldview approaches to the spiritual. In essence, this allows me to go to a higher level of abstraction so that implications can be discussed widely. This will set the stage for the next chapter in which I will make some arguments regarding the nature of the role of the spiritual in nursing. Of course, as the author of the dialogue it ultimately remains my voice. I have tried, however, to be as true to the different positions as possible. At times this is by using an argument that has been put forward by a nursing theorist within that perspective. At other times it entails falling back to arguments that have been put forward by theologians, philosophers and thinkers holding a similar view.

27 To promote the flow of dialogue I will not be referencing ideas here when they have been drawn from a particular theorist. I am trusting that the previous chapters have presented the positions well enough to give credit where credit is due.
Narrator: My thanks to you all for joining me for this discussion today. These are interesting times as it relates to the spiritual in nursing, and I am delighted to have you all around the table so that we can better understand one another’s viewpoints about this important topic in our profession. We have a number of topics to cover today. I am particularly interested in the implications of your position on the spiritual for nursing’s ontology, epistemology, and ethics, and we will move through each of these topics sequentially. But, I would like to begin by asking you a general question about your position on the spiritual. What is the spiritual? Let’s start with the monistic perspective.

**Monist:** Spirituality is the context that we exist within, a context that consists primarily of energy and light. We view the world as one indivisible, interconnected unity. All things, both animate and inanimate, are part of spirit, and what one does affects all the others. This unitary existence transcends time, space and physicality. So while humans may exist in physical bodies, they extend beyond their physical bodies as part of the energetic, cosmic consciousness. And this interconnection is powerful. Because we have the capacity to extend beyond our physical bodies, we can in turn affect those around us through higher levels of consciousness. We become more powerful as our consciousness expands. Indeed, the ultimate goal of life is to develop increasing awareness of this cosmic consciousness and to merge with it as a drop of water merges with the ocean.

God, from our perspective, is not separate from, but part of, this universal consciousness, the sum of universal consciousness so to speak. This means that there is no divine presence apart from us, and no external being that dictates to us a preferred type of life. Rather, interconnected humanity makes choices about their preferred future as they evolve as a group to a higher level of consciousness. Spirituality characterizes all of this unified existence.

**Theist:** Yes, and that final point is critical for us coming from a theistic perspective. Spirituality for us begins with content, that is, knowledge of a God whose spirit infuses and sustains all of creation, but who has the capacity to exist independently of creation. The personality or character of God is what dictates the preferred life to be lived. We agree that spirituality is a form of power, but because its origin is located within a good God, it can be exercised in moral and ethical ways that either contribute to, or detract from, that goodness. Daily we make choices that bring our power toward or away from that character of goodness.

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28 This is a key distinction in this position. For example, thinkers such as Pierre Teilhard de Chardin (1976b) would resonate with the concept of universal energy, and humankind evolving cosmically to some end, an end that he would call the omega point. However, the difference between his thinking and that of the monist is that he would hold to the existence of a creator that can be distinguished from creation.
We agree with the interconnectedness of all of creation, but our goal does not entail merging with a universal consciousness. Rather, we believe in the maintenance of individuality in the context of community, humans living side by side in a spirit of cooperation while maintaining their essential uniqueness. This community occurs through and because of the divine being. So when we talk of influencing a course of events through the spiritual, it is not something that we orchestrate independently. Rather, a power greater than ourselves works with us.

We also believe that ultimately we are meant to transcend time, space and physicality. However, we see this as living in two worlds simultaneously, a time between times so to speak. We exist in physical space bound by time and space for the present, but we are aware of a boundlessness that foreshadows a coming existence. We even experience a taste of that boundlessness now. I think it’s fair to say, however, that there are different opinions about the importance of physical existence over the history of theistic thought. If one holds to this world as being a preparatory time for the next, this physical existence becomes important. And so, like most good theological thinking it entails holding two somewhat antithetical positions in tension. Eternity touches time today, and so what happens today in terms of the context of our material existence is critical.

**Humanist:** You have both set the stage well for my explanation of the humanist position, for it is this subjective diversity that characterizes how we view spirituality. Spirituality is an innate aspect of every person, an important dimension that brings integration and meaning to life. But it is highly individual, intangible and somewhat mysterious. Individuals value certain things that evoke feelings which in turn provide meaning and a reason for existence. What is valued might be variable, but the feelings they evoke are similar, such as inner peace, hope, strength, happiness, contentment and love. And so, an individual might be a monist, a theist, or an atheist and still possess a deep spirituality that energizes his or her life.

Connectedness is also an important aspect of our position. The connectedness, however, doesn’t need to be limited to God or a universal consciousness. It might be within oneself, with nature, with other individuals or with a divine being, however that being is perceived.

Because spirituality is an innate human characteristic, it usually becomes recognizable when a need arises. Some event occurs that de-stabilizes that spiritual sense, and a need becomes apparent. Spirituality is an integrating dimension, and so those needs may be multi-faceted including what we have typically characterized as psychosocial needs. I think what differentiates our position most from the other two is that there is no need for adherence to a particular way of viewing reality. Spirituality is an innate subjective human experience that can be treated like any other dimension of the person.

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29 Lewis (1952) suggests that this idea of being absorbed into the universal consciousness would be the equivalent of ceasing to exist. He believes that humans can be taken into the life of God while retaining their essential individuality and uniqueness, indeed perhaps even becoming more so.
Narrator: It sounds as if we have some common agreement on the fact that the spiritual is a form of power, that it’s important, energizing, and that it involves connection in some way. It also seems though that we have some fundamental disagreement about the ontological origins of spirituality. It occurs to me that each of these positions add something to the understanding of the spiritual. For example, humanism starts from a subjective human dimension. Monism, while still acknowledging human subjectivity, adds a universal connectedness to the context. Theism adds creator God to the context, while still acknowledging connectedness and human subjectivity. As you are aware, one of the trends in the nursing literature on the spiritual over the last two decades has been to make religion and spirituality conceptually distinct. I am wondering if this is a trend that you would agree with. From your perspective, what is the relationship of religion to the spiritual? Let’s start with the theistic position this time.

Theist: I think it’s safe to say that religion is an integral part of our view of the spiritual. Religion, or perhaps better put theology, provides the content for the spiritual. It shows us the character of God, the meaning of life, and how we are to live. Community and rituals provide a context for shared understandings, growth and support. However, religion is a bit of a tricky term these days because it has come to represent something negative in our society. The religion that gets the most air time seems to be the sensational sort that is characterized by hatred and violence, and I do think a number of people are trying to distance themselves from that. For several decades now I have heard a fairly common statement among people within my theistic tradition, “I am not religious but I am spiritual.” I think what they are trying to do in making this statement is not to distance themselves from a core set of beliefs, but rather to indicate that their faith is a living commitment that goes beyond ritual. Indeed, the history of true religion has been the striving for an authentic spiritual experience. To put it simply, if God exists and has revealed the divine nature in various ways, then religion and theology become fundamental to the spiritual.

Humanist: I think the biggest challenge we have with your position is how exclusive it is. Can we truly delimit spirituality by religion, and if so, what do we do with all the varieties of religions laying claim to the truth? Are we to say that some people are spiritual because they have a particularly correct version of the truth? We take the position that all individuals have a spiritual dimension – regardless of religious beliefs. There is something fundamental about human nature that is spiritual. People may choose to adopt a religion as an aid to their spirituality, but not having a religion does not negate being spiritual. Atheists and agnostics are spiritual beings.

Theist: Let me clarify here. We agree with you. We believe that all individuals have a spiritual nature. Not being religious does not negate that. However, religion/theology provides crucial information about that dimension – the instruction manual so to speak of how to develop the nature of that spirituality. Whether people use it or not does not make them any less spiritual – it simply changes the character of the spirituality.

30 As C.S. Lewis (1952) would suggest, theology becomes the roadmap for our faith and the character of God, but we still have the experience of the individual journey.
Humanist: So, then how do you account for the varieties of religions, or instruction manuals as you put it?

Theist: Religion is a somewhat imperfect glimpse of divinity, primarily because once one brings it into the human realm it inevitably adopts some of the human weaknesses and imperfections. But really, your own literature about spirituality testifies to some common truth that looks remarkably like religion. Indeed, almost all of your language is characteristic of theological themes. I notice that you talk of outcomes of love, joy, peace and justice – not chaos, oppression and hatred. This seems to speak of a spiritual character of a common quality – not one that is simply subjectively defined. Religion has a long history of speaking to the nature and development of those spiritual outcomes.

Humanist. As long as you ignore the history of religion that has bred hatred and oppression. And who's to say those are not simply fundamental human values rather than religious ones?

Monist: Let me jump in here because this is where our perspective promises something unique. The old god, or religion, has been essentially negative for human development, primarily because it claims to be unchanging and to have all the answers. And these answers have all too often promoted exclusivity and hatred rather than connections. Humanity has consistently assigned to god characteristics that are not true. There is no external, unchanging god that expects us to behave in a certain way. We are all part of the process of universal change, and we collectively create a destiny by virtue of our participation in the energetic life force. We can envision how we want our world to be and work toward that preferred vision. When we transcend the old disunity between god and us, we open new possibilities for creating the universe that are not possible through the old understandings of religion. The alienation we have experienced on this planet has been a result of certain beliefs, primarily religious. But we can change the content of those beliefs. We can propose a new way of being in the world that will enable the interconnected universe to exist in peace and happiness.

Humanist: You are beginning to sound like a humanist!

Monist: Not at all. I am simply acknowledging the power of humanity as part of the evolving cosmic force. I think you will find that our understanding of the nature of the universe far exceeds a humanistic viewpoint even if we may agree on the power of collective humanity to effect change.

Narrator: As I listen to you I can't help but think that it really depends upon how we define the term religion. If we equate it with external ritual then it really does seem somewhat different than the spiritual. On the other hand, if we think of it as a web of

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31 These ideas are primarily those of Walsch (2004). Parse is relatively silent on religion; however, her view does support a self defined preferred vision of the world. Barnum (2003) discounts religion as a means by which to learn more about spirituality, thus implying a negative view similar to Walsch's. Both stress the indivisible nature of existence, thus supporting Walsch's concept of no separation between god and humankind.
beliefs that characterize our understandings of the spiritual and how we grow in spirituality it would seem quite essential. To separate the two would be to separate our rational and experiential dimensions. This redefinition of the terms religion and spirituality in our society is an interesting example of how powerful language can be in reconstructing our views.

**Implications for Nursing Ontology**

**Narrator:** Now that we have laid some groundwork about the perspectives of the spiritual let’s move on to some of the implications of these positions for nursing. Let’s talk about ontological issues. **How does your understanding of the spiritual influence the nature, scope and object of nursing – nursing ontology so to speak?**

**Humanist:** Let me start this time because my position is probably the one that will be most familiar to our readers. As I mentioned previously, humanity has a spiritual dimension. So as nurses, if we claim to give holistic care we must pay attention to this spiritual dimension. Whether our client is the person, the family or the community there are potential spiritual needs that arise, and we need to acknowledge and address those needs.

You might say that our scope of practice enlarges from this perspective, but I don’t really believe this to be so. I think we have always paid attention to spiritual needs to some extent, but it has been influenced by the nurse’s comfort level and the patient’s willingness to share those needs. It has been a somewhat invisible aspect of practice and not implemented systematically. We simply propose that it requires systematic implementation and given the same priority as physical or psychosocial care.

Likewise, the nature of practice really does not change. Spiritual care can be considered within the context of the nursing process just like other dimensions of care. We can use standardized assessment tools, common outcome statements (albeit individualized), interventions and evaluation. This systematic approach will help to ensure ethical and standardized care in the area of the spiritual. We also need to document this care so that it can be followed up by all healthcare workers and form the basis for quality improvement audits.\(^\text{32}\)

**Theist:** How can we take such a sacred and personal dimension and subject it to such an instrumental approach? From our perspective, spiritual care is less about intervening with patients than it is about a way of being, an ethic and motivation for the nurses themselves. To put it briefly, humanity as the object of care is seen primarily in relation to God. God loves humanity, and so we are called to love in the same way. The nature of practice is a vocational service in response to the nature of God. We have been loved and served by God, and so we do the same to others.

\(^{32}\) Whether and how spiritual assessment and care should be documented is a matter of debate between theorists. Some feel quite comfortable charting such personal information. Others suggest that confidentiality is a factor to be considered.
Now I know there is some variability in what that will look like, particularly as it relates to the evangelical worldview. Different theological perspectives place different emphasis on service as opposed to the sharing of doctrine. Some theorists in this area will make the sharing of doctrine an essential part of this perspective, because they believe they have a moral responsibility to share the good news they have found. Other theorists believe that loving care is a suitable expression of their faith unless they are specifically asked to share what they believe. You can imagine that the subjective experience of the patient might be quite different from these perspectives.

To some extent, physical care is spiritual care because our physical bodies are considered “temples of God”. Because the dimensions of the person are so interdependent, when we give excellent physical care we are in essence also providing spiritual care. To attend well to one dimension is to influence the other dimensions. The scope of nursing practice must include the spiritual, but rather than being a separate dimension, it is an integral part of all care.

**Monist**: So, you can see some of the problems that the religious perspective presents for a discipline such as ours. It falls back to this view that restricts God to how a particular segment of society views “him”. We believe you should never place such static labels on the universal consciousness. We are growing and changing beings with enormous potential and power. Both nurses and patients are connected in such a way that we change and evolve together. You do not want to put boundaries around that. We know that what is most central to life is this evolving consciousness, and so this becomes the central focus of our nursing care. We are just beginning to understand some of the power of these interventions that can be used to optimize and expand this energy field—even though many of them have been around literally for ages. We need to free ourselves from skepticism and limitedness to explore and engage these energy based interventions.

Of course, you can see that nursing looks quite different from this perspective. We focus much more on the patient’s soul or consciousness. Indeed, we envision a new role for nurses—as true healers rather than as mini-doctors who constrain themselves by the old biomedical model. Admittedly, our scope expands to encompass the great human potential within the cosmic consciousness but we need to envision a new scope for nursing. Our old vision has been much too restricting for the spiritual reality we now acknowledge.

**Theist**: This emphasis you place on patient psyche or soul, and de-emphasis on physical care, has not served the profession well. We have placed so much emphasis in this area that many of our students cannot perform some of the most basic nursing competencies, and this is truly placing our profession at risk. Tell me, if you were hospitalized with a

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33 This is a common theme in both Christian and Jewish theology. The New Testament Biblical reference is 2 Corinthians 6:16. The attention paid to bodily health in Jewish theology illustrates the importance of the body as a dwelling place of God’s spirit.

34 Walsh (2004) consistently uses the feminine pronoun to refer to god; however, it must be remembered that god within his perspective is equivalent to life. Margaret Burkhardt (2002), in her theoretical emphasis on connectedness, suggests that women’s spirituality is distinct from men’s thus alluding to the masculine influences of religion.
catastrophic illness what would you look to your nurse for? Do you want someone to provide good pain management, hygiene and general comfort or do you want someone to try to heal your soul? I can tell you that I expect the nurse to provide for my physical needs and would consider it highly invasive for a virtual stranger to be trying to heal my soul.

**Monist:** Perhaps you haven’t caught the vision yet. It’s not that we won’t pay attention to physical needs, it’s that there are some needs that transcend those. We may need to educate patients and healthcare workers about the vast potential of these alternate forms of healing, but that is not new. We have always had to push the boundaries of people’s acceptance and comfort. After all, even Florence Nightingale was considered bizarre with her understanding of the transmission of germs, something we all accept now.

**Humanist:** You are both really supporting my view because you are illustrating why it is so important to keep this whole area of spirituality a bit more open and subjectively driven by the patient.

**Narrator:** So, it seems that nursing might look quite different from these perspectives. What strikes me is how inextricable the spiritual and nursing are because our object of concern is humans. By trying to define the nature of humanity, we can’t help but draw in the spiritual. It occurs to me that we have a choice if we are going to bring this into our discipline. We can either settle on a disciplinary “truth” about the spiritual or we can see the spiritual as transcending and informing nursing, and hence adopt a variety of perspectives. I suspect that we might have difficulty agreeing on one perspective given that over centuries philosophers have largely been unable to come to agreement.

As I listened to how nursing might change according to these perspectives I couldn’t help but wonder whether the average nurse has the ability to provide care within these understandings. *How would nurses be prepared to provide spiritual care within your understanding of the spiritual?*

**Humanist:** We take the perspective that any nurse can, and should, be educated to provide spiritual care. This preparation includes spiritual self-awareness. This doesn’t mean that the nurse has to adopt any particular form of spiritual expression but rather that they are simply aware of their own innate spirituality and how they choose to express it. They need to be taught how to assess and intervene through the nursing process. Interventions should focus on things such as therapeutic presence and listening. It’s also helpful for the nurse to have some familiarity with religious traditions. All of this could be incorporated fairly easily into any standard nursing curriculum.

**Theist:** It’s interesting that you should add familiarity with religious traditions. I wonder if it isn’t a bit unrealistic to expect this of nurses given the variety of religious expressions in our society. I think it too quickly leads to stereotyping and potentially poor care, particularly within your interventionist perspective. Indeed, the whole idea of learning to provide spiritual care promotes a false dichotomy. It simply emphasizes the

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35 This argument is peculiar to Bradshaw (1994)
perception that spirituality is an optional add-on. Indeed, if we believe that spiritual care is an ethic and motivation that provides an essential orientation to a way of being with patients, then it is the character development of the nurse that becomes the focus for preparation. Nurses learn how they stand in relation to God and that provides an essential blueprint for how we stand in relation to, and care for, others. Therefore, some theological knowledge is necessary, but this way of being is best taught through modeling. The more mature nurses become in their faith and character, the more effective they are with patients.

**Humanist:** Well, here is the real problem I have with your perspective. You believe that acceptance of a particular doctrine leads to a life change that transforms your character over time making you more effective in this area. By that reasoning, anyone who did not adhere to your particular theological beliefs would not have the capability of developing in this area. Wouldn't that limit who could participate in spiritual care?

**Theist:** You have hit upon a key dilemma, and you will find theists responding in different ways. You are correct. We believe that working in cooperation with the Holy Spirit provides a power beyond human capacity. So someone who cooperates in that realm may be more effective. But, because we believe that these principles are based upon an underlying truth about the world, anyone who adopts and utilizes these principles will be effective.

**Humanist:** I'm confused. Can you give me an example?

**Theist:** Sure. Let's take the principle of serving patients in a way that guards their freedom and dignity. A nurse doesn't have to believe the theological foundations of this ethic to exercise it and have positive outcomes. However, those that acknowledge and draw upon the spiritual source will have an added dimension of power.\(^{36}\)

**Humanist:** Now you are sounding like a monist.

**Theist:** Not really, there is a key difference...

**Monist:** The spiritual development of the nurse is foundational to our perspective as well. Only those who are mature can effectively engage in the types of healing interventions we promote. Unfortunately, it is not simply an add-on to the nursing curriculum. It is a foundational way of viewing the world to which the nurse must ascribe. Because our understandings of these alternate therapies in Western Society are still so limited, most nurses have to seek out those familiar with these therapies and self educate. But most of all, nurses need to concentrate on the development of their own consciousness. The

\(^{36}\) This really is a bit of a dilemma from my perspective. The theistic message is one where spiritual formation is a partnership between God and humankind. We typically engage in the growth process through the spiritual disciplines. Bradshaw's perspective seems to leave some confusion in this regard. To say that it is simply an optional add on seems to belie the critical role that God plays in the transformative process.
number of ways of doing this are limited only by our imaginations. We can steer and facilitate students in this direction but ultimately the work must be theirs.

**Humanist:** It sounds as if you have some of the same preparational challenges as the theist in that one must ascribe to your perspective to engage in it?

**Monist:** Yes, I guess so, but I think that even helping nurses to understand this path is useful. They may be unable to guide patients in this healing but at least they will understand the process. But, you sound as if you think the humanist position doesn’t also contain a perspective that nurses must ascribe to. That really is the fatal flaw of relativism isn’t it-- people claim to hold no position while holding to a position. If you really looked carefully at your literature you would realize that even your own position holds a number of religious and scientific assumptions. Even the fact that you would take a position of subjectivity automatically discounts positions that hold to an absolute truth. Perhaps we have simply been a little more explicit about our assumptions?

**Theist:** I want to take a moment to make an important distinction that I alluded to previously between our position and the monistic one as it relates to the consciousness of the nurse in the enactment of care. Even though we both acknowledge the importance of the relationship between the nurse and the patient in spiritual care, we look at it quite differently. The monist believes that the nurse’s consciousness, or intention, toward the patient will contribute to a positive or negative outcome. The nurse, in himself or herself, is perceived as a powerful being that contributes to the healing capacity of the patient. So you will see statements like the nurse who harbours negative thoughts toward the patient will do harm. Although we recognize the importance of caring or good intention in the context of healing, we do not view it quite so simplistically. This relationship is enacted within a broader context of a divine presence, a third force in the relationship so to speak, and the nurse may be relatively unconscious about his or her influence on the patient. To suggest that one can simply walk into a patient room and influence the course of events for another by our consciousness, we believe is a view that leaves out the critical piece-- the divine spirit so to speak. We prefer to think of the relationship in terms of a shared, fallible humanity that stands together in the presence of a divine, good being.

**Monist:** I don’t think your characterization of our perspective is completely correct. We believe in the power of relationship and a universal force, we just don’t characterize it the way that you do.

**Narrator:** We have covered a lot of ground here and I just want to take a moment to reflect on where we are. I have appreciated your views on how nurses can be prepared to engage in spiritual care from your particular perspective. In this last brief discussion we began to unpack the differences in the relationships between the nurse and the patient, and I want to return to this later. It seems to me that this is primarily an ethical issue--

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37 Buber (1970/1996) has described a similar perception of influence that he calls magic. Magic entails believing that we have the capacity to influence without relationship and within a void. The monistic perspective would probably not view the environment as a void but a theist would argue that without the divine presence it becomes a void.
how nurses engage in an ethical way in the context of the relationship and so let’s talk about it when we get to that discussion.

So, we have talked about how your perspective influences the nature of nursing practice and how we would prepare nurses to engage in spiritual care. The monistic perspective in particular seems to represent a somewhat radical shift in the nature of nursing. In light of that, I think it is important to make explicit the implications of your position for nursing in the context of healthcare and interdisciplinary relations. After all, we do serve a function within society, and we have a responsibility to consider our role within the broader context. What are the implications of your position for the social contract of nursing and interdisciplinary relations?

**Monist:** As I mentioned previously, the nature of the discipline changes quite a bit from our perspective, and so this will naturally influence our relationship to other disciplines. As we move away from the biomedical focus I suspect there will be a gap left for physicians as they struggle to find someone to take over the aspects of care that they order. As nurses will be primarily engaging in interventions that do not require a physician’s order, they will truly be autonomous healers. It may be somewhat challenging, however, to differentiate the nursing role from other similar types of healers. Perhaps an entirely new discipline will emerge out of these understandings.

**Humanist:** How can you dismiss so lightly the bodily care that has been such a central focus of nursing’s social contract? Who is going to care for patient’s bodily well-being if we become soul healers? You know what will happen. That part of the job will be delegated to less qualified professions and patient care will deteriorate.

**Monist:** You talk about nursing’s social contract as if it was a given. Professions are continually renegotiating their role and scope. It just so happens that we believe this new role and scope is one that is desperately needed in healthcare. By pushing for this new vision we are fulfilling to a greater extent a social need.

**Theist:** I agree with the humanist. We have an obligation to provide excellent bodily care. As I have said over and over, excellent bodily care is a fundamental part of spiritual care. That is why I don’t necessarily agree with this holistic argument—that we have a responsibility to attend to the spiritual dimension as part of holistic care. By doing what we do best, providing excellent bodily care, we are attending to the spiritual dimension. You don’t find us writing books on psychology or sociology just because they too are dimensions of the person. What makes the spiritual any more our domain of expertise? We can’t pretend to be theologians or chaplains. It’s a mistake to instrumentalize religion and make it subservient to the discipline of nursing. Theology and religion really transcend disciplinary concerns for they speak to the overarching meaning and purpose of life. When we enter these realms as nurses I think we need to be conscious of our limited preparation. Don’t misunderstand me here—each one of us can speak credibly to our own personal spiritual or religious experience, but when we build theory for nursing we need to be careful that we do not go beyond our degree of preparation, and hence, competence. Theologians are essential to building a knowledge base in this area, and chaplains remain
the experts in providing spiritual care when challenges arise beyond the competence of the nurse. Further, the same attitude that we bring to patient care should characterize our relationships with the other disciplines, aiming for cooperation within a spirit of mutual service.

**Humanist:** Again, I think we have an interesting difference between the theological and the humanist position. Because spirituality is an innate human characteristic concerned with meaning and purpose, nurses are perfectly capable of intervening in this area. Granted, they may not be able to speak competently to religious issues, but that is where the chaplain comes in. One of the reasons we have been in favour of formalizing spiritual care is that it does help to promote interdisciplinary communication. Too often a single healthcare provider uncovers significant spiritual needs but fails to pass those on to the rest of the team so that they can be addressed using a coordinated approach. This emphasis on spiritual care is coming to the forefront in all the disciplines, and we need to make sure that we are communicating with one another.

**Narrator:** So in essence, only the monistic position on spiritual care would radically alter the nature of interdisciplinary relations. The other two positions seem to facilitate stronger alliances between the disciplines, albeit from different perspectives. As you have been talking I have been trying to imagine myself as a patient receiving spiritual care from each of these different perspectives, and I must confess, I have some discomfort with each of the positions. I could probably be comfortable with a nurse who used his or her religious perspective as an ethic and motivation for care, as long as I did not feel in any way coerced to accept that perspective. But, I am not sure that I would look to a nurse to help expand my consciousness or to intervene in my spiritual being. Those intimate areas of my life are best dealt with by those who are closest to me or who have some expertise within my spiritual tradition. I would appreciate a nurse who was aware of spiritual needs and supported my spiritual practices, but anything beyond that would make me quite uncomfortable. And yet, I do appreciate the acknowledgement by healthcare workers that I have a spiritual dimension and that it has a place in healthcare. How that acknowledgement is done seems a critical point for me and one that I will look forward to hearing more about when we turn to ethics.

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**Implications for Nursing Epistemology**

**Narrator:** I now want to turn to epistemology. That is, what do we know, how do we know it, and how do we evaluate the claims that we make? Nursing, as a relatively new discipline, has struggled over the past several decades to articulate its knowledge base. We have asked questions about what characterizes nursing knowledge, how we go about developing it, and what criteria of evidence we use to authenticate it. A number of foundational ways of knowing have been proposed: empirical, aesthetic, personal, ethical, sociopolitical, and even unknowing.  

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It seems to me that how we approach this issue of the spiritual has real implications for nursing epistemology. When we talk about the spiritual we are dealing with fundamental issues of meaning, being and ultimately, reality. Each of you begins from a different starting point regarding your understanding of the spiritual, and so, this naturally leads me to wonder how we as nurses, or as individuals, gain knowledge about the spiritual from your perspective. I assume also that your understandings of how we know about spiritual things will determine to some extent whether, and how, we build a disciplinary knowledge base in this area. For example, I am anticipating that your understandings of how we gain knowledge of the spiritual will determine the sources that we draw from and the methods of inquiry. Let’s begin this discussion by having each of you answer the question: *What can we know of the spiritual, and how do we gain that knowledge?*

**Humanist:** I’m sure this will not come as a surprise, but we believe that people themselves are the best source of information about the spiritual. Research findings illustrate over and over again how important this dimension is to people’s lives in the vast majority of cases. Now people may not use the term spirituality, but when you explore issues of meaning, connectedness and transcendence you will find a commonality—something that people feel is essential to their lives. So we learn about the spiritual through inquiry, similar to the ways we research other phenomena in nursing.

**Narrator:** So, is there one particular form of inquiry that is more suitable?

**Humanist:** Not really, because spirituality is so multi-faceted and mysterious it’s important to consider it from as many angles as possible. Each approach will give you a different perspective, a micro lens by which to view the proverbial elephant. Only through the different approaches can we gain a broader understanding for theory in this area.

**Narrator:** I have just one more question before we leave your perspective. How much can we really hope to know in this area? After all, most would agree that this dimension is mysterious, almost unknowable. People have difficulty even articulating their own spiritual experiences, so how much can we expect to know?

**Humanist:** Well, it’s interesting you should ask that question because this is where I believe our perspective is so effective. As you mentioned, spirituality is about reality, being and meaning. Who can speak to this better than the individual? Although they may not be able to articulate it perfectly, there is a communal experience of spirituality that will reveal itself through multiple accounts.

**Theist:** This is where your viewpoint puzzles me a bit. You speak about a highly subjective and personal experience but then fall back to a communal understanding. These seem to be contradictory positions. Can you explain?
Humanist: Sure, it's probably easiest to talk about process and outcome. The outcomes, or hallmarks, of spirituality will look similar, but the process of arriving there may be highly diverse. For example, a greater sense of meaning is indicative of spirituality, but what individuals do to achieve that meaning will be individual. So, there will be an aspect of knowledge that is sharable.\(^{39}\)

Narrator: Let's move on to the theistic perspective. What do we know in this area and how?

Theist: The foundation of our knowing, of course, would be revelatory knowledge. This revelatory knowledge provides certain truths about the nature of God, humankind, health and what it means to live well. These truths provide an overarching knowledge as a foundational assumption. This doesn't mean that we discount other ways of knowing, but when it comes to these essential ontological questions of the spiritual, this revelatory knowledge is our starting point. Also, I think it's important to note that we also believe in a personal revelatory knowledge. The Spirit of God indwells and speaks to humanity in a multitude of ways. You might liken this to what has been called intuitive or personal knowing in nursing.

Monist: I have a question about the scriptures that contain this revelatory knowledge. What really bothers me is how people have been able to take the same scriptures and use them to such different ends. In some cases, they are used to justify horrific acts. Just look at history. The Bible was used for years to justify slavery and to defend that the world was flat? How can you say that such sources provide a guide? It seems that people can make these scriptures mean whatever they want.

Theist: I think that this form of knowledge has been misused over the ages--as a scientific document or to justify our own prejudices. I don't think this knowledge should be free from critique. It should be subject to critique just like other forms of knowledge.

Monist: The best way to describe our position on epistemology is to view epistemology and ontology as united. I guess using a unitary metaphor once again doesn't surprise you! These are not separate entities. Knowledge resides within us, not external to us. By virtue of existence, as part of the universal consciousness, we know and understand. A part of the epistemological challenge has been trying to distinguish between knowledge and beliefs, on the assumption that knowledge has more credibility. We wouldn't hold to this dichotomy, our beliefs are integral to our knowledge. Further, this internal knowledge, or consciousness, has levels. The lower levels include your experiences, but it is the higher levels where we experience what you might consider spiritual things such as insight, vision and creativity.\(^{40}\) The ultimate level is of course where we merge with the universal

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\(^{39}\) This is really my argument as I could not find this question addressed in the literature. This is the most logical response I could think of given the challenge presented. Of course, if we take the subjectivity of spirituality to the extreme, even these agreed upon outcomes could be challenged. With a purely subjective experience of spirituality some might argue that appropriate outcomes are power, wealth and happiness.

\(^{40}\) Walsch (2004) divides consciousness into levels and characterizes the nature of each level. The monistic nursing theorists are more likely to simply speak in terms of an expanding consciousness.
consciousness. The higher the level of consciousness, the more open we are to the knowledge that resides within us, and the greater our effectiveness in the world.

Narrator: How does one go about discovering this knowledge?

Monist: Well, I think the only path that wouldn’t work would be the one that already has all the answers, such as religion. It is an inward journey—one that can be facilitated in any number of ways as long as one doesn’t think they are seeking for something external.

Theist: So, what about knowledge related to physical nursing care? You’re not suggesting that the knowledge of best practices to treat a pressure ulcer resides within us?

Monist: I think you might be misunderstanding what we consider real knowledge, or at least higher knowledge. The physical is really a lower expression of life. You recognize this when you acknowledge that people can remain healthy amidst devastating illness. We know there is more to life than a body. This practical knowledge can be used, but it is not what we would consider the essential knowledge or being of life. For too long we have focused on the biomedical model. Our emphasis has been upside down, and we need to correct that.

Narrator: Let’s move on to talking about the testing of spiritual knowledge. You seem to be coming from quite different understandings of what constitutes knowledge. This leads me to wonder whether you might treat knowledge differently as well. I’d like to ask you then how can spiritual knowledge claims be critiqued or evaluated?

Monist: Again, I think the concept of critique is indicative of old paradigm thinking. We had belief, and we had knowledge, and to turn one into the other you had to have certain criteria of evidence. This has led us down a road where we have lost sight of what is most important in life. Evidence became defined by the physical world, and in doing so, we lost our true place in the world. Belief is who we are—the knowledge resides within us by virtue of our place and connection within the universe. However, we may need to critique and change some of our beliefs. The very position I am putting forward shows how some of our old beliefs need to change and be brought in line with a unitary worldview.

Humanist: I must say all this seems a little esoteric and far from the real world of nursing. Don’t we have a responsibility to anchor this more in the practical realm of the profession?

Monist: I guess it depends on what you call the real world. Our position is that we have become confused over what the real world is. The universal consciousness is what transcends time, space and physicality. Hence, it is real.

Humanist: So, basically there is no critique we can level at this knowledge?
Monist: Not unless you adopt our starting point. Then from inside you may help us to critique and re-shape our beliefs.

Theist: Let me explain our position next, because I see it as a midway point between the two of you. We hold to a physical and non-physical reality at the same time, and this shapes our critique. We are not adverse to traditional forms and critique of knowledge within nursing. There is a whole body of practical disciplinary knowledge that should be subject to traditional forms of critique. However, this type of knowledge cannot provide the moral direction for practice. As I mentioned previously, this knowledge starts from theological presuppositions that provide the ethos of practice. Hence, to some extent, this knowledge sets boundaries for, provides a critique of, and gives ultimate direction for the use of other forms of knowledge. Let me give you a practical example. Ethnography has become a popular method of inquiry in nursing. I have seen a debate within the ethnographic methodological literature about the pros and cons of having sex with subjects as a means to insider knowledge. Now, from our perspective the moral presupposition of fidelity in relationships would make this debate a non-issue.

But, this leads us to the thorny question of critique. How is revelatory knowledge critiqued? Now I don’t pretend to be a theologian, and I feel a little out of my depth. Revelatory knowledge is characterized by a practical guide to living a good life, and the themes across religions are remarkably similar—kindness, love, justice, freedom from oppression. When revelatory knowledge seems to contradict these fundamental ethical positions then a critique must come to bear. And unlike the monistic view, this critique can legitimately come from outside. Indeed, the current societal critique over religious war illustrates this point well. So, let me bring this back to nursing epistemology. This revelatory knowledge brings a moral ethos to practice that can, and should, be open to critique if it does not stay true to this ethos.

Humanist: You say that your position is open to external critique, but I see that as only going so far. You hold to a fundamental truth about the world that is quite dogmatic and irreconcilable with other worldviews. And so, it would seem that this knowledge could not be part of nursing epistemology. It is too narrow.

Theist: You are correct in one sense. We see this as a meta-knowledge. We believe that the discipline should serve this knowledge rather than visa versa, and in that perhaps our position is a little bit like that of the monist. But again, even a humanist will take a position as I am sure you will show.

Humanist: Yes, if it is one thing that we have generally come to agreement on, it is that the critique or standard of evidence is tied to the underlying paradigm of inquiry. As it relates to the spiritual, we have broad agreement that it complements scientific understanding, as long as science transcends traditional positions of positivism and empiricism. As this is such a hidden and subjective realm, it requires a more

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41 This is a common stance taken by some of the “new” paradigm thinkers such as Parse.
42 For example see the work by Lincoln and Guba (2003).
constructivist approach to inquiry. Overall, the critique must match the paradigm of inquiry being used. Interestingly though, you will find little research being done within a critical tradition. Perhaps this suggests that we are reluctant to bring critique to this area yet. I will have to think a bit more about this.

**Theist:** So really, you too start from a particular assumption.

**Humanist:** Yes, but ours is not a pre-determined ethical one, and I think that is important.

**Theist:** Are you sure? Aren’t qualitative researchers in particular beginning to characterize their work as an ethical endeavour? This implies that there may be some agreed upon ethical standard.

**Humanist:** Yes, but these are human values, not religious ones.

**Theist:** The concern I have about calling these human values is they have the potential to be reconstructed in ways that might be less than desirable. At least religious values are timeless.

**Humanist:** Are they? It seems that not too long ago “religious” values supported oppression of women and minorities. You talk as if religious values have not evolved but clearly they have.

**Narrator:** So, it seems that each of you would agree to some form of critique of knowledge, or beliefs as the monists would suggest, although the nature of that critique differs substantially. I want to shift the topic to the generalizability of spiritual knowledge. We know that to take an interventionist approach we need to have some confidence in our understanding. Fundamentally, understanding comes from a level of confidence in a universal starting point that can be adapted to specific individual situations. I have noticed some of you take a more interventionist stance than others, and I wonder how that relates to the generalizability of your perspective. Is knowledge of the spiritual generalizable, and how do you feel about the use of the nursing process in the enactment of spiritual care?

**Theist:** We believe there are objective universal laws and principles that govern life, even human life to some extent. This means there is a somewhat predictable human nature; although, we also hold to human freedom and choice. This nature of the universe means that much of our knowledge is generalizable. When humans exercise choices about their health and well-being, there is some predictability about the outcome of those choices. This is why we are concerned about the tendency within healthcare to label behaviours as sick rather than acknowledging that they may be life-style choices that are simply unhealthy. But, we are such complex beings that the outcome is rarely certain.

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43 This is somewhat of a generalization I am making here. You will find spiritual research from all perspectives but the trend is more toward postpositivism and constructivism.
However, when it comes to the spiritual, we don’t believe in the interventionist perspective as embodied in the nursing process. The risk to human freedom, mutuality and relationships is too much. Standards of care are not embodied in generalizations that are simply individualized at the patient level. Excellent care is derived from the moral character of the nurse and the relationship with the patient. So while physical care includes attention to the generalizable laws of health and healing, the spiritual ethos of care resists this type of generalizability.

**Monist:** We have a point of agreement, and a point of disagreement. We agree that there is no room for an interventionist approach to care, but our rationale is quite different. There are no universal laws that apply to individuals. We make choices, and in making those choices we contribute to patterns in the universe. Cause and effect is a far too simplistic concept for the cumulative choices that synergistically make up the universal consciousness. Further, there is no right way to aspire to. Human transformation comes as a result of individuals deciding what constitutes quality of life for them. We become an interconnected part of that process as we stand alongside, help to identify patterns and envision new possibilities. Hence, the concept of generalization is really a foreign one to us. Again, it is the product of a dichotomous worldview—seeing ourselves outside of the knowledge cycle.

**Humanist:** Well, I guess we are the lone voice for the nursing process here. Although I respect your positions, I have difficulty envisioning them in the world of everyday practice, particularly the monistic one. It seems that nurses must intervene to some extent, that is part of the job. And whether we acknowledge it or not, we do draw upon generalizable knowledge for that is how we know about, and make sense of, our world. To ignore that seems to ignore a fundamental reality. We take the position that the spiritual dimension can be attended to through the nursing process just like any other dimension. The more thorough your assessment, the better basis you have to design effective interventions. Care can be evaluated using various outcome measures. Therefore, generalizability is foundational to our perspective. You have to build some basis of understanding that can be generalized to new situations. But, I acknowledge that in the spiritual dimension in particular we have just begun this process of building the knowledge base. We need more research.

**Theist:** The thing that has puzzled me a bit about your perspective is this tension between a spirituality that is almost completely subjectively defined and a normative perspective that allows for generalizability. Can you help me with that?

**Humanist:** We did touch on this briefly before. In terms of outcomes we believe that there are fairly similar manifestations, those things that humans aspire to: connectedness,

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44 This idea of a completely self defined quality of life as espoused by Parse was quite a mystery to me until I read Walsch’s work. This belief is predicated upon an assumption that individuals have no needs and are inherently good. All that is required is to allow them the support to discover who they really are. Some choices lead to more preferred outcomes, but these are not characterized as good or bad. “There is no such thing as Right and Wrong, there is only What Works and What Doesn’t Work, given what it is you are trying to do.” (2004, p.305)
love, peace, happiness, purpose, meaning. The list could go on. But how we reach those states is highly subjective. We are trying to make room for the diversity of human spirituality. And of course, like all good nursing we never just indiscriminately generalize. We individualize the care to that patient. The generalizable knowledge is simply a starting point.

**Theist:** But many of the interventions you propose are fairly prescriptive as well.

**Humanist:** Yes, I acknowledge that. You will notice that we have broadened the number of interventions significantly in our literature to try and do justice to the variability in individual spirituality.

**Theist:** Yes, and in doing so some might suggest that spirituality has become so broad as to be meaningless, or at least difficult to differentiate from the other human dimensions. Let me turn this around a bit with an example to test your thinking. Let’s say that a patient finds happiness and meaning through a purely hedonistic lifestyle that consistently harms those around them. Can you call that spiritual? After all, they have found subjective happiness and meaning.

**Humanist:** No, because they would not have healthy connections with others. You are taking subjectivity to the extreme. There is no such thing as absolute subjectivity or there would be no common basis for understanding. There must also be communal understanding, and this applies to the realm of the spiritual. Communal understanding would say that a hedonistic approach to life is not meaningful.

**Monist:** Even though you claim to have taken a non-religious approach, I see that you are simply re-inventing the religious wheel.

**Theist:** I agree to some extent. I see this particularly around some of the language of meaning. Many authors draw upon Victor Frankl’s work to support the concept of meaning without acknowledging that Frankl was speaking in terms of normative meaning associated with theism. This is quite different than an understanding of subjective meaning. It seems that when you continue to rely upon the normative understandings of religion, but divorce them from any sort of broader traditions, you potentially create bad religion.

**Humanist:** Like I said, I think we are in the beginning process of articulating our understandings of this human dimension. You will see this body of theory become stronger over time. Also, just because religion has described these outcomes over time does not mean that they don’t have a human origin. Indeed, some might argue that religion itself is a human construction.

**Narrator:** What strikes me here is the same dilemma we came to after discussing different conceptualizations of the spiritual. Do we make the spiritual instrumental to the discipline or does the discipline serve the spiritual? Do we create a disciplinary normative understanding of the spiritual out of which we intervene? Or, do we accept that
knowledge of the spiritual may transcend disciplinary knowledge? In your opinion, is this nursing disciplinary knowledge, and if not, where might it fit into a typology of knowledge?

**Theist:** As I have mentioned several times, we take the position that religious/theological knowledge resides at the top of any typological structure. What I mean by that is that this type of knowledge speaks to ultimate reality and meaning, and as such, provides knowledge that should pervade and inform everything below it. It might be considered the regulator, so to speak. Nursing disciplinary knowledge should be informed and critiqued by this greater knowledge. Knowledge might not even be the best term here for there is also an element of wisdom, how to live well.

**Humanist:** Of course, I’m sure you can guess the immediate problem I have with that. Whose religious knowledge are we going to choose? Religious knowledge should only be important as it informs the health behaviours of those who claim to be religious. As you know, we take the position that spiritual knowledge is different than religious knowledge, and because spirituality intersects with health in so many ways, it is a valid and legitimate part of the discipline’s epistemological base. Some might argue that it is a discipline in and of itself, one that can inform nursing just the way that psychology or biology does, but most of us would see this as part of our discipline. Spirituality often comes to the forefront, shapes, and is shaped, during times of change and crisis. This means that it is not knowledge to be constructed elsewhere and applied, but rather, is inherent to healthcare encounters between nurses and patients. We have an ethical responsibility to ensure that this is part of our disciplinary epistemological base.

**Monist:** I love how well your positions illustrate the challenges of dichotomies. Do you really think that assigning knowledge a particular structure is at all relevant to the healthcare encounter? Dividing these things into neat categories is a misrepresentation of how things really are. We deepen our understanding and expand our human consciousness as part of our shared experience. We discover the knowledge that resides within. Disciplinary knowledge loses all meaning within this context for we are talking about a shared knowledge that resists being broken down as part of the disciplinary pie.

**Narrator:** This has been a fascinating discussion. You each have compelling points that certainly warrant further consideration. I want to move into the final topic of our day, that of nursing ethics.

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45 Again, some of the monistic nursing theorists might not view it particularly this way. Barnum (2003) supports the discovery of spirituality through physics, psychology and philosophy. Although, she makes some rather radical suggestions like physics becomes psychology because knowledge is inherent to the knower. Parse (1998) advocates her way of discovering knowledge as a basis for all the health disciplines. She does not support the application of other disciplinary knowledge into nursing.
Implications for Nursing Ethics

Narrator: I now want to discuss the implications of your position on the spiritual for nursing ethics. As we go into this topic I am mindful of how differently each of your positions views ethics and so I want to start by laying some common ground. In 2002, nurses revised the Code of Ethics for Registered Nurses (2002). This Canadian code outlines eight values, or ideals, that form the basis of ethical nursing practice. These are safe, competent and ethical care; health and well-being; choice; dignity; confidentiality; justice; accountability; and quality practice environments. I want to structure our conversation around some of these common values. So, let’s begin with the first question. What is the relationship between your conceptualization of the spiritual and nursing ethics?

Theist: The spiritual provides the moral foundation for nursing practice. Sacred revelatory writings have provided timeless ethical principles for how we should be in the world. We acknowledge that we are created by God and so are not autonomous moral agents, we are accountable to the creator. Humans have a moral sense that allows them to make choices, and we are accountable for those choices. Our spirit is the will or force that makes those choices.46

Humanist: I am always intrigued by your concept of moral absolutes for it seems to completely deny the real world of ethical decision making. You say that you espouse these timeless laws but inevitably the working out of those laws is quite context dependent, and hence, negotiable. Any serious study of ethical decision making in practice will show that these rules are never simplistically applied. Practitioners take into account the situational factors when making their decisions. Take for example, your rule of sanctity of life. You admit in your own literature that it is difficult to determine when to remove life saving treatment, suggesting that you don’t really consider this an absolute.47

Theist: That’s true to some extent, and certainly you can observe a change over the history of religious ethical thinking. But, we still anchor ourselves in some changeless principles such as sanctity of life, even if that principle needs to recontextualized in light of life-prolonging technology.

46 Dallas Willard, professor and former director of the School of Philosophy at the University of Southern California, in his book “Renovation of the Heart”, describes persons as having five dimensions: spirit, mind, body, social and soul. He equates the spirit with the will: “Volition, or choice, is the exercise of will, the capacity of the person to originate things and events that would not otherwise be or occur” (2002, p. 33).

47 Sociologist James Ault (2004) completed a fascinating ethnographic study where he spent three years in a fundamentalist Baptist Church. In his sensitively written book “Spirit and Flesh” he describes an interesting discrepancy between espoused moral absolutes and their daily enactment. He describes examples where the congregants would state that they believed in an absolute moral law, but their negotiation of that law under practical circumstances indicated a sensitivity to context and circumstance that showed a much more situational ethic in practice.
**Humanist:** We are more inclined to see ethics and spirituality as related but not necessarily fundamental to one another. Spirituality produces certain things such as love, joy, peace, meaning and right relationships. Now, certain choices that might be considered ethical may work in producing those outcomes, but not necessarily. Spirituality is more about discovering the depths of our own being, finding connected relationships and transcending the everyday than it is about right conduct and answers. As ethics are socially constructed and variable between cultures, it would be impossible to make them co-existent with such a universal human experience as spirituality. Just look at the ethical variability between religious traditions.

**Theist:** I don’t buy that. The minute you remove ethical values from an absolute transcendent source they can be re-valued in any way that society chooses. From your perspective any behaviour could be reconstructed as ethical for that society. Take for example the polygamy and incest that has garnered so much media interest recently. Are you telling me that since society has chosen to define that as ethically acceptable practice we need to see that as okay?

**Humanist:** Not necessarily, but we are talking about spirituality here, not ethics. The two may be related, but maybe not.

**Theist:** So, you are telling me that as long as a choice produces good spiritual outcomes they would be related and acceptable?

**Humanist:** To some extent, yes. But again, you are pushing me to tie ethics to spirituality, and we believe that they are related but separate. Spirituality is inherently good, ethics is about choice, which can either be positive or negative. This universal human experience of spirituality transcends the debate of ethics.

**Monist:** We are with the humanists here but perhaps even more distant from ethics. Ethics address the day to day human interactions and so are tied to the physical realm. We might even differentiate between human and spiritual values. Human values are those meant to organize society. A good example would be the Canadian Code of Ethics for Registered Nurses. Spiritual values are those things that promote human becoming and enlarging consciousness, higher order values. These higher order values supercede the more human ones. That is why some of our theorists would decline to specify any sort of outcomes except those defined by the individual as to what constitutes quality of life for them. Spirituality is not about decision making, ethical or not, it is about context, merging and becoming into the powerful universal context that surrounds us. There is no higher being that dictates for us a preferred life. We create those possibilities together through our choices.48

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48 Walsch’s (2004) argument is a little difficult to follow but it goes something like this. To say that god requires us to follow some moral law is to imply that god needs us. Further, to say that individuals have free will but then to say that they will ultimately be punished for not living in accordance with certain laws is to make a mockery of free will. Hence, the ultimate conclusion is that god requires nothing of us and that we have the freedom to make choices that will lead to preferred outcomes. Because god is ultimately the universal, connected life force, these choices will benefit all. What Walsch seems to ignore is the possibility of a universal moral law that is less to do with God’s need and more to do with a way of the
Narrator: What really strikes me about all this is how common the referents are in the literature but how vastly different the approaches are. All of your literature talks about valuing love, peace, joy as the outcome or hallmarks of the spiritual. Yet, even with such common ground the approaches are so different. Let’s talk for a moment about health and well-being, a value espoused by the CNA code of ethics. How would your particular perspective of the spiritual view health and well-being?

Monist: Taking off from what I just said previously, health and well-being has no external referents. Individuals discover and choose the life that they desire, and it may have little to do with bodily function. As healthcare workers we are there to support choices, recognizing that true becoming transcends physical referents.

Humanist: Now that position is tough for me to accept. Are you saying that if a patient chooses to eat incessantly and weighs 400 pounds you could consider this health and well-being?

Monist: You have chosen a rather extreme example but to some extent yes—you must look at the state of consciousness or soul. Is that person at peace? Do they manifest an inner contentment and joy? You are observing a pattern. We are not here to judge and control. Our job is to stand alongside, to support with our presence and to help envision new possibilities if desired by the patient.

Humanist: This again is where your position is hard for me to even imagine. Common sense tells us that there are some conditions more conducive to health than others. And well-being is not something that you can isolate in a cosmic sense. Our human dimensions are all connected. What happens within one will impact all the others. How could we have any sort of professional common language from your perspective? There would be no agreed upon focus for the discipline and no common understanding by which to promote health either with individuals or populations?

Monist: Your understanding of the promotion of health and well-being is based upon a cause and effect model. We understand the cause, and control the cause, so we can obtain a good effect. But, the cause and effect model of well-being is far too simplistic. Why do some people avoid smoking and get lung cancer, and yet others smoke for their entire lives and do not get cancer? We need to look beyond the tyranny of causality to human potential. We need to shift our outcomes focus beyond the physical to the essence of being human.

world that seems to work. See for example Murphy & Ellis's (1996) work, “On the Moral Nature of the Universe” where they seek to illustrate how the principle of self-kenosis is an essential principle to life at every level of the universe.

49 This standing alongside rather than using external referents of health is very typical to Parse’s (1998) theory. When illustrating the priority of soul health, Walsch provides a contrast between people that work out every day but “their minds and their world are desperately sad” and people who are so out of shape they are “hardly able to lift a toothpick” yet “their minds and their worlds are bright” (2004, p. 381).

50 Walsch (2004) describes this as switching our focus to the realization that we are not a physical being, but the essence that surrounds our physical being. This perspective provides the basis for energy based
Humanist: Your position makes no sense. Pragmatically, we can see that certain things lead to longer and better quality of life. Our whole existence as a profession rests upon discovering and promoting those things.

Theist: We could certainly agree with the humanist position as it relates to our bodily function and well-being. We believe that there are universal laws related to health and well-being that are somewhat predictable, even though they cannot always be accounted for in simplistic cause and effect ways. However, our position is somewhat similar to the monist in that we also hold to the primary importance of a transcendental well-being which we would describe as living in relationship with the creator. You will find a degree of variability in how one would envision the establishment of that relationship. Some might see it as the turning away from sin, others as drawing close to God, or some combination of both. Our transcendent reference point for well-being is explicit, not self-defined like the monist.

Humanist: Again, your position is entirely too narrow. To say that well-being is tied to a relationship with God is trying to assign values to others that they may not share.

Theist: Not really. To understand our position you have to understand the dual accountability we carry. For the humanist and monist, the accountability does not go beyond the human realm. But for us, accountability begins in God. Remember, I said that our foundational ethical premise rests in the acknowledgement of God as creator and sustainer. But this doesn’t mean that others have to accept this premise. Indeed, we believe that human choice and freedom in this regard is paramount. If God allowed us choice and freedom, then we must above all allow that in others. Nevertheless, our fundamental ethical stance is that true well-being is only found in this relationship.

Narrator: This brings us naturally to the topic of the enactment of this conceptualization of the spiritual in the nurse patient relationship. Our Ethical Code states that this relationship should be characterized by choice, dignity and confidentiality. There has been a long history within nursing of proselytizing—using the intimacy of the nurse patient relationship to try and convert patients to a particular belief. Now with the secularization of most healthcare environments I think this has been far less problematic. But, with the resurgence of interest in spirituality, and a religious element in particular, doesn’t this potentially become a problem once again? How does your particular conceptualization of the spiritual support patient choice, dignity and confidentiality?

Theist: I am so glad you asked that question because I do think it's becoming a problem, but not where you would expect. There is certainly a small group of theistic theorists who

healing therapies and permits the type of out of body experiences that Barnum (2003) describes. Buber, from a theistic perspective, also addresses the error of an excessive emphasis on causality. He contrasts the “It” world of concepts with the “Thou” world of relationships, and while acknowledging the importance of the It world for science, claims that when it is used to structure the Thou world of relationships, it creates oppression and an obsession with causality. He claims this is characteristic of “sick” societies that are no longer centered in relational process (1970/1996, p.102).
see their role within spiritual care as primarily to share doctrine. They believe that their first accountability lies with God, and God has instructed them to go out and share the good news of their faith. However, you will find another group of theistic theorists who are conscious of the potential power imbalance in the relationship and issues of coercion. They focus primarily on service in the relationship. Sharing of doctrine only becomes an issue when there is an authentic interest on the part of the patient. But, it seems to me that it is the monistic spirituality that is now becoming potentially coercive. I remember reading a newspaper series that chronicled one woman’s experience of dying. She told the story of one of her nurses bringing crystals to her bedside, encouraging her to try them as a source of healing. The woman felt somewhat obligated to go along because this nurse had been so kind to her. What intrigues me is that generally these examples are not being cited as problematic situations. If the story had been that the nurse was trying to proselytize her, the reaction would have been quite different. If we accept the premise that these are interventions based upon a particular worldview and entail the manipulation of consciousness, then we need to be careful. Choice and informed consent become critical—particularly when theorists from both camps acknowledge that they are not always harmless. What concerns me to this point is that these questions are rarely being asked. Even the humanists have widely adopted these interventions without critically questioning them.

Monist: There is a huge difference here. Religion is promoting a set of beliefs. We are simply pointing to a context, one that promotes growth and becoming for humanity. This context that surrounds us is not a belief system. It is the way the world works. To say that others need to buy into our philosophy is like saying that someone needs to accept gravity to experience it. We don’t stop to get informed consent before we protect people from the effects of gravity as they fall out of bed!

Theist: No, whether you admit it or not your context is a belief system with certain implications. And your perspectives are not value neutral. Gravity is value neutral. For example, you emphasize that the nurse is a powerful cosmic force in the relationship, a presence that has the capacity to heal or do damage. You are implying that there is a right way to be in the context of the relationship. If the nurse’s conscious intentions are truly that powerful then what implications does that have for the patient? I find very little in your literature that talks about the risks of this powerful consciousness. For example, how many of us can say that we always have good feelings toward every patient no matter how difficult they are? You seem to be ignoring a significant aspect of human relationships. Further, aren’t you setting the nurse up for a chronic sense of distress by re-creating the old feminine scenario whereby the woman becomes responsible for the emotional well-being those around her? It seems you are completely ignoring the side of human nature that can’t always feel good about those they come in contact with.

51 Remember that both Shelly (1999) and Barnum (2003), writing from quite different perspectives, believe that undesirable spiritual entities can become problematic if one opens oneself up to this consciousness.
52 Much of the spiritual care literature focuses on the powerful presence of the nurse but there is little acknowledgement of an integral separation between feeling and intent. Buber makes a crucial point in this regard. Feelings do not constitute love. Love is a cosmic force that transcends feeling, and indeed love is a responsibility that cannot be equated with feeling (1970/1996, p. 66).
Monist: You seem to be misunderstanding a key part of our position—presumably because you are still stuck in the old worldview. This tendency to have negative feelings toward patients is based upon the old model that needs to control. The relationship should always be characterized by unconditional acceptance. If we accept people unconditionally there is no basis for bad feelings. It’s the old worldview that thinks in terms of right and wrong behaviours. Our job is not to label behaviours, blame or judge but to unconditionally accept patients and support them in their choices. Patients make choices that result in outcomes that support what they believe is quality of life. Our job is to stand alongside and support them as they make those choices. When we understand this positionality in the nurse patient relationship then both are free from struggling with negative thoughts and the need to control the other. This view is supported by our understanding that we are not our bodies. We transcend them and have the freedom to assign whatever meaning we want to a situation. This allows us a powerful transformative focus for even the most difficult circumstances. True choice is found in our ability to author our own lives and to assign meaning as we so desire.53

Theist: You completely deny the capacity for human evil. What about those individuals who engage in evil behaviours? Are we supposed to unconditionally accept them as well?

Monist: What you have called evil is simply those who have not yet discovered their authentic being. By focusing on evil as opposed to their potential, you are in effect limiting their potential for change.

Theist: It seems to me that this philosophy would work until there was a potential for harm, either to the patient or those around. The type of freedom of choice you are describing must always go hand in hand with responsibility, and I have trouble seeing that in your perspective.

Monist: On the contrary, true responsibility only comes when we fully grapple with the outcomes of our own choices—both on ourselves and on the entire universe. The old dialogue of right and wrong left us in an immature state of responsibility.

Humanist: As I listen to this dialogue I wonder if a monist has had any contact with the real world of nursing. Our patients are typically not your average person who has a basically good life and is searching for eternal enlightenment. They are often vulnerable, suffering individuals who are struggling to get through a day. Nurses with extreme workloads are run off their feet to provide for basic needs. I don’t see how this monistic approach is a meaningful resource for the everyday world of nursing work that entails providing protection and comfort. Patients are often in the healthcare system because their choice and dignity at a most basic level are at risk. To hold such a non interventionist approach may work for a very limited population of independent patients,

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53 This idea of no right or wrong behaviour is a cornerstone of Walsch’s (2004) new spirituality. Behaviour is simply what works or doesn’t work. Those who do “evil” deeds have simply not discovered who they truly are yet, and if we are the recipient of those deeds we have the capacity to transform their meaning, recognizing that we are not our physical bodies.
but to a large extent we must intervene to guard a patient’s dignity and choice, even in the realm of the spiritual.

**Theist:** I see we are back to the concept of intervention in the domain of the spiritual. Although some who share my worldview might disagree with me, I do not believe there is any room for intervention except in the most superficial sense. For example, we might provide a resource that is meaningful to the patient, or provide an environment that is conducive to a particular spiritual practice. But, I read things in the humanist literature like the spiritual should be assessed thoroughly, or a goal should be that the patient will reconsider the meaning of his life during his hospital stay, or that spiritual care should be documented for quality improvement processes. These statements just make me shudder. The work of the spirit will always be somewhat mysterious and ineffable, particularly as it applies to personal revelatory knowledge. To construct it in such certain terms is to lose its essence. Who are we to intervene in the lives of others in this way or to record their most intimate hopes, joys and struggles for others to see? In my opinion, this degrades patient’s choice and dignity in what is often their most vulnerable time. Just imagine yourself being a patient enduring some great suffering. In a vulnerable moment you share your challenges with a sympathetic nurse and later review your chart to see your intimate thoughts broadcast for strangers doing quality improvement audits.

**Monist:** I agree with you on this one. The interventionist perspective is characterized by judgment and coercion.

**Humanist:** You are both missing two important points. First, we are not primarily concerned with the mystery of some transcendental realm. We are dealing with fundamental human experiences of meaning, connectedness and transcendence, however that individual defines them. As such, individuals can inform us about the significance of these things in their lives as we ask open questions with sensitivity. Second, you seem to ignore that interventions are always designed in partnership with patients. We don’t just impose our will and understandings.

**Theist:** But, what if there is disagreement on those understandings? For example, I notice that some of your theorists are labeling what they call bad religion and recommending interventions to help patients think of God differently. One theorist uses the example of patients who believe they may be divinely healed as an example of bad religiosity. Are you not placing yourself in a position to judge the doctrinal correctness of certain positions, and doesn’t this trivialize religion? We have always allowed Jehovah Witnesses the right to refuse blood according to their faith tradition. Why would we now place ourselves in the position of passing judgment over the beliefs of others, and doesn’t this contradict the subjective nature of the spirituality you espouse?

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54 Heschel describes the importance of mystery in our interactions with God. “Souls are not introduced to a range of mountains through the courtesy of a definition. Our goal, then, must not be to find a definition, but to learn how to sense, how to intuit the will of God in the words. The essence of intuition is not in grasping what is describable but in sensing what is ineffable” (1955, p. 189).
**Humanist:** I think bad religion will be anything that is in opposition to what we know to be good health. Ultimately, the patient will be able to make his or her own choices, but that doesn’t mean that we can’t try to influence those choices toward health.

**Theist:** By taking the position that you can identify bad religion you are really setting yourself up as the expert on religious beliefs. I think we need to be careful in that regard. For example, some individuals believe in divine healing and it provides them with hope. When I see theorists label that as bad religiosity it deeply concerns me. What is happening to that patient when those doctrinal biases of the nurse become apparent? Further, don’t you see that many of your assessment tools contain this same potential tension between the nurse’s and the patient’s views? They represent a particular way of viewing spirituality that may not adequately represent patient’s views. For example, when your theorists advocate for tools that avoid religious language you are marginalizing those individuals for whom spirituality and religion are inseparable.

**Humanist:** I admit that tools are never perfect and always assume a particular perspective. However, one can assess in ways that allow the patient meanings to come forth. The biggest challenge is helping nurses to be insightful and confident enough to create a climate of trust for the patient to be open about these things. In my experience, most patients are happy to talk about what is most meaningful to them during times of crisis. It’s all in how it is approached. And back to your comment on confidentiality and documentation. This issue can be easily solved. One simply needs to seek patient permission to record the pertinent issues. For quality assurance purposes it only needs to be recorded that this form of care was delivered, not the specifics.

**Narrator:** You have brought up the issue of the preparation of the nurse in being sensitive in spiritual care encounters, and I think it is critical to discuss nurse competence. We have, above all, a responsibility to provide competent care, and it seems to me that nurses are at risk here for enacting care for which they have been ill-prepared. In our previous discussion we talked about how nurses would be prepared. Can nurses be expected to provide competent spiritual care within your conceptualization of the spiritual?

**Humanist:** I think it’s quite conceivable for nurses to be competent in this realm. It simply requires systematic integration into basic and continuing education. There are models and curricula out there upon which to build. We also need to remember that nurses have chaplains to refer to once they feel they are beyond their level of competence.

**Theistic:** Competence is a little more complicated from our perspective. As I alluded to previously there are really two schools of thought based upon whether one is supposed to serve patients or share doctrine. The latter requires some level of practical theological grounding. But, the service perspective of care is not about competence but about character. Competence speaks more to the principles of practice. Remember, spiritual care is embodied in a relational encounter that depends upon the character of the nurse.
This entails a lifelong process of development. We also recognize that we are not pastoral counselors and need to refer when necessary.

**Monist:** Competence is also not the best term from our perspective. Nurses will only be able to provide care to the level that they have appropriated the assumptions of our perspective. As the nurse’s own consciousness or human becoming expands they are better able to provide care within this perspective. There may be lost opportunities because of under-development in this area, but not incompetence.

**Theist:** Now, help me out here. You make claims like the nurse can heal through the manipulation of consciousness, and that bad thoughts can harm patients, and yet, there is no potential challenge of incompetence? Certainly, anything that can have that much power and benefit can also do harm if not dealt with properly?

**Monist:** That is the advantage of the energy based healing therapeutics. They seem to have no ill effects like traditional biomedical interventions.

**Theist:** Now, that is an area that needs to be explored in more detail--particularly when we have both your own theorists and theorists writing within our perspective suggesting that there are undesirable spiritual entities that can take advantage of this open consciousness. Let’s follow the logic for a moment. We both agree that there is a powerful dimension that transcends the physical. We agree that this dimension can have a significant healing impact on individuals. We also agree about the presence of a less than desirable force in this context, we call it evil, you call it unfulfilled potential. It only stands to reason that if we enter this field of existence we must be prepared to deal with both. Many of the energy based healing therapeutics that we draw upon today come from centuries of healing traditions that relied upon experts, the recognized healers, to administer these treatments. Dare we enter this realm without more understanding of the side of this dimension that allows for undesirable spiritual entities?

**Narrator:** The whole issue of competence really resonates with me. Generally, nurses are so concerned with competence. We have a tradition of over-regulating ourselves with rules and procedures to ensure that we do things right. It intrigues me that we would so quickly venture into areas where we have so little education. I can’t help but wonder why.

The final question I want to address today is related to the ethical value of justice. We live in a society with a policy of multi-culturalism, and the Code of Ethics clearly states that we have a responsibility to maintain an environment of equity and fairness, and that we cannot discriminate in the provision of nursing care based on spiritual beliefs. **How would your concept of the spiritual support the needs of a diverse, multi-cultural population?**

**Monist:** First, I think our perspective is long overdue to compensate for what has been a Western Judeo-Christian hegemonic perspective. Our perspectives are broad enough to embrace what have traditionally been considered Eastern perspectives. It opens the door
for ancient traditions of wisdom and healing to become a legitimate part of healthcare. Further, I think our perspective is necessarily visionary. We cannot afford to allow society to polarize around fundamental religious perspectives. We need a new vision that unites rather than divides and that brings some common purpose to society.\footnote{Parse advocates for her unitary view on the basis that it holds potential for the “metamorphosis” of nursing and the “betterment of humankind” (1999b, p.1387). Watson (2005) sees her view as one that can unite and restore a broken society but her unity comes through a syncretism that is quite different than Parse’s. Walsch puts forward his new spirituality as a force that will unite and change the world. With evangelical fervor he discusses how we can engage in a campaign to get this message out and become part of “Humanity’s Team” (2004, p. 390).}

**Theist:** It amazes me that you can’t see that your position is as sectarian as any religious position. You have simply chosen to shroud your position in language that promises progress, unification and other utopian things. Yet, your position is not acceptable, or even comprehensible, to some who come from other worldviews. I think to not admit how potentially hegemonizing your position is, is perhaps the most dangerous position of all.

The degree to which our position can accommodate a multi-cultural population is really dependent upon the approach one takes. If you take the position that as a nurse your primary responsibility is to evangelize by helping patients to accept your doctrine, I think the risk of coercion is high. If on the other hand, you take a perspective of vocation and service that values human dignity, choice and freedom then the risk is much less. I do believe that you can passionately hold to a particular worldview, have it provide great meaning for your nursing work, while recognizing that patients have a fundamental right to their own worldview without the threat of coercion during a vulnerable time. I suspect that the type of marginalization we need to be most sensitive to in our current societal milieu is the type where a worldview based on truth is the only one that is not permitted. We must resist the temptation to negotiate plurality through relativization.\footnote{Some theorists believe that a reverse discrimination occurs against those that hold to an absolute truth, such as that contained in the Christian worldview. What these theorists often fail to do is discriminate between the right to hold a position and the right to impose that position on others.}

**Humanist:** Because our view is so heavily based on individual subjectivity, it can’t help but do justice to a diversity of beliefs. A few years ago the nursing world adopted a great definition of pain, pain is whatever the patient says it is. To some extent, we have come to that same place with spirituality. Spirituality is whatever patients say brings meaning, connectedness and transcendence to their lives. From this perspective, we can ensure that we do justice to the diversity of spiritual beliefs that we encounter.

**Theist:** As good as your position sounds, I think you need to be conscious of a few things that are emerging in the literature about that. First, there is some indication that patients don’t know what we mean when we talk about spirituality. Many patients equate it with religion or simply don’t know what we mean when we use the term. Second, patients may not necessarily view this as a legitimate part of our nursing role. I bring this up because we may be fooling ourselves in thinking that this new spirituality that is “whatever the patient says it is” serves our patients well. It may be serving our own ends
as a discipline as we try to make our work more meaningful. We need to remember that our goal is to provide an environment conducive to the well-being of the patient. Any professional or personal agenda must serve that end.

Narrator: On that note I want to bring our discussion to a close, and in doing so, I want to leave us with some common ground. What has struck me throughout this dialogue is how dedicated each one of you feels to restoring this element to healthcare. After years where it was unpopular to speak of spirituality it is refreshing to see it emerge as a viable topic of disciplinary dialogue. Further, I am struck by how much common ground there is around the importance of authentic relatedness. All of your literature contains common themes about how to relate to patients in a way that vitalizes and nurtures the spiritual. Perhaps this issue of authentic relatedness can provide a starting point for some consensus in this somewhat divided area. Although we have covered a lot of ground in this discussion, the dialogue has really only begun. There is much more to be learned about these conceptualizations of the spiritual and how they influence our disciplinary perspectives.

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Analytical Framework

The purpose of this chapter has been to articulate more fully three possible worldview approaches to the spiritual in nursing and to further demonstrate how those approaches influence nursing’s ontology, epistemology and ethics. A number of questions asked in this chapter were intended to help us explore some of the differences between three worldview approaches. I will now end this chapter with a list of questions that point to the differences between the positions. Using these questions, one could read the work of any theorist writing on the spiritual in nursing, analyze their work in relation to these questions and understand the implications of their position for nursing. The following questions could be considered in such an analysis:

1. What is the foundational assumption of this theorist? Is God, a monistic universal consciousness, or subjective human understanding the essential ontological starting point for understanding the spiritual?

2. What is the nature of persons? Are they defined primarily by their covenantal relationship with a creator, are they indivisible unitary beings connected to a universal consciousness, or are they beings with a universal spiritual dimension characterized by needs?

3. What is the nature and scope of nursing in relation to the spiritual? Is it an ethic and motivation for care that promotes relationship to a creator, care of the evolving and expanding consciousness, or a problem oriented interventional approach toward a spiritual well-being characterized by specific emotional states?
4. How do nurses become competent in spiritual nursing care? Do they learn through modeling of a service oriented ethic, through the understanding and expanding of their own conscious healing techniques, or through a standard curricular approach of content and self-reflection?

5. How is knowledge of the spiritual acquired or constructed? Does it come from theological or revelatory knowledge, from being one with the universal consciousness, or from inquiry into the communal experience of spirituality?

6. What is the relationship of the spiritual to ethics? Does the spiritual provide the moral foundation for ethics, or are they entirely unrelated with the spiritual being simply a culmination of choices which cannot be labeled good or bad? Or, are ethics socially constructed values that may or may not promote the good value of spirituality?

7. What characterizes the positioning of the nurse in the interactions with patients in the context of the spiritual? Is the nurse a relatively unselfconscious participant in an interaction of vocational service, a potentially powerful consciousness or an expert with the authority and capacity to intervene in the spiritual dimension?

One would quickly find by using these questions that most theorists do not fit neatly into any particular perspective. We would expect that given the limited nature of typologies. Indeed, as mentioned previously, typologies facilitate understanding, but they are limited in that they do not show the interrelation between positions. What may be a more useful way is to explore contrasting poles, both within and among positions (Tillich, 1963a). For example, when considering the relationship of the spiritual to ethics there is a polarity of positions from no relationship to essential relationship. However, in some cases, even this approach would be limited because some theorists could not easily be located on a continuum. For example, a theorist might support revelatory knowledge, knowledge from the universal consciousness and knowledge from communal experience. Nevertheless, answering the above questions may help us to understand a particular theorist’s position, to see what might be unarticulated within their position, and to grasp the implications of their position for nursing. But, beyond getting insight into a particular perspective, we should also be able to make some arguments about how the spiritual should be considered within the context of the discipline of nursing. It is this task that will be the focus of the next chapter.
Chapter 6
What Approach Should We Take to the Spiritual in Nursing?

The good way must be clearly good but not wholly clear. If it is quite clear, it is too easy to reject. What is wanted is an oversimplification, a reduction of a multitude of possibilities to only two. But if the recommended path were utterly devoid of mystery, it would cease to fascinate men. Since it clearly should be chosen, nothing would remain but to proceed on it. There would be nothing left to discuss and interpret, to lecture and write about, to admire and merely think about.

Kaufmann, 1996, p. 10

The previous two chapters illustrated the diversity that exists in the nursing literature on the conceptualizations of the spiritual in nursing. Depending upon whether one starts from the ontological assumption of theism, monism or humanism, the understandings of the spiritual, and the consequences of those understandings for nursing can be quite different. However, there is also common ground in this literature. By agreement, the spiritual is a force or power that has the capacity to energize, to connect, to provide meaning, and to contribute to wholeness. Theorists place as foundational the relational process that occurs between nurses and patients in the context of the spiritual.

In Chapter 4, I considered a set of questions aimed at understanding the positions being taken by leading theorists writing on the spiritual in nursing. In Chapter 5, a set of questions were considered that were aimed at understanding how the different approaches of theism, monism and humanism shape and inform the development of the spiritual in nursing. I will now move to a final set of questions designed to address the third and final purpose of this study, to argue for a particular approach to the spiritual based upon the moral and pragmatic nature of nursing. Once again, I use a series of questions to guide these arguments, questions that address the three key concerns of nursing philosophy: ontology, epistemology and ethics. The following questions will be addressed in this chapter:

Is it possible, or even useful, to obtain agreement on the conceptualization of the spiritual in nursing? The literature review illustrated that some of the current debates in the spirituality literature concern a common definition of spirituality for the purpose of building a body of knowledge. Theorists are struggling to gain consensus on an inclusive definition of spirituality. Chapters 4 and 5 illustrated how diverse the conceptualizations of the spiritual are in the literature for we are talking about what we believe to be the nature of reality. In this chapter, I will argue against coming to an agreement on the conceptualization of the spiritual for nursing. Rather, we should be focusing on understanding the worldviews that characterize spiritual understandings in society and promoting dialogue among those worldviews.

Is the spiritual part of the ontology (nature, scope, and object) of the discipline of nursing, and if so, should we be creating normative claims about it? Fundamental beliefs about the nature of the spiritual inevitably result in a set of beliefs about the nature
of persons, health and the environment. Chapter 5 illustrated how diverse these beliefs can be depending upon whether we start from the position of theism, monism or humanism. Certain beliefs about these domains may indeed change the nature of nursing itself, as illustrated by the monistic view. We are left with the choice of either adopting a normative view of the spiritual to serve disciplinary ends or recognizing that the spiritual transcends the discipline. I will argue that if we accept that a discipline is a unique way of viewing the world, and holds a particular expert body of knowledge, then we have to acknowledge that the discipline of nursing can make no such claim in relation to the spiritual. However, we can see it as a vital part of the profession where our role is not as experts who intervene in the spiritual lives of patients but as those who create a space for the expression and development of the patient’s spirituality.

**What epistemological approach should be taken to the spiritual in nursing?** Though we may resist creating normative disciplinary claims about the spiritual, we nevertheless require knowledge of how to engage in spiritual nursing care. This is an important and valued part of practice. The literature review highlighted the debate of how we know about the spiritual. Is it something that we measure directly or only indirectly through outcomes? Is it amenable to traditional scientific inquiry or is it an alternate way of knowing about the world? The dialogue in chapter 5 illustrated how the nature and source of this knowledge differs depending upon the ontological starting point. Knowledge of the spiritual comes from sources as diverse as sacred writings, personal experience and connection with a cosmic consciousness. I will argue that in the process of spiritual care two expert sources become central, general knowledge about the spiritual from disciplines that have a legitimate claim to expertise in this area and subjective knowledge from the patient. Although the nurse may bring significant knowledge of the spiritual into the care-giving encounter, either from further education or personal experience, this knowledge should be used cautiously, particularly when it disagrees with the hopes and beliefs that characterize the patient’s spirituality.

**What ethical approach should be taken to the spiritual in nursing?** Although we can reasonably assume that all nurses support ethical values such as health, well-being, choice, and competence, we can appreciate from the previous chapter how ideas about what constitutes these values vary depending upon understandings of the spiritual. Some go so far as to argue that there is little relationship between the spiritual and ethics. I will argue that the spiritual and ethics must be logically connected and that the CNA Code of Ethics for Registered Nurses (Canadian Nurses Association, 2002), with its emphasis on primary accountability to patients, is an appropriate framework to evaluate the ethical conduct of nursing care in relation to the spiritual. Responsibilities of guarding against coercion, ensuring patient confidentiality, promoting reflection about nurse’s own positioning in relation to the spiritual and serving the needs of a diverse society provide a foundational starting point for providing ethical care in relation to the spiritual.

To make arguments one must explicate the framework, or guiding assumptions on which those arguments are being made. For example, I could argue based upon my particular view of the “true” nature of spirituality. That is, I could simply start from my

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57 From this point on I will simply refer to this document as the CNA Code of Ethics.
own location and make recommendations based upon my view of reality. However, while that approach may serve well within our individual lives it may not serve as well within a discipline that has a societal role and a public trust. My arguments will be based upon the moral and pragmatic nature of the discipline. Reed (1989/2004) has suggested that nursing theorizing is an ethical endeavour because it is a moral judgment about what we value. Nursing has societal value because it is committed to promoting and restoring health and alleviating suffering. As such, there will be moral commitments inherent in all of our theorizing, including that in relation to the spiritual. Theory building in relation to the spiritual must support and be logically connected to our societal value. Nursing then, as moral practice, exists as part of the constructed social world of health that has assigned a particular responsibility to the profession, that of the promotion and restoration of health.

Similarly, Urban Walker (1998) has proposed that moral understandings should be viewed in terms of practices of responsibility situated within a social context. Peter and Liaschenko (2003) have recommended Urban Walker’s moral philosophy as the basis for nursing practice because she recognizes that practice is always situated within a social world that shapes and informs the necessary responsibilities. Our practice as nurses is situated within a society that is characterized by spiritual and religious diversity. Hence, certain responsibilities fall to the nursing profession in light of that societal context, namely the responsibility to serve a diverse population well. So while we undoubtedly have the right to hold our own truths in relation to the spiritual in our personal context, we have an obligation to ensure that within the context of healthcare our responsibilities extend to allowing room for diverse expressions of the spiritual.

Nursing is moral, but it is also pragmatic in the sense that our ultimate end is practice. William James, author of a classic book on the varieties of religious experiences, proposed a pragmatic method of philosophy that is particularly useful for considering metaphysical issues, such as the spiritual, in the context of a practice discipline. James’ (1995) pragmatic method was designed to deal with metaphysical disputes that are not easily resolved through typical arguments or standards of evidence. If we reflect on the different ontological assumptions about the spiritual we quickly realize that there is no agreed upon standard of proof by which to prefer one over the other. How James proposed to resolve these competing claims was to use the pragmatic method to simply ask the question, what difference would it practically make to anyone if this idea rather than that idea were true? This method of approach provides theories that become instruments for use and further testing rather than definitive answers to the mysteries of life. So, using this method we can test the claims being made about the spiritual in nursing against professional practice to uncover what difference each perspective would make. Our answers in turn become theories to be tested rather than definitive answers to complex challenges.

In essence then, the arguments that follow are based upon the assumption that nursing is a moral endeavour that has a particular responsibility based upon its role and location in society. Further, in considering such a controversial metaphysical concept such as the spiritual, my ultimate goal will not be to settle on one “truth” but rather to
consider the practical outcomes of different approaches in the everyday context of practice. These arguments can then be treated as theories to be acted upon and tested rather than adopted as the answer to how the spiritual should be conceptualized and enacted within nursing.

Is it possible, or even useful, to obtain agreement on the conceptualization of the spiritual in nursing?

Nursing literature on the spiritual is replete with calls for a consensus on the conceptualization of the spiritual as a basis for building theory. Authors have proposed different ways to arrive at that consensus. Goddard (1995) advocated for a fundamental definition such as energy. Fawcett and Noble (2004) suggested we need to seek for the true nature of spirituality. Reed (1992) believed this consensus can be found through observable manifestations of the spirit such as meaning, connectedness, mystical experiences, religious behaviours or hope. In like manner, van Leewen and Cusveller (2004) suggested we should focus on functional rather than substantive outcomes, that is, focus on the how rather than the what of the spiritual. What has become apparent from chapters 4 and 5 of this work is that there are varying conceptualizations of the spiritual in the nursing literature, and that these approaches are so distinct that it becomes necessary to question whether it is possible to obtain agreement. In this section I will argue that it is not realistic to expect agreement on the conceptualization of the spiritual in nursing. Rather, we should be focusing on understanding the spiritual worldviews that characterize society and promoting dialogue among those worldviews.

Pragmatically, let’s ask what difference it would make to adopting one of the worldview perspectives described in this work as a beginning point for the understanding of the spiritual in nursing. These three perspectives, theism, monism and humanism, could be viewed as a continuum whereby each perspective adds something to the understanding of the spiritual. Theism starts with a creator God but also acknowledges the presence of a universal Spirit through which the world is connected and exists. Some have argued that it is also a humanistic perspective because of the value that it places on humanity and its development (McGrath & Packer, 1999). Monism drops the requirement of a creator God preferring instead to see the world as a connected universal consciousness with humanism remaining a central feature. Humanism starts from the assumption of a universal, individually defined spirituality with the other two perspectives being optional, but not required, for the full understanding of the spiritual. Let’s now imagine the implications of using one of these positions as the basis for the conceptualization of the spiritual in nursing.

As was apparent in chapters 4 and 5, theistic writers argue that the theistic view is the ultimate truth of reality, and as such, should form the basis for understandings of the spiritual. However, the challenge of adopting this perspective for nursing is that it sets an expectation that all individuals will subscribe to a belief they may not share. This potentially subverts one of the most important conditions upon which the covenantal relationship with the creator is sustained, that of human choice. One of the cornerstones of human freedom from the theistic perspective is that we can choose whether or not we
wish to exist in relationship with the creator. Indeed, to some extent, God remains hidden so that humanity will continue to be able to make that choice; the essence of faith is a conviction of things not seen. So, to adopt a conceptualization to which many may not subscribe is essentially a violation of human choice and freedom. If our job is to serve patients, and if we are to do that within the context of a diverse society, then we need to allow for individual choices within an array of understandings of the spiritual.

The next level then would be the monistic conceptualization. Again, we have the challenge of an exclusive worldview perspective that would be particularly difficult for the theists to adopt. To deny the existence of a creator would deny the fundamental tenets of their beliefs. Beyond that, there is the very real possibility that we would fail to serve the social contract of nursing by focusing excessively on soul care to the neglect of bodily well-being. Barnum (2003) grappled with this issue when she stated that in the new age spirituality, while attention to the body and the soul can occur at the same time, it is somewhat more difficult to find a theoretical basis that justifies why these two must be joined. If we adopt the assumption that humans extend beyond their physical bodies, and that healing comes through a universal energy, then there is a risk that good physical care, an essential part of health and healing will become de-emphasized. However, even if we were to be assured that good bodily care would remain an essential concern of nursing, the assumptions underlying this approach may be foreign to much of society. The assumption that humans extend beyond their bodies as part of a universal consciousness, and have as their goal immersion with this consciousness, is one that may not fit well with the highly individualistic spirituality characteristic of society in general, or with the segment of the population that holds to a primarily material worldview. Further, the assumption that there are no right or wrong behaviours in the context of health, but simply choices, runs contrary to the common sense notion that some habits are healthier than others. Indeed, our culture is increasingly interested in understanding and developing lifestyle habits that lead to health and longevity.

The most logical conclusion then seems to be humanism. If we embrace the humanistic perspective that recognizes, but doesn’t consider essential, the other two worldviews, can we then find a place where all could agree? This has been a popular position in the nursing literature on the spiritual, and the challenges inherent in this position are a little more difficult to spot. First, even though this seems to be an inclusive position, it still fails to embrace those individuals who would not see themselves as spiritual. Belzen (2003), in his own efforts to describe the spiritual, made it clear that he does not start from the assumption that all individuals are by nature spiritual, reminding us that even this assumption is one that may not represent all the views of a diverse society. Second, McSherry and Cash (2004) argued that universal definitions that claim to embrace all viewpoints tend to have a blanketing effect, suppressing certain views, ascribing values to others they may not share, and ultimately creating philosophic confusion and uncredibility. They have also pointed out that generic descriptors of spirituality such as meaning and transcendence rely upon the cognitive capacity to make

58 In sacred Jewish and Christian writings a direct encounter with God was so overwhelming that it produced awe and fear. Some might argue then that the less visible presence of God made manifest through things such as creation is a concession to human choice and freedom.
meaning, or to transcend the immediate, thus potentially discounting those who are cognitively impaired as spiritual beings. If what we are aiming for is a universal understanding, then even the humanistic view falls short.

This blanketing effect described by McSherry and Cash is similar to the relativistic approach to religion that characterizes society (Bibby, 1993). We assume that pluralism is best accomplished by making all positions equally valid and by refusing to pass judgments on the value of some positions over others, a movement that Bibby has suggested has been perpetrated by the academic “high priests”. In contrast to this relativistic approach, Zacharias (1996) has argued that one of the great strengths of pluralism is the opportunity to weigh and evaluate competing beliefs. James (1956) believed that the mark of an intellectually vigorous society is its ability to engage in a dialogue about religion and praised the value of fully understanding humankind’s ideals and “over-beliefs”. In essence, an approach that relativizes all positions and sets them apart from critique loses the ability to engage in a healthy discussion that would allow us to debate the relative merits of various positions. Hence, the risk of the humanistic position is that it will try to be so all-encompassing and generic that the uniqueness and merits of various worldviews will be lost.

One of the mechanisms that has been used to universalize, and to some extent relativize, the concept of the spiritual has been to make religion and spirituality conceptually distinct. Religion is being defined as external adherence to a set of beliefs and rituals; to the extent that it creates divisions in society it is considered negative. Religion is often characterized as the divisive force that prevents us from coming to a universal understanding of spirituality, and so it has been removed from the essential understandings of the spiritual to varying degrees in the literature. This phenomenon has produced what Taylor (2002) has characterized as a highly individualized spirituality where the pursuit of happiness, authenticity, and tolerance takes precedence over any commitment to an object of worship or belief. This “new” spirituality is more about emotional referents than content.

But, we must ask what we have lost by relegating religion to external forms in favour of a contentless, experiential spirituality. James (2002) believed there were two types of religion, an individual personal function and an institutional form, and that the individual personal function of being religious, even across institutional forms, is remarkably similar, a feeling of expansiveness, and inadequacy that leads to a need to feel part of something greater. However, it is the intellectual content that creates the differences in the enactment of the variety of these religious experiences. So the question is, can we conceivably remove the content from the spiritual and relegate it to external religious forms? Can there truly be a contentless spirituality? I suggest that it is impossible to consider the referents of the spiritual, such as meaning, transcendence and connectedness, without constructing a set of beliefs around what creates those conditions within an individual life. For those who hold to a particular religious worldview, precepts of that worldview help to create a meaningful framework around these referents. But, I would argue that those who do not associate themselves with religion must still work to
construct beliefs around their spirituality if they are intent upon developing it. To adopt a contentless spirituality is to separate our spiritual from our rational dimensions.

Some philosophers have emphasized the role that reason plays in relation to the spiritual (Heschel, 1955; James, 2002). This does not imply that the spiritual is entirely subject to reason, but rather that reason enables us to order our beliefs in a logical way so that our experiences can be brought into a meaningful whole and become congruent with our understandings of the broader environment. And so, one of the greatest challenges of a conceptualization of the spiritual that is so universal as to be contentless is that it tends to create a false dichotomy between our experiences and our mind where we structure our beliefs. In essence then, a humanistic view that rests upon relativizing positions and creating a contentless spirituality tends to marginalize those who would consider themselves religious, but also renders invisible those essential beliefs that determine how we come to meaning, connectedness, and transcendence.

In conclusion, adoption of any one of the three worldviews described above may not serve nursing in the context of a diverse society. Adoption of an exclusive worldview does not allow for sufficient individual choice and freedom. Adoption of a relativistic worldview tends to blanket diverse views and produce a false dichotomy between beliefs and experience. Perhaps the road ahead lies in trying to articulate as fully as possible relevant worldviews and promoting dialogue about the implications of those worldviews for the profession. This work has suggested one taxonomy of worldviews, but others have been constructed (e.g., McSherry & Cash, 2004). Often, these taxonomies have been constructed around various religious worldviews. Although this approach makes an important contribution, we must also try to understand how those who would not consider themselves religious are constructing their worldviews to account for their experiences of meaning, transcendence and connectedness.

However, we don’t need to stop at constructive debate. Part of the focus should also be discovering commonalities. Key to the negotiation of plurality is establishing some common ground as a starting point. Meilaender (2003), drawing upon the work of Augustine and Rawls, suggested that the best way to achieve stability and unity amidst a pluralistic public world is to seek the basis for unity in something that all participants hold in common. The dialogue in chapter 5 revealed a number of potential areas of agreement; the spiritual is important, it is a form of power, it is energizing and it is connecting. Although not all would agree that religion is an essential part of spirituality, most would agree on the importance of the webs of beliefs that characterize spirituality. All could agree that the relationship between the nurse and the patient is important in the process of spiritual care and that patient dignity, confidentiality and choices should be respected. Nurse competence is an important agreed upon value, as is being sensitive to the needs of a diverse population. This common ground can then provide a starting point for discussing the polarities of particular views in relation to the spiritual. For example, all could agree that a caring nurse is central to spiritual care, but polarities exist in the role of consciousness in that caring encounter, from a relatively unselfconscious exchange to a powerful conscious intent. Tillich (1963a) suggested that this exploration of common ground may help us to “go beyond the conflicts to possible unions of the
polar elements" (p. 55). For the time being, a lack of consensus over the definition of spirituality may be a strength for it promotes a measure of openness (Gordon & Mitchell, 2004).

In summary, it is neither useful nor realistic to expect an agreed upon conceptualization of the spiritual in nursing. Rather, we should be advocating for an understanding of the worldviews that characterize the spiritual in society and for dialogue among those worldviews, looking for unity in some ground. However, if we cannot expect consensus on the spiritual, can we reasonably expect normative theory in relation to the spiritual as the basis for the discipline? Is the spiritual a part of the ontology of the discipline, and if so, should we be creating normative claims around it?

Is the spiritual part of the ontology (nature, scope, and object) of the discipline of nursing, and if so, should we be creating normative claims about it?

In previous chapters we saw how different conceptualizations of the spiritual in nursing are enacted differently in the context of care. From the theistic perspective, the spiritual provides an ethic and motivation for care. From the monistic perspective, the spiritual provides a context of energy and connectedness and a goal of expanding consciousness. From the humanistic perspective, the spiritual is a subjectively defined dimension. The approach that is taken to the spiritual has the potential to ultimately shape the future of the discipline, particularly if the perspective adopted is one that focuses primarily on soul healing or human transformation. The nature, scope and object of nursing changes depending upon our conceptualizations of the spiritual. Indeed, these topics are inextricably intertwined, and attempting to create a normative discourse of the spiritual as part of the discipline of nursing will only objectify the spiritual and make it instrumental to the discipline. Hence, I will argue that if we accept that a discipline is a unique way of viewing the world, and holds a particular expert body of knowledge, then we have to acknowledge that the discipline of nursing can make no such claim in relation to the spiritual. However, we can see it as a vital part of the profession where our role is not as interveners but as those who create a space for the expression and development of the patient’s spirituality.

Prior to considering whether the spiritual should be a part of the discipline of nursing, it first becomes necessary to understand what a discipline is and what characterizes the discipline of nursing. Donaldson and Crowley (1978/2004) have suggested that a discipline is characterized by “a unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its inquiry” (p. 293). Further, they differentiate the discipline from the profession. The discipline is characterized by a specific body of knowledge; whereas, the profession has a broader scope. The profession, as embodied in practice, may draw upon many different forms of knowledge that will not necessarily be unique to that profession. Indeed, they have suggested that, “Failure to recognize the existence of the discipline as a body of knowledge that is separate from the activities of practitioners has contributed to the fact that nursing has been viewed as a vocation rather than a profession” (p. 299). So, when
we are talking about the discipline of nursing we are talking about a body of knowledge that characterizes nursing’s expertise.

Theorists have struggled with what characterizes the ontology of nursing and have tried to describe it through the discipline’s nature, object and scope. Donaldson and Crowley (1978/2004) characterized the nature of nursing by three general understandings: principles and laws of well-being, patterns of human behaviour during critical life transitions and positive health change. Nagle (1999) proposed that ontology is found in the object of nursing, a set of shared values and assumptions about what it means to be human. Still others have tried to address ontology through the scope of nursing. There is a great deal of discrepancy in the literature about this scope. For example, at one extreme there is the holistic theorists who see nursing as concerned with total well-being across life experiences (e.g., Reed, 1997/2004). These theorists, like the monistic theorists, argue that on the basis of a holistic or unitary view of the person, nurses become responsible for anything related to well-being in the context of health. In contrast, Kikuchi and Simmons (1986) argued against such a broad scope on the basis that every science contributes to total well-being. Instead they argued for the more limited perspective of bodily well-being. So, we can see that various theorists have tried to address the ontology of nursing through the nature, object and scope of the discipline, but as yet, there is no agreement.

By understanding how nursing has tried to define its disciplinary ontology, one can clearly see how understandings of the spiritual intersect with the nature, object and scope of the discipline. Donaldson and Crowley’s (1978/2004) suggestion that nursing can be characterized through its approach to well-being, behaviour during life transitions and positive life change intersects with how the spiritual influences our understandings of these themes. van Leuwen and Cusveller (2004) have identified three potential areas of intersection between nursing and the spiritual: the maintenance of the patient’s spiritual practices; spiritual crises that arise as a result of health transitions and crises; and spiritual pathology that impinges upon the nurse patient relationship. A fourth intersection that is recognized widely in the spiritual literature is the influence that the spiritual and religion plays on health. What is apparent from these intersections is that patients bring unique spiritual influences that determine their understandings of well-being, how they cope with transition and change and how they negotiate positive health change. If we accept that the spiritual is a legitimate part of our disciplinary expertise then we must come to some sort of normative understanding about what constitutes a healthy spiritual approach, something that may be challenging given the diversity of spiritual understandings.

The attempt to define the discipline through a common understanding of the object of nursing, the person, brings similar challenges. This work has shown that different conceptualizations of the spiritual bring different assumptions about what it means to be human, and the different approaches have different challenges, particularly in reconciling the physical and spiritual aspects of persons. The humanist perspective takes a dimensional approach to the person, recognizing the spiritual as one of those dimensions. However, the challenge that has confronted this approach is identifying what is uniquely spiritual care apart from religious care or psychosocial care. Typically, this
care is described in terms of promoting human meaning, but as Draper and McSherry (2002) have suggested, perhaps we already have an adequate vocabulary to support human meaning without confusing it with the language of the spiritual. If we are going to bring the spiritual into the ontology of the discipline as a dimensional aspect of the person then we must identify what is uniquely spiritual apart from religious or psychosocial considerations. The monistic perspective locates the nature of persons outside of their physical body, and in doing so, makes it difficult to keep the material and the spiritual in appropriate tension. The emphasis shifts to care of the consciousness rather than care of the body. It is really only the theistic perspective that enables us to hold to both the material and the spiritual worlds coherently in the context of care. Teilhard de Chardin (1976a) believed that the theistic approach is capable of “dethroning” the material by spirit while supporting matter as the vehicle through which spirit is enacted in the world. In essence then, if we are going to adopt the spiritual as part of the discipline we must come to some agreement about the nature of persons, and this agreement must maintain the critical connection between the spiritual and the material or we will fail to maintain our social value as a discipline that provides bodily care amidst health and illness.

The third and final consideration is that of scope. We have seen that the different approaches to the spiritual can change the scope of nursing considerably, particularly for the monistic theorists. Adopting the spiritual as part of the scope of the discipline carries three critical risks. First, is the risk of incompetence. A discipline is recognized through its claim to a body of expert knowledge. If we claim that the spiritual is part of our disciplinary scope then we are claiming to have expert knowledge in that area. Research has shown that not only do many nurses feel ill prepared to function in this area (Johnston Taylor, 2005), but that the spiritual is addressed only marginally, if at all, in the basic education of practitioners (Olson et al., 2003). Clearly, we can make no claim to expertise in the area of the spiritual. Second, is the risk of sacralizing nursing. Fenn (2003) has suggested that responsibility for the sacred is being placed upon the professions of our society, but we need to question whether this is an appropriate responsibility. Berlinger (2004), in the context of medicine, suggested that by adopting this role with our patients we may be further increasing the power imbalance that already occurs between healthcare workers and patients. By becoming the “experts” we may be depriving patients of their spiritual expertise during a time when they are particularly vulnerable. A common subtext within the nursing literature on spiritual care is the potential that the spiritual has to provide meaning and a source of power for nurses in their work. While this may be true, we must be careful we are not adopting the discourse of the spiritual to serve our own disciplinary ends at the expense of patients. Third, is the risk of instrumentalizing the spiritual and making it one more utilitarian approach to health. Berlinger again suggested that to use religion or spirituality as simply a means to health is to idolize the self. In a similar vein, Walter (1997) used the rather graphic expression of spiritual teachers “turning over in their graves” to illustrate how inappropriate it is to instrumentalize the spiritual in the context of healthcare. He calls it the routinization of vulnerability. And so

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59 I have borrowed the term sacralizing from Berlinger (2004) who used it in the context of the physician / patient relationship to characterize a role change whereby the physician becomes more powerful and the patient increasingly objectified.
we see that by adopting the spiritual as part of the scope of the discipline we run risks of incompetence, of sacralizing nursing and of instrumentalizing the spiritual—serious risks indeed.

So, how might we incorporate the spiritual into nursing if we accept the argument that the spiritual transcends the ontology of the discipline and should not be limited by our attempts to describe the nature, object or scope of nursing? The answer may lie in the useful conceptual separation between the discipline and the profession. As Donaldson and Crowley (1978/2004) suggested, not all the knowledge used within a profession comes from the discipline. The profession uses knowledge from other disciplines as well as forms of knowing that might not be considered knowledge in the traditional sense. This way we can hold to the common sense notion that the spiritual is important to many individuals in the context of health and illness, and yet, not create a false expectation that we hold disciplinary expertise in this area. Our focus as nurses then changes from intervening according to a normative disciplinary worldview to creating an inter-relational space where the patient's spirituality can grow and flourish. Our interventions, if they could be called such, consist of therapeutic presence and advocating for the spiritual resources that the patient requires. Further, in this relational encounter there will be varying degrees of effectiveness and connection. Those nurses who are more aware of their own spiritual being may be more effective in creating this space, and connection may be stronger between nurses and patients of similar worldviews. Many of the ways of being that facilitate this relational encounter are already a part of basic baccalaureate education: respect, caring, therapeutic presence and listening. The skills that are so foundational to caring for those in crisis are also those which help to support patients spiritually. Nurses are well prepared as advocates. This advocacy is then extended toward supporting the spiritual wishes of patients. We don't need to abdicate spiritual care simply because we may not be able to lay a claim to disciplinary expertise. In our therapeutic relational encounters we view ourselves as co-journeyers on the mysteries of life where we often receive as much as we give. We do not disengage from attending to the spiritual needs of patients, we simply refuse to take a stance of power or expertise in such a sacred area.

In summary, we can see that the various conceptualizations of the spiritual are inextricably related to attempts to describe the nature, object and scope of the discipline of nursing. Trying to create a unified perspective will inevitably result in the adoption of a narrow conceptualization of the spiritual. If we accept that a discipline is characterized by a unique way of viewing the world, we see that nursing can make no such claims in relation to the spiritual. The spiritual transcends the discipline. If we try to make it a part of our disciplinary expertise we run the risks of incompetence, of sacralizing nursing and of instrumentalizing the spiritual. Co-opting the spiritual as part of nursing's expertise results in trivializing centuries of spiritual insight and tradition. However, we can

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60 I make this separation fully realizing once again the limitations of conceptualizations. Like any typology, to divide knowledge into disciplinary and professional is a separation that would not bear out in the real world. Nevertheless, the separation helps us to make a useful distinction between what might be considered nursing's unique knowledge and knowledge that nursing draws upon from other disciplines in the enactment of practice.
continue to see it as part of the profession, particular if we view our role not as interveners but as creating a space for the expression and development of the patient’s spirituality.\footnote{Indeed, this issue of the inclusion of the spiritual into the discipline has been an excellent test case for the viability of the disciplinary ontological perspectives that promote broad, general scopes of practice in relation to well-being or expanding consciousness. In theory, these perspectives seem to promote a value of holism; however, by expanding our scope to such a broad extent we inevitably trivialize the contribution of other disciplines, potentially create poor theory, and ultimately undermine our value of holistic care.}

**What epistemological approach should be taken to the spiritual in nursing?**

To this point, we have determined that for nursing to serve a pluralistic society well, the spiritual should be explored and explicated from a variety of worldviews. Further, the spiritual transcends disciplinary concerns and any attempt to force it into the constraints of nursing’s unique way of viewing the world is intensely problematic. However, because it is often central to patient’s (and nurse’s) lives it must necessarily be a consideration within the profession. Assuming then that knowledge is required to engage in spiritual care, the question arises of what epistemological approach should be taken. Where do we draw knowledge from about the spiritual, and how do we critique that knowledge? As mentioned previously, nurses hold a wealth of knowledge about how to interact therapeutically with patients, and this same knowledge can be applied to create an environment conducive to spiritual care. But, what is important to consider is who the experts are in relation to the spiritual. From whom should we be drawing when we seek to know about the spiritual in patient’s lives? I suggest that two sources of expertise are central, theologians\footnote{I use the word theologian here partly in want of a better term. Theologian typically refers to those from theistic traditions. I am meaning to include those who hold the expertise or scholarly tradition within a particular worldview.} and patients. Here I will argue that to do justice to the spiritual in nursing we need to include knowledge from disciplines that have as their focus the spiritual. But beyond that, to ensure that we understand each patient’s unique knowledge of the spiritual, we need to approach each relational encounter with a posture of openness. I will use Munhall’s (1993/2004) work on unknowing and Buber’s (1970/1996) work on the I-Thou encounter to illustrate how these two sources of knowledge might work together in the context of practice. Munhall is a nurse thinker who has published in the area of qualitative research and nursing epistemology. Buber, as mentioned previously, was a Jewish philosopher and theologian. The works of these two thinkers illustrate how worldview knowledge can be considered alongside individual subjectivity in a dialectic that enables nurses to begin to understand the spiritual worlds of patients.

In previous chapters it was shown how the theistic, humanistic and monistic approaches provide a set of assumptions about what can be known. The theistic approach is foundational based upon revelatory knowledge, the humanistic approach upon the contributions of subjective experiences of the spiritual, and the monistic approach upon a unitary connection with a universal consciousness. All three approaches taken together provide a useful picture of the epistemological approaches that should be taken to the spiritual in nursing. Inevitably, patients bring their understandings of the spiritual into
their healthcare experience, and these understandings help shape how they navigate healthcare transitions and crises. For example, two patients experiencing suffering might frame that suffering quite differently based upon their worldview background. A patient who holds to theism might accept the suffering based upon a belief in a sovereign God or interpret it based upon the intentionality of that God. A patient who holds to monism might sublimate the suffering experience and focus on his or her expanding consciousness that transcends the physical suffering.

While this is hardly a new understanding, it helps to reinforce why it is so essential to better understand the worldviews of patients. Revelatory knowledge from sacred writings has not been given serious consideration as part of the ways of knowing within nursing. Having just come through the age of science where revelatory knowledge was considered nothing more than superstition, and the age of postmodernism where all meta-narratives were suspect, we give little disciplinary credence to this way of knowing. And yet, can we afford to ignore this form of knowledge when we know that patients and nurses alike use it as a foundational assumption for how they conduct their lives? To ignore this way of knowing is to ignore centuries of scholarly tradition and interpretation in the realm of the spiritual. This was Henery’s (2003) point when he suggested that the new spirituality is simply smuggling in value systems that are less coherent and developed than the worldviews upon which they have drawn piecemeal. Nurses should be incorporating this knowledge into practice in the same way that they incorporate knowledge from other disciplines. Some might argue that many nurses have already been writing about religious worldviews in the context of health, and this is certainly true. But, we need to ensure that this work goes beyond a view of religion as external ritual to understanding and explicating the webs of meaning that inform how individuals make sense of their experiences related to life, suffering and death. Further, we can’t assume that individuals will adopt traditional religious worldviews, we must also draw upon the work of sociologists and philosophers of religion to more fully understand the experience of religion and spirituality within our particular age. If we see our ethical mandate as engaging in spiritual care, then it logically follows that we have an ethical responsibility to understand the worldviews that our patients bring with them into healthcare.

But, understanding worldviews is not enough. Worldviews potentially provide a contextual framework of beliefs, but the spiritual also has a subjective meaning that we need to understand. Patients must teach us how they make sense of their spiritual experiences and what is meaningful to their lives. Munhall’s (1993/2004) work on
“unknowing” seems a particularly useful concept to apply to this process. Unknowing is characterized by openness. Munhall has proposed that in any authentic encounter we must lay aside our preconceived notions and judgments to understand the world of another. She described this as a process whereby we enter into relationship with personal universes characterized by our subjective views of reality but through unknowing, and the de-centering of our assumptions, we seek to know the patient and thus have a shared perceptual field. In this way, we come to understand something the meaning of the spiritual for another. I purposely use the term “something” of the meaning of the spiritual for another, because spiritual journeys are often characterized by mystery. We do not fully understand the meaning of certain experiences, particularly those of suffering. But, we can hope to share in the patient’s experiences and current interpretations of those experiences. This process of unknowing provides rationale for why nurses need to understand their own position in relation to the spiritual, for it is difficult to de-center assumptions that have not been explicated. They remain hidden biases that continue to shade our view of the world. The better we are able to explicate our own worldviews, the better we will be able to understand those of others.65

Martin Buber (1970/1996) provided a useful explanation of this dialectic process of balancing worldview knowledge and subjective knowledge about the spiritual. Buber characterized the world as consisting of two realms “It” and “You”. “It” refers to the realm of experience and conceptual knowledge. “You” refers to the realm of relationship. Both are essential to existence, and it is our capacity to engage in a dialectic process between the two that facilitates the growth of the spiritual. The world of “It” is necessary because only through conceptualization and ordering of objects can we make sense of and store our knowledge about the world. In the “It” world knowledge is essentially locked, but “whoever unlocks it and beholds it again as present, fulfills the meaning of that act of knowledge as something that is actual and active between men” (p. 90-91).66 As spirit is found in the relationship between “I” and “You”, this unlocking of “It” knowledge in the relational encounter allows us to engage in spirit while holding to frames of meaning about the world. For example, our understandings of worldviews are a part of the “It” realm, a way to organize our knowledge about how individuals might perceive reality. However, when it comes to a spiritual relational encounter we unlock that knowledge through a process of unknowing. We enter into an inter-relational understanding of meaning, a spiritual encounter, and we gain new understanding which must then be stored as “It” knowledge of that particular individual. So, as nurses we enter a relational encounter with a patient and in the early process of that encounter we discover a piece of information that leads us to place a patient within a particular worldview. In a spirit of openness, we explore further the shades and nuances of the meaning of that worldview for that particular patient which we then store as unique knowledge.

65 This is typically a difficult process. Sometimes the result of becoming “increasingly spiritual” is a tendency to ascribe our reality to others. Instead, part of our aim in “becoming spiritual” is to unpack our assumptions so that we can lay those aside to try and understand the positions of others.
66 Buber makes an insightful observation of how often we attempt to yield power by refusing to unlock the “It” knowledge. That is, we hold to a particular conceptualization and use it to force our way in the world.
Buber (1970/1996) warned against using the I-You encounter as a way to manipulate or cause some effect in another. Our tendency is to want to use the “It” world to predict how we can intervene to cause some desired change. While acknowledging the fundamental importance of causality in the natural realm, the spiritual I-You encounter is an encounter of reciprocity, not “tainted by any causality” (p.100). He believed that in “sick ages” we become preoccupied with causality which becomes an oppressive force, squeezing the life out of the I-You encounter. This principle is particularly important when engaging in the process of unknowing as described by Munhall (1993/2004). Our intent is to know the world of another for the sake of understanding and support, not to use that knowledge to cause some desired spiritual effect.

This understanding of the I-You encounter is probably one of the most compelling arguments against the use of the nursing process67 in the enactment of spiritual care. The nursing process represents the “It” world and only captures a moment in time. It fails to acknowledge the dynamic, limited nature of spiritual understanding or the relational encounter upon which it is based. Each process of unknowing could indeed reveal different knowledge, because patients are always in process, particularly during critical life events. Further, patients will choose to reveal facets of their spirituality based upon the nature of the relationship between the nurse and the patient. Patients will simply feel more comfortable with some nurses than others, and that will influence this process of spiritual encounter. The nursing process, within some theoretical understandings, also implies an intent of causality. We implement interventions which are likely to cause the outcomes we envision thus potentially contributing to the oppression that Buber (1970/1996) warned against. Although the nursing process may be a useful heuristic to consider some of the physical aspects of nursing practice, it may oppress the relational encounter of spirit when used to address the spiritual in healthcare.

To this point we have seen that each conceptualization of the spiritual contributes something essential to our epistemological approach and that the understanding of worldviews, sometimes contained in theological or revelatory knowledge, provides an important contribution to nursing practice. Further, a dialectic process of knowing and unknowing in the context of care helps us to understand the meaning of the spiritual for each patient. This leaves one remaining question and that is, what is the role of critique in this knowledge? In the process of coming to know the spirituality of patients, are there times when it is appropriate for the nurse to identify “harmful religiosity” (Johnston Taylor, 2002a) or spirituality, and to intervene toward an outcome that the patient may disagree with—for the nurse’s knowledge of the spiritual to pre-empt the patient’s knowledge of the spiritual? In some cases, this would be entirely appropriate. For example, a patient who is hospitalized for religious delusions might indeed need to have

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67 My argument against the nursing process is really against the use of the nursing process in a particular way. As Varcoe (1996) has suggested, the meaning of the nursing process is not self evident. I am essentially arguing against a process that attempts to standardize a set of normative diagnoses, goals and interventions that are used to influence a patient toward a pre-specified spiritual outcome (see Pesut & Sawatzky, 2005 for more of this argument). An example would be the standardized spiritual care plan proposed by Johnston Taylor (2002) where the nurse simply ticks the appropriate boxes. I am not arguing against the moment by moment assessment and reasoning process that characterizes the cognitive work of the nurse when interacting with patients.
those delusions reframed. But, what about the patient who feels certain they will be divinely healed, or the patient who refuses pain medication choosing instead to experience suffering, or the patient who believes that God has led them into a "dark night of the soul" for character development and refuses treatment for "depression"? What is the nursing role or obligation when spiritual or religious claims contradict what nurses consider healthy behaviours?

An example might help to illustrate the potential complexity of an interaction of this nature. Consider a diabetic patient who believes in divine healing. The patient believes he has received a personal revelation that his diabetes will be healed, and as a result, refuses to practice diabetic self-care. He believes that any sort of medical intervention would be a lack of faith in the promise of divine healing. His knowing consists of a doctrinal belief in the ability of God to miraculously heal and a personal revelatory knowing of a promise. The nurse, on the other hand, knows the consequences of uncontrolled blood sugar and knows that in many cases patients choose to hold to unrealistic hope or to find reasons to not follow diabetic regimes. How does the nurse approach a situation of this nature? Using the principles outlined above, the nurse could fully explore the understandings of the patient in relation to this situation. Ideally, this would entail momentarily de-centering his or her assumptions about divine healing and personal revelation to more fully understand the patient’s perspective. Beyond that, the nurse also has a responsibility to educate the patient about the consequences of failing to practice self-care. Further, the nurse could sensitively and diplomatically introduce nursing knowledge about similar trajectories that patients take when trying to adjust to chronic illness. It might even be appropriate for the nurse to try to negotiate a solution that would allow the patient to stay true to his revelatory knowing while continuing to engage in self-care. However, a critical inter-relational boundary may be crossed if the nurse attempts to re-create doctrinal beliefs or personal revelation. Nurses need to know the boundary between facilitating a healthy outcome and protecting the rights of patients to hold to the webs of meanings that characterize their particular hopes in the world. Knowing this boundary is perhaps one of the most challenging aspects of the spiritual inter-relational encounter, and a boundary that has not yet been delineated well in the spiritual care literature. This final example is also an ethical dilemma that arises out of different views of the world between science and religion which naturally leads us into our last question, what ethical approach should be taken to the spiritual in nursing?

*What ethical approach should be taken to the spiritual in nursing?*

I have argued that to serve a diverse population we need to maintain a worldview approach to the spiritual and that although we cannot lay claim to disciplinary expertise about the spiritual, it remains an important consideration in the enactment of the professional care. Further, I have argued that expert sources of knowledge about the spiritual come from disciplines for whom spirituality is legitimately their area of expert

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68 This principle must be taken in context. There are cases where it may be important to challenge beliefs or personal revelation if they are not in keeping with credible religious claims. However, in this case there is fairly widespread acceptance of divine healing within particular religious traditions.
focus and from patients. This brings us the final, and perhaps most important question, what ethical approach should we take to the spiritual in nursing?

In previous chapters a number of ethical considerations were discussed: the relationship of the spiritual to ethics, the definition of health and well-being, the guarding of patient choice and dignity, the challenge of potential nursing incompetence and the need to serve a diverse population. The dialogue contained in chapter 5 demonstrated that the three conceptualizations of the spiritual lead to different conclusions about the relationship of the spiritual to ethics. For the theist they were inextricably bound, for the humanist they were related, for the monist they were separate, or at least distant. Concepts of well-being varied in the emphasis that was placed on the material versus spiritual, with the monistic position placing the heaviest emphasis on a view of humans that transcends physicality. It was shown how issues of coercion are always a potential when we locate ourselves as nurses within a particular worldview approach. Nurse's competence to engage in spiritual care depends upon the approach one takes to the spiritual in practice. And finally, it was shown how certain worldview approaches may have difficulty serving the needs of a diverse population. In this section I will argue that ethics and the spiritual are inextricably bound and that our overarching ethical responsibility as nurses is to create a context that is sensitive to, and respectful of, the patient's view of the spiritual. Unlike the freedom that we have to support various conceptualizations of the spiritual, because nursing is moral practice, we have an obligation to come to an agreed upon ethical approach to the spiritual in nursing. The CNA Code of Ethics for nursing locates ethics within a framework of accountability to the patient, and in doing so, is an appropriate guide for the support of patient's spirituality in practice. Finally, I will discuss four ethical responsibilities: guarding against coercion, ensuring patient confidentiality, promoting reflection about nurses own positioning in relation to the spiritual and serving the needs of a diverse society.

Pierre Teilhard de Chardin (1975) provided a discussion of the question of whether moral science can dispense with a metaphysical foundation. He defined moral science as a "coherent system of action, accepted by necessity or agreement" and metaphysics as "every solution or vision of the world (of life) 'as a whole'...whether that solution of the complete world imposes itself on our intelligence, or whether it is adhered to categorically as a choice or a postulate" (p. 130). He suggested that any moral science presupposes a certain view of the world and that the multiple definitions of good, evil and obligations are indicative of the many solutions to the world. Obligations are derived from the philosophical metaphysic that establishes the relationship between individual freedom and the universe. A metaphysic provides the motivation for action, and in turn, a metaphysic is tested by the moral system that derives from it. So, descriptions of the spiritual, insofar as they portray a "solution or vision of the world" are logically related to ethics. Our definitions of the spiritual are by nature inherent value judgments about what is good and right (Bash, 2004).

This connection between ethics and a metaphysic can be seen in the three approaches to the spiritual in nursing described in this work. The theistic approach starts from a metaphysic of a covenantal God. Individual freedom is envisioned within a
voluntary service to God which produces a set of ethical criteria for how that service should occur. The humanistic approach starts from a metaphysic of humanity. Ethical criteria reflect an evolving and diverse perspective of what best serves humanity. The monistic approach also results in an ethical framework, even though some might argue that the spiritual and ethics are unrelated. The metaphysic of connectedness and progress tends to result in an ethic of human unity and hard work (Teilhard de Chardin, 1975). This ethic is apparent in the continuing attempt by the monistic theorists to lay claim to a new view of the world that should replace all old views. This ethical approach is also apparent in the work of Walsh (2004). Two metaphysical assumptions characterize his view, that we are all interconnected and that we bear no accountability to an external God. These assumptions result in an ethical emphasis on working hard to do what is right so that our progress and health as a unified universe can be assured. His definition of doing what is right is located within an understanding that our behaviour affects the universe of consciousness in a unitary way. So we can see that any attempt to draw a distinction between the spiritual and ethics is impossible. Even a metaphysic that we have failed to reflect upon will ultimately affect our values and choices.

So, if our conceptualization of the spiritual inevitably results in an ethical system, we are back to the question of negotiating the diversity of perspectives. Some coming from a theistic perspective have argued that their position holds the truth about the world and so they are in the best position to implement effective strategies for the goal of spiritual well-being (Fawcett & Noble, 2004). Others have argued that to take such an approach is actually a denial of human rights in a pluralistic society (van Loon, 2005). The monistic approach at first glance appears less ethically intrusive, because it focuses on such agreeable goals as connectedness and becoming, and typically does not make claims about how one should be in the world. However, it too reflects a philosophical base that may not be acceptable to patients, particularly those from a worldview of theism. Further, without a normative ethical perspective we have no way to determine what is good and right to do in practice (Thorne et al., 1998). So then we are left with the humanistic conceptualization. Perhaps a humanistic metaphysic could provide common ethical grounding.

To test this argument we need to go deeper and look at the argument that is being seen increasingly in the nursing literature, that we have an ethical responsibility to attend to the spiritual dimension of patients. The argument goes something like this, we say we provide holistic care, the spiritual is a dimension of the person, and so we have an ethical responsibility to attend to the spiritual dimension. By not doing so, we are committing an ethical violation, we are “neglecting fundamental nursing obligations in a situation where the nurse knows that the action or lack of action is not appropriate” (CNA, p. 5). But what does attending to the spiritual dimension mean? Is it working to ensure that we create a sensitive and respectful environment for the patient’s spirituality, or does it mean intervening toward some normative view of what the spiritual should look like? The ethical implications of these positions are quite different. The tension between these two approaches is apparent in a chapter by Simington (2004) entitled “Ethics for an Evolving Spirituality” in a recent Canadian textbook on nursing ethics. Simington proposed that spirituality is simply the capacity to live fully and suggests that we have a void of soul.
healing in healthcare. She believed that nurses have an ethical responsibility to advocate for patients in a way that removes any barriers to full living. Her exemplars include supporting a patient who chooses alternate instead of conventional treatment, allowing a dying mother to hold her infant, and listening to an elderly person's life review. These examples illustrate creating a sensitive and respectful environment for patients, something that few individuals would argue with. Indeed, her examples are simply good nursing care that respects the wishes of persons to the ultimate extent possible. However, there is another sub-theme to her chapter and it is that of soul healing. She wrote of her own practice of using a variety of interventions to help heal the soul of patients. These interventions imply a normative view of the health of the soul toward which we work as nurses, and here is where the ethical challenges arise. For example, the desired normative outcomes of spiritual well-being are often described in the literature by positive emotional referents. However, centuries of spiritual tradition in a variety of worldviews suggest that suffering (and by implication negative emotional referents) is a necessary road to spiritual growth, and many patients take comfort in that knowledge when enduring illness. If we adopt a normative worldview that denies the potential spiritual power of suffering we may, with the best of intentions, end up further disempowering patients during vulnerable times. So, even a humanistic approach has the potential to be coercive if we construct the nursing role as spiritual intervention toward a disciplinary defined outcome.

Part of the motivation for needing to go beyond simply supporting patients in their spiritual perspectives comes from the need for renewal of the nursing profession. A sub-text of the dialogue on the spiritual in nursing is how integration of this concept promises a renewed source of meaning and status for the profession. Watson's (2005) work is an excellent example of this. She has included outcomes of attending to the spiritual for nurses as purpose, self-esteem, gratitude, fulfillment and ultimately a love of nursing. Parse (1998) and Barnum's (2003) work promoted new, expanded and independent roles for nursing. However, this professional renewal must not be allowed to occur at the expense of our primary accountability to the patient. If the conceptualizations of the spiritual that we adopt do not support the worldviews of our patients, then we are not fulfilling our social responsibility as a discipline. In light of this, I suggest that our ethical responsibility for the spiritual rests with creating an environment that is sensitive to, and respectful of, the patient's spirituality, or absence of, as the case may be. Indeed, a key part of an ethical obligation is that patients agree that this is an obligation owed to them by nurses, and research suggests that this may not always be the case. Not all patients see spiritual care as a legitimate role of the nurse (Johnston Taylor, 2005). Many nurses are citing policy papers, accreditation standards and charters as the authority for this emphasis on the spiritual in nursing. But, these documents emphasize providing a context to support the spirituality of a diverse group of patients rather than an interventional disciplinary based spiritual mandate.

If we agree that the primary focus of our care of patients in the area of the spiritual should primarily be one of support and facilitation, the CNA Code of Ethics for Registered Nurses becomes an appropriate guideline. Because it clearly locates

69 It is important to note that Simington has advanced training in the area of soul healing.
professional ethics within a framework of primary accountability to the patient, it provides useful criteria for how we might evaluate our ethical integration of the spiritual into nursing. We can then ask what our ethical responsibilities are in relation to the spiritual. There are four primary responsibilities: guarding against coercion, ensuring patient confidentiality in such a highly sensitive area, ensuring that nurses are reflective about their own positioning in relation to the spiritual, and serving the needs of an increasingly diverse society.

The CNA Code of Ethics makes clear statements about the responsibilities of nurses in relation to patient choice and dignity: “Nurses must be sensitive to their position of relative power in professional relationship with persons. Nurses must identify and minimize (and discuss with the health team) sources of coercion” (p.12).

Nurses must recognize the vulnerability of persons and must not exploit their vulnerability for the nurse’s own interest or in a way that might compromise the therapeutic relationship. Nurses must maintain professional boundaries to ensure their professional relationships are for the benefit of the person they serve (p.13).

Patients often enter healthcare during times of intense vulnerability related to sickness or developmental challenges. Their dependence upon healthcare worker’s knowledge, and the depersonalizing effects of institutional care only compound this vulnerability. In this context, we can see how spiritual presuppositions brought into the encounter by healthcare workers, particularly if they are used as the basis for intervention, have the potential to increase this vulnerability. Berlinger (2004) identified key ethical questions in relation the spiritual and healthcare worker’s perspectives. Should we condemn what we perceive to be unhealthy spiritual practices if they are meaningful to the patient? Should we be encouraging patients to accept spiritual practices that we believe are healthy? Where do we unwittingly introduce our own dogmas into care? She used the example of defining spirituality as a concept apart from religion as one particular dogma. The example used in chapter 5 of the patient who did not want to offend the nurse who had been so kind to her, even though the nurse was offering a spiritual intervention that was foreign, illustrates this point well. The nurse, enthusiastic about crystal therapy, provided the patient with a crystal for healing believing that this was an appropriate spiritual intervention. The issue of giving offense in the context of a nurse patient relationship goes far beyond what would happen in a normal interpersonal encounter. The patient will continue to be dependent upon the nurse and so will have to consider whether not accepting the offered spiritual intervention will impact the nurse’s willingness to provide care in other ways.

The issue of patient vulnerability, and the ethical responsibility for patient choice and dignity, support the argument that our goal in the context of spiritual care should be to create space for the enactment of patient spirituality rather than intervening by some predefined professional idea or norm. Most spiritual care textbooks propose nursing interventions to develop patient’s spirituality, (e.g. prayer, meditation, journaling, talking about spiritual difficulties) and yet, Johnston Taylor and Marnier’s (2005) research has suggested that patients are looking for nurses to support their independent practices of
spirituality, not to intervene with them in a personal way. As discussed previously, we have the expertise to suggest that some behaviours may not contribute to health, but we do not have the right to promote spiritual practices that we believe may contribute to health if they are in conflict with what patients believe. This is particularly important to emphasize for the energy and consciousness based alternative therapies which, although they are being presented as spiritually neutral therapies, many believe to be spiritually unhealthy. Under no conditions do we have the right to take advantage of vulnerabilities to promote our own spiritual agendas in the healthcare encounter. Our focus is to create space for authentic expression and exchange. We seek for understanding of the patient’s spiritual preferences and follow those wishes (Winslow & Winslow, 2003). Does this mean that we should never be allowed to share our own expressions of the spiritual? I do not believe so. To take this position would mean that we would not be authentic in our relational encounters. True authenticity means that we share our own hopes and beliefs when desired by the patient. The literature is replete with stories where the sharing of spiritual perspectives benefited both nurses and patients.

The second risk is that of patient confidentiality. The Code of Ethics states the following:

Nurses must disclose a person’s health information only as authorized by that person, unless there is substantial risk of serious harm to the person or to other persons or a legal obligation to disclose. Where disclosure is warranted, information provided must be limited to the minimum amount of information necessary to accomplish the purpose for which it has been disclosed (p. 14).

The argument that a comprehensive spiritual assessment should be documented for quality assurance and communication purposes must be weighed against the consideration that patients have a right to confidentiality of the information they disclose. Most patients will accept that certain factors related to their care will become part of a permanent healthcare record. However, the assumption is that this documentation will be related to the needs for which the patient has sought help and that the patient views this as a legitimate role of the professional. We cannot assume that patients see spiritual care as a legitimate nursing function (Johnston Taylor, 2005). If in the context of care patients choose to disclose personal details related to the spiritual, we also cannot assume they would agree to these personal details being part of their healthcare record. The guideline that suggests that any disclosure should be kept to the “information necessary to accomplish the purpose for which it has been disclosed” is a useful one to consider in the context of the spiritual. Many patients choose to confide in the nurse because they need support and encouragement, and they choose who they will confide in carefully. Indeed, the purpose of that disclosure may be accomplished within that particular relationship and moment in time. We cannot assume that the patient would like similar moments of intimacy to occur in other healthcare encounters.

However, there may be times when communication is vital across the healthcare team. For example, some patients may require a particular diet or desire at certain times to be left alone for spiritual contemplation or support by significant others. Spiritual care
interventions that extend beyond therapeutic presence should be documented just as other interventions would be documented. The caution here is against indiscriminately exposing patient’s most intimate hopes and meanings. Nursing diagnoses are also recommended as part of the documentation in the nursing literature, but again, we need to question whose purposes we are serving. Are we trying to make visible our own work and worth at the expense of the patient? Does recording a diagnosis contribute to care or simply serve to medicalize and objectify this most mysterious and intimate dimension? Ensuring that patients agree to what would be documented, and considering the purpose for which the information has been disclosed, will help to guard patient confidentiality in this personal area. An excellent test of the documentation of spiritual assessment and diagnoses would be to see how patients respond to what is recorded on their health record.

The third ethical responsibility is that nurses will be clear and reflective about their own positioning in relation to the spiritual. The Code of Ethics states that “nurses should be sufficiently clear and reflective about their personal values to recognize potential value conflicts” (p. 9). Much of the literature on spiritual care education emphasizes the importance of having nurses clarify their own positioning in relation to the spiritual, and I agree that this is essential. However, in this values clarification it is important to pay attention to what has traditionally been allowed or disallowed in the context of discussion. What worldview perspectives are voiced, and what worldview perspectives are silenced in the educational context? It is popular in nursing education to base curricular frameworks on philosophies such as critical social theory or feminism. As such, these ideologies become legitimate frameworks for discussion and debate. However, as society has become increasingly concerned with separating religion from the public realm, religious dialogue has essentially been silenced in the forum of public education. It is considered inappropriate to discuss personal religious views in the public context. I have argued elsewhere that we need to find ways to create safe and inclusive environments for these discussions to occur (Pesut, 2003). After all, how can we expect students to competently and sensitively address the realm of the spiritual in practice, if they have not first had the chance to engage these discussions in the classroom? It is in the context of dialogue that we learn to articulate our positions, understand and respect the positions of others and begin to grapple with the similarities and differences between those positions. If we are going to advocate for dialogue among worldviews in society, then we need to be able to take that same risk within nursing education. By silencing these discussions we inadvertently contribute to a culture that allows ideas about the spiritual to enter the mainstream nursing literature with little critical debate.  

This brings us to the ethical responsibility of ensuring that our enactment of spiritual care is always sensitive to the needs of an increasingly diverse society. The Code of Ethics states that nurses “must not discriminate in the provision of nursing care based

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70 I understand some of the challenges inherent to what I am recommending here. My goal is not to create a classroom scenario whereby students challenge and or promote religious worldviews. Rather, my goal is to make room for an area that has been somewhat silenced. Doing this presents a real challenge for educators, and I have written on this more extensively in another forum (Pesut, 2003).
on a person's race, ethnicity, culture, spiritual beliefs" (p. 15). Nurses are called to uphold justice for all. However, this can be difficult given that different cultures bring fundamentally different social values into healthcare. In an insightful article Douglas Todd (2005) wrote about what he called the unseen moral values that many Eastern immigrants bring to Canada. These values are characterized by a respect for social order, past and tradition; a social as opposed to an individualistic orientation; and an otherworldly emphasis as opposed to a focus on control wealth and power. We need to ensure that our enactment of the spiritual is not unconsciously informed only by a Western orientation. Our emphasis on a highly individualistic, present time oriented spirituality needs to be tempered by the cultural orientations that focus more on community and tradition. However, negotiating competing claims in the context of healthcare may not always be easy, particularly when they conflict with legal criteria and economic realities (Buryaska, 2001). Part of our work ahead in the area of the spiritual within healthcare lies in discovering how to negotiate competing claims in a spirit of equity and justice.

Summary – Creating Inter-relational Space

In this chapter I addressed the question of what approach should be taken to the spiritual in nursing. In summarizing the conclusions of how we should be approaching the spiritual in nursing, the concept of inter-relational space seems to be an appropriate one. I introduce this concept tentatively, fully appreciating its undeveloped nature. Although development of the concept of inter-relational space is beyond the scope and purpose of this work, this is an important area for ongoing inquiry. Indeed, it would be useful to look at the intersection between the spiritual literature and the wealth of literature already present in nursing that examines relational development between nurses and patients, and to incorporate literature from disciplines such as chaplaincy that have traditionally been concerned with spiritual relational encounters in the healthcare context. I will begin, however, by suggesting some important principles of spiritual inter-relational space in nursing theory, practice and education.

In our theoretical development of the spiritual in nursing we resist the temptation to relativize differences and to assume that what is discovered about the spiritual within one worldview will necessarily translate into others. We need to keep spirituality and beliefs firmly connected, seeking to discover the characteristics of the spiritual worldviews currently operating in society. In this discovery, we liberally draw upon scholarly traditions related to the spiritual. We create an inter-relational space where we compare and contrast ideas both within and among these worldviews in a spirit of dialogue, maintaining a critical tension between articulating our own beliefs and being open to the wisdom and ideas of other.

In our practice of the spiritual in nursing, we focus on creating an inter-relational space where patients feel comfortable engaging in their own spiritual practices in a supportive environment. Key to creating this space is refusing to adopt the role of expert or intervener in the spiritual life of another. We must firmly resist all attempts to use the spiritual as a means to disciplinary gain. Our temptation will be to co-opt the potential
power of the spiritual as a means to advancing the importance of the nursing role in healthcare. The paradox, however, is that as we serve patients well in this area they will benefit greatly from nursing presence, thus indirectly benefiting the profession. So, what makes the difference? When do we step over the line between serving nursing’s needs as opposed to patient’s needs? I believe it is when we adopt a stance of control over patients, whether that control be as subtle as the intentional manipulation of consciousness or as overt as pre-defining spiritual interventions and outcomes toward which we attempt to direct patients. Buber’s (1970/1996) admonition that true spiritual inter-relational space is not pre-occupied with causality is an important one. Nurses enter into a spiritual relational space where the spiritual “work” is often characterized by mystery, and where the benefits of the encounter flow just as readily from patient to nurse as from nurse to patient.

In our education of the spiritual in nursing we teach nurses how to take part in this inter-relational encounter. As part of generic nursing education, nurses are already well prepared in relational skills and advocacy. They learn to listen well, to engage therapeutically and to discover and advocate for patient wishes. Beyond that, we need to create relational spaces in the classroom for students to explore worldview perspectives of the spiritual, both generally in society and specifically in their own lives. Students need to grapple with their own beliefs, understanding how these might potentially intersect with the beliefs of others in the context of healthcare. The curriculum should include courses in religious and worldview understandings alongside courses in psychology, sociology and biology. If we take seriously the ethical mandate to care for the spiritual needs of our patients, then we have an ethical responsibility to help students acquire the insight and the knowledge they will need to do that well. The nursing process is a tool frequently used to help students think about the care they deliver, but we should be wary of using this learning tool in the context of spiritual care. We run the risk of socializing students into thinking about spirituality as a diagnosis to be made and a problem to be solved rather than as a relational encounter. We give them the false impression that the mysteries of life and suffering that so often come to the forefront in healthcare are something to be resolved. We must hold fast to the belief that the spiritual journeys of our patients may always remain shrouded in mystery, while acknowledging that a human supportive presence, particularly one that provides expert nursing care, can make all the difference on the experience of that journey.
Chapter 7
Summary and Conclusions

Language is the place we stand on in the spiritual universe. For out of the word by which we grasp our world and our own being all other spiritual creations grow: knowledge and the arts, social traditions and philosophical beliefs. The word gives man the strength to build a world above the given world (Tillich, 1963b, p. 150).

The purpose of this work has been to investigate and clarify the various conceptualizations of the spiritual and spiritual care in nursing literature; to discuss the implications of these conceptualizations for nursing's ontology, epistemology and ethics; and to argue for a particular approach based upon the moral and pragmatic nature of nursing. A literature review explored understandings of the spiritual in Canadian society and nursing. Three Canadian societal trends are important in relation to the spiritual: the changing role of religion in society; the emergence of a new individualistic spirituality; and the changing epistemological landscape that has opened the door for alternative ways of knowing, potentially leading to new understandings of religion and spirituality within the academy. The development of the spiritual in nursing can be thought of as reflecting three understandings: the religious, the scientific, and the existential/postmodern. The current literature on the spiritual in nursing is characterized by three debates: the conceptualization of the spiritual, the relationship of the spiritual to science and the relationship of the spiritual to religion.

I then addressed the central questions of this work. What are the various conceptualizations of the spiritual and spiritual care in the nursing literature? What implications do these conceptualizations of the spiritual have for nursing’s ontology, epistemology and ethics? What approach should we take to the spiritual in nursing? In chapter 4, a set of questions was posed to help us understand how leading nurse theorists are conceptualizing the spiritual and spiritual care in nursing and how their conceptualizations influence nursing ontology, epistemology and ethics in relation to the spiritual. A distillation of the work of nine theorists was presented along with some of the potential dilemmas inherent in their positions. In chapter 5, a set of questions was posed to help explore the worldview approaches to the spiritual of theism, monism and humanism, and the implications of these worldviews for nursing’s ontology epistemology and ethics. This was accomplished through a hypothetical dialogue between a narrator and participants representing the three worldview approaches. This chapter concluded with a set of questions that could be used to analyze the foundational assumptions of any theorist writing on the spiritual in nursing.

Chapter 6 addressed the question of what approach we should take to the spiritual in nursing. In response to the question of agreement on the spiritual, I argued that it is not possible to expect agreement on the conceptualization of the spiritual in nursing. Rather, we should be focusing our energies on understanding the worldviews that characterize spirituality in society and promoting dialogue among those worldviews. In response to
the question of whether we should be creating normative claims about the spiritual as part of the ontology of the discipline, I argued that if we accept that a discipline is a unique way of viewing the world, and holds a particular expert body of knowledge, then we have to acknowledge that the discipline of nursing can make no such claim in relation to the spiritual. However, we can see it as a vital part of the profession where our role is not as interveners but as those who create a space for the expression and development of the patient’s spirituality. In response to the question of what epistemological approach should be taken to the spiritual in nursing, I argued that knowledge of worldviews, including theological and revelatory, should be incorporated as part of the profession and that a dialect of knowing/unknowing in the context of the care helps us to understand the meaning of the spiritual for each patient. In response to the question of what ethical approach should be taken to the spiritual in nursing, I argued that the spiritual and ethics must be logically connected, and that the CNA Code of Ethics, with its emphasis on primary accountability to patients, is an appropriate framework to evaluate the ethical conduct of nursing care in relation to the spiritual. Responsibilities of guarding against coercion, ensuring patient confidentiality, promoting reflection about nurse’s own positioning in relation to the spiritual and serving the needs of a diverse society provide a foundational starting point for providing ethical care. I concluded this chapter with a description of how we should be approaching the spiritual through the concept of inter-relational space in our research, our practice and our education.

The method used in this work has both strengths and limitations. The typologies of theism, monism and humanism have been useful in teasing out the areas of difference among the various perspectives and in illuminating the implications of those differences for practice. The use of conceptual typologies allowed me to freely explore these three positions on the spiritual, including their potential advantages and limitations, thus helping to clarify how nursing should be dealing with this complex aspect of care. However, these very strengths have resulted in parallel limitations. I wrote as if these categories were discrete and static in the real world. This idea was reinforced by the categorization of theorists, when it might be argued, that there is just as much variability among theorists within a category as theorists between categories. Further, when highlighting the implications of a position there is always a tendency to focus on what stands out as unique or troubling with a particular perspective rather than upon areas of confluence. Finally, the arguments in the final chapter are challenging in that they deconstruct and problematize some of the trends within the spiritual nursing literature without a comparable emphasis on the ways that nurses do make a significant difference in the spiritual lives of patients. That is always the risk of a work of this nature. Perhaps, this deconstructive approach could be justified in the context of a rather large body of literature that already makes visible the nursing role in the care of the spiritual.

I have characterized this philosophic work as a journey, a journey that rather than being complete with this conclusion, is simply at a resting point along the way. For a philosophic endeavour should result in two things, another set of questions to explore and direction for social conduct. And so, I would like to conclude this work with a set of questions that could represent the next phase of this journey and the direction for consideration of the spiritual in nursing that is the central message of this work.
What are the worldview approaches patients are using to account for their experience of, and growth in, the spiritual? I concluded in this work that we need to promote understanding, dialogue and critique among worldview approaches. But, what are those worldviews given the individualistic nature of much of current spirituality? With a percentage of the population claiming that they are spiritual but not religious, and concerned about the nature of God, the meaning of life, and the existence of an afterlife, we must ask what they are drawing upon to answer these fundamental questions. How are patients making transcendent sense of their experiences of development, illness and suffering, and what sources are they drawing from in their construction of these beliefs?

Who are the experts in terms of worldview knowledge? In this work I argued that we should be drawing upon those who have a claim to expertise in the spiritual. Certainly, theologians with centuries of scholarly tradition would qualify as experts, but what about those voices not traditionally associated with theology? What determines expertise? Is it longstanding disciplinary recognition, longstanding tradition, or simply the ability to construct a worldview that captures the imagination of the populace?

What factors contribute to a safe and supportive environment for the expression of patient’s spirituality in healthcare? In this work I argued that our ultimate goal should be to create a space for the expression of patient’s spirituality. But, what does that look like? What kind of climate do we need to be working toward within our institutions? What do patients want from us as healthcare workers? What interpersonal factors contribute to a spiritual encounter between nurses and patients? How do patients feel about the approaches currently being recommended within the spiritual care literature? We need to continue to empirically explore the patient responses to the theoretical positions being taken by nurses in the area of the spiritual.

How should we negotiate competing religious and spiritual claims when there are conflicting legal, ethical and economic realities? In this work I argued that because of our multicultural society we need to negotiate these claims in a spirit of justice and equity. One of the most immediate pressing claims is that of alternative therapies, in particular the nurse initiated energy based interventions. What potential risks do they carry, and what constitutes competence? If they are based within a worldview, how do we safeguard against coercion or potential harm to a dimension of the patient that we as yet know little about?71

In conclusion, it seems to me there are three potential pitfalls that as a profession we must avoid as we continue with the integration of the spiritual in nursing. The first is contained in the quote by Buber (1970/1996) that began this work, taking the noetic or validity out of the spiritual. Such was the result of the age of science. We traded the world of the spirit for the world of physicality. Discourse on the spiritual in nursing...

71 As I was writing this final chapter I noticed an advertisement in a nursing magazine that typifies my concern. It was a course on Integrative Energy Healing and promised a three year program of expertise taught in four - 4 ½ day retreats. If these healthcare interventions are as powerful as they claim to be, and if a mature spiritual consciousness is their basis, then we need to question this type of preparation.
became essentially invisible. In that respect, the burgeoning interest in our society about
the spiritual is heartening. Nursing has a longstanding tradition of holistic care that
includes attention to the spiritual in nurse patient encounters. Seeing this care become
visible in the nursing literature is an important step forward, for as Tillich (1963b)
suggests in the quote that began this chapter, language is essential to the construction of
the spiritual in humanity. By beginning to “language” the process of spiritual care in
nursing we are helping to create and make room for the spiritual. We are validating and
helping to build a world where nurses and patients can find meaning and sacredness in
their daily lives.

Further, it is encouraging to see the diversity of viewpoints and emerging roles for
nurses that characterize this literature. Theorists are helping to make visible those
populations that have been so invisible in this dialogue (e.g., Narayanasamy & Andrews,
2000). The tendency within traditional religious dialogue has been to dismiss those who
hold to an unchurched spirituality as simply theologically wrong without a serious
engagement with their ideas and an acknowledgement of the sincerity of their spiritual
journey (Fuller, 2001). The nursing literature has provided a respectful forum for these
ideas. Along with diversity of ideas has come diversity of roles. Roles such as spiritual
healers and parish nurses provide new avenues for nurses to respond to the needs of
particular populations in the context of their spiritual beliefs and traditions. Truly, nursing
seems to be leading the way in healthcare to making visible, and hence lending validity
to, the spiritual.

However, despite our progress in validating the spiritual, I fear we are now
bordering on the second potential pitfall, that of objectifying the spiritual so that its
inherent power becomes harnessed as an instrument of control. Despite wide
disagreement on what the spiritual is, there is general agreement that it is an essential
power for human existence and growth. Indeed, perhaps it could be agreed that it is the
most fundamental power of life. Ultimately then, we must grapple with the use of this
power, asking ourselves how we are using it and to what end. We would do well to
remember Foucault’s perspective that our knowledge and power are intricately related,
and that our knowledge has the power to create and re-create our subjects (Honderich,
1994). How we choose to build our knowledge around the spiritual will ultimately dictate
the relations of power that will characterize those interactions. William James (2002) had
an interesting perspective on the typical evolution of corporate religious life. He noted
how a particularly charismatic individual would attract disciples, who in turn would
attract sympathizers, who in turn would build ecclesiastic institutions that resembled
ambitious corporations. Such could be the fate of the spiritual in nursing. We need to
guard against particular characterizations of the spiritual that attract disciples who in turn
become powerful disciplinary forces that are more concerned with disciplinary status and
progress than caring for the spiritual needs of those who have been entrusted to them. At
all costs, we must guard against the use of spiritual power for personal or disciplinary
gain.
In reaction to this objectification we cannot make the third mistake, that of opening the nature of the spiritual to the point where it becomes everything, and hence, nothing. We are rightly concerned about being inclusive in our perspectives and in trying to find a language through which we can engage these ideas. Tillich (1963b) recognized that the foundation of a strong spiritual universe rests in a common language, and that we lack that common language today. “Our period is weak, because we can no longer speak to each other. Each one has his own language, and the word has lost its power. It has become shallow and confused. We have experienced earthquake and exile in the spiritual world” (p. 151). However, it is important to differentiate between a common language and a normative one. A common language does not imply agreement of ideas, it implies understanding of ideas. Therefore, the language must be both distinct and diverse enough to promote this understanding. In contrast, normative language tries to create language that all can agree upon as what constitutes the “normal” view. By nature, this language must rely to some extent on non-specificity, a non-specificity has a tendency to obscure important distinctions. Language, and particularly spiritual language, is powerful to the extent that it communicates a distinct message, one that may not be agreed upon but at least it is clearly understood. Only as we make room for the diversity of spiritual language messages, and engage a dialogue between these messages, can our spiritual creations grow.

As we continue this dialogue of the spiritual in nursing we must forge a way between these three potential pitfalls. We will know we are on the path if we continue to make visible this powerful presence, using all our human capacities to language and engage the diversity of ideas, while resisting the temptation to construct it as an instrument of personal or disciplinary control.

One can compare the Spiritual Presence with the air we breathe, surrounding us, nearest to us, and working life within us. This comparison has deep justification: in most languages the work ‘spirit’ means breath or wind. Sometimes the wind becomes storm, grand and devastating. Mostly it is moving air, always present, not always noticed. In the same ways the Spirit is always present, a moving power, sometimes in stormy ecstasies of individuals and groups, but mostly quiet, entering our human spirit and keeping it alive; sometimes manifest in great moments of history or personal life, but mostly working hiddenly through the media of our daily encounters with men and world; sometimes using creation, the religious communities and their Spiritual means, and often making itself felt in spheres far removed from what is usually called religious. Like the wind, the Spirit blows where it wills! It is not subject to rule or limited by method.

(Tillich, 1963b p. 86-87)
References


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**Appendix A: Selected Concept Analyses / Reviews of Spirituality and Spiritual Care in Nursing**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Method of Analysis</th>
<th>Definition of Spirituality</th>
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<tbody>
<tr>
<td>(Burkhardt, 1989)</td>
<td>Literature review</td>
<td>“Spiritual is the unfolding of mystery through harmonious interconnectedness that springs from inner strength” (p.72).</td>
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<tr>
<td>(Emblen, 1992)</td>
<td>Literature review &amp; Walker &amp; Avant’s concept analysis</td>
<td>“Personal life principle which animates transcendent quality of relationship with God or god being” (p. 45).</td>
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<tr>
<td>(Reed, 1992)</td>
<td>Paradigmatic proposal</td>
<td>“Spirituality refers to the propensity to make meaning through a sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual. This relatedness may be experienced intrapersonally (as a connectedness within oneself), interpersonally (in the context of others and the natural environment), and transpersonally (referring to a sense of relatedness to the unseen, God, or power greater than the self and ordinary resources). There is an expansion of boundaries inward, outward, upward” (p.350).</td>
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<tr>
<td>(Mansen, 1993)</td>
<td>Avant’s (1991) concept analysis – pathway of difference</td>
<td>“The spiritual dimension is an integral part of an individual and it is important for nurses to assess and intervene when appropriate. However, the spiritual dimension is not to be confused with the religious aspect of an individual. Neither is the spiritual dimension to be confused with the psychosocial component. To differentiate between these dimensions, verification and validation of the concept of spiritual must be made through appropriate methods. Intuition and qualitative analysis would seem to be the methods of choice related to concept development of spirituality” p. 145.</td>
</tr>
<tr>
<td>(Ross, 1994)</td>
<td>Literature review</td>
<td>Themes: need to find meaning, purpose and fulfillment in life, suffering and death; need for hope/will to live; need for belief and faith in self, others and God.</td>
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<tr>
<td>Reference</td>
<td>Methodology</td>
<td>Description</td>
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<td>(Goddard, 1995)</td>
<td>Philosophic analysis using logic theory</td>
<td>“Integrative energy” (p. 808)</td>
</tr>
<tr>
<td>(Dyson, Cobb &amp; Forman, 1997)</td>
<td>Literature review</td>
<td>Themes: self, others and god; meaning; hope; relatedness; connectedness; beliefs.</td>
</tr>
<tr>
<td>(Golberg, 1998)</td>
<td>Walker and Avant’s concept analysis</td>
<td>“Connection” (p. 836)</td>
</tr>
<tr>
<td>(Meraviglia, 1999)</td>
<td>Walker and Avant’s concept analysis</td>
<td>“Spirituality is defined as the experiences and expressions of one’s spirit in a unique and dynamic process reflecting faith in God or a supreme being: A connectedness with oneself, others, nature or God; and an integration of all human dimensions” (p. 18).</td>
</tr>
<tr>
<td>(Greasley, Chiu, &amp; Gartland, 2000)</td>
<td>Focus groups of care providers and service users</td>
<td>“Spiritual care relates to the acknowledgement of a persons' sense of meaning and purpose to life which may, or may not, be expressed through formal religious beliefs and practice. The concept of spiritual care was also associated with the quality of interpersonal care in terms of the expression of love and compassion toward patients” (p. 629).</td>
</tr>
<tr>
<td>(Tanyi, 2002)</td>
<td>Literature review</td>
<td>“Spirituality is an inherent component of being human, and is subjective, intangible and multidimensional. Spirituality and religion are often used interchangeably, but the two concepts are different. Spirituality involves human’s search for meaning in life, while religion involves an organized entity with rituals and practices about a higher power or God. Spirituality may be related to religion for certain individuals, but for others, such as an atheist, it may not be” (p. 500).</td>
</tr>
<tr>
<td>(Unruh, Versnel, &amp; Kerr, 2002)</td>
<td>Literature review</td>
<td>Themes: relationship to God, spiritual being, higher power; a reality greater than the self; not of the self; transcendence or connectedness unrelated to a belief in a higher being; existential, not of the material world; meaning and purpose in life; life force of the person; integrating aspect of the person; summative.</td>
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Appendix B: The Art of Philosophic Thinking

The philosophic method promises many things in the context of an inquiry: to reveal hidden assumptions, to problematize what otherwise seems self evident, to clarify views, and most of all, to discover the questions that may have otherwise been neglected. And yet, all of this depends upon a fallible instrument, the human mind. Philosophy is necessary primarily because we tend to view complex issues simplistically, to not critically consider our most cherished beliefs, and to consistently locate ourselves within answers that feel comfortable. Paradoxically, this mind that so easily shrouds itself in its own biases and assumptions becomes the very instrument by which we are expected to problematize and clarify those assumptions. The question then becomes, what strategies do we implement to push ourselves beyond our own limited thinking when we engage in this method of philosophic inquiry—-to sharpen the tool of philosophic inquiry, our mind?

The importance of this question first became evident to me when I defended the proposal for this dissertation. One of the examiners asked what my assumptions were going into this project. I confess to being completely confounded by the question. Wasn’t my purpose to suspend my assumptions while I examined a variety of positions? Only later did I realize how naive that position was. As I came to grapple with some of the different worldviews, in particular monism, I found myself almost incapable of viewing the world from this perspective. Having come from a lifetime of theistic assumptions, it was like reading life in a foreign language. And yet, I knew that for centuries monism had captured humanity as a viable way of viewing the world. Obviously, I was missing something. I realized then that there is no such thing as suspending our own assumptions. Rather, the best we can hope to do is to put strategies in place to consistently challenge our way of viewing the world and to enable us to understand the views of others better. The following are some of the strategies I implemented in the context of this inquiry.

One of the most useful strategies was reading widely among philosophers and theologians who have informed perspectives of the spiritual. I have found that many nursing theorists draw upon the ideas of philosophers or theologians but because those ideas come second-hand, and somewhat out of context, they are difficult to reconstruct in a logical way. When I returned to the original work I gained a better sense of whether the nursing theorists had drawn upon a more comprehensive and logical body of work, or whether they had simply brought ideas in that lost their logic when taken out of context. This strategy was particularly useful when it came to the monistic theorists who I had difficulty comprehending. Neal Walsch’s writings (e.g. Tomorrows God) were useful in this regard as he has written extensively on the “new spirituality” that has many of the same spiritual assumptions as that of the monistic theorists. I also tried to read within other theistic traditions such as Islam and Judaism. I also chose books that problematized my own particular Christian tradition.

Another strategy was dialoguing with others about my topic. For example, on one propitious plane ride I was seated between two women who were both reading books on spirituality. One woman in particular was enthusiastic about the ideas of Rosemary Parse and so I took the opportunity to ask a number of questions about that perspective. On
another occasion, I had the opportunity to talk to someone who had no expertise in this area, other than as a consumer of healthcare. I first spoke with her about the idea of nurses engaging in spiritual care. She was enthusiastic until I explained to her some of the approaches that were being proposed in the literature. Her reactions affirmed for me how easy it is to engage in the academic realm of ideas without fully considering the implications of our ideas on prospective patients. Interestingly, as fascinating as these conversations were at times, I found my "conversations" with various authors generally more fruitful.

I used a number of cognitive strategies to think about these positions in different ways. I would try to argue against the position that seemed most familiar and logical to me. I would imagine myself taking a particular perspective in nursing practice and trying to implement it. Better yet, I would imagine myself as the patient and consider how I would feel within the different approaches. I would consider a particular concept of spirituality from a professional perspective, and then consider how my feelings changed when I viewed it from a personal perspective. For example, on a professional level I might heartily agree with facilitating the need of a Hindu patient to sacrifice to a particular statue, but on a personal level I find it highly distasteful to imagine sacrificing to something created by one's hands. What was particularly intriguing was my capacity to move back and forth and to realize how the comfort/discomfort could change depending upon which "hat" I was wearing. I made a number of grids comparing the different perspectives on as many different factors as I could think of. This helped to illuminate areas where my understanding of a theorist might not be as complete as it could be. In some cases, it simply highlighted areas that the theorist needed to explore further.

One of the specific challenges I encountered in this work was trying to balance the seemingly contradictory notions of reading the works of theorists with both an attitude of awe and amazement and an emphasis on critical engagement with the ideas. I envisioned these seemingly antithetical approaches as an important polarity that needed to be held in tension. Hence, if I found myself engaging with a work with an excessive amount of skepticism, it was an indicator that perhaps my gaze needed to shift more toward an appreciation of the ideas. Likewise, if a work was so familiar to my own particular worldview that I felt little but appreciation, it was a trigger to search deeper for potentially problematic areas. In this way I tried to do justice to the type of situational thinking described in the methods section.

As I progressed in the analysis of the works I began to see what an important role power played in this debate. Indeed, Dallas Willard (2002) has suggested that the spiritual is unbodily personal power, and so when we begin to talk about influencing this realm, power becomes a key factor. I began to explore the work of Foucault to see if his ideas could contribute further to my understanding of the topic, and most specifically to the implications of adopting some positions over others. His ideas of how power produces the subject were particularly useful. I began to consider how we were creating "subjects" through our conceptualizations of unbodily personal power.
Despite all these strategies, I am not sure that I can ever rest assured that I have philosophized well. It seems that the difficult process of discovering the questions is a never ending one and one that is infinitely humbling. Ultimately, the readers are the judge. Will they come away from the work feeling that they have better clarity on a subject and some nugget of guidance on how to proceed in the everyday business of life? That, of course, remains to be seen.
Appendix C: Data Collection Questions

1. What are the underlying ontological assumptions about the spiritual dimension?
2. How do these assumptions influence the nature and goal of nursing?
3. How do these assumptions influence the scope of nursing?
4. How do these assumptions influence the object of nursing?
5. What spiritual interventions and outcomes are being proposed?
6. How is the spiritual being defined in relation to other domains of the person? That is how might this type of care differ from humanistic psychosocial interventions or physical care?
7. What are the underlying epistemological assumptions about the spiritual?
8. What knowledge is required to “nurse” another within the spiritual dimension?
9. What preparation is required to gain this knowledge?
10. What paradigms of inquiry are suitable to the development of this form of knowledge?
11. Are there some nurses who would be unable to nurse within this dimension?
12. Who is the expert according to this perspective?
13. Is there the potential for unique disciplinary knowledge within this dimension?
14. What is the nature of the spirituality? (i.e. positive or negative)
15. What are the ethically desirable goods, and upon what grounds are these goods constructed?
16. What are the inherent ethical problems or challenges?
17. How might this perspective accommodate or do justice to the variety of worldviews held by nurses and clients?