

# Journal of Holistic Nursing

## **Spiritual Dimensions of Nurse Practitioner Consultations in Family Practice.**

Journal:	<i>Journal of Holistic Nursing</i>
Manuscript ID	JHN-18-Feb-0027.R2
Manuscript Type:	Qualitative Research
Keywords:	Spirituality < Common Themes, Nurses (advanced practice) < Group/Population, Nurses (basic) < Group/Population

SCHOLARONE™  
Manuscripts

## **Spiritual Dimensions of Nurse Practitioner Consultations in Family Practice.**

### **Original Empirical Research – Qualitative:**

#### **Abstract:**

##### Purpose of Study:

To explore the spiritual dimensions of Advanced Nurse Practitioner consultations in Primary Care through the lens of Availability and Vulnerability.

##### Design of Study and Methods Used:

A Hermeneutic Phenomenological enquiry exploring the spiritual dimensions of Primary Care consultations consisting of two interviews per participant over an eighteen-month period was conducted with Advanced Nurse Practitioners in the United Kingdom.

A purposive sample of 8 Advanced Nurse Practitioners were recruited and interviewed. Interviews were fully transcribed and analysed thematically.

##### Findings:

Participants identified that spirituality can be difficult to conceptualise and operationalise in practice. Participants articulated the meaning of spirituality and gave examples of when they had witnessed a spiritual dimension in practice. Key themes included how ANPs conceptualise spirituality, the context for spirituality to be integrated into care and the importance of spirituality as an aspect of holistic care. The concepts of Availability and Vulnerability were used intentionally as a lens in the study to explore whether these concepts and approaches to practice could enhance integration of spirituality into practice.

##### Conclusion:

Knowledge and understanding regarding spirituality in Advanced Nurse

1  
2  
3 Practitioners consultations in Primary Care has been uncovered. A framework for  
4  
5 operationalising spirituality has been developed.  
6  
7  
8  
9

### 10 **Introduction:**

11  
12 Over recent decades, research on spirituality in nursing and healthcare has  
13  
14 increased globally (Pesut et al., 2009, Milligan, 2011, Clarke 2013, Beres, 2017,  
15  
16 Martins, Romeiro & Caldeira 2017, Penman, 2018; Ross et al., 2018,). The  
17  
18 International Council of Nurses (ICN) (2012), American Association of Nursing  
19  
20 (2015) and the Nursing and Midwifery Council (NMC) (2009 & 2014) in the UK have  
21  
22 recognised the importance of spirituality to good nursing practice. Challenges of  
23  
24 conceptualising spirituality often obscure the issue of how to integrate spirituality in  
25  
26 practice (Cook, 2011, Reinert & Koenig, 2013, Rogers & Wattis 20015; Wattis,  
27  
28 Curran & Rogers., 2017).  
29  
30  
31  
32  
33  
34

35  
36 The word spirituality was introduced into the English language in the 17<sup>th</sup> century  
37  
38 (from the French *spiritus*) to denote direct knowledge of the divine or supernatural  
39  
40 (McGrath 1999). In its original meaning it was close to the modern English 'mystical'  
41  
42 and was religious in connotation. However, over the years a concept of spirituality  
43  
44 has developed that also embraces the secular. In line with Cook's (2004) definition,  
45  
46 our understanding of spirituality embraces issues of meaning, purpose, hope and  
47  
48 connectedness whether or not they expressed through religion (Wattis, Curran &  
49  
50 Rogers, 2017). Spirituality is an innate part of being human and attention to  
51  
52 spirituality is a fundamental aspect of holistic care (Rogers, 2017).  
53  
54

55  
56 Defining spirituality for research purposes is complex and for this reason, some  
57  
58 authors have used religious observance as a surrogate for spirituality, especially in  
59  
60

1  
2  
3 quantitative research (Koenig King and Carlson 2012). Robust studies have  
4 demonstrated the importance of spirituality (sometimes expressed through religion)  
5 in helping patients regain hope, meaning and purpose in the midst of illness  
6 (Burkhardt, 2007, D'Souza, 2007, Koenig, King and Carlson 2012; Penman 2018).  
7  
8 Growing evidence suggests that addressing spirituality improves comfort levels  
9 (emotionally and physically) and has a positive effect on patients' responses to  
10 illness and treatments (Koenig, King and Carlson 2012).  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20

21  
22 Holistic care has been defined as "all nursing practice that has healing the whole  
23 person as its goal" (American Holistic Nursing Association 2018, p.1). It should  
24 consider the mind-body-spirit- emotion-environment approach to nursing practice  
25 (Klebanoff 2013). Clarke (2013) argued that spirituality epitomises holistic care and  
26 is at the heart of nursing. One helpful (but not very specific suggestion) is that  
27 spiritual care in practice "begins with encouraging human contact in compassionate  
28 relationships and moves in whatever direction need requires" (National Health  
29 Service Scotland, 2009, p.6). All nursing care should be based on compassion and  
30 human connection but spiritual care goes further, including helping patients find or  
31 re-establish meaning, hope and purpose in lives disrupted by illness and suffering  
32 (Cook, 2004, Pesut, et al 2009; Pfeiffer, Gober & Johnson-Taylor 2014).  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45

46  
47 Nurse Practitioners (NP) are in an ideal place to put holistic care, including spiritual  
48 care, into practice because of the nature of their daily work, including long-term  
49 involvement with many patients (Shuler & Davis, 1993; Rogers 2016). Familiarity  
50 with ongoing aspects of the patient's life enables NPs to address many areas of  
51 concern. However, there has been very little research into how they do this. The  
52 first step is to establish how NPs experience and deal with spiritual issues in their  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 consultations. The researcher explored how a concept of Availability and  
4  
5 Vulnerability that she had found helpful in developing her own work as an NP could  
6  
7 be applied in the experience of others.  
8  
9

### 10 11 12 **Methodology:**

13  
14 In 2016, the author completed this phenomenological study as part of her doctoral  
15  
16 studies. A two-stage study was conducted which comprised of two interviews over  
17  
18 an 18 month period. The first stage interview examined the issue of how NPs  
19  
20 experienced and understood spirituality in clinical practice, their lived experience.  
21  
22 Perceptions of the words availability and vulnerability were explored during this  
23  
24 stage to ascertain participants' thoughts about these words. The second stage  
25  
26 interview 18 months later explored the utility of the concept of Availability and  
27  
28 Vulnerability, derived from the traditional wisdom of a Christian community, in  
29  
30 developing a framework to enhance understanding. This specific concept of  
31  
32 Availability and Vulnerability was only introduced after the first stage interview. The  
33  
34 concept of Availability and Vulnerability was seen by the Celtic Christian community  
35  
36 as key to authentic living and building relationship. This concept included  
37  
38 welcoming and accepting others as they are, being authentic in relationship and  
39  
40 being willing to connect with others (Miller, 2014). Details of the community's  
41  
42 understanding of the concept was given to participants prior to the second stage  
43  
44 interview. In the second stage interview, in addition to clarifying issues from the first  
45  
46 interview, the utility of the concept of Availability and Vulnerability in understanding  
47  
48 NP experiences of addressing spiritual issues was explored in depth.  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

### **Aim and objectives:**

The study aimed to establish a phenomenological understanding of the spiritual dimensions of Nurse Practitioner consultations in family practice and to examine the utility of the concept of Availability and Vulnerability as a framework for this understanding. The research aimed to address:

- How the NPs interviewed experienced and conceptualised spirituality in practice.
- Whether or not spirituality was experienced as an important aspect of their consultations.
- How spirituality was operationalized in consultations by these NPs.
- Whether these NPs identified spiritual dimensions of practice.
- Whether they experienced any barriers to integrating spirituality into practice.
- Whether a framework of Availability and Vulnerability was useful in understanding and operationalizing spirituality within NP consultations.

### **Design:**

A hermeneutic phenomenological enquiry (Gadamer, 2006) using face-to-face interviews was designed to allow the unique lived experiences of the NPs to be explored and understood (Paley, 1997). Prolonged engagement allowed dialogue to occur between the researcher and participants facilitating a thick description of the phenomenon of spirituality (Gadamer, 2006). In the second stage, the concept of Availability and Vulnerability was applied to the developing dialogue to examine their utility as a framework for further exploration of spirituality in this context.

### **Participants:**

1  
2  
3 A purposive sample of 8 experienced NPs (Table 1) was recruited in 2012 via a  
4 local NP forum. This small sample size was appropriate for a phenomenological  
5 study as the aim of the study was not generalizability (Munhall, 2012). Participants  
6 were interviewed twice over an 18-month period. The data collected during both  
7 interviews enabled extended interactions with participants to refine and clarify  
8 meaning and integrate personal interpretation of the data. Prolonged engagement is  
9 recommended to support in depth analysis and increase credibility of the findings  
10 (Houser, 2015).  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

23  
24 The inclusion criteria were: experienced Nurse Practitioners (5 years post  
25 qualification); members or affiliates of a regional Nurse Practitioner Forum; and  
26 active Nurse Practitioners working in family practice.  
27  
28  
29

30 Ethical approval was given by the relevant University and National Health Service  
31 ethics boards. All participants gave written consent prior to being interviewed and  
32 agreed to prolonged engagement for up to 2 years. All were aware they could  
33 withdraw from the study.  
34  
35  
36  
37  
38  
39  
40  
41

#### 42 **Data collection:**

43  
44 Data were collected during two interviews per participant over an 18-month period  
45 from November 2013 to June 2015. Interviews (Moule & Goodman, 2006; Munhall,  
46 2012) allowed for dialogue between the researcher and participant to explore their  
47 thoughts, feelings and experiences with the aim of gaining understanding and clarity  
48 about the phenomenon (Laverty, 2003). To explore the lived experiences of  
49 spirituality enough time was allowed for each interview to develop in whatever  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 direction the participant wanted it to. A topic guide was used as a prompt and to  
4  
5 ensure all participants covered the same areas for comparison (Table 2).  
6  
7  
8  
9  
10

### 11 12 **Data Analysis:**

13  
14 Data were analyzed using Fleming et al.'s (2003) method. Interviews were  
15  
16 transcribed and anonymized. Transcripts were read repeatedly to ensure deep  
17  
18 understanding of and familiarity with the data (Moule & Goodman, 2006).  
19

20  
21 Manual systematic coding of the data was carried out (Fleming et al, 2003). Codes  
22  
23 were abstracted into broad overarching themes then scrutinised for any duplication.  
24

25  
26 After each interview individual participant summaries were made after transcript  
27  
28 analysis of key findings. Each summary was then sent to the participant and later  
29  
30 discussed via email or phone after the participants had chance to reflect on the  
31  
32 findings. Participants deemed all summaries to be accurate analyses of meaning  
33  
34 and understanding. Ongoing dialogue with the participants was used to orientate  
35  
36 participants to the study and initial findings, allowing them the opportunity to  
37  
38 challenge interpretations and understandings that might have been misconstrued by  
39  
40 the researcher.  
41  
42  
43  
44  
45

46  
47 After transcription, interpretive understanding of themes and patterns were sought  
48  
49 via thematic analysis. The major themes emerged from this textual analysis and  
50  
51 recognition of repeated patterns. This process followed Gadamer's (2006)  
52  
53 hermeneutic rule of movement looking at the whole of the data, then the part and  
54  
55 returning to the whole. Each interview was analysed before proceeding with further  
56  
57 interviews. This was then related back to the whole research completing a  
58  
59  
60



1  
2  
3 continuous hermeneutic circle. A fusion of horizons, marrying the participants and  
4 researchers views, enabled a thick description of the phenomenon of spiritual  
5 dimensions in NP consultations to be developed (Gadamer, 2006; Vessey 2009).  
6  
7  
8 Synthesis of the data and returning a second time to the participants enabled the  
9  
10 researcher to discover whether this thick description was accurate and gave the  
11  
12 participants time to reflect on the interviews and material presented to them.  
13  
14  
15  
16  
17  
18

### 19 **Rigor and Credibility:**

20  
21 Rigor was attained through the completeness of the data collection and analysis in  
22 addition to the interpretation (Yardley, 2000). Hermeneutic phenomenology does  
23 not fit stringently into the validity and reliability methods terminology (Moule &  
24 Goodman, 2006). Bradbury-Jones (2007, p.291) has suggested that credibility is a  
25 term most qualitative researchers use rather than validity or reliability as it “refers to  
26 the fit between the experiences of the respondents and the researchers’  
27 representation of them”. Prolonged engagement and ongoing reflexivity supported  
28 in depth analysis, which as Houser (2015) suggested increases credibility of the  
29 findings and enhances rigor. Exploration of the authors’ subjectivity through the use  
30 of a research journal supported ongoing reflexivity. This was important in  
31 demonstrating rigor and enhancing credibility as it identified the interplay between  
32 myself and participants in addition to my own reflections (Bradbury-Jones 2007).  
33  
34 Credibility is important in hermeneutic phenomenology. It was enhanced during this  
35 study by allowing each participant to review the key findings of their interview and  
36 offer continued dialogue with participants to develop of shared understanding  
37 through the fusion of horizons and completing the hermeneutic circle. Despite this  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 study having a small sample the findings may have transferability to other  
4  
5 populations and settings (Slevin & Sines, 2000)  
6  
7  
8  
9

10 The freedom of the methodology is liberating in allowing for flexibility in the structure  
11 of analysis but, in order to ensure rigor, maintaining the focus on the phenomenon  
12 under investigation is paramount (Crotty 1996). Others have suggested the lack of  
13 structured “rules” for the methodology leads to questions of rigor and validity  
14 (Sharkey 2001). He argued that method in itself does not lead to good interpretation.  
15 It was the researchers’ ability to explore and understand the nuances of the  
16 phenomenon with the participants and engage in dialogue to confirm the  
17 understanding with the participants which appeared to increase rigor and validity  
18 (Gadamer 2006). However, in the hermeneutic phenomenological context of this  
19 study rigor was achieved and demonstrated through acknowledgement of bias,  
20 prolonged engagement with the participants and reflexivity throughout the study. Set  
21 criteria for rigor are “problematic” and not consistent philosophically with hermeneutic  
22 approaches (Witt & Ploeg 2006) Subjectivity with hermeneutic phenomenological is  
23 well recognised (Bradbury-Jones 2007) and integral to the process. However to  
24 enhance rigor prolonged engagement with the participants over 18 months at and  
25 between interviews in addition to presenting the summaries back to each of them  
26 allowed for the findings to be as authentic as possible Strengths:  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49

50 The methods followed during this study followed the hermeneutic process fully.  
51 Prolonged engagement with the participants and ongoing dialogue enhanced  
52 credibility and rigor of the study.  
53  
54  
55  
56

### 57 **Findings:**

### 58 **Description of Participants:**

59  
60

1  
2  
3 Out of 8 participants were interviewed, seven were Caucasian and one was Afro-  
4 Caribbean. The mean age was 48 years. Only 1 participant had not attained a  
5 master's degree in advanced practice. Three participants reported to having a  
6 Christian faith, three had been brought up as Christians but were now agnostic and  
7 two participants did not mention any religious belief or background.

8  
9  
10 Drawing on both interviews, broad findings are articulated in this paper under the  
11 inclusive subheadings of *defining spirituality*; *integrating spirituality into the*  
12 *consultation* and *Availability and Vulnerability*.  
13  
14

### 15 **Defining Spirituality:**

16  
17 During the first interview some participants had not thought about a personal  
18 definition of spirituality and were confused about spirituality. Their ideas developed  
19 and were revisited in the second interview.  
20  
21

22  
23 Some participants recognized that spirituality was difficult to define. One suggested:

24  
25 *"You can't quite put your finger on it"*

26  
27 Others had a much clearer understanding of spirituality. One described spirituality  
28 as being unique like a fingerprint:  
29  
30

31  
32 *"Spirituality for me is about the essence of a person... it's about your make-up,*  
33 *some of the things you are born with, some things you develop because of your*  
34 *environment and how you are brought up. I think it's probably like a fingerprint*  
35 *really, it's different for everybody... You have to know it's about being who you are".*  
36  
37

38  
39 For some religion was linked to spirituality (one asked: *"Is there a difference? I don't*  
40 *suppose there is really.....they must be interlinked to a certain extent"*)  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 Two participants had considered definitions of spirituality and articulated  
4 differences between spirituality and religion. They differentiated religions as being  
5 about “*guidance*” and a “*belief in God*”. One suggested that religion was:  
6  
7

8  
9  
10 *“...a set of guidance and principles which you can adopt and adhere to and there’s*  
11 *a church and maybe there’s a doctrine and a ritual”*  
12

13  
14 For another, time to develop her ideas between interviews took her from initially  
15 confusing spiritualism with spirituality to a clearer definition:  
16

17  
18 *“...[Spirituality].involves experiences of deep seated sense of meaning and*  
19 *purpose in life, a sense of belonging, a sense of connection of the deeply personal*  
20 *with the universal, acceptance, integration and a sense of wholeness.”*  
21  
22

23  
24 During the second interview meaning, hope and purpose were all reflected in  
25 definitions of spirituality, as was human-to-human connection and a willingness to  
26 recognise human need and suffering during consultations and respond to these.  
27  
28

29  
30 Spirituality was seen as pervasive:  
31

32  
33 *“...spirituality is how you live...”*  
34  
35

### 36 37 38 39 **Integrating Spirituality within the Consultation:**

40  
41 The first interview explored whether there were consultations when spirituality was  
42 particularly relevant. For many participants this led to examples of complex, long-  
43 standing cases and for one spiritual issues most often arose in consultations about  
44

45  
46 *“...life and death...”*  
47  
48

49  
50 Spirituality could also be a part of minor presentations or a one-off consultation.:  
51

52  
53 *“In a consultation I think it [spirituality] is something that sometimes happens. I*  
54 *don’t think it’s always a conscious effort. I think it comes back to whether you are*  
55 *having time to sit and let the person talk and tell you what’s important to them”*  
56  
57  
58  
59  
60

1  
2  
3 During the second interview participants recognized that spirituality included  
4 connecting with patients, presencing, empathy, compassion and care. Having a  
5 depth of connection with patients was seen as rewarding but could also impact on  
6 the NP emotionally:  
7  
8  
9

10  
11  
12 *“being able to connect with them [patients] on that level [depth] I think is sort of*  
13 *spirituality in nursing....and I have always accepted there is a sort of spiritual*  
14 *element...it’s about a deeper connection that you sometimes experience in a*  
15 *consultation ... and then you feel that something has happened there that isn’t run*  
16 *of the mill, that isn’t your normal consultation, I think it’s really rewarding, when it*  
17 *does happen”.*  
18  
19  
20  
21  
22  
23  
24  
25

26 Participants discussed whether the term spirituality might cause misunderstanding  
27 for patients as it had initially for them. One observed:

28  
29  
30 *“....sometimes words create huge barriers”.*  
31  
32

33 For participants, spiritual dimensions of practice included openness and willingness  
34 to be present and fully hear the patient. This led to reflections on the emotional  
35 impact of the consultations and an awareness of professional and personal  
36 boundaries. One participant recalled revealing her humanity when she had to: “  
37 ..blink back tears ..”. Another was aware that she sometimes risked sharing her  
38 own similar experiences and that she:  
39  
40  
41  
42  
43  
44  
45

46 *“tried to share empathy with them [patients] ... saying ... I understand it’s difficult*  
47 *and perhaps I can understand a bit more because I am going through the same*  
48 *thing. Now whether that’s a good thing or a bad thing would be debatable”*  
49  
50  
51  
52  
53  
54  
55

#### 56 **Availability and Vulnerability:**

57  
58  
59  
60

1  
2  
3 Participants' recognition of spiritual elements to practice and the related emotional  
4 and professional impact facilitated growing discussion of the concept of Availability  
5 and Vulnerability. All recognized availability within their NP role and related it to  
6 being "*there when you're needed*", "*being open and ready to respond to someone's*  
7 *needs*", and "*being ready to listen*".  
8  
9

10  
11  
12 They recognized availability could be physical, which could be closely controlled, or  
13 emotional which involved more choice. Vulnerability was closely connected as it  
14 could be a consequence of availability:  
15  
16

17  
18  
19 "*On occasions you do show your vulnerability and it's not a bad thing to do because*  
20 *it shows you are a human being at the end of the day not automatons*"  
21  
22

23  
24  
25 After participants had read and reflected on the origins of the concept of Availability  
26 and Vulnerability, in the second interviews their thoughts and views about this  
27 concept included more "*spiritually focused*" concepts with availability being seen as  
28 involving "*human connection*", "*love*", "*hospitality*" and "*opening oneself up more*  
29 *with others*".  
30  
31

32  
33  
34 Vulnerability was viewed as more complex and multi-faceted than availability. The  
35 NPs were insightful in recognising the varied facets of vulnerability. One  
36 summarised this:  
37  
38

39  
40  
41 "*I am vulnerable because I am a human being...I am vulnerable because I have to*  
42 *manage risk and make decisions minute by minute...I am vulnerable because I*  
43 *have to make the right diagnosis, because I need to choose the right treatment, to*  
44 *prescribe the right drug, I am vulnerable because if I screw up I can be sued and I*  
45 *am vulnerable because I am a nurse in a traditionally medical domain. I am*  
46 *vulnerable because I stood on the parapet to be a spokesperson for my*  
47 *professional discipline...I am vulnerable because I am trying to say that what I do is*  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 *as good as medicine so I am vulnerable on so many levels. My main vulnerability,*  
4 *the one that makes me anxious, is that I am doing the right thing for the right patient*  
5 *at the right time”.*  
6  
7  
8  
9

10 The final point, was for her was a deeply spiritual connection with patients,  
11  
12 indicative of the “*transformative*” nature of vulnerability.  
13

14 Multiple narratives of consultations where participants had given of themselves  
15  
16 emotionally revealed the depth of care and compassion the NPs had for their  
17  
18 patients and were powerful examples of how vulnerability had impacted them,  
19  
20 including the recognition of the risk of burn out.  
21  
22

23 During the second interview participants linked availability and vulnerability to  
24  
25 spirituality. One felt that:  
26

27  
28 “ *they [availability and vulnerability] are important for me....they fit with my spiritual*  
29 *beliefs because of what spirituality means for me”*  
30  
31

32  
33 Another returned to the issues of professional and personal balance:  
34

35 “*It’s [spirituality] how I think it is [Availability and Vulnerability], it’s probably how a*  
36 *lot of people think really....I think it’s what we do .... I think I agree with the fact that*  
37 *you need to be available and vulnerable but I do think it needs balancing with rules*  
38 *[boundaries]. I think it’s about trying to ensure that you are clear as a professional*  
39 *that the things you put into your work time and your life have balance....that*  
40 *whatever vulnerability you experience at work you can balance with the rest of your*  
41 *life.....”*  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51

## 52 53 **Discussion:**

54  
55 In this unique study, understanding aspects of the spiritual dimensions of NP  
56  
57 consultations in family practice has been developed. Spiritual dimensions of  
58  
59  
60

1  
2  
3 practice are multi-faceted and at times difficult to verbalize. The specific concept of  
4  
5 Availability and Vulnerability has not been studied before however, the authors'  
6  
7 personal experience of integrating this concept personally and professionally had  
8  
9 revealed their possible application to NP practice in general. The concept derives  
10  
11 from the Northumbria Community, a dispersed Celtic Christian monastic  
12  
13 community, based in Northumberland, England (Miller, 2014). Availability and  
14  
15 Vulnerability are seen as ways of relating to others and God in order to build  
16  
17 relationship. Although the heritage of this concept is Christian, the author hoped to  
18  
19 explore whether the concept of Availability and Vulnerability could be applied to a  
20  
21 secular setting. The study findings appear to show that Availability and Vulnerability  
22  
23 enable spirituality to be more easily operationalized by the participants. Author bias  
24  
25 of introducing the concept was explored and acknowledged throughout the study.  
26  
27 The finding that spirituality is difficult to conceptualize is unsurprising and reflects  
28  
29 findings from other studies (Miner-Williams, 2005, McSherry, 2007; Reinert &  
30  
31 Koenig, 2013). Struggling to define spirituality is a common experience of nurses  
32  
33 (McSherry & Jamieson, 2013). Burkhardt (2007) suggested that spirituality is like  
34  
35 the wind, it can be sensed and felt but cannot be tied down. However, recognizing  
36  
37 that spirituality is connected to hope, meaning and purpose and is innate may make  
38  
39 understanding spirituality easier (McSherry, 2006, Burkhardt, 2007; Pesut et al,  
40  
41 2008).

42  
43  
44  
45  
46  
47  
48  
49  
50  
51 There appeared to be some confusion about the difference between religion and  
52  
53 spirituality. This reflected other research (Treloar, 2000, Stranahan, 2001, Hubbell  
54  
55 et al, 2006, Helming et al, 2009; Carron et al., 2011). For this reason Sessana et al,  
56  
57 (2007) and Pesut et al., (2008) suggested separating spirituality completely from  
58  
59  
60



1  
2  
3 religion. However, it seems logical to view them as distinct but overlapping concepts  
4  
5 (Wattis, Curran & Rogers, 2017). One approach to the problems of defining  
6  
7 spirituality is to look instead at the concept of spiritually competent practice (Wattis,  
8  
9 Curran & Rogers, 2017). Spiritually competent practice engages with each person  
10  
11 as a unique individual supporting a sense of meaning, hope, purpose and  
12  
13 connection. It involves the clinician recognising and addressing suffering and  
14  
15 helping patients to develop coping strategies to improve their quality of life.  
16  
17 Fundamentally, it requires compassionate, holistic approaches to care to be offered  
18  
19 whilst accepting a patient's beliefs and values and practicing with spiritual  
20  
21 competency (Rogers & Wattis, 2015, Wattis, Curran & Rogers, 2017). This  
22  
23 approach may reduce some of the confusion and complexities associated with  
24  
25 defining spirituality.  
26  
27  
28  
29  
30  
31  
32

33 To provide space for spiritually competent practice to be part of the consultation  
34  
35 NPs need to build relationships based on trust where the patient can feel safe,  
36  
37 listened to and valued. Milligan (2011) suggested this leads to a positive and  
38  
39 healing experience for the patient by creating a sense of shared humanity. O'Brien  
40  
41 (2008) asserted that shared humanity needs to be authentic with a possibility for  
42  
43 mutuality including the sharing of self. Participants in this study acknowledged that  
44  
45 at times sharing common experiences of life could enhance spiritual care. However,  
46  
47 discernment was needed about what experiences would be shared with the aim of  
48  
49 being helpful to the patient and not making the consultation about the NP.  
50  
51 Spirituality is entwined with love and relationship (Young & Koopson, 2011).  
52  
53 Helming (2009) suggested that many NPs entered nursing with a sense of love and  
54  
55 care for others. They may have felt called to compassion in alleviating human  
56  
57  
58  
59  
60

1  
2  
3 suffering which she termed “spiritual work”. The NPs all recognized that a  
4  
5 motivation for their work was a desire to care, to support and help their patients  
6  
7 altruistically. One participant also talked of “love” in terms of her patients and her  
8  
9 vocation but suggested that the word love like spirituality was often misunderstood.  
10  
11 What she meant connects to *agape* (Ancient Greek ἀγάπη): love which includes  
12  
13 compassion, connection, care of patients and presencing (Lindström, Nyström &  
14  
15 Zetterlund, 2014). Martinsen (2006) suggested that love necessitates emotional  
16  
17 involvement which is an aspect of vulnerability.  
18  
19  
20  
21  
22

23  
24 Stevens Barnum (2011) suggested that physically being with patients and trying to  
25  
26 understand what was happening for them and how it was affecting them was crucial  
27  
28 to building relationship and integrating spirituality into care. Sherwood (2000)  
29  
30 suggested that *presencing (being fully available)* was an integral aspect of  
31  
32 operationalizing spirituality. Simply being with patients can help them to explore the  
33  
34 many unanswerable questions about their illness and life. Sherwood described this  
35  
36 as one of the highest forms of human interaction. These NPs recognized that by  
37  
38 choosing to be present, open, ready and focused on the person in front of them  
39  
40 they were able to offer a level of availability that helped their patients, this  
41  
42 connected to spirituality for some though others felt this was just “good nursing  
43  
44 care”.  
45  
46  
47  
48  
49

50  
51 White (2006) recognized that spirituality has an emotional cost and if offering truly  
52  
53 holistic care the practitioner must be prepared to realise this could be positive or  
54  
55 negative. There was a sense from the findings that giving of oneself in the  
56  
57 relationship with the patient increased connection, trust and safety. Young and  
58  
59  
60

1  
2  
3 Koopson (2011) viewed a deeply spiritual dimension when the practitioner was  
4  
5 willing to share something of their own life experience.  
6  
7  
8  
9

10 After participants reviewed the origins of Availability and Vulnerability and reflected  
11  
12 on their practice they viewed them as a useful concept for understanding spirituality.  
13

14 This concept have been developed into a framework for learning about and  
15  
16 operationalizing spirituality in practice (Figure 1). Availability and Vulnerability are  
17  
18 aspects of spirituality that help practitioners connect with their patients as fellow  
19  
20 humans. They enable them to offer hope, meaning and purpose through care,  
21  
22 compassion, emotional connection, respect and understanding. They allow the  
23  
24 practitioner to be vulnerable and honest in their interactions leading to greater  
25  
26 authenticity. Like spiritually competent practice, the framework for Availability and  
27  
28 Vulnerability is one way of addressing the confusion about how spirituality can be  
29  
30 operationalized in practice.  
31  
32  
33  
34  
35  
36  
37

38 The framework suggests that availability includes the NP being firstly connected  
39  
40 and available to themselves, taking time to understand their own spirituality.  
41

42 Participants recognized the need to be aware of their own spirituality to integrate  
43  
44 spiritual care into their own practice. They viewed welcoming patients as unique  
45  
46 human beings with the same needs as themselves and being willing during a  
47  
48 consultation to be fully present, to listen attentively and understand and accept their  
49  
50 patients as they were, as important aspects of spiritual care. Additionally, they  
51  
52 viewed availability as being part of how care and concern were shown for their  
53  
54 patients, providing a safe place for them to share their concerns.  
55  
56  
57  
58  
59  
60

1  
2  
3 Participants identified with vulnerability and the need to be open and connect with  
4 their patients authentically and as fellow humans. This necessitated a need to be  
5 self-reflective and willing to engage in supervision and respond to constructive  
6 criticism to maintain appropriate boundaries. They connected vulnerability with  
7 recognizing that practitioners do not have and never will have all the answers and  
8 knowledge. Sharing this with patients created honesty in the relationship. They also  
9 accepted, that vulnerability included being willing to share aspects of oneself, within  
10 professional boundaries, to bring authenticity and connection as a fellow human  
11 being. Vulnerability included being an advocate for patients, challenging authority  
12 and being honest and truthful in interactions  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

### **Limitations:**

29  
30 The sample size was consistent with hermeneutic phenomenological studies. The  
31 richness of the data, prolonged engagement throughout the study between  
32 researcher and participants and faithful adherence to the methodology ensured a  
33 robust and valid study but further work is needed to explore the transferability of the  
34 findings. Purposive sampling was a limitation as those who volunteered might have  
35 had a special interest in spirituality, again suggesting the need to explore the  
36 findings in a wider group.  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48

49 This study was influenced by the researcher's personal and professional  
50 experience. This was addressed by the two-stage design, specifically introducing  
51 the concept of Availability and Vulnerability only at the end of the first interview.  
52 This, combined with analysis and summarization of the first interviews and  
53 agreement of the summaries before the second interview when the concept was  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 explored in more detail made the process transparent. The issue of bias was also  
4  
5 addressed by analyzing the findings from the practitioners' experiences before re-  
6  
7 examining them in the light of Availability and Vulnerability . The processes of  
8  
9 Gadamerian phenomenology (including fusion of horizons) then enabled a dialogue  
10  
11 which resulted in the suggested Availability and Vulnerability framework for further  
12  
13 exploration. Unconscious bias was minimised by careful reflection to minimise the  
14  
15 risks of selecting data for analysis that fit the researchers' preconceptions. The  
16  
17 supervision team was also used to challenge preconceptions and to ensure  
18  
19 integrity.  
20  
21  
22  
23  
24  
25

### **Conclusion:**

26  
27  
28 There is no definitive answer to what spirituality is or how to operationalize it in  
29  
30 practice. Our understandings change and respond to the experiences we have and  
31  
32 are dynamic. However, this study has explored the richness of potential meanings  
33  
34 of spirituality in NP consultations. This study gives a glimpse into the lived  
35  
36 experience of experienced NPs who all view holistic care as the central tenet to  
37  
38 their practice. From this study it is clear that Availability and Vulnerability have  
39  
40 helped NPs to operationalize spirituality. A framework of Availability and  
41  
42 Vulnerability has been developed to help NPs utilize this concept in clinical practice.  
43  
44 It is hoped that this concept allows spirituality to be operationalized to improve  
45  
46 holistic patient care. It is also hoped that this framework supports NPs in their own  
47  
48 self-development and practice. The transferability of this concept into wider NP  
49  
50 clinical practice needs further evaluation.  
51  
52  
53  
54  
55  
56  
57

### **References:**

1  
2  
3 American Nurses Association (2015) *Code of Ethics for Nurses*. American Nurses  
4 Association, Silver Spring.

5  
6  
7 American Holistic Nursing Association (2018) *What is Holistic Nursing?* AHNA

8  
9 accessed at: <http://www.ahna.org/About-Us/What-is-Holistic-Nursing>

10  
11  
12 Beres, L. (2017) *Practicing Spirituality: Reflections on Mean-Making in Personal*  
13 *and Professional Contexts*. London, UK: Palgrave Macmillan.

14  
15  
16  
17 Bradbury-Jones, C. (2007) Enhancing Rigor in Qualitative Health Research:  
18 Exploring Subjectivity through Peshkins l's. *Journal of Advanced Nursing* (3) 290-  
19 298. Doi: 10.1111/j.1365-2648.2007.04306.x

20  
21  
22  
23  
24 Burkhart, M. 2007 Commentary on Spirituality in Nursing and Health-Related  
25 Literature: A Concept Analysis, *Journal of Holistic Nursing* (4) 263-264.  
26  
27 Doi:abs/10.1177/0898010107308452

28  
29  
30 Carron, R. & Cumbie, S. (2011) Development of a Conceptual Nursing Model for  
31 the Implementation of Spiritual Care in Adult Primary Healthcare Settings by Nurse  
32 Practitioners. *Journal of the American Academy of Nurse Practitioners* (23) 552-  
33 560. Doi:10.1111/j.1745-7599.2011.00633.x

34  
35  
36  
37  
38  
39 Clarke, J. (2013) *Spiritual Care in Everyday Nursing Practice- A New Approach*.  
40 Palgrave, Hampshire.

41  
42  
43  
44 Cook, C. (2004) *Addiction and Spirituality*, *Addiction* 99, 531. Doi:10.1111/j.1360-  
45 0443.2004.00715.x

46  
47  
48  
49 Cook, C. (2011) *Recommendations for Psychiatrists on Spirituality and Religion*.  
50 Royal College of Psychiatrists, London.

51  
52  
53  
54 D'Souza, R. (2007) The Importance of Spirituality in Medicine and its Application to  
55 Clinical Practice. *The Medical Journal of Australia* (10) 57-59

- 1  
2  
3 Fleming, V. Gaidys, U. & Robb, Y. (2003) Hermeneutic Research in Nursing:  
4 Developing a Gadamerian-Based Research Method. *Nursing Inquiry* (2) 113-120.  
5  
6 Doi:/10.1046/j.1440-1800.2003.00163.x  
7  
8  
9  
10 Gadamer, H. G. (Translators Weinsheimer, J. & Marshall, D.) (2006) *Truth and*  
11  
12 *Method*, 2<sup>nd</sup> Edition. Continuum, New York  
13  
14  
15 Helming, M. A. (2009) Integrating Spirituality into Nurse Practitioner Practice: The  
16  
17 Importance of Finding the Time. *Journal for Nurse Practitioners*. (8) 598-8  
18  
19  
20 Houser, J. (2015) *Nursing Research- Reading, Using and Creating Evidence*, 3<sup>rd</sup>  
21  
22 *Edition*. Jones and Bartlett, Burlington  
23  
24  
25 Hubbell, S. Woodard, E. Barksdale-Brown, D. & Parker, J. (2006) Spiritual Care  
26  
27 Practices of Nurse Practitioners in Federally Designated Nonmetropolitan Areas of  
28  
29 North Carolina. *Journal of the American Academy of Nurse Practitioners*. (8) 379-  
30  
31 385. Doi:10.1177/0898010114544302  
32  
33  
34 International Council of Nursing, (2012) *The ICN Code of Ethics for Nurses*. ICN,  
35  
36 Geneva.  
37  
38 Koenig, H., King D. and Carlson V. (2012) *Handbook of Religion and Health*, 2<sup>nd</sup>  
39  
40 *Edition*. Oxford University Press, Oxford.  
41  
42  
43 Klebanoff, N. (2013) Holistic Nursing: Focusing on the Whole Person. *American*  
44  
45 *Nurse Today* 8 (10). Accessed November 2018 at [www.americannursetoday.com](http://www.americannursetoday.com)  
46  
47  
48 Lavery, S. (2003) Hermeneutic Phenomenology and Phenomenology: A  
49  
50 Comparison of Historical and Methodological Considerations. *International Journal*  
51  
52 *of Qualitative Methods* (3) 1-29. Doi:full/10.1177/160940690300200303  
53  
54  
55 Lindström, U. Nyström, L., & Zetterlund J (2014) *Theory of Caritative Caring*. In  
56  
57 In Alligood, M .Nursing Theorists and their Work. 8<sup>th</sup> Edition. Elsevier, Missouri  
58  
59  
60  
Martinsen, K. (2006) *Care and Vulnerability*. Akribe, Oslo

1  
2  
3 McGrath A (1999) *Christian Spirituality*. Blackwell, London

4  
5 McSherry, W. (2006) *Making Sense of Spirituality in Nursing and Healthcare*  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

*Practice- An Integrative Approach (2<sup>nd</sup> Edition)*. Jessica Kingsley Publishers,  
London.

McSherry (2007) *The Meaning of Spirituality and Spiritual Care within Nursing and Health Care Practice*. Quay Books, London

McSherry, W., & Jamieson, S. (2013) The Qualitative Findings from an Online Survey Investigating Nurses' Perceptions of Spirituality and Spiritual Care. *Journal of Clinical Nursing* (21-22) 3170-3182. Doi:10.1111/jocn.12411

Martins H, Romeiro J & Caldeira S (2017) Spirituality in Nursing: An Overview of Research Methods. *Religions* 8 (10) 226. Doi: 10.3390/re100226

Miller, T. (accessed 2014) *The Northumbria Community: Who are we?* Accessible at: <http://www.northumbriacommunity.org/who-we-are/>

Milligan, S. (2011) Addressing the Spiritual Care Needs of People Near End of Life. *Nursing Standard* (4) 47-56. Doi:10.7748/ns2011.09.26.4.47.c8730

Miner-Williams, D. (2005) Putting a Puzzle Together- Making Spirituality Meaningful for Nursing using a Evolving Theoretical Framework. *Journal of Clinical Nursing* (15) 811-821. Doi: 10.1111/j.1365-2702.2006.01351.x

Moule, P., & Goodman, M. (2009) *Nursing Research: An Introduction*. Sage, London

Munhall, P. (2012) *Nursing Research: A Qualitative Perspective, 5<sup>th</sup> Edition*. Jones and Bartlett, Sudbury.

NHS Scotland, (2009) *Spiritual Care Matters. An Introduction Resource for all NHS Staff*. NHS Education for Scotland, Edinburgh



- 1  
2  
3 Nursing and Midwifery Council, (2009) *NMC competence domain*. NMC, London  
4  
5 Nursing and Midwifery Council, (2012) *Maintaining Boundaries*. NMC, London  
6  
7  
8 Nursing Midwifery Council, (2014) *The Code: Standards of Conduct Performance*  
9  
10 *and Ethics for Nurses and Midwives (Draft Revised Version)*. NMC, London.  
11  
12 O'Brien, M. (2008) *Spirituality in Nursing- Standing on Holy Ground*. Jones and  
13  
14 Bartlett, Sudbury  
15  
16  
17 Paley, J. (1997) Husserl, Phenomenology and Nursing. *Journal of Advanced*  
18  
19 *Nursing* (1) 187-193  
20  
21 Penman J (2018) Finding Paradise Within. How Spirituality Protects Palliative Care  
22  
23 Client and Caregivers from Depression. *Journal of Holistic Nursing* 36 (3) 243-254.  
24  
25 Doi: 10.1177/0898010117714665  
26  
27  
28 Pesut, B. Fowler, M. Taylor, E.J. Reimer-Kirkham, S., & Sawatzky, R. (2008)  
29  
30 Conceptualising Spirituality and Religion for Healthcare. *Journal of Clinical Nursing*  
31  
32 (21) 2803-2810. Doi:10.1111/j.1365-2702.2008.02344.x  
33  
34  
35 Pesut, B. & Reimer-Kirkham, S. (2009) Situated Clinical Encounters in the  
36  
37 Negotiation of religious and Spiritual Plurality. A Critical Ethnography. *International*  
38  
39 *Journal of Nursing Studies* (7) 815-25. Doi.org/10.1016/j.ijnurstu.2009.11.014  
40  
41  
42 Pfeiffer J, Gober C & Johnson-Taylor E (2014) How Christian Nurses Converse with  
43  
44 Patients about Spirituality. *Journal of Clinical Nursing* 23 2886-2895.  
45  
46  
47 Reinert, K. & Koenig, H. (2013) Re-examining Definitions of Spirituality in Nursing  
48  
49 Research. *Journal of Advanced Nursing* (12) 2622-2634. Doi/10.1111  
50  
51  
52 Rogers, M. & Wattis, J. (2015) Spirituality in Nursing. *Nursing Standard* (39) 51-57.  
53  
54 Doi/10.7748  
55  
56  
57  
58  
59  
60

1  
2  
3 Rogers (2016) *Spiritual Dimensions of Nurse Practitioner Consultations in Primary*  
4 *Care through the Lens of Availability and Vulnerability. A Hermeneutic Enquiry.*  
5  
6  
7  
8 PhD. University of Huddersfield.

9  
10 Rogers (2017) *'Utilizing Availability and Vulnerability to Operationalize Spirituality'*.  
11  
12 In: *Practising Spirituality: Reflections on Mean-Making in Personal and Professional*  
13 *Contexts*. London, UK: Palgrave Macmillan.

14  
15  
16  
17 Ross L, McSherry W, Giske T, van Leeuwen R, Schep-Akkerman A, Koslander T,  
18  
19 Hall J, Ostergaard Steinfeldt & Jarvis P (2018) *Nursing and Midwifery Students'*  
20 *Perceptions of Spirituality, Spiritual Care and Spiritual Care Competency. A*  
21 *Prospective Longitudinal, Correlational European Study. Nurse Education Today*  
22 *67 64-71. Doi: 10.1016/j.nedt.2018.05.02*

23  
24  
25  
26  
27  
28 Sessana, L. Finnell, D., & Jezewski, M. (2007) *Spirituality in Nursing- A Concept*  
29 *Analysis. Journal of Holistic Nursing (4) 252-262.*  
30  
31  
32  
33 Doi/abs/10.1177/0898010107303890

34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
Sherwood, G. (2000) *The Powers of Nurse-Client Encounters- Interpreting Spiritual*  
*Themes. Journal of Holistic Nursing (2) 159-175.*  
Doi/10.1177/089801010001800207

Shuler, P. & Davis, J. (1993a). *The Shuler Nurse Practitioner Practice Model: A*  
*Theoretical Model for Nurse Practitioner Clinicians, Educators and Researchers.*  
*Journal of the American Academy of Nurse Practitioners (5)1-18*

Slevin, E. and Sines, D. (2000) *Enhancing the Truthfulness, Consistency and*  
*Transferability of a Qualitative Study: Utilising a Manifold of Approaches. Nurse*  
*Researcher 7 (2) 79-84. Doi: 10.7748/nr2000.01.7.2.79.c6113*

Stevens Barnum, B. (2011) *Spirituality in Nursing: The Challenges of Complexity,*  
*Third Edition.* Springer Publishing, New York

- 1  
2  
3 Stranahan, S. (2001) Spiritual Perception, Attitudes about Spiritual Care, and  
4  
5 Spiritual Care Practices among Nurse Practitioners. *Western Journal of Nursing*  
6  
7 *Research* (1) 90-104. Doi:10.177/01939450122044970  
8  
9  
10 Treloar, L. (2000) Integration of Spirituality into Health Care Practice by Nurse  
11  
12 Practitioners. *Journal of the American Academy of Nurse Practitioners*. (7) 280-  
13  
14 283. Doi:10.1111/j.1745-7599.2000.tb00305.x  
15  
16  
17 Vessey D (2009) Gadamer and the Fusion of Horizons, *International Journal of*  
18  
19 *Philosophical Studies*, 17:4, 531-542, Doi: [10.1080/09672550903164459](https://doi.org/10.1080/09672550903164459)  
20  
21  
22 Wattis, J. Curran, S., & Rogers. (2017) *Spiritually Competent Practice in Health*  
23  
24 *Care*. London, UK: CRC Press Taylor and Francis Group.  
25  
26  
27 White, G. (2006) *Talking about Spirituality in Health Care Practice- A Resource for*  
28  
29 *the Multi Professional Health Care Team*. Jessica Kingsley, London.  
30  
31  
32 Yardley, L. (2000) Dilemmas in Qualitative Health Research, *Psychology & Health*,  
33  
34 (2) 215-228. Doi: [abs/10.1080/08870440008400302](https://doi.org/abs/10.1080/08870440008400302)  
35  
36  
37 Young, C., & Koopsen, C. (2011) *Spirituality, Health and Healing - An Integrated*  
38  
39 *Approach*. Jones and Bartlett, Sudbury.  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55

56 **Table 1: Basic Demographics**

58  
59  
60

Age: 40-50
------------

Gender: All female

Specialist Interest in addition to generic role: Mental Health, Eating Disorders, Homelessness, chronic disease, acute care, women's health, education

Years working as an NP: 7-10 years

MSc Qualification Nurse Practitioner: 7 participants full MSc

1 participant In-house training plus some post registration modules.

## **Table 2: Interview Guide**

### Interview 1 Guide:

Initial background- discussion of current role, years qualified and any areas of specialist practice will be ascertained.

What made you decide to become an NP? What influenced your decision?

Discuss your views about the differences in NP consultations with patients who may present with serious medical problems, complex presentations and mental health problems as opposed to minor illness. How do you view the relationship you develop with these patients? Is it different to those consultations with minor presentations? What happens over a period of time when you see these patients regularly?

What do you see as the most important aspects of the NP consultation? Does this differ from the role of other nurses in primary care?

What do feel is important in a holistic assessment of your patient?

Does spirituality have any importance in your approach to your patients? Does your consultation include acknowledgement of the patient's spirituality?

1  
2  
3 Is there a difference in your mind between spirituality and religion?  
4

5 Do you make an emotional connection with your patients or do you keep a  
6  
7  
8 “professional distance”? How much of yourself do you share with patients who you  
9  
10 may be seeing regularly?  
11

12 What do the words availability and vulnerability mean to you? Is this something  
13  
14 important in a consultation?  
15

16  
17 )Have you ever felt that you have become more involved in a patient’s life than you  
18  
19 should have done as a professional? Can you tell me a little about that  
20  
21 experience?  
22

23  
24  
25  
26 Interview 2 Guide:  
27

28  
29  
30  
31 Summary of previous interview and initial findings. Feedback of current  
32  
33 progression of research.  
34

35 Opening conversation with discussion about the concept of Availability and  
36  
37 Vulnerability as expressed by the Northumbria Community.  
38

39  
40  
41  
42 You have now read the information I sent you from the Northumbria Community  
43  
44 about Availability and Vulnerability, how does this correlate to your understanding  
45  
46 of these terms?  
47

48  
49 Do you feel this concept has any relationship to what we have discussed about  
50  
51 “spiritual dimensions” within NP consultation?  
52

53  
54 Are there any areas which would make you feel uncomfortable about consciously  
55  
56 observing for, and participating in “spiritual dimensions” of care?  
57  
58  
59  
60

1  
2  
3 Do you see Availability and Vulnerability as a useful lens to address “spiritual  
4 dimensions”?  
5

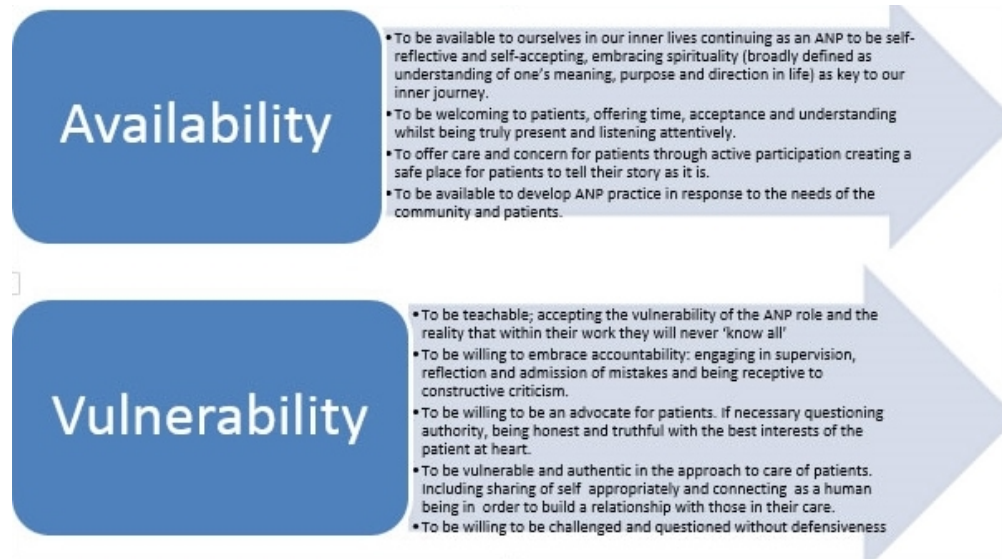
6  
7  
8 Does integrating Availability and Vulnerability include an acceptance of the role  
9 spirituality may have in a consultation  
10

11  
12 Have you thought further since reading this information about the role of spirituality  
13 in your life and work?  
14

15  
16 What do you feel the safeguards should be when a “spiritual dimension” is  
17 apparent in a consultation?  
18  
19  
20  
21

22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

For Peer Review



Availability and Vulnerability