Views of mental health practitioners on spirituality in clinical practice, with special reference to the concepts of spiritually competent practice, availability and vulnerability: A qualitative evaluation.

Melanie Rogers[a], John Wattis[a], Rachel Moser[b], Rachel Borthwick[c], Phil Waters[d] Rose Rickford[e]

[a]University of Huddersfield, [b]South West Yorkshire Partnership NHS Foundation Trust, [c]University of Kent, [d]Creative Minds, Wakefield, and [e]University of York, UK

ABSTRACT

Addressing spirituality is part of holistic care. Spirituality is hard to define and may be confused with religion. Thus, it may be neglected by practitioners in mental health care. This study explores the views of mental health practitioners about approaches to spirituality in their practice and the perceived utility of the concepts of 'Spiritually Competent Practice' and 'Availability and Vulnerability' for integrating spirituality into practice. It confirms the need for more education in this area and suggests ways to include spirituality in Mental Health Care. Survey responses were gathered from 104 clinical staff within a mental health trust (8% response rate) in 2018. Thirteen participants were also interviewed. Data were analysed thematically using template analysis with NVivo software. Participants identified that they wanted to integrate spirituality into practice and found the concepts of Spiritually Competent Practice and Availability and Vulnerability useful. Spiritually Competent Practice enabled practitioners to be clearer about addressing spirituality in practice; embracing Availability and Vulnerability enabled truly holistic care to be offered. These concepts provided ways of understanding the conditions and personal qualities helpful in providing spiritual care to mental health service users. Implications for practice are that Spiritually Competent Practice and Availability and Vulnerability may be helpful concepts in integrating spirituality into practice in mental health care.

KEYWORDS Mental health, Qualitative Research, Spirituality

Introduction

Person-centred approaches to care are widely accepted as important in health care (McCormack and McCance 2017, WHO 2015). The modern philosophical roots of person-centred practice lie in the ideas of Martin Buber, who argued that there were two different ways of approaching people and things: the *I-It* mode and the *I-Thou* mode (Smith 1937; Kaufmann 1996). The *I-It* mode, corresponding to the reductionist approach of conventional science, can be identified with Swinton's (2012) neo-Kantian concept of nomothetic (rule-based) knowledge. The *I-Thou* mode is the mode of personal relationship aligned with Swinton's idiographic (experiential) knowledge.

Person-centred care also draws on biopsychosocial and holistic care models. The biopsychosocial model (Engel 1980) recognised a hierarchy of interactive systems in and beyond the person. Holistic care embraces 'the whole person through the integration of physiological, psychological, socio-cultural, developmental and spiritual dimensions'

(McCormack and McCance 2017: 58). Addressing spiritual needs of service users is thus a vital aspect of person-centred care.

Research has shown that spirituality is important to service users but is not often addressed in clinical practice, and that the term spirituality can be confused with religion (Ellis and Campbell 2004; Holmes *et al* 2006; Rogers 2016). A large UK study of nurses found that, whilst nurses were interested in spirituality and spiritual care, they felt they needed more guidance and support in this role (McSherry and Jamieson 2011). Swinton (2001) argued that spirituality was a forgotten dimension of mental health care.

In response to this problem, a multi-disciplinary group of researchers have developed a concept of *Spiritually Competent Practice* (SCP) (Wattis *et al* 2017). SCP strives to rehabilitate the place of *spiritual care* in person-centred, holistic care through an emphasis on personal and relational qualities as well as *spiritual care competencies* and appropriate *opportunities* in the healthcare environment. An *Availability and Vulnerability* (A and V) framework (Rogers 2016, Rogers *et al* 2019b) has also been proposed to suggest ways to develop the personal and relational qualities to enable SCP. This qualitative study explored whether mental health practitioners in England found the concept of SCP, and the A and V framework, useful in helping them to deliver person-centred and holistic care.

Background

Spirituality has, historically, been central to the development of concepts of person-centred care, which have drawn on Buber's *I-Thou* approach. In the mid-20th century, Tournier, a Swiss general practitioner, argued for a *Médecine de la Personne* and his philosophical underpinnings have been traced to Buber's Hasidic existentialist concepts (Cox and Gray 2013). Client-centred therapy (Rogers 1957), later renamed person-centred therapy, originated in the same period and Rogers also had links to Buber (Anderson and Cissna 1997). Rogers argued for three *core conditions* in the therapeutic relationship that were related to successful outcomes in psychotherapy: empathy, non-possessive warmth and congruence. Kirshenbaum and Jourdan's (2005) review of the history of person-centred therapy (incorporating reviews based on empirical and experiential studies as well as expert opinion) provided evidence for the importance of the core conditions and, more broadly, for the importance of the therapeutic relationship. Kitwood (1997), in developing person-centred care for people with dementia, argued that personhood was undermined by impersonal care and explicitly traced the roots of his concepts to Buber who argued that 'Extended, the lines of relationship intersect in the eternal you' (Kaufmann, 1996: 123). Kitwood (1997:8) argued strongly for the importance of discourses of 'transcendence' and 'a very powerful sense, held in almost every cultural setting, that being-in-itself is sacred', citing Christianity, Buddhism and other 'non-theistic spiritual paths', even asserting that secular humanism saw 'the ultimate as personal'.

Integrating spirituality in clinical practice is hampered by several things. First, spirituality is a 'slippery concept' that is not easy to define, teach or investigate (Swinton 2001). There are many definitions of spirituality in healthcare from Hill and Pargament's (2003) assertion that spirituality is characterised by the 'search for the sacred' to Clarke's (2013) definition which referred to spiritualty as providing a method for finding hope, meaning and purpose, and simply 'being human'. An online survey of 100 multidisciplinary health care educators in the UK found that, whilst 90% of the 29 respondents believed that spirituality was relevant to healthcare education and 50% thought it was integral to teaching and learning, only 17% thought was integrated into curricula (Prentis *et alet al* 2014). In practice, Swinton (2010) argued for a 'thin, vague and useful understanding of spirituality'.

Second, the biomedical model challenged by Engel (1977) focuses on logical positivist methods of investigation, which have yielded enormous benefits for the technical aspects of health care but are not well suited to the investigation of topics like experience and spirituality.

Third, despite its spiritual roots, person-centred care has begun to be seen increasingly from the perspective of a consumer-oriented model. NHS England (2019) has now relabelled person-centred care as personalised care, which emphasises shared decision-making, patient choice and self-managed care, rather than centring the relationship between practitioner and the person needing healthcare. However, the professional interest in person-centred care including spiritual issues, particularly in mental health and end of life care has continued (Cook *et al* 2009; Gordon *et al* 2011; Cobb *et al* 2012). Public policy on spirituality has gradually evolved (Rumbold *et al* 2012), but educational responses to this development have been slow and patchy (Puchalski *et al* 2012) and practitioners report a lack of guidance in this area (McSherry and Jamieson 2011).

SCP has been developed in response to recognition that spirituality is an important part of person-centred care, and that there are currently barriers preventing practitioners from integrating spirituality into care. SCP requires *spiritual competencies* (van Leeuwen and Cusveller, 2004; McSherry *et al* 2020), *personal qualities (compassionate engagement)* and *opportunity* in the workplace for the practitioner to exercise these competencies and qualities (Wattis *et al* 2017:3). Initially developed from an observational study in occupational therapy (Jones 2016), SCP has been adapted to apply more widely to healthcare workers (Wattis *et al* 2017:3). The description used in this study can be found in Figure 1.

[Figure 1 about here, please]

Rogers (2016) developed the additional concept of *Availability and Vulnerability* as a framework for enhancing and expressing the personal qualities of compassionate engagement.

The current study begins to explore the usefulness of SCP and A and V in mental health practice. It is a small step towards developing wider use of these concepts in healthcare and we hoped it would help us refine and understand our ideas, and help the participants to develop their own ideas and practice.

Aims

The aim of this study was to begin to explore the views of a multidisciplinary group of mental healthcare professionals relating to spirituality in practice and the utility of the concepts of SCP and A and V in implementing spirituality in their practice.

Methods

The initial survey data were collected in 2018. Our sampling technique involved taking one large mental health trust in the North of England as a case study and inviting the entire population of interest in that trust (all clinicians) to participate. The survey was circulated to the whole target population using the 'Online Surveys' system (formerly Bristol online survey). The survey included a description of SCP. Participants were invited to give short written responses to four open questions which asked: how they would define spirituality; what their views were on the description of SCP; whether they integrated SCP into their clinical work; and whether they had any concerns about SCP. The survey also included a

quantitative element, the results of which are reported elsewhere (Rogers *et al* 2019a). This included Likert scales to measure spirituality in both everyday life and in practice, plus questions designed to explore how respondents viewed the relationship between spirituality and religion and whether spiritual issues had featured in their education.

Respondents to the survey were asked to volunteer to participate in interviews. An information sheet was provided to those who volunteered and full informed consent was obtained in advance of the interviews and confirmed at interview. A semi-structured interview guide was used. Interviewees were provided with a reminder of the description of SCP and the A and V framework (see Figure 1) and given time to consider them. The interview explored participants' personal views on spirituality, including the relationship of spirituality to religion; the participants' own personal approach to spirituality (if any); and their approach to spirituality at work. They were asked about their views on SCP and its relevance in clinical practice; and how the concepts of A and V resonated with their experience in practice. Finally, participants were asked about other ideas that might be useful in improving the approach to spirituality in practice. The interviews were audio-recorded and professionally transcribed. All transcripts were anonymised.

[Table 1 about here please]

A preliminary thematic analysis of the written answers to the questionnaire was performed by three authors (MR, RM and RB), with further discussion and analysis within the team. The interview transcripts were initially analysed by JW using template analysis (King and Brooks 2017), using N-Vivo software. Template analysis is a flexible style of thematic analysis appropriate to our philosophical stance of limited realism. It is largely inductive in its reasoning but does allow for some *a priori* themes to be explored (and abandoned if not relevant). After initial familiarisation with all the transcripts, three transcripts were thematically analysed to develop a preliminary template. The preliminary template was then applied to further groups of interviews over several iterations until a draft of the final template was arrived at. This template was discussed and agreed with other members of the team before it was re-applied to all the interview transcripts. The team also agreed that the themes were similar to those emerging from the written answers and that the same final template could be applied to them. The only exception to this was the analysis of participants' views of the A and V framework, which was only covered in the interviews. Throughout the analysis, the philosophical underpinning was one of limited realism, combining a realist ontology with a constructivist epistemology (King and Brooks 2017: 18).

The study was approved by the University Research Ethics Panel. NHS Integrated Research Application System Management approval was also obtained from the participating NHS Trust.

Results

104 mental health practitioners responded to the survey (approximately 8% of the target population). Their professional and demographic characteristics broadly corresponded to the characteristics of the entire clinical staff group. The final survey sample was:

- Two thirds female
- Aged 22-64
- From both acute and community services
- From a variety of roles, including nursing, occupational therapist, health care assistant, psychologist, psychiatry, social work, counselling and more.

Thirteen clinicians participated in interviews. Interview participants' personal religious/spiritual beliefs and other characteristics are briefly summarised in Table 1. The occupational backgrounds of the interviewees were reasonably representative of the overall sample.

The higher-level themes were generated from the interview schedule, while the sub-themes emerged from the data An additional theme, the need for further education in this area, was generated largely from participants responses to probes for "any other ideas/thoughts around spirituality in clinical practice".

[Table 2 about here]

The quotations are coded as P1-13 for the individual participants and SR (survey response) for written answers.

1. Ideas about spirituality:

1.1 Complexity and subjectivity of spirituality

Spirituality was seen as a subjective concept with a variety of meanings.

> *So, it's about the person as a whole, and it's about their beliefs and their expectations and about how they want to live their life.* [P10]

> *A personal belief that means very different things to different people.* [SR]

Spirituality was thought to be both inward looking, but also transcendental; to do with connecting and being part of a greater whole:

> *A belief that a person is more than a sum of their parts and that there is more to life than the material.* [SR]

> *It is a true inner quality of a person.* [SR]

> *Connection with others and the world (universe)…* [SR]

Some participants linked spirituality to self-integration, ethics and relationships:

> *Perception of, and integration of, self, ethics, behaviours and attitude towards self, others and wider systems.* [SR]

A few, however, felt spirituality was not a useful term:

> *…it's not a useful term for me. It's too vague, based on personal preferences.* [SR]

1.2 Spirituality and Religion

Views concerning the relationship of spirituality to faith or religion differed. They were seen as overlapping or even interchangeable:

> *… they are often interchangeable. In a way I would say that spirituality is what one is left with as one's own belief system and perception. I think that religion is the framework that we call how we set those things up and how we operate within them.* [P1]

> *I think there is an overlap between religion and spirituality. For me, I think, spirituality brings more freedom. Whereas my experience of a religion has been more structured 'You must do this. You must do that. You can't do this. You can't do that'.* [P2]

1.3 Spirituality, (Religion) and mental disorder

A few interviewees commented that religious or spiritual beliefs or experiences could also be symptoms of mental disorder:

> *Obsessions with religion.* [P9]

> *'Support people in their spiritual beliefs' as long as not delusional or mixed up in hallucination.* [P11]

2 Spirituality in practice:

2.1 Indirect Approaches

Approaches to spirituality in practice were by indirect communication and careful listening:

> *I never talk about it directly to people. It comes across in how I am as a person…* [P12]

> *Asking about values a person has and what gives meaning to their life and asking about goals.* [SR]

2.2 Being There (Presence)

Participants focused on the importance of personal *presence* with the service user:

> *I think that the place of this is that we utilise ourselves, whether we agree or see, or whether we like it or not, we are working with people interpersonally.* [P1]

> *My most important work with service users is just being there.* [P7]

2.3 Working with a person's own beliefs/religion

A non-judgemental approach was advocated and links were seen between person-centred care and respect for spirituality:

> *Try not to judge and make assumptions; try not to 'impose' own ideas onto others…* [SR]

> *Within person-centred care…linking people's feelings about their stories, their faith and creating a full picture of the person and how they find or have lost meaning in their lives.* [SR]

The importance of wider cultural and community connections was recognised:

> *Supporting people to return or to find their place within their community.* [SR]

> *Social inclusion around their interests and aspirations.* [SR]

3 Views on the description of Spiritually Competent Practice:

3.1 Generally Positive

Participants were largely enthusiastic about SCP:

> *I actually really like that. I really like it as a statement and it should be how we all practise.* [P13]

> *I totally agree with it* [SCP description] *… and particularly what I like about this is, contrary to what I've been speaking about, is that it pushes it on to… and shines a spotlight on the other person a bit more than perhaps I have …* [P1]

SCP was seen as an aid to understanding and clarifying the discussion of spirituality in the context of mental health care, especially identifying the distinction between spirituality and religion:

> *…the SCP definition has made me more aware of what spirituality encompasses and how it relates to practice.* [SR]

> *I think referring to SCP in these terms is less threatening. Many practitioners have had a bad experience within a denominational religion and prefer not to work within this remit as a result.* [SR]

3.2 Some reservations

There were some reservations:

> *I don't see myself as providing people with a sense of* [meaning and purpose] *I see myself as helping them to find what it means for them….* [P2]

> *You could cross out the word 'Spiritually' and just leave it saying 'Competent Practice'. So you could cross out both of those words, and perhaps put 'Good'.* [P8]

These included specific issues for mental health practice:

> *See, for some people, they wouldn't experience a sense of wellbeing in their community… you'd hope they would, but that's not always their experience. So, for example, if you work with a paedophile… within their living community, they might not experience that.* [P2]

> *… we work with a lot of people with substance misuse issues who… who tend to hang out with similar people. And the drug taking is important for them… they get a sense of well-being, they get a community, and they obviously see it as a way of addressing their problem, and I was thinking 'with that definition…. how would that work with such a client group* [P4]

Some people questioned the relationship of SCP to cultural/religious awareness:

> *There seems to have been a subtle shift in the definition of spirituality here, which hints at cultural/religious awareness, which for me are different from spirituality.* [SR]

3.3 Incorporation into practice

SCP was seen as already practised by some services:

> *It reflects the approach we take in the engagement with our clients and should continue to develop.* [SR]

> *We work holistically with our clients and spirituality is very important. We listen to and respond to the deepest values and meanings by which people live and do not impose our own values.* [SR]

However, it was not recognised in all teams with some confusion between spirituality and religion:

> *We really have no 'SPC'* [sic] *officially or even any training towards, so any spirituality we bring to the workplace is our own.* [SR]

> *I can't say it is ever mentioned except on the legally required assessment forms.* [which asks about religion rather than spirituality] [SR]

3.4 Facilitators and obstacles to SCP

Working in a team which acknowledged the importance of spiritual issues and sympathetic supervision facilitated SCP:

> *We have group discussions all the time, within the team. We also have management supervision, we have personal supervision.* [P3]

Better education was also seen as a possible facilitator (see Theme 5, below). Service constraints and the management culture in an over-stretched service presented obstacles to SCP with pressure to treat religion and spirituality as a 'tick-box' exercise:

> *Management is focussed on targets and funding. And my focus is on the care of the client and working with them. But there is nothing in between.* [P2]
>
> *My main concern is that the service within which we work… is far more interested in saving money and through-put of clients than in meeting their spiritual and holistic needs.* [SR]

The risk of confusion between spirituality and religion or spirituality and culture was recognised together with the importance of distinguishing between them:

> *Spirituality competent practice should not be used to mean cultural awareness or awareness of religious beliefs. There is culture and diversity training for that.* [SR]
>
> *…there is a generally held misunderstanding that 'spiritual' is akin to 'religious', and therefore to be avoided.* [SR]

Some noted a prejudice against discussion of religion or spiritual issues. One participant reported that on a course:

> *… we spoke about religion and [a younger participant] said 'No… Stay away from that'.* [P6]

There was some concern about the perceived lack of an 'evidence base' for SCP and its effectiveness. Also, there was a concern about the possible danger that spirituality could be seen as an alternative 'treatment' rather than as a part of holistic care:

> *It concerns me that spiritually competent practice is not evidence based or effective…* [SR]
>
> *Uncertainty about discussing spiritual matters. That spirituality is mistakenly seen as an alternative, rather than an addition to, medical and other forms of conventional care.* [SR]

4. Availability and Vulnerability Framework

4.1 Generally positive

Interview responses to the A and V framework were generally positive with parallels to person-centred care offered:

> *They basically highlight things which I have always considered to be absolutely essential to good practice … don't view them with any scepticism because I have seen it work and I have seen the value and I have had it play out for me.* [P1]
>
> *… if I think about my particular area of practice which is dementia care and we look at seminal works in dementia care… Tom Kitwood etc., then… it's… in some ways, it can be restating the same kind of ideas…* [P8]

Some saw the A and V framework as more practical to use than the concept of SCP:

> *… with the [A and V] framework… that's a lot easier for me to get through* [than the description of SCP] – *even though it's longer… you know with the availability bit which comes next and that is easier for me to take in, because it's bullet points.* [P11]

4.2 Availability

Different aspects of availability (as outlined in Figure 1) were highlighted by participants:

> *Yes. I really like the availability. And I suppose if I deconstruct it a little… for me… When I offer my care, and my concern, I also offer challenge.* [P2]
>
> *I try to work towards the first one… self-reflective and self-accepting. Yes. Be available to develop and practise response to the needs of the community.* [P10]

One interviewee, however, expressed a reservation about *Having enough time to do all of that!* (P13)

4.3 Vulnerability

Different interviewees highlighted different aspects of this sub-theme:

> *There is an acknowledgement there that we can make mistakes and that's OK and that there is a way out of that…* [P1]

> ['To be willing to be challenged'] *… 'and questioned'… Yes. Yes… So… I think this is beautiful… so I don't know if it would make an impact on managers. How do we bring in this framework into our client practice… If people won't accept this… We need something that like this for people to sit up, think about: 'Oh! The Clients!' You know… Not the clients as targets… And… err… meeting the funding requirements, but the clients… err… caring for them.* [P2]

Advocacy was seen as a useful aspect of vulnerability:

> *I think we must advocate because…umm… we can't not take on a position of real or perceived influence, if not power, without taking on some responsibility with that… I think it's actually a duty. I think it's a much wider human duty, if not an ethical duty, to protect people who can't protect themselves. That doesn't mean that we have to rescue, but I think that we have to help… if we can.* [P1]

> *We advocate… I advocate for my people all the time. I fight tooth and nail… I get myself in trouble all the time… I've done it. I've questioned authority and been told off for it as well…* [P3]

One interviewee related the impact of personal experience of vulnerability:

> *…it's* [personal experience of vulnerability] *improved my practice…* [P3]

4.4 Relevance to SCP

Most participants viewed the A and V framework as helpful for SCP:

> *Well. I think,* [A and V framework is useful for SCP] *very, actually. Because I think it covers everything it needs…* [P11]

> *I think it will. It would be nice for people to take time out and go through this… and go through it… and… as you say, reflect. It would give them something to really think about.* [P7]

Only one participant expressed reservations:

> *But if you're trying to bring it into some kind of practice and for spiritual competency, say, 'you can practise being more vulnerable'… I just don't think so really.* [P4]

5. Other ideas/thoughts

5.1 Requests for more education and training in spiritual aspects of care

This theme emerged without any prompts specifically about education. Over half of the participants raised this issue. One nurse, whose education had centred on basic themes of *physical, intellectual, spiritual, social* and *emotional needs,* thought spirituality should still be incorporated from the start of vocational education:

> *I think it starts with students, I have to say. I do. I really do. I think it starts that early. I think it needs that learning process for students. It needs to start at the beginning. You know… as it did for me. Because then it becomes part of every day.* [P11]

She also saw spirituality as a thread that should be running through training:

> *…so there should be a thread through the training that's already there… I don't think it does at the moment… we don't have that thread running through our practice at the moment. In order to integrate it…* [P11]

Others suggested specific educational initiatives with concerns about how 'space' could be found for this:

> *I wonder if there was a workshop. An in-house workshop? … Like a CPD event. Interestingly, in our team we don't talk about religion or spirituality. But then, we don't have a lot of time to talk because we are focussed… you know… on the targets*. [P2]

> *I wonder… where the space is to learn and to reflect on spirituality. … I think … away days are good for stuff like this.* [P9]

> *…whether you can incorporate this framework in the whole of the health scene… in the whole of education, to be there all the time. That would be more productive…* [P5]

Similar concerns were raised in survey responses.

> *I don't have much training so am probably not aware enough/not very 'spiritually competent'.* [SR]

> *I do not feel that staff are… suitably trained or have access to such training in the trust.* [SR]

Discussion

Although the response rate for the survey was low (8%), respondents represented a good cross section of frontline clinical staff in terms of demographic characteristics and clinical roles. A potential weakness of a sample based on participants' volunteering to take part is that results may be skewed towards those with a particular interest in the subject. However, the quantitative results did not suggest they were particularly biased for or against spirituality in everyday life or in practice. Furthermore, the qualitative responses highlighted aspects of the definition of spirituality that are well-rehearsed, suggesting external reliability. For example, spirituality was seem as 'a way of life' and a 'source of meaning', which largely corresponds to the definition Cook *et al* (2009:4) garnered from the alcoholism literature. The importance of *personal presence* and *just being there* with the person were stressed. These reflect the core conditions of *congruence and unconditional positive regard and empathic understanding* identified by Rogers (1957) and subsequently verified by research over many years (Kirschenbaum and Jourdan 2005). The recognition of spirituality as 'a way of life' rather than something other-worldly chimes with the views of health care educators that spirituality is a practical concern in the here and now (Prentis *et al* 2014).

The concept of SCP was well-received. It was helpful in emphasising the distinction between spirituality and religion. Some participants, but not all, felt their service effectively practised in this way. There were reservations about the mention of cultural appropriateness, which some felt to be a distinct issue. There was also some concern about overlap with other issues but we feel that the description of SCP emphasises the need to recognise that human beings are 'meaning-making' individuals and this aspect of how we construct our life stories needs to be recognised (Rogers and Beres 2017). There are overlaps with the concept of eudaimonic well-being in humanistic psychology (Ryan and Deci 2001) which is also concerned with meaning and purpose in life (and self-actualisation).

Participants expressed other reservations about the description of SCP. One did not see herself as *providing meaning and purpose* but as helping people find it for themselves. We agree that the wording in our description should be changed from 'providing' to 'helping people find'. There were specific problems about working in mental health, including the

possibility that some experiences (e.g. delusions or obsessions) could themselves be symptomatic of mental health issues, and potential issues of service-users connecting with communities that may be unhelpful to them, such as groups involved in paedophilia or substance abuse. These reservations suggest the need to qualify our description of SCP making it clear that the practitioner's role is facilitative and emphasising that connections with social groups need to be appropriate to the person's condition. One participant liked the description of SCP but questioned whether the term spirituality was necessary suggesting that it could simply be described as 'good practice'. Whilst we are sympathetic to this notion, we believe that retaining the term 'spiritually' encourages a focus on aspects of person-centred, holistic care that are most often neglected.

Other concerns were largely about the importance of distinguishing spirituality from religion and not imposing personal beliefs; an issue voiced elsewhere (Prentis *et al* 2014). Respondents recognised that the description of SCP helped in this area. There was also concern about lack of an 'evidence-base'. We suggest this may be due to the tendency of the 'bio-medical model' to downplay the importance of relationship factors which have, in fact, been well evidenced by Rogers (1957) and his successors (Kirschenbaum and Jourdan 2005).

Data from the quantitative and qualitative analysis identified issues about perceived lack of training in this area. There is research into the practicalities of filling this gap (Puchalski *et al* 2012; Smothers *et al*, 2019). Ali *et al* (2018) have stressed the importance of paying attention to ontological and phenomenological issues to provide authenticity and congruence in care-giving approaches. This is related to the 'compassionate engagement' component of SCP and A and V provides a framework that supports this kind of approach. Carlin *et al.* (2012:444) wrote about 'professional formation' being needed, alongside the acquisition of cognitive and technical skills to ensure that physicians were prepared to lead lives of compassion and service. This is equally important for other healthcare disciplines.

Concerns about service constraints also reflect other research. Jones (2010) has explored the importance of psychological as well as physical time in nursing. This is linked to the concept of 'presence' (being there, being with) in nursing philosophy and practice. Our participants recognised the importance of a supportive team and management culture and the need for appropriate education and professional development to facilitate SCP.

The overall A and V framework was generally liked, with participants recognising the link to person-centred care, as described in dementia care by Kitwood (1997). The importance of availability, including specific components (e.g. self-acceptance and being welcoming), was recognised. Being welcoming has been recognised independently through the 'Hello My Name Is' campaign (Granger 2019). Vulnerability is a topic approached with caution because of negative connotations; but in this study vulnerability (as described within the framework) was welcomed, especially the acceptance that anyone can make mistakes and should be open to challenge. The willingness of interviewees, when appropriate, to make themselves vulnerable by acting as advocates and supporting the people they were working with against 'authority' suggests a basic respect for those people, with some similarities to Rogers's (1957) *unconditional positive regard.*

Conclusion

Participants made positive connections between spirituality and person-centred care. They generally found the description of SCP helpful, especially in distinguishing between spirituality and religion. Several participants held reservations about the applicability of some of its terms to people with mental health problems. The participants generally welcomed the A and V framework and found its more practical orientation to be helpful in grounding SCP

in practice. Obstacles to SCP included the lack of relevant education and some aspects of task and target-centred management culture.

Although our sample was small, and potentially skewed towards those interested in spirituality, the combination of correlation with findings of other research on spirituality, plus a broad spread of opinions on spirituality in the accompanying quantitative survey (Rogers *et al* 2019a), indicate our findings are potentially useful in offering understanding of practitioners' views.

To further explore the themes identified, additional study is needed. Our next planned study was to explore the views of service users, but this has been interrupted by the COVID-19 pandemic. We would then like to expand our research to other organisations and ultimately other areas of practice.

These preliminary findings, however, suggest that Spiritually Competent Practice and Availability and Vulnerability are potentially useful tools to help practitioners engage in truly holistic, person-centred care. They help restore the emphasis on the person-to-person relationship in person-centred care and provide a way of restoring the spiritual component to holistic care. They emphasise the need for spiritual competencies, personal qualities and a management culture that facilitates personal engagement. The findings are an antidote to the over-emphasis on reductive concepts of 'evidence-based' care and provide a framework for understanding and putting into practice an often-neglected aspect of interpersonal care. Development of educational approaches to enable practitioners to sustain compassionate motivation in the face of time pressures and task/target-focused management is needed. SCP and A and V may be useful tools in this effort. Ultimately a change in management style may also be necessary.

Notes on Contributors

All the researchers are members or associates of the Spirituality Special Interest Group at the University of Huddersfield, UK.

Dr Melanie Rogers is a University Teaching Fellow for Advanced Practice and Spirituality, and an Advanced Nurse Practitioner at the University of Huddersfield, UK.

Prof. John Wattis is a Visiting Professor of Psychiatry for Older People at the University of Huddersfield, UK.

Rachel Moser is a Research and Development Manager at South West Yorkshire Partnership NHS Foundation Trust, UK.

Rachel Borthwick is a Researcher Facilitator at the University of Kent, UK.

Phil Waters is the Creative Minds Strategic Lead in Wakefield, UK.

Rose Rickford is a PhD Student at the University of York, UK.

References

Ali, G., Snowden, M., Wattis, J., and Rogers, M. (2018). Spirituality in nursing education: Knowledge and practice gaps. *International Journal of Multi-Disciplinary Comparative Studies* 5 (23), 27-49.

Anderson, R., and Cissna, K. N. (1997). *The Martin Buber-Carl Rogers dialogue: A new transcript with commentary.* Albany: State University of New York Press.

Carlin, N., Cole, T., and Strobe, l. H. (2012). Guidance from the humanities for professional formation. In Cobb, M., Puchalski, C. M., and Rumbold, B. (Eds). *Oxford textbook of spirituality in healthcare* (pp.443-449). Oxford: Oxford University Press.

Clarke J (2013) *Spiritual Care in Everyday Nursing Practice- A New Approach.* Palgrave, Hampshire

Cobb M, Dowrick C, Lloyd-Williams M. (2012) What can we learn about the spiritual needs of palliative care patients from the research literature? *Journal of Pain and Symptom Management* 43 (6):1105-1119. doi:10.1016/j.jpainsymman.2011.06.017

Cook, C., Powell, A., and Sims, A. (eds 2009). *Spirituality and psychiatry.* London: Royal College of Psychiatrists.

Cox, J., and Gray, A., (2013) Médecine de la Personne and the lost morality of the NHS in England. The Lancet. 93: 696

Ellis, M., and Campbell, J. (2004). Patient's views about discussing spiritual issues with primary care physicians. *Southern Medical Journal* 97 (12), 1158-1163.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science* 196 (4286), 129-136.

Engel, G. L. (1980). The biopsychosocial model. *American Journal of Psychiatry* 137 (5), 535-544.

Granger, K. (2019). Hello my name is campaign. Accessed June 2019 at https://www.hellomynameis.org.uk/

Gordon, T., Kelly, E., and Mitchell, D. (2011). *Spiritual care for healthcare professionals.* London: Radcliffe.

Hill, P., and Pargament, K. (2003) Advanced in the Conceptualization and Measurement of Religion and Spirituality. *American Psychologist* 58 (1) 64-74

Holmes, S., Rabow, M,. and Dibble, S. (2006). Screening the soul: communication regarding spiritual concerns among primary care physicians and seriously ill patients approaching the end of life. *American Journal of Hospice and Palliative Medicine* 23 (1), 25-33.

Jones, T. L. (2010). A holistic framework for nursing time: Implications for theory, practice, and research. *Nursing Forum* 45 (3), 185-196.

Jones, J (2016) A Qualitative Study Exploring How Occupational Therapists Embed Spirituality into Their Practice. Doctoral thesis, University of Huddersfield.

Kaufmann, W. (1996). *I and thou* (translated from Buber,M., *Ich und du*). New York: Simon and Schuster (Touchstone edition).

King, N., and Brooks, J. M. (2017). *Template analysis.* London: SAGE publications.

Kirschenbaum, H., and Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training* 42 (1), 37-51.

Kitwood, T. (1997). *Dementia reconsidered: The person comes first.* Milton Keynes: Open University Press.

McCormack B. and McCance T. (2017) *Person-centred practice in nursing and health care*. Chichester: John Wiley and Sons Ltd.

McSherry, W., and Jamieson, S. (2011). An online survey of nurses' perception of spirituality and spiritual care. *Journal of Clinical Nursing* 20 (11-12),1757-67.

McSherry, W., Ross, L., Attard, J., van Leeuwen, R., Giske, T., Kleiven, T., Boughey, A., and the EPICC Network (2020) Preparing undergraduate nurses and midwives for spiritual care: Some developments in European education over the last decade, *Journal for the Study of Spirituality*, 10:1, 55-71, DOI: 10.1080/20440243.2020.1726053

NHS England (2019) Universal Personalised Care. Implemented the Comprehensive Model. Department of Health, London.

Prentis, S., Wattis, J., Rogers, M., Jones, J., and Stephenson, J. (2014). Healthcare lecturers' perceptions of spirituality in education. *Nursing Standard* 29 (3)**,** 44-52.

Puchalski, C., Cobb, M., and Rumbold, B. (2012). Curriculum development, courses and CPE. Part 1: Curriculum development in spirituality and health in the health professions. In Cobb, M., Puchalski C., and Rumbold, B. (Eds). *Oxford textbook of spirituality in healthcare* (pp.417-428). Oxford: Oxford University Press.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, Vol. 21(2), pp.95-103.

Rogers, M. (2016). *Spiritual dimensions of advanced nurse practitioner consultations in Primary Care through the lens of Availability and Vulnerability. A hermeneutic enquiry*. Doctoral thesis, University of Huddersfield.

Rogers, M., and Beres, L., (2017). How two practitioners conceptualise Spiritually Competent Practice. In Wattis *et al* (Eds). *Spiritually competent practice in health care* (pp.53-69). Boca Raton: CRC Press.

Rogers, M., Wattis, J., Curran, S., Stephenson, J., and Khan, W. (2019a). A questionnaire-based study of attitudes to spirituality in mental health practitioners and the relevance of the concept of spiritually competent care. *International Journal of Mental Health Nursing* - In Press

Rogers, M., Hargreaves, J., and Wattis, J. (2019b). Spiritual dimensions of nurse practitioner consultations in family practice. *Journal of Holistic Nursing*. Eprint: https://doi.org/10.1177/0898010119838952

Rumbold, B., Cobb, M., and Puchalski, C. (2012). Policy. In Cobb, M., Puchalski, C., and Rumbold, B. (Eds). *Oxford textbook of spirituality in healthcare* (pp.383-389). Oxford: Oxford University Press.

Ryan, R. M., and Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology* 52,141-166.

Smothers, Z. P., Young Tu, J., Grochowski, C., and Koenig, H. (2019). Efficacy of an educational intervention on students' attitudes regarding spirituality in healthcare: A cohort study in the USA. *BMJ Open*, 9. http://dx.doi.org/10.1136/bmjopen-2018-026358

Smith R.G. (1937) *I and Thou*. Edinburgh: T. and T. Clark.

Swinton, J. (2001). *Spirituality in Mental Health Care: Rediscovering a "Forgotten Dimension".* London: Jessica Kingsley

Swinton, J., and Pattison, S. D. (2010). Moving beyond clarity: Towards a thin, vague, and useful understanding of spirituality in nursing care. *Nursing Philosophy* 11, 26-37. https://doi.org/10.1111/j.1466-769X.2010.00450.x

Swinton, J. (2012). Healthcare spirituality: A question of knowledge. In Cobb, M., Puchalski, C., and Rumbold, B. (Eds). *Oxford textbook of spirituality in healthcare* (pp.99-104). Oxford: Oxford University Press.

Van Leeuwen, R., and Cusveller, B. (2004). Nursing competencies for spiritual care. *Journal of Advanced Nursing* 48, 234-46.

Wattis, J., Curran, S., and Rogers, M.. (2017). *Spiritually competent practice in health care.* Boca Raton: CRC Press.

World Health Organisation (2015) *WHO Global Strategy on People-Centred and Integrated Health Care: Interim Report.* Retrieved from: https://www.who.int/servicedeliverysafety/areas/people-centred-care/global-strategy/en/ (accessed 2 June 2020)

Correspondence to: Melanie Rogers, University of Huddersfield.
Email: M.Rogers@hud.ac.uk

FIGURES and TABLES:

The following definition of Spiritually Competent Practice was provided to interview and survey participants.

Spiritually competent practice involves compassionate engagement with the whole person as a unique human being, in ways which will provide them with a sense of meaning and purpose, where appropriate connecting or reconnecting with a community where they experience a sense of wellbeing, addressing suffering and developing coping strategies to improve their quality of life. This includes the practitioner accepting a person's beliefs and values, whether they are religious in foundation or not, and practising with cultural competency. (Wattis *et al*., 2017 p3)

The following definition of Availability and Vulnerability was provided to interview participants.

Availability:

- To be available to ourselves; continuing as a practitioner to be self-reflective and self-accepting, embracing spirituality (broadly defined as understanding of one's meaning, purpose and direction in life) as key to our inner journey.
- To be welcoming to those in our care, offering time, acceptance and understanding whilst being truly present and listening attentively.
- To offer care and concern for those in our care through active participation creating a safe place to tell their story as it is.
- To be available to develop professional practice in response to the needs of the community and those in our care.

Vulnerability:

- To be teachable; accepting the vulnerability of our role and the reality that within our work we will never 'know all'.
- To be willing to embrace accountability, engaging in supervision, and reflection. Being willing to admit mistakes and being receptive to constructive criticism. To be willing to share uncertainty with those in our care and act in a way which is open, honest and transparent working within personal and professional limitations.
- To be willing to be an advocate for those in our care. If necessary questioning authority, being honest and truthful with the best interests of those in our care at heart.
- To be vulnerable and authentic in the approach to those in our care.
- To be willing to be challenged and questioned without defensiveness (Rogers 2016)

Figure 1. Information provided to participants

Table 1. Characteristics of interviewees.

Identifier	Gender	Age	Job	Personal Spirituality
P1	M	48	Child and Adolescent nurse lead	Acknowledges higher power inclined toward Buddhism and yoga
P2	F	57	Counsellor	Practises mindfulness
P3	M	52	Learning Disabilities Nurse	Christian
P4	M	57	Physiotherapist/manager	Spiritual person
P5	M	55	Child and Adolescent Consultant Psychiatrist	Personal spirituality
P6	F	48	Cognitive Behavioural Therapist	Personal spirituality +, concept of 'higher power', not religious
P7	M	49	Health Care Assistant	Church of England – very committed
P8	M	54	Advanced Nurse Practitioner older people	Secular
P9	F	30	Assistant Psychologist autism	Secular, atheist,
P10	F	61	Social Worker	Christian in belief
P11	F	50	Community Psychiatric Nurse	Not religious but spiritual
P12	F	49	Social Worker Early Intervention psychosis team	Spiritual not religious
P13	F	36	Child and Adolescent practitioner	Not religious but believes there is 'more to life than just this'

(Numerical identifiers have been given to maintain anonymity.)

Table 2. Themes and sub-themes

Theme	Sub-themes
1. Ideas about spirituality	*1.1 Complexity of the concept* *1.2 Spirituality and religion* *1.3 Spirituality, religion and mental disorder*
2. Spirituality in practice	*2.1 Indirect approaches* *2.2 Being there ('presence')* *2.3 Working with client's own beliefs/religion*
3. Views on the concept of Spiritually Competent Practice	3.1 Generally positive 3.2 Some reservations 3.3 Incorporation in practice 3.4 Facilitators and obstacles
4. Views on Availability and Vulnerability	*4.1 Generally positive* *4.2 Availability* *4.3 Vulnerability* *4.4 Relevance to SCP*
5. Need for education in spiritual approaches	