Spirituality and secularization: nursing and the sociology of religion

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Aim. The concept of spirituality is much discussed in the UK nursing literature, despite the fact that Britain is one of the most secular countries in the world, and steadily becoming more so. Here, I pose the following question: given this increasing secularization, what accounts for the current interest in spirituality among UK nurses?

Background. The literature on spirituality in nursing has blossomed in the last 10 years, and various attempts have been made to define 'spirituality', 'spiritual need' and 'spiritual care'. Most definitions distinguish between 'spirituality' and 'religion', acknowledging that the latter is more institutional, and theologically more restrictive, than the former; and they suggest that spirituality is universal, something which (unlike religion) all human beings share.

Method. I draw on the sociology of religion – neglected, for the most part, in the nursing literature – to establish two main points. Firstly, that the UK and the USA are at opposite ends of the religion/secularity spectrum, implying that it is a mistake to assimilate USA and UK sources. Secondly, that the concept of spirituality, as currently understood, is of very recent origin, and is still 'under construction', having become separated from its associations with Christian piety and mysticism only since the 1980s.

Conclusions. The extension of spirituality into secular domains is part of a professionalization project in nursing, a claim to jurisdiction over a newly invented sphere of work. For the time being, it remains an academic project (in the UK) as it is not one with which many clinicians identify.

Relevance to clinical practice. What counts as 'spiritual need' or 'spiritual care' may not be the same in both countries, and UK clinicians are unlikely to welcome the role of surrogate chaplain, which their USA colleagues are apparently willing to embrace.

Key words: nursing, professionalization, religion, secularization, sociology, spirituality

Introduction

Here is something which, at first sight, appears to be a paradox. The UK is one of the most secular countries in the world (Gill *et al.* 1998, Brierley 2000), church attendance having fallen so low that some denominations are in imminent danger of extinction (Sawkins 1998), and the number of people involved in less conventional forms of

religion being marginal (Heald 2000, Bruce 2002). Yet the level of interest in spirituality among nurses in the UK has never been higher, judging by the rate of contributions made to the 'spirituality in nursing' literature, and illustrated by the recent appearance of a special issue of the *Journal of Clinical Nursing* (vol. 15, no. 7), in which seven out of the 12 papers were by UK authors. Of course, the literature does say that spirituality should not be identified with religion, or at least not exclusively; but the sociological evidence strongly implies that, whatever interest in the UK people might have in non-denominational spiritual activity, it does not even begin to compensate for the dramatic decline in traditional religious affiliations and commitments. So there is a puzzle here, a question worth asking. How can we account for the interest in spiritual matters among academic nurses in the UK, when the UK population as a whole is apparently indifferent?

This is the question which I will attempt to answer; but it cannot properly be tackled without a review of sociological research. Surprisingly, the nursing literature on spirituality seems generally oblivious to the sociology of religion: few writers make even a passing reference to it, and I have found no more than a handful who cite important work from the past 30 years (by authors such as Martin 1979, Wilson 1982, Beckford 1989, Davie 1994, Bruce 1996, Heelas 1996, Roof 1999, Wuthnow 1999). This neglect of sociology may be one reason why it is difficult to find in the nursing literature any mention of the fact that the UK and the USA are, from a religious point of view, markedly dissimilar. The USA is, in fact, a more religious country than the UK and most of the other advanced industrialized nations (Davie 1999, Bruce 2002), to the point that it is currently regarded as a deviant case (Norris & Inglehart 2004). It is interesting, therefore, that both European and USA nurses contribute to the literature on spirituality without any acknowledgement of the fact that their respective working assumptions may be significantly different. Certainly, the *prima facie* paradox of 'spiritual' nurses in a secular culture does not apply to USA in the way that it does to the UK. In the rest of this paper, I will be primarily concerned with the UK; but I will find it useful, once or twice, to point to contrasts with the USA to justify the view that what counts as 'spiritual need' or 'spiritual care' will not necessarily be the same on both sides of the Atlantic.

The plan of the paper is as follows. I will first provide a brief review of the sociological research which demonstrates that the UK is about as secular as a country can be (except for France and Denmark), and that the more recent, non-religious forms of 'spirituality' have had no meaningful impact on people's lives. Turning to the nursing literature, I will argue that there is a central dynamic inherent in almost all the work that has been published in the last decade. I will refer to this as the 'stretch' dynamic, because its purpose is to massively extend the range of experiences that can be described as 'spiritual', while still trading on the term's religious connotations. As this is essentially a propaganda exercise (in a non-pejorative sense) rather than an exercise in conceptual analysis, it is designed not to *identify* spiritual needs but to *create* them. Finally, I will pose the question: why should nurse academics be motivated to engage in this 'stretching' exercise? My answer, that it is part of a jurisdiction-claiming strategy which exploits the political resonances of spirituality, is akin to those offered by Walter (1997) and Gilliat-Ray (2003), but subject to a number of important qualifications.

Christianity in the UK

On every measure, Christianity in the UK is in decline, a process which appears to have been gradual following the 1851 census of religious worship (Cox 1982, McLeod 1996), but which accelerated after 1950 (Brown 2001, Gill 2001). By all the best estimates, church attendance in the UK currently stands at roughly 7·5% of the population (Brierley 1999, Heelas & Woodhead 2005), down from 12% in 1979 (Brierley 2000), with all but the smallest churches and denominations affected. According to Brierley, there has also been a steady fall in church membership, from 27% of the population in 1900 to 10% in 2000. In fact, if current trends continue, certain denominations will cease to exist before long. The Methodist Church, for example, has experienced a steady reduction in membership of between 2%–3% every year (with just one exception) since 1957 – a trend which, if it continues, will see the end of Methodism by 2031 (Sawkins 1998). At the same time, the numbers of full-time clergy, across all the denominations, fell by 25% between 1900 and 2000, a period during which the UK population almost doubled (Bruce 2002).

Christian belief, as opposed to membership or attendance, is obviously harder to measure; but it seems that there is a corresponding decline, despite the claims of some authors (Davie 1994, for example) that the UK is now a nation of people who 'believe without belonging'. Certainly, belief in a personal God has decayed, falling from 43% in the 1950s to 31% in the 1990s (Gill *et al.* 1998), and to 26% in 2000 (Heald 2000). Moreover, evidence from the British Household Panel Survey suggests that the number of those who say that religious beliefs make a difference to their lives 'is declining more rapidly (in absolute terms) than active belonging' (Voas & Crockett 2005, p. 16). This is reflected, for example, in the fact that even the proportion of religious weddings is plummeting. In 1971, the figure for weddings in

England (all denominations) was 60%, but by 2000 it had dropped to 31% (Brierley 1999).

The signs are, unmistakeably, that these trends will continue, as there appears to be a very strong age cohort effect. It is often supposed that people tend to become more religious with age, and it is widely acknowledged that older people are more likely to attend church services than younger people (Heald 2000). However, the proportion of churchgoers who are aged 65 and over has been steadily rising since at least 1979 (Brierley 2000), a fact which cannot be explained simply as a consequence of the ageing process. In fact, data from the British Household Panel Survey and the British Social Attitudes Survey implies that each successive generation is less religious – in terms of belief, affiliation, and attendance – than the previous one, and stays that way as it gets older. Moreover 'the gap between cohorts has been increasing' (Voas & Crockett 2005, p. 18). The situation is such that even writers who are sympathetic to church life in Britain now contemplate the possibility that organized Christianity will eventually fall below the critical mass required to reproduce itself (Brierley 2000).

It is worth adding here that gender is also implicated in religiosity, as women are more likely to believe in God, more likely to go to church, and more likely to pray, than men (Beit-Hallahmi & Argyle 1996). And, just as the generation gap is widening, so is the discrepancy between sexes (Brierley 1991). This is true, not merely of the UK, but of Europe and America as well; and in all these countries the gender imbalance is long-standing (McLeod 1981, McDonnell 1986). There is no consensus about why this should be, but one theory relevant to nursing is that women are 'protected' from secularization by the extent to which their work, both paid and unpaid, involves looking after others (Walter & Davie 1998).

Spirituality in the UK

Suppose we were to group together bananas, books, Manx cats, ice cream, small islands and building sites, and say that they were all examples of 'umbricity'. We could then expect to find numerous papers devoted to the concept of 'umbricity', most of which would point out that it was an elusive, difficult-to-define, poorly understood notion, requiring further research and analysis. The situation, as I shall argue later, is not vastly different with 'spirituality' (for reasons which I will try to elucidate). In this section, therefore, I will restrict myself to a brief discussion of three identifiable layers of quasi-religious belief, two of which represent an attenuation of traditional – though not exclusively Christian – religious ideas. The evidence suggests that, in each case, UK levels of activity and affiliation are extremely low.

Many people in the UK retain vague echoes of Christian belief even when they have no interest in, or connection with, the church. They do not believe in a personal God with specifically biblical attributes but, when approached by pollsters, 21% will claim belief in some kind of 'life force' or 'higher power' (Gill *et al.* 1998, Heald 2000), an entity to which they ascribe no particular characteristics. Twenty-three percent opt for the even more vacuous formulation of 'something there'. This is not the basis for non-secular activity, affiliation or commitment; it does not even contribute to a 'belief system'. It just reflects the fact that religion is no longer of any great practical interest to them, and that 'when confronted with the need to make a choice, they pick the least specific response' (Bruce 2002, p. 138).

There is, *prima facie*, greater interest in the assortment of beliefs and practices which, in the broadest sense, can be called 'New Age', a term which is inevitably elastic, but which includes the wide range of topics to be found in the *Mind, Body, Spirit* section of the bookshop, borrowings from non-Western and pre-Christian religions, a good deal of popular psychology, and at least some types of alternative medicine. In terms of the 'spiritual marketplace' (Roof 1999), what is most impressive about this sector is the sheer volume of commodities, especially books, available to the New Age consumer. Indeed, in the view of some writers (Bauman 2000, Carrette & King 2005, for example) 'spirituality' has been transformed into a powerful market brand over the last two decades, representing the commodification of religion in a newly privatized and subjective form. However, when we ask how many people in the UK do more than read books, wear charms, or check their newspaper horoscopes, the answer is: very few. Even authors who believe that a spiritual revolution is taking place do not put the level of active weekly involvement at more than 1·6% of the population (Heelas & Woodhead 2005); and even this figure includes visits to osteopaths, homeopaths and Alexander teachers in addition to classes in tai chi, yoga and Buddhism. Moreover, if we only count those who regard their involvement in alternative therapies as having an explicitly spiritual dimension, the figure drops to 0·9%, something above 350 000 people. To put that in perspective, it is roughly equal to the numbers lost by a single denomination (the Methodists) since 1947. It is true that many people have had some experience of astrology, reflexology, meditation, faith healing, and so on; but only a small proportion regard these experiences as having any real bearing on how they live their lives (Heald 2000).

Finally in this brief review, we can consider people who engage in quasi-religious and spiritual activity through the medium of more formally constituted groups, ranging from those based on various Eastern philosophies (such as Hare

Krishna, and Friends of the Western Buddhist Order) to those with pagan origins (Druidism, or Wicca). According to the best estimates, membership of such groups is not likely to be much above 10 000 in total, or 'fewer than the numbers lost to the Christian churches in a month' (Bruce 2002, p. 139). There is only one form in which this kind of spirituality appeals to more than a tiny minority of UK people, and that is the bowdlerized version found in books, magazine articles and weekend courses – the ones which promise self-improvement and enlightenment without any of the traditional costs: discipline, effort, changes in belief, or disruptions to established patterns of behaviour (Kaminer 1999, Carrette & King 2005).

In summary, the UK population appears to manage its spiritual life according to a very simple formula. The more specific and demanding the belief, the fewer people adopt it. Conversely, the forms of belief which attract the greatest assent are those which are least specific and least demanding. Unsurprisingly, then, the faith which can fairly claim to be the most popular in the UK is the one which is most content-free: a vague belief in 'something there', completely free of any practical implications.

Britain and the USA

A brief comparison with the USA will be useful at this point. According to the General Social Survey, between 30% and 37% of USA citizens attended religious services at least weekly during 1996 (Smith 1998). Even allowing for the fact that the higher figure may be inflated by over-reporting, this is well in excess of the UK. Moreover, according to the World Values Survey, belief in God has remained at a steady 94% in the USA since 1947 (Norris & Inglehart 2004). In the UK, even if we combine the figures for belief in a personal God and belief in a 'higher power', the total is no more than 47% (Bruce 2002). Even more interesting is the fact that, in the USA, spirituality and religion are barely differentiated: 60% see themselves as both religious and spiritual, while 20% see themselves as spiritual but not religious, and 8% see themselves as religious only (Marler & Hadaway 2002). On almost every measure, the USA is the most religious of the modernized nations (along with Ireland and Italy), while the UK is the most secular (apart from France and Denmark). So it is unfortunate that the nursing literature on spirituality routinely lumps together UK and USA sources (most recently, Ross 2006), in a way that can easily lead to misconceptions. Dyson *et al.* (1997), for example, report that when Americans were asked to define spiritual well-being, 'the majority of responses were given in terms of religious faith'. They describe this as a 'confusion', an observation which clearly

betrays unfamiliarity with the extent to which, in the USA, spirituality and religion are associated.

Under construction

Return to the UK paradox. If the UK is a secular nation, with steadily declining church attendance and little interest in quasi-religious activity, it will be a difficult task to persuade most Britons that they are invested with something called 'spirituality', and that everyone has 'spiritual needs'. Yet we find in the nursing literature some unexpectedly sweeping and unargued claims. Spirituality is 'a dimension within every person' (Golberg 1998, p. 837), 'present in all individuals' (Narayanasamy 1999b, p. 124). It is the 'very essence of the human person' (Kendrick & Robinson 2000, p. 702), 'at the core of our human existence' (McSherry & Draper 1998, p. 688), the 'essential essence of the person' (Hall 2006, p. 804). It is the 'mainstream of life which unifies all aspects of the human being' (Baldacchino & Draper 2001, p. 834), an 'everlasting phenomenon that sustains and pervades all cultures' (Narayanasamy & Owens 2001, p. 447). And that is just a selection. There is, at the very least, a tension between the portrait of a largely secular the UK and these casually universalising claims made by UK nursing academics. On the one hand, most UK people are not particularly bothered about matters spiritual; on the other hand, spirituality is the essence of their humanity, and the everlasting phenomenon that sustains their culture. How is this tension to be resolved?

The answer to this question has a number of threads woven into it. Firstly, it is crucial to realise that the concept of spirituality is under construction, so much so that the cranes and scaffolding are still visible. This is not, of course, how the project of 'defining spirituality' is usually understood. The imagery in much of the literature is of something whose essential attributes can, with sufficient intellectual effort, be specified. Fawcett and Noble (2004), for example, think that we should be trying to capture 'the true nature of spirituality' (p. 137); McSherry and Draper (1998) observe that nurse theoreticians have tried 'to identify and describe the different components which make up the concept of spirituality' (p. 684); Bash (2004) asks: 'What *is* spirituality?' In each case, and in the vast majority of attempts to delineate the term in the nursing literature, there is an underlying picture of an independent conceptual entity – a dimension of existence, an inherent (if hidden) meaning, a phenomenon with a nature and components. Spirituality is already 'there', so to speak, and the task is to describe it.

Inevitably, however, the describing project breaks down. Successive attempts to 'clarify the meaning' of spirituality

merely add to the smörgåsbord of attributes it is said to possess, and this only serves to increase the scope for disagreement. Therefore, the notion becomes one more example of an 'elusive concept' (Narayanasamy & Owens 2001, Coyle 2002), lacking an 'authoritative definition' (McSherry 2005), and inviting 'many interpretations' (McSherry 2006). [For a sample of these interpretations, combined with yet another stab at a theoretical framework, see Miner-Williams (2006).] A standard explanation for this breakdown is that spirituality is just too complex, too deep a mystery, too far beyond the reach of human comprehension, to be amenable to definition. 'Perhaps', say McSherry and Draper (1998), 'the phenomenon is beyond the sphere and realm of our finite minds' (p. 684), a view echoed by Aldridge (2000), Swinton (2001) and Narayanasamy (2004). But there is a simpler explanation. The authors who contribute to this debate are not describing a concept which is 'already there', mysterious or otherwise. They are bolting modules on to a structure that is still in the process of being built.

Although some nurse writers give the impression that current understandings of spirituality have ancient roots (Dawson 1997, Narayanasamy 1999a, Peacock & Nolan 2000, Tanyi 2002, Hall 2006), the range of senses now associated with the term is of very recent origin. As Gilliat-Ray (2003) notes, virtually no major dictionary or encyclopaedia of religion (Eliade 1987, Bowker 1997) discusses spirituality in a generic sense, divorced from particular religious traditions; and, according to historian and theologian Walter Principe, 'spirituality' only began to detach itself from Christian associations with mysticism, piety and the contemplative life during the 1950s (Principe 1983: also Sheldrake 1992). Even in the late 1980s, the idea of spirituality still overlapped with the discourse of mysticism; but since then the latter term has been quietly superseded, as 'spirituality' was incorporated into the humanistic psychology and New Age movements, and rapidly became big business (Carrette & King 2005).

This, then, is the historical and sociological site on which the nursing debate about spirituality is taking place, a site on which various interest groups are still manipulating and manoeuvring, still attempting to chisel the concept into a congenial (or profitable) shape. The real question is not what spirituality, that 'unfathomable mystery', *is* (because there is no 'complex phenomenon' needing to be described). It is, rather, what 'spirituality' can successfully be *represented as*, deploying a range of rhetorical devices to achieve (and legitimate) a desirable outcome. Subject, of course, to the qualification that what counts as a desirable outcome will not necessarily be the same for all parties.

The stretch dynamic

Picture spirituality as a conceptual elastic band, with one end looped around a very specific religious tradition. Initially, the area contained within the elastic band is confined to the immediate vicinity of the tradition, but we can imagine it being stretched in one or more directions. If we now suppose that a number of people are engaged in the stretching, then the loop might come to have an irregular shape, and there may be arguments about exactly what the configuration should be, even if everyone involved agrees that stretching is necessary. This is, I think, a useful metaphor for the debate about spirituality in nursing, because it captures the way in which the idea is extended in different ways, and to differing extents, while retaining connotations derived from its original association with organized religion.

The range of experiences, commitments and projects which – as different authors have argued – should be considered significant aspects of spirituality is enormous, and can be arranged (very roughly) along an elongated continuum running from sacred to secular. It begins with full-blown religious faith, and continues with: a less fully specified account of the relationship between self, others and God; belief in a 'higher power' or 'transcendence'; an experience of 'integrative energy', 'connectedness' or 'ultimate reality'; reverence, awe, and other 'numinous' emotions; a search for meaning and purpose; hope; the person's highest values; close relationships; various complementary therapies; art, poetry, music; the contemplation and enjoyment of nature; personal well-being; political ideals; work or physical activity; personal gain (for reviews, see Ross 1994, Dyson *et al.* 1997, Coyle 2002, Bash 2004, Miner-Williams 2006, Ross 2006; for an excellent discussion from the psychologist's viewpoint, see Hill *et al.* 2000).

At its most elastic, then, 'spirituality' embraces almost every aspect of human experience, confining the non-spiritual and secular to a 'concern with fitted kitchen units and grouting' (Bruce 2002, p. 200). Not all authors, of course, are prepared to stretch the concept quite this far. At the conservative end of the spectrum, for example, Fawcett and Noble (2004) would prefer 'spirituality' not to be used 'outside of a belief in God' (p. 137); but this is very much a minority view. The Murray and Zentner (1989) definition is more popular: 'a quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any god. The spiritual dimension tries to be in harmony with the universe, and strives for answers about the infinite' (p. 475). This extends the concept beyond belief in God, but still includes reference to the infinite, and stops short of

well-being, work and relationships, making it possible to distinguish between the 'spiritual' and the 'psychosocial' (Murray *et al.* 2004), in a way that a more all-embracing version would find difficult. However, there are plenty of authors who argue that any exploration of meaning, any set of values – indeed, anything which has particular significance for the individual – counts as an expression of spirituality (examples include Oldnall 1996, Dyson *et al.* 1997, Nolan & Crawford 1997, Golberg 1998).

(All of which makes references to the ambiguity, uncertainty, and confusion surrounding spirituality a little ironic. When academic writers are proliferating interpretations of spirituality to such an extent, it is hardly surprising if clinicians and patients become disorientated. To adapt the famous remark of Bishop Berkeley: they have raised a dust and then complained that others cannot see.)

Occasionally, there are minor disputes. For example, van Loon (2005) takes Fawcett and Noble (2004) to task for 'tightening' the definition too much, and recommends a broader account, which includes hope, meaning and purpose. Dawson (1997) thinks that 'energy' (Goddard 1995) is too scientific a concept to have anything to do with spirituality. Whitehead (2006) expresses disappointment that existentialism is 'virtually excluded' from the account offered by McSherry *et al.* (2004). Bash (2005) comments on the same paper, and argues that spirituality is 'a spectrum of human responses to the numinous' (p. 1269). McSherry (2005) returns the compliment, and criticises Bash (2004) for being a 'reductionist' in that he represents spirituality as 'a construct of the personality' (p. 1020). But these are no more than local spats. Most authors agree with Dyson *et al.* (1997) in thinking that the 'narrow and restrictive view of relating the concept to religion must be challenged and expanded' (p. 1184). The disputes concern only matters of detail, and exactly which permutation of experiences will count as 'spiritual'.

What motivates this broad consensus? Here is one answer to the question. If 'spirituality' is defined in a 'narrow and restrictive' way, then it will apply to only a limited number of people. In the secular UK, as I have already suggested, only a very small proportion of the population has any specific interest in religion or quasi-religious activity, so the narrow definition will imply that few people – perhaps more significantly, few patients – have 'spiritual needs' or require 'spiritual care'. Therefore, to justify the claim that spirituality is 'present in all individuals', that *everybody* has spiritual needs, it is necessary to stretch the concept, and define the term much more widely.

This 'working-backwards' logic underlies the whole debate in nursing. We begin with the assumption that 'spirituality'

must apply to everybody, and define it accordingly. Inclusiveness, universality, is the criterion that any definition must satisfy, the test which all frameworks and interpretations must pass. Interestingly, this logic is sometimes made explicit. For example, in discussing the Murray & Zentner definition, McSherry and Draper (1998) say:

there is a need to provide a definition of spirituality which is universal in its approach…by having such a definition the concept of spirituality will be applicable to all individuals (p. 685).

Similarly, Baldacchino and Draper (2001) say:

If spirituality is defined only synonymously with religion and belief in God, then several persons, namely the atheists, agnostics, humanists and hedonists would be excluded from the possibility of using spiritual coping mechanisms. Therefore, spirituality applies to both believers and non-believers (p. 835).

I like that 'therefore'. Dyson *et al.* (1997) observe:

If the profession is to establish a definition and conceptual framework of spirituality that encompasses the needs of all its clients, this narrow and restrictive view of relating the concept to religion must be challenged and expanded (p. 1184).

Comparable remarks are made by Golberg (1998), Greasley *et al.* (2001), Bash (2004), and Miner-Williams (2006).

The Dyson statement is particularly revealing. 'Spirituality' must apply to everyone, because only on that basis can the claim that *all* patients have spiritual needs be justified. Crudely, then, the 'working-backwards' logic goes like this: we want to establish the conclusion that every patient, irrespective of faith (or lack of it), has spiritual needs; so we must first establish that, despite appearances, spirituality is universal; but we can only establish *that* by defining 'spirituality' so broadly as to make it true by fiat. Pursuing this logic, as we have seen, results in a paradoxical contrast between the UK's relatively secular culture and the hyperbole about spirituality being the 'mainstream of life' and the 'core of our human existence'. This brings us, however, to a question I have not so far addressed. Why, in the midst of this secularity, do nurses want to propound the view that all patients have spiritual needs?

Spirituality as a jurisdiction

Medicalization (Zola 1972, Fox 1977) is a familiar sociological idea, defined as 'a process by which non-medical problems become defined and treated as medical problems' (Conrad 1992, p. 209). There have been numerous studies of this process. Classic examples include mental illness (Szasz 1984) and hyperactivity in children (Conrad 1975); more

recent studies focus on women's sleep (Hislop & Arber 2003) and shyness (Scott 2006). It has been less frequently noted that there is a nursing equivalent to medicalization, a process for which no sociological term has yet been devised. The main difference is that, while medicalization fastens on non-health issues and redefines them as 'problems' that can be medically treated, 'nursification' identifies non-health issues and redefines them as 'needs' amenable to 'nursing care'. In both cases, however, the process is a manifestation of a professionalizing strategy which, as far as medicine is concerned, has often been portrayed as a form of social control (Zola 1972) and a means of acquiring power (Freidson 1970), though Conrad (2005) takes a much broader view.

The most familiar example of this redefining project in nursing is what Dingwall and Allen (2001) call 'holistic emotion work'. This is a concept which reclassifies one unavoidable aspect of working with people (that is, face-to-face contact) as a specialized field of expert practice, and transforms the various consequences of becoming a patient (emotional reactions, family relationships, practical arrangements and so on) into 'psycho-social needs'. Under the rubric of 'caring', it has dominated the last 20 years of nursing theory, developing a literature which, despite intrinsic weaknesses (Paley 2001), is impressive in its sheer scale. A 'key element of nursing's mandate', 'holistic emotion work' has become 'part of a claim to a distinctive jurisdiction in the division of labour in health-care', and is offered in justification of nursing's 'status as a separate and independent profession' (Dingwall & Allen 2001, p. 65).

As these observations imply, the demarcation of a particular sphere of work is a critical strategy in the development of any profession, usually involving claims to jurisdiction over a particular occupational territory, and often provoking competition with other professional groups (Abbott 1988). Indeed, some jurisdictional claims constitute an attempted 'invasion' of another profession's domain, although in other cases the claim is founded on the identification of a new 'problem' or 'need', defined in such a way as to imply the claim's legitimacy and to confirm the profession's entitlement to 'ownership' of the zone in question. A successful bid for jurisdiction is always a political achievement and, if the occupational zone is a hitherto unfamiliar one, represents a considerable rhetorical investment in the introduction of new definitions, new labels, new proposals for professional intervention, and new language to describe existing practices (Nancarrow & Borthwick 2005).

It is necessary, however, to distinguish between a profession's jurisdictional claims in the public arena, and the accommodations reached with other occupational groups in the workplace arena (Abbott 1988), a distinction which corresponds, roughly, to that between its 'mandate' and its 'licence' (Hughes 1971). It is not unusual for these to diverge. In the case of nursing, for example, as Allen (2001) demonstrates, the 'holistic emotion work' of the public mandate has been left high and dry by real-life developments in the workplace, and by the consequent shift towards tasks that would formerly have been the province of medicine. These tasks require new skills, but are 'still primarily those of an adjunct or subordinate profession' (Dingwall & Allen 2001, p. 70).

As Walter (1997) and, more especially, Gilliat-Ray (2003) suggest, it is tempting to see the promotion of spirituality in nursing as another jurisdictional claim, another effort to secure the profession's status. The strategy, as we have seen, is to reclassify a melange of unrelated projects – from making sense of life, to work, to close relationships, to complementary therapies, to the contemplation of nature – as expressions of 'spirituality', and correspondingly redesignate an impressively wide and disparate range of experiences as 'spiritual needs'. Of course, given its elastic nature, the 'spirituality' jurisdiction will overlap considerably with the 'psycho-social' jurisdiction; and 'spiritual care' might be regarded as an attempt to reconfigure 'holistic emotion work' using a new label (Walter, in fact, predicts that 'spiritual care will become indistinguishable in practice from emotional/psychological care', p. 29). However, it is not difficult to spot advantages that might accrue from making a bid for the 'spirituality' imprint.

It is not simply that the *Patient's Charter* (Department of Health 1991) tells its readers: 'you can expect the NHS to respect your privacy, dignity and religious and cultural beliefs', or that *Your Guide to the NHS* (Department of Health 2001) says that NHS staff will be 'sensitive to, and respect, your religious, spiritual and cultural needs at all times'. More generally, references to spirituality and religion remain embedded in legislation, policy and guidance, not only in the health services but also in education (as well as other parts of the public sector). The Government is committed to 'placing spiritual/religious care firmly within the holistic care the NHS has always striven to offer' (Department of Health 2003); spiritual education and development are an essential component of the National Curriculum (Department of Education and skills 1996, section 351); and there has been investment in the expansion of state-funded voluntary-aided faith schools (Department for Education and Skills 2001, Reed 2006). The UK might be socially secular, but politically there is a powerful incentive to maintain a myth to the contrary (Smith 2004). So the inclusion of 'spiritual care' in any claim to jurisdiction is arguably good politics.

In any case, however far 'spirituality' is stretched, the word still retains its religious connotations; and this, together with its place on the political agenda, gives it a certain fireproofing quality. For example, there is a significant rhetorical difference between referring to complementary therapies as 'health-care practices for whose efficacy there is no good evidence' and referring to them as instruments of 'nursing spirituality' (Heelas 2006). Similarly, it is not self-evidently part of a nurse's role to counsel the patient who is saddened by 'a sense that her life has not added up in the way she would have wanted' (Walter 2002); but describe this experience as 'spiritual pain', and the nurse's response as 'spiritual care', and the idea becomes much more resistant to attack. Finally, a third instance, to 'support, acknowledge, and applaud verbalized comments of peace, harmony and satisfaction with family circumstances' (Tanyi 2006), sounds like a non-job... until you call it 'spiritual intervention', at which point it is transformed into an activity whose legitimacy can be more confidently defended. It is this dynamic – the stretching of 'spirituality' beyond religion, so that it incorporates a mixed bag of secular domains, while hanging on to the term's religious associations, politically powerful as those are – which is characteristic of the spirituality-in-nursing literature, and which represents the staking out of a jurisdictional claim. Or so it is very plausible to argue.

Qualifications

The matter is, however, somewhat more complicated than this, and I will now outline three important qualifications. The first is that, in Abbott's (1988) terms, the jurisdictional claim is restricted to the public arena and, specifically, the academic nursing community. So it is vulnerable, in principle, to the same discrepancy between mandate and licence that we find in the case of 'holistic emotion work' (Dingwall & Allen 2001). It is also likely that the academics will be obliged to educate clinicians – and conceivably patients – in the new, extended sense of 'spirituality' (by introducing them to one of the mixed-bag permutations currently on offer). Certainly, what little evidence we have suggests that UK clinical nurses do not understand the academic agenda (see Ross 2006, for a review) although, like the rest of us, they are quite capable of reproducing some of the vague ideas typical of the popular *Mind, Body, Spirit* literature (interestingly, McSherry *et al.* 2004 claim that several of their respondents offered accounts resembling the Murray and Zentner definition; but close inspection of their examples shows that this resemblance is imaginary). Nor do clinical nurses actually provide spiritual care; or, when they do, it is infrequent, inconsistent, unsystematic, and apparently uncomfortable (again, see Ross

2006). In most cases, 'spiritual intervention' is equivalent to referring a patient to the chaplain. So one is not surprised to learn that 'the overwhelming and recurring need identified in almost all studies is for nurses to be properly prepared and educated in spiritual care' (Ross 2006, pp. 860–61).

A substantial part of this education, given the 'confusion' so frequently attributed to clinicians, will be socialization into the idea that terms such as 'spirituality', 'spiritual need', and 'spiritual intervention' are now universal, and can refer to almost any aspect of the patient's life. This is the point that Walter (2002) makes so neatly – and to which Swinton (2006) takes exception, reporting Walter as describing a 'mode of indoctrination wherein narrowly defined understandings of spirituality worked out by nurse academics with their own particular agenda are put forward as *the only* understandings...' (p. 921). But this is not what Walter is saying. Walter is not concerned with any particular definition of 'spirituality', with any specific choice from an elastic range of possibilities. He is simply alluding to the fact that the new definitions, all of them, are designed to be universal in scope, applicable in principle to everybody; and that it is *this* understanding of the concept that clinicians will need to be inducted into.

As for patients, the evidence is even more sparse. Interestingly, however, the process of reinterpreting 'what patients say' in terms of spiritual concerns has already begun. For example, Murray *et al.* (2004) interviewed patients with inoperable lung cancer and end-stage heart failure, and reported that 'spiritual issues were significant' for many of them. But anybody examining the transcript excerpts will (on my reading) find very little to support this claim – unless they already believe that 'How long have I got?' is a spiritual question, and that 'Well, it's just something I've got to accept' is an expression of spiritual need. Correlatively, when patients were asked about their understanding of 'spirituality' by McSherry *et al.* (2004), they 'all expressed difficulty in articulating a definition or even identifying with the term' (p. 937). The only curious thing, given the sociological data outlined earlier in this paper, is that anyone should be surprised by this.

The second qualification is that nursing's jurisdictional claim to spirituality must be considered in the context of chaplaincy. Given that over 90% of hospital chaplains, full-time and part-time, in England and Wales are Christians (Sheikh *et al.* 2004), and in view of the UK Government's commitment to the religious, spiritual and cultural needs of all NHS patients, against a background of increasing diversity and secularization (Department of Health 2001), there is clearly a strong incentive for the chaplaincy to expand its base of operations. Therefore, it is not surprising that the

clergy also engage in the stretch dynamic of 'spirituality', even if some of them wish to retain the 'transcendent' (Kendrick & Robinson 2000) or the 'numinous' (Bash 2005) in their understanding of the concept. This is articulated more explicitly, perhaps, in the American literature:

'Spiritual' is a label strategically deployed to extend the realm of relevance to any patient's 'belief system', regardless of his or her religious affiliation…[s]uch moves transform chaplaincy from a peripheral service, applicable only to the few 'religious' patients, into an integral element of patient care for all (Lee 2002, p. 339).

However, it applies equally to the UK, and the generic term 'spiritual caregiver' appears to have been accepted (e.g., of the six ordained members of The NHS National Services Scotland Spiritual Care Committee, five refer to themselves as 'Spiritual Caregivers' and one is a 'Spiritual Care Co-ordinator').

To this extent, then, nurses and chaplains have a shared agenda: to stretch the definition of 'spirituality' well beyond its anchorage in formal religion, to vindicate the claim that 'spiritual needs' are universal. But the implications of pursuing this agenda are unclear, since both groups (on the face of it) are proposing to do similar kinds of work, even though the overlap is not complete. This is recognized occasionally:

There is an interesting tension in the guidelines between opening up the task of spiritual care more widely among the hospital staff and making the role of the chaplain more professional…it will be important to ensure that these areas of spiritual care develop in a complementary way and not competitively (Elliot 2002, p. 19, writing about Scotland).

But others do anticipate competition:

If chaplaincy is to hold its own in an evidence-based environment as a competing profession…it needs to have a robust method of enquiry (Mowat & Swinton 2005).

Exactly how this tension will be resolved is not something that can be readily predicted.

According to Abbott (1988), there are several possibilities, several different types of 'settlement' in jurisdictional disputes. They include: exclusive jurisdiction going to one profession; subordination of one profession to another within the jurisdiction; a division of labour; one profession securing advisory control over aspects of another's work; a separation into more than one jurisdiction, according to client group. The subordination option sometimes takes an intellectual form, one profession retaining control of the 'cognitive knowledge area' (Abbott 1988, p. 75), but with other occupational groups practising under its intellectual supervision; and this, along with 'division of labour' and 'advisory

control', may be a candidate for the jurisdictional relation between chaplaincy and nursing (Nancarrow & Borthwick 2005 is an illuminating discussion of some related issues). In the meantime, the ambiguities remain. In Scotland, for example, a recent report on spiritual care by NHS Quality Improvement Scotland (NHS QIS 2005) is still asking fundamental questions such as:

Where does religion fit in?, How can we recognise spiritual care needs?, Where does spiritual care end and psychosocial care begin?, and Who is responsible for providing which elements of spiritual care? (p. 33).

Concerning the last of these questions, the report adds: 'A clear guide is needed, with definitions of roles and responsibilities'. So it would appear that there is still plenty of jurisdiction-determining work left to do.

The third qualification begins with some of the statements about spirituality I quoted earlier: it is the 'mainstream of life' which unifies all aspects of the human being' (Baldacchino & Draper 2001), an 'everlasting phenomenon that sustains and pervades all cultures' (Narayanasamy & Owens 2001), 'at the core of our human existence' (McSherry & Draper 1998). Such statements convey an intensity, a personal enthusiasm, which goes beyond any professional, jurisdiction-claiming manoeuvre; and we may well wonder whether one function of 'spirituality discourse' in nursing is to provide some kind of emotional uplift, or an experience of solidarity, for those who participate in it. As Bruce (2001) notes, one 'great role for religion is as guarantor of group identity', particularly where 'culture, identity and sense of worth are challenged' (p. 259). So perhaps it is not entirely coincidental that the literature on spirituality has blossomed during an 'epidemic of health-care reform' (Ham 2005, p. 192), which has sometimes been experienced as a threat to nursing identities and values (for example, Attree 2005). In this context, we might interpret the spirituality literature as a kind of quasi-religious practice in itself, providing succour to both writers and readers as they exchange supplication and response in a kind of academic litany. This is not, I hasten to add, a dismissive portrayal; it is, rather, an acknowledgement of a significant thread in the literature, something which appears to motivate at least a proportion of those who engage with it.

Conclusion

In closing, I would like to emphasise again that this paper is concerned, almost exclusively, with the UK, and that a different paper would have to be written about spirituality and nursing in the USA. Here is one further illustration of the gulf between the two countries. When asked 'How often, if at

all, do you think about the meaning and purpose of life?' 58% of people in the USA say 'often'. In the UK the figure is 25% (Norris & Inglehart 2004). The impact on nursing is considerable. Grant *et al.* (2003) conducted what they describe as 'the most in-depth survey on the topic of spirituality ever administered to a group of nurses', a study omitted from Ross's (2006) review. Among the findings are these: 85% of nurses claim there is 'something spiritual about the care that I provide'; 42% believe that 'All things considered, nurses provide more spiritual care to patients than chaplains'; and 30% say they would be willing to 'provide the same services as chaplains if given the time and training' (pp. 481/483). There are no comparable data from the UK; but, given the evidence we do have, it would be surprising if these results were replicated in Britain. In the USA, there is a case for arguing that nurses are, potentially, a group of 'new suppliers' of spiritual services (Roof 1999), at least to a to a segment of the population, commensurate with the observation that some non-religious organizations are becoming 'sacralized' (Demerath 1999). The signs are that this is unlikely to happen in the UK.

Finally, nothing I have said implies that experienced religious practitioners of the major faiths should not be available to the patients who wish to consult them. The UK is a secular country, but a significant minority maintain affiliations of a kind which are likely to become more salient during illness. This is the sort of spirituality which UK people understand, and which some of them claim to benefit from. In periods of ill-health, they should certainly be given the opportunity to take advantage of whatever services they believe a priest, imam, minister, rabbi, elder, or equivalent clergy, can provide.

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