Spirituality and Spiritual Care in the Deployed Australian Military Nursing Context:

A Hermeneutic of Understanding

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SUMMARY

An increasing body of literature has emerged on spirituality and spiritual care in a variety of acute, chronic and palliative care nursing settings. However, there is a paucity of research into spirituality in military nursing populations. The literature confirmed the continuing lack of a unified definition of spirituality. Further, it identified that spirituality is positively associated with resilience in the face of adversity.

This work addressed an identified gap in the literature by seeking to understand how Australian military nurses experienced spirituality and spiritual care in a unique deployed operational context. The researcher conducted phenomenological interviews of ten Australian military nurses, underpinned by the Philosophical Hermeneutics of Gadamer.

The analysis indicated that family and community support the spiritual needs of military personnel when at home and transfer that responsibility to the military family when deployed.

A new model of spiritual care was developed based on the findings of study and incorporated elements of an earlier model of spirituality by the researcher. The model was produced to improve the awareness and delivery of spiritual care of Australian military nurses on deployment.

The study confirmed the centrality of the military nurse, throughout the continuum of deployment (pre-deployment, deployment and post-deployment), to the delivery spiritual care. Further, it identified the reciprocal nature of spiritual care that assisted the nurse to also cope with the stressors of deployment.

Having identified the dangers and other challenges that deployed military operations present to the provision of spiritual nursing care, the research suggested that spirituality and spiritual care may provide positive benefits in protecting against the long-term psychological, emotional and spiritual impacts of military service on deployed operations.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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I owe a great debt of gratitude to a number of people who have assisted me throughout this journey. Firstly, to the nurses who gave willingly and openly of their experiences I feel truly humbled that you let me capture your stories. This research would not have been possible without your input.

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PART ONE
Horizons of Understanding

There can be no doubt that the great horizon of the past, out of which our culture and our present live, influences us in everything we want, hope for, or fear in the future. History is only present to us in light of our futurity (Gadamer, 1976/2004 p.8-9).

PROLOGUE

On the 22nd of August 1994 I arrived at Kigali Airport, Rwanda on a United States Air Force C-5 Galaxy aircraft as part of a contingent of 308 Australian Service men and women. Our role was to provide medical support to the eventual 7000 United Nations peacekeepers. Around fourteen nations had sent peacekeepers to oversee the peace process in Rwanda in the aftermath of the genocide of over 800,000 Rwandans. I was designated as second in charge of the intensive care unit but also worked as a trauma resuscitation team member, as an aeromedical evacuation flight nurse, and later ran humanitarian aid clinics in the camps for Internally Displaced Persons in Kibeho and other parts of the country.

When deployed on military operations I regularly journaled. Journaling provided me with an opportunity to reflect on my practice, ascribe meaning to the events of the day and consider my reactions and feelings to those events. At the end of that first day I reflected on my immediate impressions of the country and the sights I had seen. Below is an excerpt from my journal entry on 22 August 1994:

> *Arrive Kigali 1200hrs local. A peaceful air to the place (Airport) except for the obvious signs of warfare and troops with rifles…Issued with our weapons and 60 rounds of ammunition…Everywhere you see signs of war – mortar holes in the road and in buildings, cars peppered with small arms fire, squalid buildings with large holes and collapsed roofs…The people seem friendly and wave to us though we are warned not to take photographs of RPA* (Rwandan Patriotic Army) *troops – the conquering army whose members are as young as 14 & 15 years…there is no running water and no power to most of the rooms* (in accommodation)*…Many of the rooms have blood splashes and bullet holes in them.*

It was against the backdrop of humanity displaying its absolute worst and most destructive qualities that I began to deepen my personal spiritual journey. It was also at this time that I reflected more critically on the way that I and my fellow military nurses provided spiritual care during clinical contacts. On one level, spiritual care was directed to my patients, whether military or civilian. On another level, spiritual care involved spiritual support to the colleagues who were sharing the deployment experience with me, and also how I attended to my own spiritual needs.

The journal entry quoted below provides an example of my spiritual self-care on deployment. However, it also refers to the emotional care I provided to my colleagues. On reflection I understood that much of the peer support I provided my colleagues was also spiritual care because it touched their spirit in a moment of need.

> *September 15th 1994. Very stressful start to night - One week old baby girl brought into unit post-op following laparotomy to drain pus filled peritoneum probably caused by poor umbilical care perinatally…I was stroking her head when at 2200 she ceased spontaneous respiration - attempts to resus futile…decision made to cease active resus due to overwhelming septicaemia…feelings of sadness, difficulty holding back emotions – debriefing session with <> of worthwhile value…Lord's strength carried me through with the knowledge that young <> was going to Heaven and to the love of her Father. It was difficult not to relate death to how I would have felt if* [my daughter] *ever had an accident of such proportion. I spent some time making sure others were alright emotionally by talking through experience.*

Rwanda was my first overseas deployment as a military nurse and it was an incredibly confronting experience. However, at the same time it was personally and professionally rewarding. As I reviewed and reflected upon my journal entries it

became apparent that my sources of spiritual support came from engagement with the military chaplain who had accompanied us into Rwanda and my personal relationship with God through prayer and reading the bible. This was evidenced by the biblical quotes and personal prayer points of thanks, guidance and support that I wrote in my journal at the end of each day. It is important to remember, however, that the journal entry above is an example of my personal spirituality as a Christian nurse and does not reflect the views of the participants.

The experience of deploying to Rwanda was a seminal point in my life and provided the inspiration to begin my first Master's Degree foray into spirituality and spiritual care in the Australian military (Ormsby, 2001). The enduring influence that this event has had on me, along with an ongoing desire to understand spirituality and spiritual care on deployment at a deeper level, were the catalysts for the thesis presented here.

CHAPTER 1: INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 Introduction

This thesis presents an interpreted view of spirituality and spiritual care in a deployed military nursing context as expressed through the experiences of ten Australian military nurses. The findings have been interpreted through the Philosophical Hermeneutic lens of Gadamer (1976/2004). Gadamer (1976/2004) asserted that understanding is always an interpreted event.

The literature (recorded in Chapter two) traced a paradigmatic shift in how spirituality was perceived by the nursing profession. Where spirituality in the Western world was once largely discussed from a Judeo-Christian perspective, it now reflects an increasingly pluralistic meaning, a point that was not lost on the participants in this study. Nursing, however, retains a strong historical association with spirituality that is expressed through religion in both Western and Eastern nursing traditions (O'Brien, 1999; Lovering, 2008).

Nursing also retained a strong historical connection with the military. Many religious nursing orders were formed to care for the sick and wounded on the battlefield (Johnson et al, 2006). Indeed, modern nursing generally acknowledges a debt to Florence Nightingale for transitioning nursing into the professional body that it is today (Wagner & Whaite, 2010). Nightingale (1898) developed a large portion of her ideas on nursing from her deployed experiences caring for casualties during the

Crimean War (O'Brien, 1999). Deployment during Nightingale's time meant long absences from home, austere conditions, arduous work hours and the dangers of disease and injury (Dossey, 2010).

The contemporary deployed military nursing context still poses considerable challenges to the delivery of care and is, therefore, presented as a unique area of nursing practice (Wilgus, 2011). Indeed, deployment is offered as a defining characteristic of military nursing that differentiates it from civilian nursing practice.

1.2 Thesis Structure

The thesis is presented in four parts that reflect the Philosophical Hermeneutic approach of Gadamer (1976/2004). Philosophical Hermeneutics suffused all aspects of this study from inception, to data collection, analysis, writing and conclusion. The four parts that form the framework for the thesis represent what the researcher believes are arguably the most salient elements contained within the Philosophical Hermeneutics of Gadamer (1976/2004). However, the elements should be viewed as inclusive of the other aspects of Philosophical Hermeneutics that include, for example: prejudice; historicity; the hermeneutic circle; temporality; facticity; and the game, as:

> it is a circular relationship…the anticipation of meaning in which the whole is envisaged becomes actual understanding when the parts are determined by the whole themselves also determine this whole (Gadamer, 1960/2003 p.291).

Philosophical Hermeneutics is described and applied throughout the thesis and, therefore, the headings should be understood as signposts from which to access the data, analysis and findings. While no clear series of analytic steps were offered by Gadamer to the interpretive endeavour, the following headings have been used to provide a pathway for the reader to follow throughout the ensuing pages:

Part One – Horizons of Understanding

- Introduces the study and situates the thesis within the historical and present horizons of understanding found in the nursing and wider literature on spirituality and spiritual care. Further, it discusses military nursing and the unique nature of deployment.

Part Two – Method and Truth

- Presents the Philosophical Hermeneutic methodology[1] that underpinned this study and the methods used to structure the analysis of the data. Gadamer's (1976/2004) claims of truth over method are tested.

Part Three – The Hermeneutic Dialogue

- Introduces the study participants and details the reflective, descriptive and interpretive modes of understanding used in the analysis of the study data and presents the findings in thematic form.

[1] Methodology and method are different but related concepts. Methodology is used throughout this thesis to refer to the philosophical assumptions that underpinned the research process, in this case Gadamer's (1976/2004) Philosophical Hermeneutics. Method refers to the specific techniques used to collect and analyse the data consistent with the philosophical assumptions (Merriam, 2002). In this thesis Van Manen's (1997/2007) approach to researching lived experience and Colaizzi's (1978) phenomenological method of data analysis are used in combination to reflect upon, describe and interpret the data.

- Brings together the literature, the analyses and the themes into a cohesive discussion and presents the findings in a new model of spiritual care.

What follows is a view of spirituality and spiritual care in a deployed military nursing context that is presented through the interpretive lens of the researcher after Gadamer (1976/2004). Gadamer (1976/2004) asserted that every interpretation of an event is subject to the historicity[2] evident in the horizon[3] of understanding of the interpreter and "includes a reflective dimension" (p.45) (see Chapter three for a detailed examination of Philosophical Hermeneutics). Therefore, the next section offers part of the researcher's story as a military nurse to provide the reader with an understanding of the historicity that shaped the interpretations contained within this thesis. The horizon of understanding of the researcher was merged with those of the participants and the text and found a temporal closure in the fusion of horizons (Gadamer, 1976/2004).

1.3 Background to the Study

The researcher has spent over 23 years as a Registered Nurse in the Royal Australian Air Force and was fortunate enough to have deployed on three major military

[2] Gadamer (1960/2003) asserted that *understanding is essentially a historically effected event* (p.300). In this way understanding is always influenced by a person's historicity or past.

[3] Horizons are used by Gadamer (1976/2004) to identify the temporal nature of understanding that incorporates the ever expanding history that we carry into an interpretive act. A fusion of horizons occurs when agreement is reached between the interpreter and the interpreted in which both have expanded their horizon of understanding (Dorstal, 2006).

operations during that time. Reflection on those deployments and the literature highlighted that while spirituality was increasingly well understood in a variety of acute (Timmins & Kelly, 2008; Daaleman, 2012; Linhares, 2012), chronic (Yang et al, 2011; Ennis & Kazer, 2012) and palliative (Harrington, 2003; Evans & Hallett, 2007; Penman et al, 2013) care; military veteran (Crompvoets, 2011; Sixsmith et al, 2013) civilian nursing and health settings, it was not so well understood in relation to the serving military nursing context (Ormsby, 2001; Ormsby & Harrington, 2003). The lack of research into the deployed military context was identified as a gap in the nursing research and literature.

Study purpose

In light of the high number of military operations to which Australian military forces have deployed to since 1999, the purpose of this study was to understand the phenomena of spirituality and spiritual nursing care as expressed by Australian military nurses themselves. In this way the researcher sought to address the knowledge gap identified above. The underlying assumption of the study was that a better understanding of spirituality in the unique context of deployed military nursing would assist nurses to improve the delivery of spiritual care to their patients. What was not immediately apparent at the outset of the study was that spiritual care was not exclusive to nurse-patient interactions but also extended to nurse-nurse, nurse-chaplain and nurse-community interactions. While the original focus of the study was on nurse-patient interactions, it expanded to incorporate all of the spiritual caring relationships identified above. This study, therefore, examined how Australian military nurses understood spirituality and applied and responded to spiritual care in a deployed military context.

A personal journey

The prologue provided the context from within which the spiritual journey of the researcher as a military nurse began. However, it only captured a glimpse of the background in the Australian Defence Force. This section, and the section to follow, examine the researcher's journey in the Australian Defence Force and are presented in first person to reflect the personal experience of that journey.

My career as an Air Force officer has taken me to many parts of the world where both my skills as a nurse and my personal boundaries have been challenged. I was fortunate enough to have worked with the United Nations in Rwanda in 1994. In 1999 I also deployed to East Timor as part of INTERFET,[4] following the vote for independence from Indonesia. I deployed again in 2002 into Bali as a Flight Nurse with the retrieval teams to evacuate victims of the bombings in Kuta. Finally, I returned to East Timor (now Timor Leste) in 2005 as part of the United Nations as Australia was withdrawing its military from this fledgling nation. During these experiences I was constantly reminded of the frailty of life, the limitations of military solutions to global threats, the importance of family and community, the difficulties experienced by military personnel in undertaking their work while separated from their homes and families, and the importance of spirituality as a protective factor against the challenges of deployment.

I have seen and felt the highs of achieving the mission objectives and of making a tangible difference to the lives of those to whom I had provided care on deployment.

[4] The International Force in East Timor was an Australian led multinational military force that oversaw the transition of East Timor from Indonesian rule to independence.

Equally, I have observed the devastating physical and psychological effects of deployment experienced by many of the men and women who serve, or have served, our nation in the Australian Defence Force. These observations included personal friends and acquaintances who had died, been seriously injured, or who had been psychologically scarred by the overwhelming experiences that can and do occur on deployment.

Military personnel, including nurses, are not immune to the often confronting challenges of deployment (Hodson, 2002; Gibbons et al, 2012; Simmons, 2012). Emotional resilience and spiritual values, therefore, may be negatively affected through: the viewing of immense personal tragedy; feelings of impotence at being unable to intervene in massacres of civilians by warring parties[5]; critical injury and illness leading to hospitalization; separation of a person from the military unit that may lead to feelings of "letting your mates down"; and the effects of separation from family and normal support networks. Gibbons et al (2012) supported this view when they suggested that United States military healthcare providers exposed "to life-threatening situations will increase the probability of adverse psychological disorders following these traumatic experiences" (p.3). These issues, therefore, laid the foundation for understanding some of the unique challenges that the participants identified in their practice context that impacted the provision of spiritual care.

[5] Australian Defence Force personnel deployed on military operations are required to abide by specific Rules of Engagement that are consistent with the Geneva and Hague Conventions that form the basis for the International Laws of Armed Conflict (DoD, 2006a). In many operational settings, for example Chapter Five United Nations Peacekeeping operations (UN, 2008), military personnel may not be permitted to intervene directly in acts of aggression unless they are in imminent threat themselves.

My initial research into spirituality

During my time in Rwanda I "grew" tremendously in my personal spiritual journey. My spiritual growth led me to reflect more consciously on the spiritual needs of my patients as part of a holistic approach to care. However, spiritual care provision by my colleagues at the time appeared to be largely *ad hoc* and led me to question whether spiritual care issues were considered in caring interactions with patients.

I began my initial exploration of spirituality within a military nursing context in 1999 in a thesis for my Master's degree. A mixed method descriptive framework of interpretive investigation was used to understand how Registered Nurses working within the Royal Australian Air Force, one of the three arms[6] of the Australian Defence Force, understood and applied spirituality in their practice (Ormsby 2001). Data were obtained from questionnaires (35 respondents) and interview (five participants). The research sought to understand:

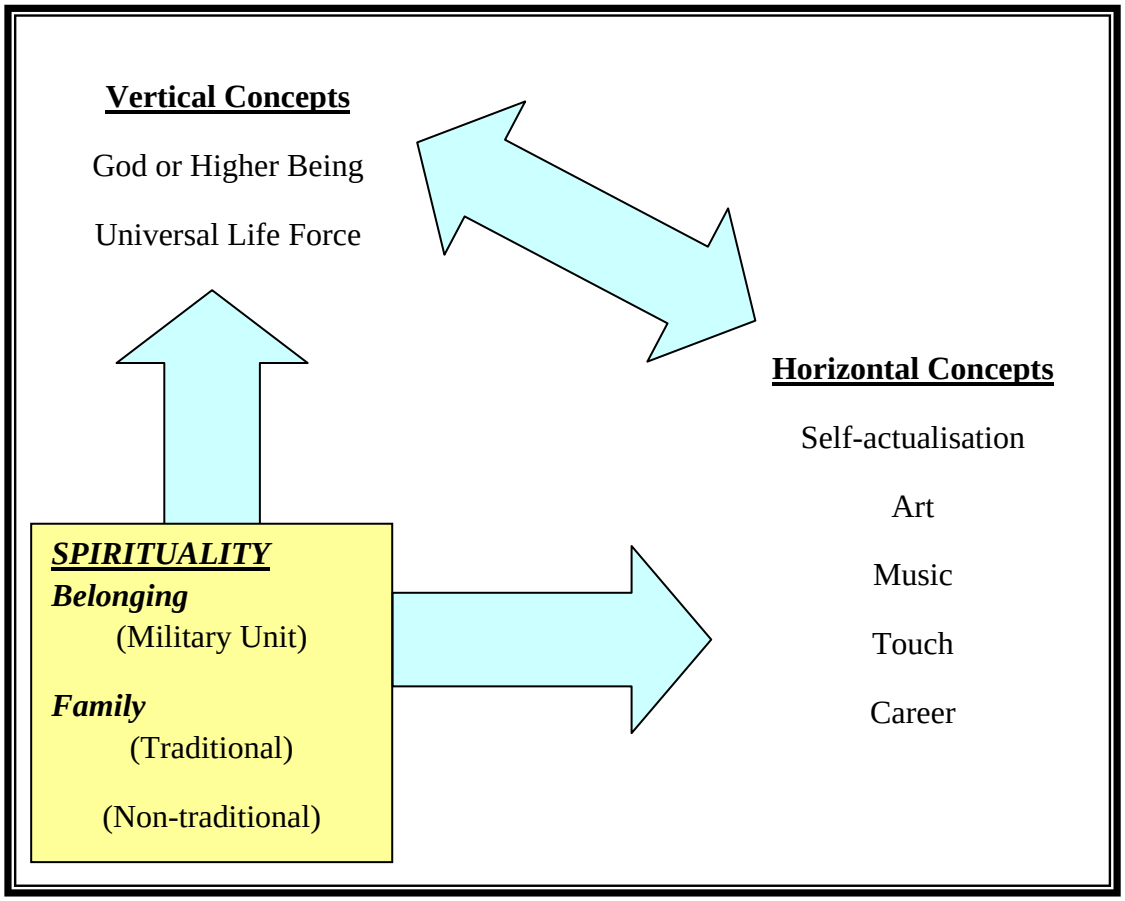
- how the nurses defined spiritual care;
- what methods the nurses used to assess and implement care for spiritual needs; and
- what factors influenced the provision of spiritual care.

Analysis of the data led to the development of a model of spirituality (Figure 1.1) that highlighted the central significance that was placed on both a traditional and a

[6] The Australian Defence Force comprises three military arms: the Royal Australian Navy; the Australian Army; and the Royal Australian Air Force.

non-traditional concept of family in the military. The findings also indicated that Air Force nurses situated spirituality in vertical (transcendent) and horizontal (humanistic) terms after Moberg (1979). These concepts, to be discussed below, were found to be pivotal to the understanding of spirituality and spiritual care in the military setting by military nurses.

Figure 1.1: Conceptual Model of Spirituality as Defined by RAAF Nurses (Ormsby 2001)



The differing concepts of family identified in the earlier research, along with a desire to better understand how military nurses ascribed meaning to spirituality and their roles in spiritual care, were important considerations for this current research. I acknowledge that an acute care military setting may appear an unlikely focus for

research into spirituality. However, my argument is that research into spiritual care is applicable to all nursing settings. For example, the research of Harrington (2003), Evans & Hallett (2007), and Penman et al (2013) were applicable beyond the palliative care contexts that were the foci of those studies. Cockell & McSherry (2012) noted a bias in the research toward palliative care and oncology care settings when reviewing the international nursing literature. However, they supported my argument above when they wrote that "if spiritual care is a useful concept here, it is likely to be useful in other contexts" (p.965).

The discussion begins by exploring the concept of family and a sense of belonging identified in Figure 1.1.

Family and a sense of belonging

The conceptual model of spiritual care visually represented the relationships that formed the basis for spirituality and spiritual support networks for the individual. The data suggested that military personnel found spiritual support in two distinct family constructs (Ormsby, 2001). The first family construct was that of the "traditional family". The second family construct involved the relationships that military personnel formed with their military unit as a "military family".

Traditional family

The traditional family of an individual comprised the spouse, partner, children, parents and other significant people, that included friends and faith communities. These people, individually or collectively, helped to form the spiritual reality of the

individual. In belonging to a traditional family, military personnel had a core group of people in whom they could confide, express their spiritual self, and find solace and support when needed. The participants (Ormsby, 2001) generally agreed that when not deployed, military personnel sought their spiritual support outside of the military in the relationships that transcended their military life.

Military family

Non-deployed. Every member of the Australian Defence Force belonged to a unit that administered all aspects of their career. Military personnel generally developed a strong identification and sense of belonging with their unit which began to take on the nature of an extended family. The military family, however, did not supplant the role of the traditional family in providing spiritual support when the individual was not deployed. That did not mean that the military family was not an important part of the life of an individual. Rather, the participants agreed (Ormsby, 2001) that when military personnel were injured or ill, the unit facilitated support to the person and their family, but the traditional family maintained the role of primary carer and support for the individual.

Deployed. When military personnel deployed on military operations, the significance of the role of the unit as a military family increased. Individuals no longer had ready access to their traditional family to provide spiritual support. Indeed, separation from home could be for periods of up to a year. It was within this context that individuals within a unit became surrogate carers for each other in a military family dynamic. The participants agreed (Ormsby, 2001) that a sense of camaraderie developed within a unit through the shared experiences of deployment. The *esprit-de-corps*, the

spirit of a body of persons (Oxford, 1975), within a deployed unit enabled individuals to develop a mutual trust between one another that fulfilled the role of a *de facto* family.

The role of the nurse. Military nurses on deployment approached their patient care from within the culture and context of the military. In this way they shared the common experiences of deployment with the military colleagues with whom they deployed. As part of the broader military family, military nurses were placed in a unique and privileged position in caring for their comrades in arms. The participants (Ormsby, 2001) suggested that when military personnel were injured or ill, and consequently separated from their unit and their family at home, that the military nurse stepped into the role of spiritual carer for their patients. This last point emphasized how important the role of the nurse was to the delivery of spiritual care on deployment that will be taken up later in this thesis.

The next part of the discussion examines spirituality within horizontal and vertical dimensions.

Spirituality defined

The contemporary nursing literature indicated that the discussion on spirituality had moved on from the view that religion and spirituality were interchangeable terms (Clark et al, 1998; Saunders & Retsas, 1998; Sumner, 1999). However, there were still some researchers who continued to use almost exclusively religious terms (Dennis, 1991; Post-White et al, 1996; O'brien, 1999; Shirahama & Inoue, 2001).

The participant responses from the previous study (see Figure 1.1) (Ormsby, 2001) indicated that spirituality should be discussed and defined using inclusive language. A broad definition of spirituality that included, but was not subordinated to religion, could avoid the confusion of understanding that Harrington (1995) noted in her participants around the terms. Further, by broadening the definition of spirituality nurses would be less likely to miss a spiritual need in a patient when the spiritual expression of the patient was not religiously based.

Broader spiritual concepts had become more prominent in the nursing literature (Bradshaw, 1994; Barnum, 1996; Ronaldson, 1997; Cumbie, 2001; Stranahan, 2001). Spirituality had increasingly been understood in humanistic terms that related to a spiritual journey that sought meaning in life (Ross, 1994; Clark et al, 1998; Saunders & Retsas, 1998). The "new" definitions did not invalidate the religious aspects of spirituality. Rather, they included the religious as a genuine pathway to unlocking meaning in life, but only one of many pathways (Ronaldson, 1997; Dossey et al, 2000; Cumbie, 2001; Stranahan, 2001). This view was aligned with those of the participants in Ormsby's (2001) study who, while largely expressing their personal spirituality as Christian religious (91.4%), still indicated that the nurse needed to provide care that was appropriate and targeted to the individual spiritual needs of the patient.

Spirituality and religion were separated into discrete and distinctive terms in the previous study (Ormsby, 2001). Spirituality was offered as a personal "expression of self that brings meaning, purpose and fulfilment to one's existence" (p.14). The

model of spiritual care (Figure 1.1) included what Moberg (1979) termed the vertical and horizontal dimensions of spirituality.

Vertical dimensions of spirituality

The vertical dimensions of spirituality were directed toward a personal search for meaning through an association with a God, higher being, religion or any other expression of a universal life force (Moberg, 1979; Ormsby, 2001). Spirituality in the vertical dimension had a transcendent quality that found its expression in a relationship with a higher power (e.g. God, Allah, Buddha). Religious spiritualities, therefore, fitted within the vertical spiritual dimension due to their transcendent qualities (Post-White et al, 1996; Emblen & Pesut, 2001).

Horizontal dimensions of spirituality

According to Moberg (1979), the horizontal dimensions of spirituality provided meaning in life through the material, humanistic and aesthetic pursuits that brought spiritual fulfilment. The participants (Ormsby, 2001) indicated that spirituality in this dimension included family, career, sense of belonging, or artistic endeavours among other relationships and pursuits. The horizontal dimensions were not immediately apparent as spiritual and this proved a barrier to spiritual care.

While the vertical and horizontal dimensions appeared at polar ends of the spiritual spectrum, what became evident in the research (Ormsby, 2001) was that spirituality may vary throughout the lifetime of an individual. Spiritual fulfilment could be expressed entirely in transcendent or humanistic terms. However, it could equally be

expressed as a composite of both ends of the spiritual spectrum. With this understanding in mind, the nurse needed to be careful to provide spiritual care that was appropriate to the spiritual need of the patient at the time of the caring interaction. This later point was expressed by the participants in this current study and will be examined in more detail later.

Tentative first steps

The researcher's previous study (Ormsby, 2001) raised as many questions as it answered in relation to spirituality. One such question identified a need for further research into spirituality in wider military nursing populations. The question was addressed in this research by approaching Australian Defence Force nurses as a collective of Navy[7], Army and Air Force nurses. The findings lent themselves to phenomenological investigation.

Penman et al (2013) asserted that phenomenology "enables human experience to be studied as it is lived, examining the phenomena to the fullest breadth, depth and extent" (p.40). The study of spirituality, therefore, was well suited to phenomenological investigation. However, the collective experience of the military nurse, and the soldiers under their care, was mediated through the common language of the military and was uniquely cultural. Consequently, spirituality in the military

[7] The researcher placed an expression of interest for participants from all three arms of the Australian Defence Force. However, the responses received did not include any Navy nurses. It is argued in this study that a lack of representation from all three Services did not manifestly alter the findings as these nurses often deploy together (see Chapter five for a more thorough discussion on this issue).

context was also open to the anthropological gaze and this point was confronted in the next question.

One significant question raised in the earlier research asked how one validated the reporting of spiritual care provision by the participants in a deployed setting[8]. The likely answer lay in observing military nurses interacting with their patients on deployment and undertaking targeted interviewing to better understand the phenomena of spirituality and spiritual care from the perspective of both the nurse and the patient.

In an attempt to answer this question, approval was sought from the Australian Defence Force to conduct observational field research at a deployed military health facility. However, operational restrictions imposed on visits to active operations prevented this research approach. These restrictions, along with privacy and geographic difficulties[9] involved in interviewing patients after their return to Australia from operations, prompted the researcher to focus entirely on the views of military nurses who had deployed from a Philosophical Hermeneutic perspective (Gadamer, 1976/2004).

[8] A deployed setting is one in which military personnel have been sent overseas to achieve military objectives. However, the scale of deployments may vary between humanitarian assistance, to peacekeeping, and war.

[9] Military personnel injured on deployment are located across all states and territories of Australia. Access, therefore, is difficult and cost prohibitive. Furthermore, many of the Australian military personnel who have been injured on operations in the past 20 years are posted to Special Force Units such as 2 Commando Regiment or the Special Air Service Regiment. This last point increased the difficulty of access as these personnel are allocated protected identity status while posted to those units.

This study still captured the cultural aspects of the spiritual phenomena. However, the research aim was achieved through the Philosophical Hermeneutic approach of Gadamer (1976/2004). The research, therefore, sought to interpret the essence of spirituality from the perspective of military nurses while concurrently seeking to understand the unique nature of military nursing in the context of deployment.

1.4 A New Spiritual Journey Begins

Spirituality and spiritual nursing care have been extensively researched in the nursing literature in acute, chronic and palliative care settings. Chan (2009 – acute medical and surgical), Lundberg & Kerdonfag (2010 – intensive care), Yang et al (2011 – mental health), Linhares (2012 – midwifery), Ronaldson et al (2012 – palliative and acute), Penman et al (2013 - hospice) all provided evidence of the rapidly expanding nursing literature directed toward spirituality in a variety of practice domains.

In spite of the increasing body of nursing literature that examined spirituality (Clarke, 2009; Cockell & McSherry, 2012; Reinert & Koenig, 2013) there was no further research that explored spirituality in deployed military nursing settings, apart from the study by the researcher cited above (Ormsby, 2001), that could be found. This study has sought to redress this nursing knowledge gap and present an original contribution to nursing knowledge through the exploration of a unique nursing practice context.

The examination of spirituality and spiritual care in this study makes an original contribution to nursing knowledge in two ways. Firstly, the study adds to the

contemporary body of research and literature on the experience of spirituality and spiritual care in nursing care settings (Casarez & Engebretson, 2012; Cockell & McSherry, 2012; Cone & Gisky, 2012; Daaleman, 2012; Gisky, 2012; Kevern, 2012; Linhares, 2012; Meehan, 2012; Reimer-Kirkham et al, 2012; Ronaldson et al, 2012; Timmins & McSherry, 2012; Ennis & Kazer, 2013; Hodge, 2013; Koren & Papamiditriou, 2013; Penman et al, 2013; Pesut, 2013; Reinert & Koenig, 2013; Torskenaes et al, 2013). Secondly, the study contextualises the understanding of the spiritual phenomena into a unique deployed military nursing environment. Meaning was attached to the phenomena via a hermeneutic conversation with the participants and the interview transcripts, guided by the Philosophical Hermeneutics of Gadamer (1976/2004).

Contemporary spirituality

Returning to the literature after 13 years it was apparent that a debate still existed on spiritual definitions. The majority of the contemporary nursing literature presented a pluralistic view of spirituality (Tanyi, 2002; Clarke, 2009; Swinton & Pattison, 2010; Timmins & McSherry, 2012). Indeed, the vagueness of definition was viewed positively by Swinton & Pattison (2010) who suggested that “the vagueness and lack of clarity around the term spirituality is actually a strength that has powerful political, social, and clinical implications” (p.226). Limiting spirituality to a singular concept was argued here as counterproductive to meaningful spiritual care because it did not allow the nurse to take into account the individual nature of spiritual expressions. Sawatzky & Pesut (2005) alluded to this when they noted that “one of the greatest barriers to spiritual nursing care may be a narrow understanding of

spirituality that prevents us from hearing the spiritual journeys of our patients" (p.24). This view was valid in the earlier research (Ormsby, 2001), and as will be seen later, remained valid for this current study.

Houtman & Aupers (2007) highlighted the changing nature of spirituality through what they termed the spiritual turn:

> What we are witnessing today is not so much a disappearance of religion, but rather a relocation of the sacred. Gradually losing its transcendent character, the sacred becomes more and more conceived of as immanent and residing in the deeper layers of the self. At least in many places, religion is giving way to spirituality (p.315).

In spite of the reference by Houtman & Aupers (2007) to the spiritual turn, there was an apparent resurgence in religiosity reported in some of the nursing literature. Reinert & Koenig (2013) suggested that spiritual care should be delivered to meet a broad variety of spiritual expressions in mental health. However, when discussing mental health constructs they proposed that nurses would be able to better define spirituality through a religious framework:

> We suggest that spirituality in nursing research should be measured in religious involvement as a proxy of the 'intrinsic religiosity' construct (Reinert & Koenig, 2013 p.9).

A religious framework may provide a structure within which to understand spirituality. However, the researcher argues after Swinton & Pattison (2010) that it is more useful to approach the meaning of spirituality broadly. To do so assures inclusive care that is not subject to a particular spiritual or religio-ideological

doctrine that may be at odds with the needs of the patient. This view was supported by Sessanna et al (2011) who suggested that:

> Measures of spirituality that assess or evaluate spirituality as religiosity with items about God, a Higher Power, an Ultimate Other or religious practices and rituals are not acceptable or appropriate for the spiritual assessment and evaluation of nonreligious individuals (p.1692).

Pesut et al (2008) highlighted a global resurgence in religion and emphasised what they viewed as a need to return to religion as a strong determinant of spirituality. Indeed, they appeared to merge the two concepts in a critical discourse when stating that "a healthy spirituality or religion will transcend itself in compassion" (Pesut et al, 2008 p.2809) beyond political, personal or economic gain. Reimer-Kirkham et al (2012) suggested:

> Nursing, along with other practice and academic disciplines, is (re)engaging with religion. Following several decades of focusing on spirituality as a generic and universal experience, with an accompanying tendency to disparage religions, nursing scholarship is shifting to encompass both spirituality and religion (p.E1).

Paley (2009) on the other hand refuted the assertion that religion was resurgent on a global scale when he noted that industrial countries had shifted toward more secular expressions of spirituality. He further argued that there should be a separation between religion and health care in an increasingly secular world.

The view taken throughout this thesis is that spirituality encompasses religious expressions as one of a number of valid expressions within a broader pluralistic

definition. The researcher does not, however, support Paley's (2009) view of excising religion from health care settings as this represented a subjugation of religion to a secular ideology, a point that was taken up next by Moberg (2011). As will be argued throughout this thesis religion remained a valid expression of spirituality and therefore needed to be considered in a holistic approach to patient care at the clinical nursing level (Reimer-Kirkham et al, 2012) and the hospital administrative level (HCCVI, 2012).

Moberg (1979) entered the debate on pluralistic expressions of spirituality when he alluded to the changing face of spirituality in the literature that accepted transcendent and humanistic meanings as equally valid spiritual expressions. However, Moberg (1979) acknowledged the dominant religious spiritual framework that existed at the time that he wrote that paper. More recently Moberg (2011) commented on the multitude of spiritual "languages and dialects that is like a modern tower of Babel" (p.3) when describing the explosion of definitions that formed part of the contemporary spiritual landscape. Moberg (2011) highlighted the "overwhelming positive relationships of spirituality to healing, health and well-being" (p.36). However, he cautioned against conceptual definitions that "strengthen certain findings…while they ignore or repress others" (Moberg, 2011 p.23). These last two points were accepted as valid within the context of this thesis.

Despite the ongoing debate surrounding spirituality in the literature it was apparent that, whether in a religious, new age[10], or post-modern construct[11], spirituality was

[10] There is no absolute description that captures the essence of the 'New Age' spiritualities. Houtmann & Aupers (2007) suggest it "is a basically romanticist conception of the self that is

generally concerned with a search for meaning and purpose in life (Tanyi, 2002; Sawatzky & Pesut, 2005; Swinton & Pattison, 2010; Carron & Crumbie, 2011; Timmins & McSherry, 2012). MacKinlay (2010) identified spirituality as an:

> Individual response to what each person finds meaningful, as mediated through relationship, environment and the arts (and religious practices for those who practice a religion) (p.17).

Further, as alluded to by MacKinlay (2010) above, spirituality and spiritual care involved a relationship with someone or something that was beyond the self (Carron & Crumbie, 2011; Penman et al, 2013). Carron & Crumbie (2011) underscored the notion of relationship in a nurse practitioner setting "where spiritual care evolved from the reciprocal, caring relationship between the patient and the NP" (p.557). Wagner & Whaite (2010), on the other hand, returned to the writings of Florence Nightingale that concerned her views on spirituality and caring relationships. In this respect, a caring relationship was expressed through other terms like "attend to, attention to, genuine, competent, and nurture" (Wagner & Whaite (2010) The view that is argue in this thesis is that spirituality is always a construct of the personal horizon and historicity of the individual (Gadamer, 1976/2004). Spirituality, however realised, seeks to find meaning, purpose and fulfilment in life and does so in

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intrinsically connected to an immanent conception of the sacred" (p.307). The New Age encompasses a multitude of spiritual views that range from Astrology, Feng Shui, Kinesiology to mysticism, humanism and other movements that may borrow eclectically from other spiritual and religious traditions but appear to generally be focused on finding meaning from within (Harrington, 2003)and are often based on Eastern rather than Western spiritualities.

[11] Post Modern spiritualities, like New Age spiritualities, are an agglomerate of spiritual ideas. According to Shelly & Miller (1999) Post Modern spirituality "restores the integration [of mind and body], but it insists that while my truth is important to me, I cannot impose it on you" (p.16). As will be seen later in this thesis the participants could be viewed as Post Modern in their spiritual views.

relationship to family, significant others, the world or a transcendent power or being such as God (Bruce et al, 2011; Penman et al, 2013).

Another factor in the literature that concerned spirituality suggested that it was pervasive throughout all aspects of human existence (Harrington, 2003). Harrington (2003) further argued that the "pervasiveness of spirituality…is the thread of our humanity. It is pervasive in that it is ongoing from birth throughout life to death" (p.319). The researcher contends that spirituality is pervasive in suffusing all aspects of our lives and relationships. Spirituality sits at the core of our humanness, whether it be internalised or externalised in its expression (Solomon, 2002).

Relationship, particularly in the military, was expressed through the *esprit de corps* that translates as the spirit of the unit. It was through the *esprit de corps* that military personnel found connection and camaraderie (Stanton et al, 1996). In secular society nationhood was often referred to as the spirit of the nation, friends coming together in a spirit of friendship and people often giving in a spirit of generosity (Darbyshire, 2011).

Whether understood in secular or religious terms, our spirit affected all aspects of our lives and was therefore pervasive. This point was supported by McDermott (2010) who described the pervasiveness of spirituality to Indigenous Australians through the story of a Christian pastor. He stated that "his complex spirituality pervaded everything that he did" (McDermott, 2010 p.100). This point was also taken up by Clarke (2009) and Sawatzky & Pesut (2005) who noted that "integrative spiritual care pervades all dimensions of nursing care" (p.28).

The final points to be made in this section are that the literature indicated that spirituality provided resilience in difficult times (Wester, 2009; Kim & Esquivel, 2011; Simmons, 2012), that it constituted a normal part of holistic nursing practice (Rankin & DeLashmutt, 2006; Baldacchino, 2008; Kevern, 2012) and that it was often reciprocal (Pesut & Thorne, 2007).

Spirituality was generally viewed as positively affecting the resilience of an individual to the challenges of life. Kim & Esquivel (2011) identified the protective effect of spirituality in a study on adolescent resilience when they noted:

> The resilience literature identifies spirituality as one of the core characteristics of resilience in adolescents, because spiritual values serve to maintain an optimistic outlook on life and even help one to find meaning in adverse situations (p.757).

The pervasiveness of spirituality in those that ascribe strongly to a system of belief, whether secular or religious, is argued here as protective against the challenges that may be experienced on deployment. This point will be confirmed later in the thesis, but was further supported by Simmons (2012) when discussing resilience in active duty soldiers:

> Spirituality may play a role in developing resilience in active duty Soldiers, which may affect mental health outcomes when disruptions occur. It is well documented in the literature that there is a positive relationship between those who are considered resilient and a belief in someone or something greater than themselves (p.12).

The literature suggested that spiritual care should be a normal extension of holistic nursing care regardless of the setting in which the spiritual care took place (Baldacchino, 2008; Daaleman, 2012; Kevern, 2012; Wright & Neuberger, 2012). Timmins et al (2014) further identified that there was "general agreement that nurses need to have an understanding of the concept of spirituality and how it applies to health care situations" (p.120) to achieve integrated and well directed spiritual care. However, to ensure that nurses were more aware of spiritual issues and more confident and competent in addressing these issues, it was suggested that nurses needed to be better prepared educationally (Rankin & DeLashmutt, 2006; Cone & Giske, 2012; Giske, 2012; Glick, 2012; Timmins et al, 2014). Educational preparation, therefore, is argued here as essential to ensuring that spiritual care is considered by all nurses whether in acute, chronic, aged or palliative care settings.

Lastly, the nursing literature was still building evidence that spiritual interactions had a mutual or reciprocal affect on the nurse who provided that care (Carron & Crumbie, 2011; Koren & Papamaditriou, 2013). Penman et al (2013) alluded to the reciprocity of care when they noted that "the phenomenon of spiritual engagement was understood to include distinct actions such as 'maintaining relationships with others', 'showing and receiving love'" (p.45). More importantly, however, was the assertion that in the reciprocity of the nursing interaction the nurse may find spiritual support for their own needs. Koren & Papamiditriou (2013) noted in a study of the attitudes of staff nurses to spiritual care that "they experienced spirituality or found meaning and purpose through…their nurse-patient relationships and the caring moments during patient care" (p.41). Spiritual reciprocity and spiritual self care,

therefore, were major resilience factors for the nurses that may be supported through relationship with patients in caring interventions (Vouzavali et al, 2011).

Spirituality and the hermeneutic endeavour

It was noted above that spirituality was pervasive through all aspects of our existence and relationships (Harrington, 2003; Clarke, 2009; McDermott, 2010). What is also argued here is that spirituality sits at the core of our human search for understanding and meaning in life (Schmidt, 2004; Wright & Neuberger, 2012). Moberg (2011) wrote that "spirituality is so central to the defining essence of human nature that everything…is positively or negatively related to it" (p.41). Spirituality may be situated within the context of the major world religions with a God[12] dimension or relationship to some other higher being (Lovering, 2008; Reinert & Koenig, 2013). It was also understood from within an eclectic spiritual framework where spirituality was directed inward as part of our holistic "self" (Houtman & Aupers, 2007 p.315). Whichever way a person framed their spirituality, it was a basis for a personal system of belief and provided a way in which to make sense of the world (Tanyi, 2002).

In attempting to understand the spirituality of an individual, the researcher asserts after Gadamer (1976/2004), it is necessary to engage in a genuine dialogue with the individual (Harrington, 2010; Kevern, 2012; Penman et al, 2013). Gadamer (1976/2004) argued that "language is the real medium of human being (p.66) and that there is in fact an infinite dialogue in questioning as well as answering" (p.65).

[12] In the major God based world religions spirituality is situated outside the physical world and is expressed in relationship to God. Christian, Jewish and Muslim religious adherents all worship that same God but understand their relationship to God in different ways (Kyle, 1988).

To understand spirituality and spiritual care in the nursing context then, was to engage in a dialogue with the patient. Harrington (2010) suggested that in assessing spiritual needs it was necessary to engage in dialogue. However, she also noted that dialogue could be a limitation for some nurses "who are unable or unwilling to converse" (p.185).

This thesis is structured upon the Philosophical Hermeneutic[13] approach of Gadamer (1976/2004). Entering into relationships that strive to understand the spiritual points of view and needs of care recipients is argued throughout this thesis as essential to the effective provision of spiritual care (Harrington, 2003; Keeling et al, 2010; Murphy & Walker, 2013). Murphy & Walker (2013) noted that spiritual care "exists within the context of the nurse–patient relationship where all interactions with the patient may be understood as implicitly spiritual" (p.152). Accordingly, the spiritual endeavour was a hermeneutic task as "the principle of hermeneutics simply means that we should try to understand everything that can be understood" (Gadamer, 1976/2004 p.31).

In stating his case for Philosophical Hermeneutics, Gadamer (1976/2004) decried the earlier Husserlian (Husserl, 1973) concept of bracketing by asserting that true understanding, in its temporal sense, could only occur through dialogue. In a genuine dialogue the participants recognised the historical grounding that each individual

[13] Philosophical Hermeneutics is identified here as an extension of the German phenomenological school of philosophy of which Edmund Husserl is considered the founding father (Dowling, 2004). Husserl sought to raise phenomenology to a rigorous human science and suggested that in attempting to understand phenomena it is necessary to set aside (Bracket) one's presuppositions and biases to view it anew and objectively (Husserl, 1973).

brought to the exchange. Grenz (1996) confirmed this understanding of the ideas of Gadamer when he noted the following:

> He [Gadamer] credits Heidegger for pointing out that human existence is thoroughly "in the world" or historical. Because we stand within the world, we can never escape our historical context. But because we stand in different places in the world, we naturally develop different perspectives on the world and different interpretations of the world. In this light, Gadamer follows Heidegger in arguing that history is not an external object from which we stand detached but is rather an ongoing process that embraces us (Loc. 2064).

Gadamer (1976/2004) posited that meaning was derived from a cyclical process of dialogue between the observer and the observed. The dialogue may be manifested in any interpretive act ranging from a conversation to the viewing of a work of art or to the reading of a text. Dialogue, however, was not a passive act and was only truly effective when it sought to understand the *other* in a genuine act of questioning and requestioning that only ends when we are fulfilled by what is said (Gadamer, 1976/2004). The fulfilment, though, retained a temporal dimension. In the act of reading and re-reading, our understanding of the meaning of a text changes in line with our changing horizons of understanding as the hermeneutic act. Gadamer (1960/2003) asserted:

> That in dialogue spoken language-in the process of question and answer, giving and taking, talking at cross-purposes and seeing each other's point-performs the communication of meaning that, with respect to the written tradition, is the task of hermeneutics…the task of hermeneutics as entering into dialogue with the text (p.368).

In this thesis, the researcher undertook the task of presenting a temporal interpretation of the phenomena under investigation. The interpretation was through the hermeneutic lens of the researcher, influenced by Gadamer (1976/2004), and reflected the prejudices and effective history of the researcher. The approach was consistent with the hermeneutic approach taken by Harrington (2003) in examining spirituality in a palliative care setting. It was also similar to other phenomenological approaches applied to spirituality in the nursing literature by Penman et al (2013), who used Van Manen's (1997/2007) approach to researching lived experience, and Vouzavali et al (2011) who used a Heideggerian (Heidegger, 2007) hermeneutic approach. The interpretation presented in this thesis represents the outcomes of the hermeneutic conversation between researcher and text at the time of interpretation. The study remains open to further interpretation by the reader, who will apply their own interpretive horizons to the discussion.

Gadamer (1976/2004), however, presented a conundrum to the researcher in providing a philosophical methodology for understanding the meaning of phenomena. On one hand, Philosophical Hermeneutics provided a way to engage with a phenomenon in a hermeneutic conversation that was satisfied in the fusion of horizons between the interpreter and the interpreted. However, Gadamer (1976/2004) did not provide a structured approach for the analysis of data in his Philosophical Hermeneutics. This point will be examined in greater detail in Chapters three and four.

The research approach

Ten Australian military nurses were interviewed on their experiences of spirituality and spiritual care on deployed military operations. The interviews took the form of hermeneutic conversations after the Philosophical Hermeneutics of Gadamer (1976/2004). The researcher personally transcribed the recorded interviews and engaged in a further hermeneutic dialogue with the text to build an interpreted understanding of the phenomena under investigation.

As noted above, there was scant research identified on contemporary military nursing that examined spirituality and spiritual care (Keith, 1998; Willis, 2001[14]; Ormsby, 2001; Ormsby & Harrington, 2003). Some previous research existed into spirituality in military veterans (Trevino et al, 2011; Sixsmith et al, 2013) and families of military personnel (O'Brien, 2004; Chambers, 2013), though the latter two studies focussed more on resilience with reference to spirituality. However, the overwhelming majority of the literature targeted civilian nursing care settings (Daaleman, 2012; Ronaldson et al, 2012; Ennis & Kazer, 2013; Moberg, 2011; Penman et al, 2013; Ruder, 2013; Torskenaes et al, 2013). While civilian nursing settings provided a fertile and rich source of data to situate the current debate and dialogue into spiritual nursing care they failed to provide insight into the transference of spiritual care to the military. This is an important point to note, as the inference within this study is that nurses in all practice settings share many symbolic understandings and cultural meanings. However, the military nursing environment is

[14] It should be noted that Keith (1998) and Willis (2001) are generic studies into spiritual nursing care but are not related directly to nursing in a deployed operational context.

a unique sub-culture of nursing, as it has many features which are both foreign to and little understood by nurses outside the military (Griffiths & Jasper, 2007).

The military nurse practices within a rapidly changing and often volatile environment (Agazio, 2010). That is, the day to day peacetime functions of the military nurse, which include those roles akin to the normal practice setting of the civilian nurse, can be rapidly cast aside by military imperatives (Wilgus, 2011). The military nurse is frequently placed on notice and ultimately deployed to foreign countries in support of military operations (Kovats et al, 2001). On these operations the nurse is often required to carry firearms, work out of tented or rudimentary fixed facilities, is on high alert for possible attack by combatant parties, is working extreme periods without adequate rest, is coping with war related trauma, and is separated from home, family and normal support networks (Parish, 2007).

With these factors in mind, the military nursing environment places overt stresses on its nurses that civilian nursing generally does not (Griffiths & Jasper, 2007; Parish, 2007). Seen in this light, research into the culture of nursing in the military takes on a unique quality. Therefore, this research remains exploratory and unique in both its approach and application.

Setting for the study

Military nurses practice within a culture that is outwardly similar to that of their civilian counterparts (Griffiths & Jasper, 2007; Agazio, 2010). However, it is also often devoid of direct comparison. The differences were particularly obvious when

military nurses were sent by their governments to provide care to sailors, soldiers and airmen/airwomen within operational settings in zones of conflict, such as East Timor, Iraq and Afghanistan (Parish, 2007; Wilgus, 2011).

It was from the perspective of an insider within the Australian military nursing culture that the researcher sought to further examine the nature of spirituality in this study. Having practiced within an Australian military nursing setting for over 23 years as both a clinician and a manager in peacetime, United Nations peacekeeping and war like operations, the researcher was uniquely positioned to understand the military nursing culture and to gain access to the group of nurses under study. This access provided an opportunity to verify and deepen the current understanding of the spiritual phenomenon as experienced by military nurses. The research was conducted in a peacetime Australian setting but involved nurses who had returned from deployed military operations. The participants were either full-time Australian military nurses, or military reservists who brought with them a closer relationship to current civilian nursing practice.

Aim of the research

The aim of the research was to expand the current knowledge and understanding of spirituality and spiritual care within a unique deployed military nursing context.

Research Question

What do military nurses on deployment understand about spirituality and spiritual care?

1.5 Summary of Chapter one

This chapter introduced the background for the research. The background highlighted the personal experiences and motivations that led the researcher to explore spirituality in this study and in their previous Master's Degree thesis. What the previous research provided was a preliminary model of spirituality in a military nursing context that centred on notions of family and vertical and horizontal dimensions of spirituality. However, it left some questions unanswered about spirituality and spiritual care in a deployed military setting.

Chapter one examined the contemporary debate on spirituality in the nursing and broader literature. In doing so, it briefly discussed the ongoing debate on how spirituality is defined within religious and pluralistic spiritual perspectives within an increasingly secular world. Spirituality was identified as a pervasive and relational phenomenon that sought to find meaning and purpose in life.

The following chapters and parts will guide the reader through the research process that culminated in the major findings of this thesis. The findings represent spirituality and spiritual care as expressed by the participants, through the interpretive horizon of the researcher, after the manner of Gadamer (1976/2004). The study focused on the deployed military nursing setting that provided the unique context for this research. The data were generated, analysed and interpreted through an ongoing hermeneutic dialogue. The dialogue found its completion in the fusion of interpretive horizons between the research and the participants that made evident the inherent truth value

of the phenomena. Chapter two will review the literature on spirituality and military nursing to situate this thesis within the contemporary discussion on spirituality.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This thesis represents the second exploration by the researcher into spirituality and spiritual care in the context of an Australian military nursing setting. Returning to the literature for this current exploration of spirituality revealed that the spiritual discussion had progressed since 2001 (HCCVI 2009; Moberg, 2011; Barss, 2012) to ever more inclusive definitions and caring practices. However, what remained evident was a continuing lack of a consensus on a singular definition of spirituality and spiritual care (McSherry, 2006; Sessanna et al, 2011; Swinton & Pattison, 2010; Narayanasamy, 2011). Also clear was that, while the research and literature on spiritual care continued to grow in a multitude of palliative (Penman et al, 2013), chronic care (Burkhart & Hogan, 2008) and acute care settings (Hilbers et al, 2010), the deployed military nursing context remained largely unexplored.

A positive nexus between spirituality and health was well evidenced in the literature (D'Souza, 2007; Williams & Sternthal, 2007; HCCVI 2009; Moberg, 2011). Kaldor et al (2004) identified that "a spiritual orientation, whether religious or broader, appears positively linked to some aspects of wellbeing" (Kaldor et al, 2004 p.15). However, they also cautioned against assuming that spirituality always had a positive impact on well-being. Kaldor et al (2004) noted that in some circumstances spirituality may have an undesired effect on health where negative connotations were associated with spirituality. Indeed, Reinert & Koenig (2013) supported this view

when suggesting that “the nature of one’s spiritual experiences varies and can produce negative emotions (guilt, bitterness) during trying circumstances” (p.3). Miner-Williams (2006) also drew attention to “scepticism” (p.812) on the relationship between spirituality and health in some elements of the health community. What she did identify, however, was that “most studies found that religious involvement and spirituality are associated with better health outcomes” (Miner-Williams, 2006 p.812). The positive nexus between spirituality and health, therefore, supported the importance of this current study to the expanding body of research into spirituality in the nursing care domain.

The literature review to follow will be largely confined to definitions and expressions of spirituality and spiritual care found in the Western literature. However, this chapter will touch on aspects of Islamic spirituality as many of the participants did care for Muslim patients during their operational deployments.

The researcher acknowledges that many New Age and Post Modern spiritualities derived elements of their philosophies and practices from Eastern religious paradigms (Moberg, 2011). However, while some participants used Eastern spiritual language (one participant spoke of Karma) to express their personal spirituality their views on spiritual care were generally aligned with a Western spiritual paradigm. Confining the literature review to the Western literature also ensured the information available was manageable and reflected the predominant spiritual culture of the Australian Defence Force where 63 percent of personnel “identified as being Christians” (DoD, 2012a p.17).

This chapter will provide the foundation for an examination of the research question: *How do Australian military nurses experience spirituality and spiritual care on deployed military operations?* The chapter begins by examining the search strategy (2.2) used to explore the literature on spirituality and the military. An overview of the literature is then provided under the heading of researching spirituality (2.3). A brief history of spirituality and nursing (2.4) will be explored before spirituality and spiritual care (2.5) are discussed as concepts. Finally, the military nurse (2.6) will be discussed to establish the unique context of military nursing prior to offering a summary of chapter two (2.7).

2.2 Search Strategy

Chapter one provided an overview of the nursing conversation on spirituality at the time of the researcher's previous study (Ormsby, 2001). The information was used in this study as a foundation for re-engaging with the spiritual discussion and as a baseline for evaluating the evolving debate on spiritual nursing care in the contemporary literature. A search was then conducted of electronic health databases, the internet and physical journals to identify relevant literature. The databases included: CINAHL, Medline, Ovid and Wiley online library. Further searches were conducted of the Uniformed Services University of the Health Sciences and Google.

Key words and word strings used in the literature searches included: spirituality, faith, religion, religiosity, spiritual care, spiritual nursing care, military, military nursing, nursing history, military nursing history, military nursing and spirituality, family and resilience. The literature on spirituality, spiritual nursing care, military

and military nursing was extensive (For example a search in CINAHL for spirituality yielded over 8000 results for the period 2000 to 2014 and on Medline for spiritual nursing care over 33000 results). However, searches that included military nursing and spirituality in combination were scant with only seven articles identified. The results were refined to include the articles that were deemed to be the best fit to inform the research question with 127 primary articles and documents included that directly related to spirituality and spiritual care. The articles and documents identified included a mixture of research (64 research articles), literature and critical review (18 literature and 12 critical reviews), discussion papers (23 papers), and a combination of research proposals (3 proposals), theses (3 theses), historical reviews (2 reviews), conference proceedings (1 proceedings), and analytical essays (1 essay). Significantly, of the 64 research articles the majority (47 qualitative, 15 quantitative and 2 mixed method studies) used qualitative research methods.

2.3 Researching Spirituality

This section briefly explores two themes in the literature surrounding spirituality that were directly relevant to this study. The first theme related to the ongoing lack of a singular definition of spirituality. The second theme identified issues surrounding spirituality as a form of resilience.

Theme One: tower of Babel

In an analytic essay titled Expanding Horizons of Spirituality Research, Moberg (2011) identified that “spirituality has so many languages and dialects that it is like a modern tower of Babel” (p.3). Indeed, in reviewing the ongoing conversation on

spirituality in the contemporary literature the lack of a common spiritual language remained evident (Tanyi, 2002; McSherry & Cash, 2004; Houtman & Aupers, 2007; Pesut et al, 2008; Clarke, 2009; Swinton & Pattison, 2010; Timmins & McSherry, 2012; Reinert & Koenig, 2013). Tanyi (2002) conducted a review of the spiritual literature (17 articles and 19 books) spanning a 30 year period and noted a continuing ambiguity in what constituted spirituality. She concluded that any definition of spirituality needed to be broad enough to capture a wide variety of religious and non-religious perspectives. Further, Tanyi (2002) argued "that spirituality is a personal search for meaning and purpose, which may or may not be related to religion" (p.506). McSherry & Cash (2004) also reviewed the spiritual literature in nursing between 1989-2002 and noted left (religious/theistic), right (secular/humanistic) and middle ground concepts of spirituality. However, unlike Tanyi (2002), McSherry & Cash (2004) cautioned against defining spirituality too broadly to avoid what they perceived as a "danger that the word may become so broad in meaning that it loses any real significance" (p.151). The general consensus in the literature, however, was that spirituality focussed on a search for meaning, was individualised and most importantly formed a distinct part of the nursing role (Lovering, 2008; Casarez & Engebretson, 2012; Daaleman, 2012; Kevern, 2012; Reimer-Kirkham et al, 2013; Ruder, 2013).

Theme two: spirituality as resilience

Reinert & Keonig (2013), in a review of the nursing literature (2007-2011) as it related to mental health, observed a continuing inconsistency in definition. Important to this study, however, was their assertion that the use of an appropriate definition

"facilitates the identification of protective factors and resilience mechanisms" (Reinert & Koenig, 2013 p.10) through spirituality to cope with adversity. Simmons (2012) in a descriptive, cross-sectional survey of 350 active duty United States soldiers, also found "spirituality was significantly related to resilience" (p.132), however, spirituality did not appear to have a strong protective effect against Post Traumatic Stress Disorder or depression. The evidence on the relationship between spirituality and resilience was well articulated by Richardson (2002), Pargament & Sweeney (2011), Trevino et al (2011), Gibbons et al (2012), and Chambers (2013). However, Simmons (2012) made the point that there was a need for further research into the long-term protective effects of spirituality to "provide a more accurate assessment of resilience and mental health symptoms" (p.143). The findings of a study by Shinbara & Olson (2010) into the role of spirituality role in coping for nurses added to the debate. They administered spiritual related questions from a Needs Assessment Questionnaire to 62 nurses working a variety of settings. Their findings supported "the importance of spirituality in their [nurses] daily lives, in coping with grief and loss and as an aspect of the support they receive" (Shinbara & Olson, 2010 p.36). Resilience, therefore, was offered in the literature as a protective factor against the challenges and adversities of life for patients, nurses and military personnel.

The literature above largely confined itself to non-military or military veteran populations (Pargament & Sweeney, 2011; Trevino et al, 2011; Simmons, 2012). However, the findings were applicable to the contemporary military nursing environment.

The next section will detail the historical relationship between spirituality and nursing to set the scene for a more thorough discussion on the literature surrounding spirituality.

2.4 A Brief History of Spirituality and Nursing

The development of health care institutions and the rise of the nursing profession in Western society had, until relatively recently, been closely tied to the Christian church (Shelly & Miller, 1999; Johnson et al, 2006; Bruce et al, 2011). Historically many institutions and nursing bodies reflected the traditions and moral/religious values ascribed to the church (Avalos, 1999). While health care predated the 2000 years history since the birth and death of Jesus Christ, the institutionalisation and formalisation of health in the Western world belonged to the Christian millennia (O'Brien, 1999). This view was true for both nursing and medicine (Gadamer, 1996). Therefore, much of the history of health in the Western world during this period was intricately entwined with the rise of the Christian church (Shelly and Miller, 1999).

Lovering (2008) suggested that nursing care in the Islamic world began before "the era of Florence Nightingale" (p.33) with the first Islamic nurse Rufaidah bint Sa'ad in the 8th Century. While this point is not disputed, it was clear from the literature that nursing predated both Islamic and Christian times. Nursing traced its origins to the Egyptian and Greek cultures, and the history of Christian nursing preceded both Florence Nightingale and Rufaidah bint Sa'ad (Carson, 1989; Shelly & Miller, 1999; O'Brien, 1999; Johnson et al, 2006; Helmstadter & Godden, 2013). Contemporary

nursing, therefore, had a rich and diverse history that was not restricted to a single spiritual or religious tradition or world view.

The core principles of nursing from its earliest iterations were derived from a perceived need to dedicate one's time and energy to assist the ill and injured back to health (Schmidt, 2004; Helmstadter & Godden, 2013). Nursing care, historically, was often provided in association with a physician. However, nurses had practiced independently (Carson, 1989; Johnson et al, 2006) and in ancient times within the structure of the extended family unit (O'Brien, 1999). Carson (1989) noted:

> Nurses in ancient Hebrew cultures contributed a family-centered approach to nursing as they visited families in their home and provided both physical and spiritual ministrations not only for the sick ones but for the family members who were caring for the ill (p.55).

In latter times the provision of nursing care became more formalised and was provided by recognised bodies such as the Knights Hospitallers of St John of Jerusalem during the Crusades (Shelly & Miller, 1999). The formalisation of nursing was a move away from a family based model and toward an institutional paradigm of nursing care, though the home based model certainly still existed (Johnson et al, 2006).

Johnson et al (2006) argued that nursing, in an institutional context, reflected the calling that monastic orders attached to the provision of care to the sick and indigent. Ironically, Evans (2004) in a paper examining the role of men as nurses noted that while nursing was very much integrated into the early monastic orders, the nursing

work was undertaken by either women or men of low rank and social status. The lowly status of nurses persisted through to the mid 18th Century (Helmstadter & Godden, 2013).

Nursing continued to be both church based and institutional, within monasteries, throughout the subsequent centuries (Helmstadter & Godden, 2013). The subjugation of the nursing profession to medicine was the subject of much discussion and social critical research (Gardner, 1989), but will not be explored within the context of this paper. However, the low status of nursing that began its journey to respectability and professionalism with Florence Nightingale (Wagner & Whaite, 2010) persisted in some quarters of the global health domain even today. Lovering (2008) argued that nursing in the Middle East continued to hold a low societal status due to educational entry requirements, poorly defined roles, Muslim cultural gender taboos, the professional subjugation to medicine and the demeaning nature of the work.

> Society views nurses in the Middle East as having a low status and compromised moral standing…The moral issues relate to the cultural taboos against mixing of genders in work places and a history of nurses coming from lower classes in society. The society's lack of respect for nurses and the lack of status of nursing as a profession mean few are willing to study nursing and families are reluctant to let their women enter nursing (Lovering, 2008 p.34).

It is interesting to note, however, that nursing research from Iran, an Islamic State (Mahmoodishan et al, 2010), took a contrary view to Lovering (2008) on the status of nursing in Islamic culture. The literature was inconclusive on this point, however, Taleghani et al (2013) argued that nursing work was spiritual in nature and therefore, was held in high esteem in Islamic culture.

> From the viewpoint of Islamic scholars, nursing is a holy job and in parallel with the supreme kinds of worship (Taleghani et al, 2013 p.276)…From the viewpoint of Islamic scholars, a nurse has the duty of not only serving all humans regardless of their ethnicity, nationality, and other material criteria, but also considering the spiritual needs of the patients and trying to fulfil them (p.277).

Nursing has a long history and, as with other aspects of society, has reflected the predominant social constructs and worldviews of the time in which it has been practiced (Gardner, 1989; Helmstadter & Godden, 2013). Spiritual nursing care as a component of nursing practice also followed historical trends (Carson, 1989). As noted above, nursing care had been practiced within the societal confines of the paganistic traditions (Carson, 1989); through the Christian religious traditions of the organised church during the Middle Ages (Schmidt, 2004) extending into the 20th century; through the humanistic traditions of the later 20th century (Johnson et al, 2006) and into the eclectic world views of today (Kevern, 2012; Reimer-Kirkham et al, 2012; Ronaldson et al, 2012; Ennis & Kazer, 2013; Pesut, 2013). That is not to argue that the nursing profession has only followed those trends within the periods proposed. However, while there are always exceptions to the rule, nurses as a subset of society generally followed the predominant thought paradigms (horizons) of the age in which they were historically immersed (Gadamer, 1976/2004).

2.5 Spirituality and Spiritual Care

The section to follow provides a more thorough examination of spirituality and spiritual care presented above in section 2.3.

Spirituality

Spirituality traces its origin to the Latin *spiritus* and Greek *pneuma* that both referred to a life animating breath or breeze. However, over time spirit came to be associated with incorporeal souls (Solomon, 2002); "the body and that which animates it" (Gadamer, 1996 p.98); "the breath of God" (Erikson, 1995 p.302) and any number of other references to the soul of a person, a team spirit, the spirit of an age, a person having spirit or courage (Oxford, 1975), something beyond the "material life" of a person (Honderich, 2005 p.892) and even a form of liquor (Erikson, 1995; Solomon, 2002).

In the Judeo-Christian perspective spirituality, through spirit, always related back to God (Erikson, 1995). This relationship to God carried through the early history of nursing within the Western Christian context (O'Brien, 1999). O'Brien (1999) argued that God was present in the act of caring between the nurse and the patient because "it is here, in the act of serving a brother or sister in need, that the nurse truly encounters God" (p.1). Therefore, in the Judeo-Christian view, the patient was a holistic being in whom the physical and the spiritual, through God, were inseparable (Shelly & Miller, 1999).

The Islamic view of spirituality also integrated the mind, body and spirit but enculturated the spiritual through all aspects of life and society (Lovering, 2008; Abdalla & Patel, 2010). A Muslim is a person who "submits to the Will of Allah" (Gulam, 2003 p.81). According to Taleghani et al (2013):

> The spiritual dimension is the most important part of human being because it is impossible for humans to have a healthy life and to serve the humanity and the civilization without spirituality (idea, desire, and faith) (Taleghani et al, 2013 p.277).

More recently, however, spirituality has become increasingly associated with self-transcendence and pluralistic searches for meaning beyond its traditional religious origins (Solomon, 2002; Kaldor et al, 2004; Reinert & Koenig, 2013). Moberg (2011) noted spirituality in the current discussion was used as a label for:

> The ineffable, transcendent, and private aspects, including the interiorized or intrinsic commitments, values, beliefs, feelings, and purpose or meaning of life of individual persons (p.4).

Tracing the historical origins of nursing there was a clear connection between spirituality and the nursing profession. Johnson et al (2006) argued that "spirituality, whether nurses acknowledge it or not, has always been present in the profession" (p.60). There was a trend toward the use of more inclusive spiritually focused nursing care (Holmes, 2012). However, much of the history of nursing was focused on religiously associated spirituality (Schmidt, 2004).

Religious spirituality

Australian society remained relatively consistent in its identification with the Christian religions between the 2006 (63.8% (Nielsen, 2009)) and 2011 census (63.7% (ABS, 2011)). There was, however, a small but steady increase in the number of people reporting non-Christian religious affiliations (5.7% (Nielsen, 2009); 7.2% (ABS, 2011)) and no religion (18.7% (Nielsen, 2009); 20.6% (ABS, 2011)). Despite

the relatively steady status of religion in Australia the nursing literature had become increasingly pluralistic in defining the characteristics of spirituality (Dyson et al, 1997; Tanyi, 2002; McSherry & Cash, 2004; Pesut et al, 2008; Clarke, 2009; Swinton & Pattison, 2010; Timmins & McSherry, 2012).

Chapter one discussed the predominance of religious definitions and understandings attributed to spiritual nursing care within the earlier nursing and health literature (Dennis, 1991; Post-White et al, 1996; O'brien, 1999; Shirahama & Inoue, 2001). Also noted was that until relatively recently spirituality was used synonymously with the term religion (Tanyi, 2002; Moberg, 2011; Timmins & McSherry, 2012). While the contemporary literature separated religion and spirituality conceptually there had been some recent resurgence in studies that focussed on religion as a framework for understanding spirituality (Paley, 2009; Smith, 2009; Ammerman, 2013; Reimer-Kirkham et al, 2012). Moberg (2011) noted that there were many overlapping elements between spirituality and religion that led some researchers to use both terms in combination rather trying to separate them. He went on to describe religion as incorporating "extrinsic and collective aspects of worship, rituals, creeds, organizational structures, and institutional processes" (Moberg, 2011 p.4).

Regardless of an increasing spiritual pluralism in the modern society in which nurses practiced, there remained many examples within the holistic and Christian nursing literature that continued to discuss spirituality and spirituality as a religious, God centred calling and phenomenon (For example: the InterVarsity Christian Fellowship; the Journal for the Scientific of Religion; the Journal of Christian Nursing; and the Holistic Nursing Journal). Two very good examples of a religious

spiritual nursing paradigm were the books written by nursing academics that held more firmly to the Christian worldview. Sister Mary Elizabeth O'Brien (1999), a Catholic nun and registered nurse, and Shelly & Miller (1999) each published books that exhorted nurses to provide care that was Christ centred and acknowledged the Matthew 28:18 call to "therefore go and make disciples of all nations, baptising them in the name of the Father and of the Son and of the Holy Spirit" (NIV, 1983 p.930).

In their writings, O'Brien (1999) and Shelly & Miller (1999) made the argument that nursing had come perilously close to losing touch with its religious roots by becoming too professionally oriented. Further, they suggested that nursing had become less an expression of the love of Christ that reflected the art of nursing through previous centuries. Shelly & Miller (1999) argued that "nursing…must return to its roots in the church and Christian faith in order to work toward the goal of true health" (p.25).

Shelly & Miller (1999) contended that spirituality was an expression of God's grace and love for humankind. Indeed, O'Brien (1999) suggested that to ignore the connection between spirituality and Christ was tantamount to failing in a sacred calling. In this calling, nurses stood on God's Holy Ground while tending to the needs of those in whom they were called to care (O'Brien, 1999). The views expressed by these writers clearly situated contemporary spiritual care as an integral part of nursing practice that connected nursing to its Christian history. A similar connection could be inferred by Muslim nurses in relation to their own religion based history (Taleghani et al, 2013). However, Taleghani et al (2013) in conducting a

literature review of nursing and Islamic thought identified that there was little literature to support this view.

Religion and the Australian health care sector

In the Australian health care context enduring links existed between some health institutions within the private hospital system and the Christian biblical principles of selflessness and humility (HCCVI, 2009). This association with the Christian religions had much to do with the existence of many health facilities that were founded by and/or are still run by Christian religious orders. Simmons & Stavropoulos (2010) provided an example of this connection when they referred to the church based St Basil's Homes providing culturally appropriate aged care to the Australian Greek community. They noted that:

> Our success has been based on not only meeting the physical needs of those for whom we care…but also looking after their spiritual needs…daily life unfolds hand-in-hand with the church (Simmons & Stavropoulos, 2010 p.176).

Another good example of the inclusion of a Christian ethos in a modern Australian Health Care setting was found in the philosophy booklet of the Little Company of Mary Health Care (Calvary Ministeries, 2012):

> The spirit of Calvary – we strive to excel in the spirit of 'being for others' our mission identifies why we exist. To bring the healing ministry of Jesus to those who are sick, dying and in need through 'being for others' (2012 p.9).

The association between nursing and religious orders within the wider public health care system in Australia was not as well defined as it was in the private healthcare system (HCCVI, 2009). Paley (2009) argued that in secular society public health care had, rightly in his view, increasingly become a welfare function of Government rather than the domain of religious institutions. However, while the ethos of Australian public hospitals was secular, hospital chaplaincy services remained embedded in most hospitals in Australia (HCCVI, 2009). Notable also was that hospital chaplaincy services available in an increasingly multicultural Australian spiritual landscape were either faith specific, non-sectarian or interfaith (Holmes, 2012). Field (2008) also supported this view in an Australian Defence Force chaplaincy context:

> Chaplains will find that ADF units are not dominated by a single religion, but are fragmented into the major world religions, minor religions, and non-believers. All of these people need to be embraced, usually by a sole chaplain (Field, 2008 p.110).

Chaplaincy services, whether embedded within hospitals, the Australian Defence Force or sourced from faith communities, were increasingly being drawn from non-Christian spiritual providers such as Islamic or Buddhist leaders. For example, the website for the Royal Children's Hospital (RCH, 2013) at Randwick listed Muslim, Buddhist and Jewish Chaplains in addition to multi-denominational chaplains as available for pastoral services to their patients and families.

Moving away from the religious, largely Western Christian spiritual worldview, this paper will now explore the effects of pluralism on our present understanding of

spirituality. As the influences of the humanist, Eastern religion and the earth based spiritualities become more prominent in societal thinking, it is necessary to understand these views in order to provide for spiritual needs that go beyond the purely religious. In the following discussion this paper will examine the changing face of spirituality and spiritual nursing care beyond the confines of organised religion.

Pluralistic spirituality

The increasing secularisation of Australian society may infer that the spiritual aspects of life are less important to contemporary Australians entering the health care system. However, the Australian literature on spirituality in health care settings did not appear to support the notion that spirituality was fading into irrelevancy (Lo and Brown, 1999; Eckersley, 2007; Penman et al, 2013).

It would be expected that nurses, as a subset of Australian society, would reflect the societal shift from the sacred to the secular. Accordingly, there is a danger that spirituality may be subjugated to a secular world view that does not support spiritual care provision. Paley (2007) argued this view in the United Kingdom where he suggested that nurses, despite research in that country that supported the importance of spiritual care (McSherry and Jamieson, 2011), should not provide spiritual care.

> In those parts of the world where secular-rational values are clearly established, it is unnecessary for nurses to provide something called 'spiritual care', and there should be no expectation – on the part of governments, educators, managers, or health care policy makers – that they should do so (Paley, 2007 p.1971).

However, it is argued here that increasing secularisation within society does not necessarily denote a decrease in spiritual need in patients. Baldacchino (2008), Daaleman (2012) and Kevern (2012) supported this view with Kevern (2012) arguing that secularization did not abrogate the responsibility of the nurse to provide appropriate care to meet a spiritual need.

> It is not necessary to give any ontological or theological weight to the idea of the spiritual to recognize the importance of spiritual care. Even treated as a cultural construct, it clearly has a role to play in patient care (Kevern, 2012 p.988).

This view was further supported in the National Competency Standards for Australian Registered Nurses (NMBA, 2006).

> The registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual's responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately (p.1-2).

Contemporary nursing researchers and writers (Sawatzky & Pesut, 2005; Flere & Kirbis, 2007; Baldacchino, 2008; Keeling et al, 2010; Carron & Cumbie, 2011; Cockell & McSherry, 2012; Ronaldson et al, 2012; Ennis & Kazer, 2013) espoused a multiplicity of views of spirituality that were both broad and inclusive. Swinton & Pattison (2010) affirmed the broad nature of spirituality noting the lack of a "unitary, universal essence to spirituality, spiritual need, or spiritual care that all can come to agree on as the definitive and universally acceptable ontology of 'the spirit'" (p.227).

The literature generally suggested that nurses must understand that every person reflects their personal spirituality in individualistic ways (Hilbers et al, 2010; Carron & Cumbie, 2011; Penman et al, 2013). Indeed, Penman et al (2013) argued the importance of providing spiritual care in a palliative care setting as part of a person centred approach to care. Individualized spiritual care, therefore, assisted the nurse to make a connection with a patient and aided them in meeting a multitude of expressed spiritual needs (Swinton & Pattison, 2010). MacKinlay (2010) noted that "real pluralism seeks to allow people to practice their religion and culture according to their understandings and needs" (p.18). In this way the nurse was able to ensure spiritual care was appropriate and culturally sensitive for the individual (Draper & McSherry, 2008).

Eastern philosophic and religious traditions emphasised a connectedness with the universe or various paths to a state of enlightenment derived from within the individual (Martin, 1989). Rayner & Bilimoria (2010) noted that Buddhist and Hindu adherents "spend a good part of their life not just preparing for a peaceful death, but also looking forward to a new life" (p.137). In Australian society (ABS, 2011) and in the Australian Defence Force (DODa, 2012) there was an increasing number of people that practiced Eastern religions. The changing demographic mirrored the increasing number of migrants that had settled from Asia (Seebus & Peut, 2010). Reimer-Kirkham et al (2012) argued, in a Canadian context, that it was necessary for health care institutions to provide sacred spaces for all, regardless of spiritual view, to be able to reflect, pray, meditate or worship as their spiritual reality requires.

> We offer several recommendations – some practical, some conceptual. Intentionality in the creation and maintenance of inclusive ecumenical designated spaces should be pursued, and creative informal sacred spaces facilitated. Healthcare providers should seek opportunities to nurture relational spaces for enhanced healing, and leaders should ensure organizational attentiveness to spatial practices (Reimer-Kirkham et al, 2012 p.210).

The contemporary literature was almost unanimous in describing spirituality as a search for meaning (Moberg, 1979; Stoll, 1989; Dossey, 2000; Tanyi, 2002; Harrington, 2003; Pesut et al, 2008; Hilbers et al, 2010; Nabolsi & Carson, 2011; Timmins & McSherry, 2012; Pesut, 2013). Moberg (2011) asserted that spirituality provided a way of ascribing life meaning to an individual. Tanyi (2002) stated that spirituality was "subjective, intangible and multidimensional…Spirituality involves humans' search for meaning in life" (p.500). Nabolsi & Carson (2011) noted that in Jordanian Muslim men that spirituality "helped them to find meaning and purpose in their life" (p.716).

Despite the consensus evident in the use of a *search for meaning* as a defining characteristic of spirituality, the debate continued on the provision of spiritual care by nurses. As noted above, Paley (2007) did not advocate for nurses to provide spiritual care in a secular society and health system. Casarez & Engebretson (2012) cautioned against the nurse imposing their spiritual beliefs in patient care episodes. They stated that it was necessary to take a moderate approach to spiritual care "by avoiding the imposition of one's own personal beliefs of a religious persuasion or beliefs of extreme secularisation, and focusing on the beneficence to the patient" (p.2099). However, they also noted that some nurses (Holmes et al, 2006) were

resistant to the provision of spiritual care citing a lack of training and education in the area.

There was a trend in the literature toward describing spiritual care in relational terms (Carron & Cumbie, 2011; Ferrell & Baird, 2012; Kevern, 2012; Reimer-Kirkham et al, 2012; Penman et al, 2013). Penman et al (2013) argued it was important for the nurse to engage with patients "as the phenomenon of spiritual engagement was understood to include distinct actions such as 'maintaining relationships with others'" (p.45). Keeling et al (2010) suggested several levels of relationships that were important to the maintenance of spirituality and spiritual care from a family therapy perspective. These included a relationship with a God, family, the carer, a group to which someone identified and touched on aspects of the therapeutic relationship (keeling et al, 2010). Murphy & Walker (2013) also stressed the importance of the therapeutic relationship, but from a Christian nursing perspective.

> Spirit-guided care exists within the context of the nurse–patient relationship where all interactions with the patient may be understood as implicitly spiritual. Simple things such as empathy, warmth, genuineness, and kindness contribute to relationship, which in turn can help meet patients' spiritual needs, particularly in situations where the patient is isolated from his or her family and community and a meaningful relationship has developed with the nurse (Murphy & Walker, 2013 p.152).

The last point that Murphy & Walker (2013) made about the relationship between the nurse and the patient who was isolated from family and community was very important in the context of this research and will be expanded upon later in the

analysis and discussion. The discussion will now shift its focus to the delivery of spiritual care.

Spiritual care

Spiritual care, like definitions of spirituality, had undergone a transformation from its original religion focused assessment and practice to one that was more pluralistic in its approach (Johnson et al, 2006). Sawatzky & Pesut (2005) noted:

> A brief historical review indicates that our current understandings of spiritual nursing care have been shaped by three eras characterized by particular approaches: the religious approach, the scientific approach, and the existential approach (p.19).

What Sawatzky & Pesut (2005) identified was that spiritual care was founded in the religious aspects of society (to be discussed below). By the middle of the twentieth Century the approach to care had changed to one which was influenced by the desire of nursing to be professionalized and accepted by the scientific and medical communities (O'Brien, 1999; Govier, 2000; Sawatzky & Pesut, 2005). More recently, however, spiritual care had become more pluralistic and focused on supporting the plethora of individualized existential spiritual expressions now evident in the literature (Sawatzky & Pesut, 2005; Draper & McSherry, 2008; Baldacchino, 2008; Cockell & McSherry, 2012; Ruder, 2013).

Houtman & Aupers (2007) emphasised the pluralistic aspects of contemporary spiritual care occurring in what they termed the spiritual turn. Spiritual care from this viewpoint remained cognizant of religion but saw its significance and influence

waning in the caring environment. Indeed, Barss (2012) in her model for inclusive spiritual care suggested that nurses needed to treat each individual according to their personal spiritual world view. She went on to provide a definition of spiritual care as:

> Relevant, nonintrusive care, which tends to the spiritual dimensions of health by addressing universal spiritual needs, honoring unique spiritual worldviews, and helping individuals explore and mobilize factors that can help them gain/regain a sense of trust to promote optimum healing (p.25).

Holistic care

Spiritual care was also well established in the literature as an important facet of holistic nursing care (Carson, 1989; Lo & Brown, 1999; O'Brien, 1999; Ormsby, 2001; Glick, 2012; Harrington, 2010; Ronaldson et al, 2012; Murphy & Walker, 2013). Ronaldson et al (2012) in surveying palliative and acute care nurses in an Australian care setting argued that "spiritual caring is an integral component of holistic nursing" (p.2133). Harrington (2010) noted further that in providing spiritual care that "case notes need to reflect spiritual care as part of holistic nursing" (p.193). What these researchers alluded to was the inclusion of spiritual care as a normal component of any holistic caring interaction. This view was supported by Narayanasamy (2009) who, paraphrasing Chan (2009), argued that "spirituality should be prominent in nurse education as an integral feature of holistic care" (p.915). Indeed, Chan (2009) in conducting a quantitative survey of 110 nurses in a Chinese public hospital found that "the greater the nurse's spiritual care perceptions, the more frequently spiritual care is included in that nurse's practice" (p.2135) when providing holistic care.

Education

In a study of nurses in the United Kingdom, Narayanasamy (1993) found that "the practice of spiritual care by nurses is probably infrequent and if it is at all given, it is on an ad hoc basis" (p.199). In 2009 Narayanasamy (2011) also suggested that the practice of spiritual care had not greatly increased in its frequency after 16 years. Further, he noted "concerns in the literature about nurses' knowledge and competence in spiritual care" (p.915) due to a lack of education in this area of holistic nursing practice. Rankin & DeLashmutt (2006), however, identified an increasing trend to include spiritual care in nursing education. They suggested that spiritual education was necessary to address a "worldwide resurgence of interest in spirituality, as well as the holistic approach to care" (Rankin & DeLashmutt, 2006 p.282).

Giske (2012) argued that it was necessary to take spiritual care education beyond the classroom into a variety of settings in which it could be normalized within practice. It was clear in the literature that education was key to ensuring appropriate and adequate consideration was given to spiritual needs in the nursing care context (Carson, 1989; Shelly & Miller, 1999; Rankine & DeLashmutt, 2006; Leeuwen et al, 2008; Taylor et al, 2008; Cone & Giske, 2012; Giske, 2012; Glick, 2012; Carson & Geradi, 2013; Timmins et al, 2014).

Palliative and chronic care

As previously identified, the literature surrounding spirituality in nursing had largely examined palliative, aged and chronic care settings (Harrington, 2003; Draper &

McSherry, 2008; Evans & Hallett, 2007; Hsiao et al, 2010; MacKinlay, 2010; Moberg, 2011; Yang et al, 2011; Molzahn et al, 2012; Ronaldson et al, 2012; Penman et al, 2012; Leeuwin & Laarhoven, 2013; Penman et al, 2013). The emphasis on palliative and aged care settings appeared to support the notion that as people approach end of life spirituality became more important (MacKinlay, 2010). Harrington (2010) affirmed this view when she suggested that "when people age, existential questions become more prominent and include questions of spirituality" (p.179).

Acute care

There was an increasing trend to examine spirituality within wider nursing care settings (Ormsby, 2001; Draper & McSherry, 2008; Timmins & Kelly, 2008; Lundberg & Kerdonfag, 2010; Carron & Cumbie, 2011; Nabolsi & Carson, 2011; Vouzavali et al, 2011; Linhares, 2012; Ronaldson et al, 2012). The contemporary nursing literature extended to spiritual care in intensive care, mental health, parish, midwifery, acute and primary health care nursing contexts. What Ronaldson et al (2012) observed, however, was that despite the increasing literature in acute care settings, "the relationship of spiritual perspective to spiritual practice was significant for palliative care, but not for acute care RNs" (p.2133). Indeed they argued that the age of the nurses, time in practice, education and time were all contributing factors in determining how nurses considered and applied spiritual care in their practice (Ronaldson et al, 2012).

Spiritual self awareness

The notions of spiritual awareness and care of the nurse were also beginning to emerge in the literature (Chung et al, 2007; Fisher & Brumley, 2008; Ekedahl & Wengstrom, 2010; Mahmoodishan et al, 2010; Salmon et al, 2010; Shinbara & Olson, 2010; Koren & Papamiditriou, 2013). Chung et al (2007) noted that "nurses' self-awareness and personal spiritual perceptions are important when providing spiritual care" (p.161). They argued that nurses needed to have a "personal spiritual perspective in order to provide spiritual care" (p.161). Narayanasamy (2011) suggested that nurses needed to be trained to be spiritually sensitive to patient need. However, he also cautioned that not all nurses should necessarily provide spiritual care arguing that "spirituality in the wrong hands could be dangerous to patients' well-being" (p.916). Indeed, providing spiritual care that was not respectful of and directed to the needs of the patient might cause distress and be counterproductive to effective patient care (Narayanasamy, 2011).

Spiritual self-care

Shinbara & Olson (2010) acknowledged that the spiritual needs of the nurses should be considered and accommodated in health care settings. They noted "that very little is said about spirituality's role in nurses coping with their own grief" (Shinbara & Olson, 2010 p.33). This point was expanded upon by Koren & Papamiditriou (2013) who referred to the need of both the patient and the nurse for spiritual self-care. They argued that:

> If nurses have their basic needs met, they in turn can establish meaningful relationships with their patients. Thus, nurses who practice

> self-care may indeed be better equipped to provide quality patient care (Koren & Papamiditriou, 2013 p.38).

Baldacchino (2011) brought the discussion on spiritual self awareness and care back to the education of nurses. She noted that education on spirituality allowed nurses to reflect on their practice and gain spiritual self awareness. This view was also expressed by Fisher & Brumley (2008) who identified in their study "a need for nurse education to redress the clearly inadequate preparation nurses are given for this aspect of their role" (p.55). Vouzavali et al (2011) also supported the need for education in spirituality for nurses. However, in a study of critical care nurses they noted that spiritual care, as part of holistic patient care, was also symbiotic and reciprocal:

> Even more importantly, the relationship with patients was perceived as 'symbiotic'. The use of this metaphor was quite powerful because it signified that according to the participants' perceptions, nurse and patient belong together, they interact and affect each other reciprocally and are mutually dependent on each other (Vouzavali et al, 2011 p.148).

Relationship

MacKinlay (2010) suggested that "relationship lies at the heart of spiritual care and makes the provision of spiritual care a privileged place of presence, one with another" (p.19). This view was supported by Harrington (2003) and Penman et al (2013) who noted that in the palliative care dialectic between nurse and patient that a mutually caring relationship was developed. Chung et al (2007) suggested that effective nursing education in spiritual care "fosters a climate of spirituality that promotes intra- and interpersonal connectedness between…nurses and clients"

(p.167). The development of a positive caring relationship between the nurse and their patient was therefore seen as central to effective spiritual care. Carron & Cumbie (2011) argued this point from the perspective of nurse practitioner settings when they noted that "authentic, transpersonal, caring–healing NP–patient relationships are important in the provision of spiritual care" (p.553).

Practice

Aside from specific religion based spiritual rituals there was no well defined formula that the nurse could apply to the practice of spiritual care. However, there were a number of spiritual assessment tools offered in the literature to aid nurses in the provision of spiritual care (Ellison, 1983; O'Brien, 1999; Puchalski, 2001; Galek et al, 2005; Sessanna et al, 2011; Leeuwen et al, 2013). Stoll (1979) offered a spiritual assessment tool that while useful, was weighted toward religious spirituality (Timmins & Kelly, 2008). Examples of more pluralistic tools were provided by Narayanasamy (2004) who focused on meaning and purpose and Hodge (2013) who proposed a two stage assessment that determined "relevance of spirituality to service provision and…to ascertain whether a comprehensive assessment is needed" (p.7). Leeuwen & Laarhoven (2013) identified 120 different spiritual assessment tools in the literature and noted that there was some judgement required by the nurse to choose an appropriate tool for their practice setting.

Sawatzky & Pesut (2005) identified a diversity of practices in the literature that ranged "from general conceptions of a caring presence to religiously oriented interventions such as prayer" (Sawatzky & Pesut, 2005 p.20). Daaleman (2012) argued for a health services framework that provided an environment that supported

spiritual caring practices. Spiritual caring interventions in a dementia care setting were listed by Ennis & Kazer (2013) who offered 30 separate spiritual interventions ranging from:

> active listening, creating a trusting environment and demonstrating empathy to facilitating spiritual environments, practicing presence, praying with or for another and visitation facilitation (p.110).

Spiritual caring practices were as diverse as the definitions of spirituality that abounded in the literature. However, while there was no general consensus of what defined spiritual care, the literature largely agreed that it included identifying and meeting the expressed spiritual needs of the patient (Baldacchino, 2008; Pesut et al, 2008; Casarez & Engebretson, 2013; Murphy & Walker, 2013). Further, spiritual care involved direct (e.g. therapeutic touch, prayer, talking/listening), supportive (e.g. being present, empathetic, non-judgemental) or facilitative care (e.g. providing a space for reflection/ prayer/ meditation, referral to a spiritual carer, providing access to family) (Carson, 1989; O'Brien, 1999; Harrington, 2003; Sawatzky & Pesut, 2005; HCCVI, 2009; Moberg, 2011; Reimer-Kirkham et al, 2012).

The preceding sections reviewed the extant understandings of spirituality as they applied within broader societal thought. They also examined how nurses in civilian practice identified with spirituality within the context of professional practice. The text to follow will narrow the exploration thus undertaken to the context of military nursing. Indeed, the paper will now detail the unique nature of military nursing, the historical background of military nursing, its roots within the Christian church and situate the debate on spiritual care in military nursing practice in its current context.

2.6 The Military Nurse

Nursing had maintained a significant association with the military for many centuries (Griffiths & Jasper, 2007). This association was clearly evident in the eleventh and twelfth century where orders such as the Knights Hospitallers, Knights Templars and the Teutonic Knights tended to the sick, through the American Civil War and then later during the Crimean War. At this time Florence Nightingale, recognised as the founder of modern nursing, organised nurses to care for the sick and injured (O'Brien, 1999; Shelly & Miller, 1999; Helmstadter & Godden, 2013). O'Brien (1999) remarked:

> Out of the 11th-, 12th-, and 13th-century Crusades to the Holy Land came the military nursing orders, orders of men who were committed by their religious ministry to the care of those wounded in battle (p.31).

Griffiths & Jasper (2007) noted that "until the era of Florence Nightingale nursing, on or near a battlefield, was officially confined to men or those in holy orders" (p.93). However, Nightingale firmly established nursing as "a women's occupation…women as 'natural' nurses did not require education before working in hospitals" (Evans, 2004 p.322-323) in the apprenticeship style training of the day. Male nurses, thereafter, remained largely an aberration, except in mental health nursing, until the 1970-1980s (Evans, 2004). Evans (2004) identified that the paucity of men in nursing until the 1980's was reflected in the military nursing services globally where, for example, men were banned from military nursing in the United States during World War Two. Halstead (1994) in her history of the Royal Australian

Air Force Nursing Service also noted that male nurses were denied entry to the Air Force in Australia until after 1977.

While the early history of military nursing in the 20th Century clearly reflected a predominantly feminised view of nursing, its association with the military remained significant (Halstead, 1994; O'Brien, 1999; Shelly & Miller, 1999; Evans, 2004; Johnson et al, 2006; Griffiths & Jasper, 2007; Parish, 2007; Darbyshire, 2011; Helmstadter & Godden, 2013). Indeed, internationally military nurses had and still do deploy with military forces to all major areas of military conflict (Reid et al, 1999; Griffiths & Jasper, 2007). For Australian military nurses, whether as regular (full-time) or reserve (part-time) forces personnel, their nursing duties had taken them to South Africa during the Boer War, involvement around the globe during the 1st and 2nd World Wars, including support to the ANZACS at Gallipoli, Korea, Vietnam, The Gulf Wars of 1990 and 2004, Afghanistan (the longest conflict that the Australian military had been involved in (AWM, 2014) and peacekeeping operations to such areas as Bosnia, Rwanda, East Timor, Cambodia and Bougainville (Reid et al, 1999).

Military nurses generally undertake their nursing education prior to joining the military and then bring their civilian skills and experience into the service (DFR, 2013). In the Australian Defence Forces registered nurses are recruited as Commissioned Officers, with the incumbent responsibilities that are normally associated with military service as an officer (Keighley, 2003; Griffiths & Jasper, 2007). Griffiths & Jasper (2007) noted in the British Armed Forces that nurses wore a "double hat" (p.95) that indicated the duality of their roles as nursing and military

professionals. Indeed, Keighley (2003) remarked when discussing a senior British Army nurse that “it is impossible to separate the nurse from the officer” (p.10). In the Australian Defence Force nurses may serve in the Royal Australian Navy, The Australian Army or the Royal Australian Air Force (DFR, 2013). The focus of nursing practice roles, while there are many overlaps, will vary to some extent between different arms of the Australian Defence Force. Naval nurses were trained to practice in a sea going environment (DFR, 2013), Army nurses traditionally worked within a ground based field hospital (Keighley, 2003; DFR, 2013) and Air force nurses typically provided flight nursing skills from a field health facility located near or next to an airfield (Halstead, 1994; DFR, 2013).

It was generally accepted in the literature that many of the nursing skills practiced by military nurses did not differ from those of their civilian counterparts (Stanton et al, 1996; Reid et al, 1999; Norman & Angell, 2000; Keighley, 2003; Scannell-Desch, 2005). However, the conditions under which military nurses operated were a vast departure from those normally experienced in the civilian nursing field. Stanton et al (1996) discussed “the physical hardships of wartime service” (p.348). Further, they noted that military nurses when deployed worked out of makeshift and rudimentary hospital facilities, often tents, where there was little or no civil infrastructure, and in areas where there was recent or ongoing conflict (Stanton et al, 1996; Agazio, 2010). Agazio (2010) argued that “specialized skill sets and personal adaptation were necessary for practice under austere conditions in these environments” (p.166).

Military nurses also carried personal weapons, were subject to military control and constraints and might be placed in situations of grave risk (Keighley, 2003; Agazio,

2010; Wilgus, 2011). The latter point was emphasized by the Hon. Bruce Scott (then Minister for Veteran's Affairs) in Reid et al (1999) when he noted that "more than 100 nursing sisters have paid the ultimate price in serving their country, losing their lives to enemy action, illness and as prisoners of war" (Minister's Message).

Hodge (1997), in discussing the reasons why military personnel separated from the Australian Defence Force, also considered the unique nature of military service. He remarked:

> Much has been said about the unique or special nature of military service…those who join the Services make a professional commitment quite unlike any other, to:
>
> - accept the risk of serious injury of death in defence of the country;
> - train for the application of extreme violence;
> - accept lawful direction without equivocation; and
> - forego any right to withdraw labour or refuse a task.
>
> Service in the armed forces involves more than just an occupational choice. What differentiates the military from civilian occupations is the requirement to commit to a lifestyle that permeates almost every aspect of the life of the member, including his (sic) family life. But it is not a commitment which is necessarily understood or appreciated by the community it serves (Hodge, 1997 p.36).

The military nurse was, therefore, an integral part of the military organization and subjected to the same conditions of service as their non-nursing military peers. The nurse deployed at the direction of Government to support the operational mission of the military (Smith, 1998) as part of "an instrument of national power" (Morrison, 2013 p.11). Though nurses deployed as non-combatant carers to the fighting units of the military in which they served and not in direct combat roles (Ganser, 1984;

Baumann, 2007) they were still at a high risk of physical and psychological trauma from their experiences (Hodson, 2002; Friedman, 2004; Scannell-Desch, 2005). Tricarico (1998) noted that one of the other major differences between military and civilian nurses was the concept of "readiness". Readiness described the ability to be constantly at an advanced status to leave home at short notice (sometimes within hours) and deploy for periods of months to years[15] (Kovats et al, 2001). It was acknowledged in the current global climate of aid provision to countries that had experienced natural disaster, such as Banda Aceh or Nias in the wake of tsunami or earthquake, that civilian health resources including nurses were often called upon at short notice to volunteer and aid these communities. This was evidenced by the advent of Australian Medical Assistance Teams (AusMAT) that now form part of the Australian Government response to humanitarian and disaster relief efforts (NCCTRC, 2014). However, while these persons did maintain a high state of readiness they were not subject to the same constraints as military nurses (Agazio, 2010) discussed above.

Spirituality in the military context

Nursing, spirituality and the military appear to be strange bedfellows at first appearance. Indeed, Baumann (2007) suggested that the aims of the military were at odds with the aims of nursing. He noted that "nursing in the military, particularly in war time, is…(an) example where the usual aims of nursing are altered by the mission to maintain the fighting force" (Baumann, 2007 p.280). However, as

[15] In addition to the requirement to maintain a readiness posture to deploy at short notice, readiness in the military is also focused on the need to be current and competent in the range of skills, both military and nursing, demanded of the operational setting (Kovats et al, 2001).

discussed above, strong historical linkages did exist between religious orders, nursing and the battlefield particularly in the Western nursing paradigm (O'Brien, 1999; Shelly & Fish, 1999; Johnson et al, 2006; Helmstadter & Godden, 2013).

Despite the historical linkage between nursing, the military and spirituality very little literature existed to situate the current discourse on spiritual nursing care within the context of military nursing practice (Ormsby & Harrington, 2003). There was a growing, though as yet limited, body of literature identified into spiritual care in military veteran and non-deployed military populations (Keith, 1998; Willis, 2001; Trevino et al, 2011). However, the military remained an under researched sub-set of the modern nursing profession internationally.

Two recent studies were identified by United States military nurses that explored spirituality in military veteran (Trevino et al, 2011) and military family populations (Chambers, 2013). Trevino et al (2011) conducted qualitative focus groups to explore religiosity and spirituality in military veterans who had survived cancer. Their findings suggested that the spirituality of the majority of participants in their study was strengthened by the cancer experience. Notable, however, was that despite a positive correlation being established in the literature (Drescher et al, 2007; Pargament & Sweeney, 2011; Simmons 2012) between spirituality and coping, "relatively few participants [in the focus groups] discussed how their R/S beliefs and/or practices helped them deal with cancer" (Trevino et al, 2011 p.631).

Chambers (2013) explored the impact of separation on the physical, psychological and spiritual well-being of ten military wives whose husbands were indefinitely

deployed to Iraq. The study involved phenomenological interviews informed by Moustakis (1994) and identified that "support from the military community, and the protection of spirituality and prayers summarized the women's problem-focused coping techniques" (Chambers, 2013 p.41).

A further search of the grants database of the Uniformed Services University of the Health Sciences identified one research proposal for a study that was being undertaken into military nursing (Stanton, 2011). Stanton's (2011) proposal was titled *Reintegration of Military Nurses* and was examining spirituality, storytelling and mindfulness activities in nurses returning from active duty in Iraq and Afghanistan. However, Stanton's (2011) research had not yielded any findings at the time of writing this thesis. The only other nursing study identified by the researcher was by Clark and Heidenreich (1995) who conducted a descriptive study of spiritual care in a cohort of patients in a military hospital in the Midwestern United States. Their findings emphasised the importance of the care provider, family and friends, and religion and spirituality to the effective delivery of spiritual care in intensive care settings (Clark & Heidenreich, 1995).

In the wider medical and psychological literature a number of articles were identified that examined spirituality as a coping strategy in military veteran and family populations (Drescher et al, 2007; Hamlin-Glover, 2009; Wester, 2009; Brelsford & Friedberg, 2011; Mahboobi et al, 2012; Simmons, 2012). Discussing strategies for mental health providers dealing with Post Traumatic Stress Disorder in military veterans, Drescher et al (2007) suggested that "spirituality may play as a healing resource for those recovering from warzone trauma" (p.432). Hamlin-Glover (2009)

and Brelsford & Friedberg (2011) supported the view expressed by Drescher et al (2007). Indeed, in a thesis exploring religiousness and spirituality in relation to resilience in military families, Hamlin-Glover (2009) stated that "spiritual beliefs and religious practices are key in assisting families with overcoming their adversities" (p.118). Finally, in a quantitative descriptive study on the relationship between spiritual health and social anxiety in Iranian military veterans affected by chemical weapons Mahboobi et al (2012) identified that "it is possible to reduce social anxiety in such people by improving their spiritual well-being" (p.190).

While the nurses that streamed into the military were educated within the civilian nursing sphere, there were some distinct differences between civilian and military nursing practice (Felton et al, 1998). Indeed, Felton et al (1998) remarked that military nursing was distinct from civilian nursing because it "fulfils an important social function in preventing and resolving conflict under conditions that can have profound negative and positive effects on health" (p.89) within a war fighting construct.

Military nursing bodies worldwide ascribed to the International Council of Nursing Code of Ethics (ICN, 2012) and in Australia aligned with the Australian Nursing and Midwifery Council Codes of Ethics and Professional Conduct (ANMC, 2008). The International Council of Nursing (ICN, 2012) entreated nurses to provide care that "promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected" (p.2). Australian Defence Force nurses were also required to "provide care, simultaneously attending to the biological, psychological, social and spiritual needs of the person" (DNSADF,

1996). While the underpinning philosophy of Australian Defence Force nursing was drawn from an older document (DNSADF, 1996) it had yet to be superseded and remained valid in the current military nursing context. The professional nursing bodies identified above, along with the nursing literature, affirmed holistic practice as being the hallmark of modern complete nursing care for patients (Murphy & Walker, 2013). Brimblecombe et al (2007) provided a concise definition of holistic care from a mental health nursing perspective that fitted well with this thesis. They defined holistic care as "care that recognizes people…as whole persons with interrelated psychological, social, physical and spiritual needs" (Brimblecombe et al, 2007 p.340).

At the policy level the acknowledgement of the spiritual as an integral component of nursing care was established above in both civilian and military nursing cultures. In the civilian sector the translation of the spiritual from policy into nursing care practice had occurred in some defined areas (Harrington, 2003; Cockell & McSherry, 2012; Penman et al, 2013). However, Cockell & McSherry (2012) noted that "a preponderance of research in the areas of palliative care and oncology… skews the field of spiritual care, giving it a home only at the margins of health care" (p.966).

Hospice and aged care settings remained the vanguards for spiritual nursing care provision, though the recognition and use of spiritual care within other more acute settings was an evolving area (Ronaldson et al, 2012). There was an increasing body of research and literature that supported this assertion though whether this was well established practice remained open to debate. Daaleman (2012) asserted that to

deliver spiritual care more effectively it was necessary to develop a health service framework that supported nurses in providing holistic care. He argued that:

> By focusing on the structure, process and outcome elements of spiritual care within organisational settings, this framework can help nursing move from exploratory and descriptive approaches of individual-level spirituality to effective, meaningful and sustainable ways of implementing and improving the delivery of this unique type of care (Daaleman, 2012 p.1027-1028).

In the military nursing setting, spiritual nursing care remained something of an anomaly in terms of visibility within the established nursing literature and research. Despite the efforts of the researcher to begin to address this area of nursing practice within the Royal Australian Air Force (Ormsby, 2001) there remained a dearth of data that verified the acceptance of military nurses to providing spiritual nursing care to their patients. This may have been in part due to the health and age demographics of military personnel, who are generally fitter and healthier than the general population. A 2001 report by the Australian Department of Defence (DoD, 2001) noted that the average age of Australian military personnel was 29 years compared to 37.7 the general Australian workforce. It may have also reflected the secular shift in the general populace of whom military personnel were likely to mirror in attitudes and spiritual practice. However, as Price (1965) so succinctly stated in acknowledging the spiritual quality of nursing:

> The nurse should not be distressed if a patient professes to have no faith in prayer, in medical science or in anything. Even the most skeptical person has faith in many ways (p.287).

One area within the military where spirituality had gained some recognition was in the area of resilience. The Australian Defence Force had initiated a program titled *Faith Under Fire* that aimed to build spiritual resilience alongside emotional and physical resilience (DoD, 2011a). The course booklet introduced spiritual resilience in the following way:

> ADF personnel are trained to be physically, mentally and emotionally fit, but very few of us consider the importance of also being spiritually fit or resilient. This course promotes the idea that it is important to recognize our own spiritual needs and concerns, as well as those with whom we serve (DoD, 2011a p.3).

While the course was not specific to nursing the idea that spiritual resilience was a protective factor against mental and emotional trauma was significant for military nursing. Simmons (2012) noted "that individuals with a high level of resilience are able to successfully handle change and adversity while those with a low level of resilience are negatively affected by change or adversity" (p.11). Indeed, the literature was strongly suggestive that one of the most significant long term sequelae of operational deployment was the development of mental health disorders such as depression and Post Traumatic Stress Disorder (Hodson, 2003; Friedman, 2004; Hoge et al, 2004; Sixsmith et al, 2013) potentially caused by a lack of resilience. The literature also supported the notion that a strong personal spirituality had a positive protective effect against the development of Post Traumatic Stress Disorder (Wester, 2009; Simmons, 2012). Gibbons et al (2012) suggested that military nurses were not immune to the effects of Post Traumatic Stress Disorder and noted: "similar to military combatants, military healthcare provider exposure to life-threatening situations will increase the probability of adverse psychological disorders" (p.3).

Further, they indicated that religion was protective against psychological disorders resulting from exposures to traumatic events on deployment. Spirituality was therefore offered as important for the well-being of both patients and nurses in the military.

2.7 Summary of Chapter two

The study was positioned within the context of the contemporary nursing literature and the ongoing discussions surrounding spirituality and spiritual care. It was evident that while definitions of spirituality were beginning to align, there was still a lack of consensus in the literature. Indeed, while much of the research examined spirituality in pluralistic language, the prominence of religion was undergoing a resurgence. Notwithstanding the variations in spiritual definitions, there was agreement that the provision of spiritual care was an important component of the holistic care of the patient. Furthermore, there was a positive correlation between spirituality and well-being.

The chapter returned to the origins of spirituality and spiritual care within the historical context of nursing. It defined spirituality in both pluralistic and religion based frameworks and identified its operational meaning in the provision of spiritual care. Spiritual care was argued as an important part of holistic patient care that needed to be extended more actively into acute care settings.

Historically nursing retained a strong association with spirituality. Its early origins in the Western world were closely aligned with the rise of the Christian church and the

monastic orders that evolved from the religious institution. Only in the past century had nursing, following societal trends, moved away from religion based spirituality to embrace a more pluralistic framework around spirituality and spiritual care. Spirituality was more widely understood in the contemporary literature as a pervasive aspect of life that provided meaning and purpose that was often developed through relationship with others. Spirituality was inclusive of religion but was not defined by religion.

Nursing also shared a long history with the military religious orders in providing care to the wounded on the battlefield. Military nurses were argued as a unique cultural sub-set of the nursing profession who were defined by the nature of military service and deployment. Spiritual nursing care was not well understood in the literature and was therefore a fertile ground for further research.

What follows is an examination of the study design that is underpinned by the Philosophical Hermeneutics of Gadamer (1976/2004). It is in the hermeneutic dialogue that this study will explore the essential nature of spirituality in the unique context of military deployment.

PART TWO
Method and Truth

> The understanding and the interpretation of texts is not merely a concern of science…It is a question of recognizing…an experience of truth that not only needs to be justified philosophically, but which is itself a way of doing philosophy…Hermeneutics…is [therefore] an attempt to understand what the human sciences truly are, beyond their methodological self-consciousness, and what connects them with the totality of our experience of world (Gadamer, 1960/2003 p.xxi-xxiii).

Part two presents the philosophical approach that underpinned the research endeavour from inception to completion. It also describes the data analysis methods that provided the foundation for the reflective, descriptive and interpretive analyses that will follow in Part three. The information will be detailed in the following chapters:

- Chapter Three – Methodology
- Chapter Four – Method
- Chapter Five – The Participants

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter discusses the research methodology that underpins this study. That is, to understand spirituality and spiritual nursing care as experienced by a group of Australian military nurses within the context of deployed military operations. Koch (1993) stated the methodology makes explicit the "philosophical framework and assumptions" (p.140) that form the researcher's approach to the data. In this study the methodology was seen as the interpretive lens through which the preconditions for understanding data were identified, data interpreted and insights generated to bring meaning to the experiences of the study participants (Gadamer, 1976/2004; Van Manen, 1997/2007).

In order to approach the research in a meaningful way it was necessary to find a conceptual and philosophical framework that was consistent with the research intent. The philosophical approach defines the context of the research in relation to the world, the researcher and the participants in that research (Hoffmann, 2004). In constructing a philosophical framework for this study the researcher sought a qualitative research approach that would facilitate deeper understanding of the spiritual phenomena. According to Denzin & Lincoln (2005) "qualitative research is a situated activity that locates the observer in the world…attempting to make sense of…phenomena" (p.3). Merriam (2002) added that "the key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals in interaction with their world" (p.3). A qualitative approach, therefore,

was better suited to the phenomena in this thesis that were focused on human experience rather than causation and generalizability that remain the “stock and trade” for quantitative study designs.

A thorough search of the literature led the researcher to the Philosophical Hermeneutics of Hans-Georg Gadamer (1976/2004). Harrington (2003) approached spiritual care in a hospice setting through Philosophical Hermeneutics as the approach situated her preconceptions and history within the research. Kociszewski (2003) argued that spirituality lent “itself well to a phenomenological approach” (p.134) (of which Philosophical Hermeneutics is a part) when seeking to understand the lived experience of nurses working in a patient care setting. According to Laverty (2003) hermeneutics is “a process of co-creation between the researcher and participant, in which the very production of meaning occurs through a circle of readings, reflective writing and interpretations” (p.22).

Philosophical Hermeneutics, therefore, set as its purpose the uncovering of meaning in all that could be understood. In doing so it sought to understand the world in a genuine dialogue that was mediated through language. It was a philosophical perspective that encapsulated the interconnection between the interpreter and the interpreted in developing an ontological understanding of the human experience (Gadamer, 1976/2004; Mantzavinos, 2005). The approach was consistent with the aims of this study and provided the overarching philosophical framework for data interpretation.

The Philosophical Hermeneutic approach of Gadamer (1976/2004) presented a quandary for the researcher. Philosophical Hermeneutics was largely a-methodical in its intent (Moran, 2000; Gadamer, 1976/2004). Indeed, Gadamer (1960/2003) argued that "to think beyond the concept of method in the human sciences…is to ask the question of the "possibility" of the human sciences" (p.512). However, data analysis was more easily managed within a structured framework. The researcher in this study wanted to remain aligned with the philosophical intent of Gadamer but chose to apply two phenomenological analytic methods to bring structure to the process of analysis. Collaizi's (1978) method of data analysis and Van Manen's (1997/2007) approach to research in the human sciences provided the analytic framework for this study (to be discussed in Chapter four).

This chapter begins by presenting the historical context of the methodology (3.2) to provide a pretext to the philosophical approach that has been taken in this study. The next section examines the context of the study by situating the researcher (3.3) in the discussion. The underlying assumptions of qualitative research (3.4) will then be discussed followed by the philosophical framework of the study (3.5) that informed this study from inception to completion. This section will include the basic assumptions, concepts and principles of Philosophical Hermeneutics. The researcher will provide supporting arguments throughout the chapter to demonstrate the appropriateness and centrality of the philosophical framework to the study. Finally, a summary of chapter three (3.6) will be provided to close the chapter and lead into Chapter four.

The ensuing pages will trace the broad philosophical and socio-political movements in continental Europe that ultimately led to the development of phenomenological philosophy. The history and evolution of phenomenology as a distinctive philosophical tradition will be examined, laying open the main concepts of phenomenology's major adherents.

3.2 Historical Context of the Methodology

The road to "enlightenment"

Rene Descartes (1596-1650) in his 17th Century *Meditation*s made the statement *cogito ergo sum*, "I think, therefore I am" (Cottingham, 2001) and in so doing encapsulated the dualist separation of mind and body that became the catalyst for the reductionist world view that continues to pervade science. His treatise presented the notion that understanding our place in the world was no longer to be viewed as being related to an ordered cosmos, but rather was a search for meaning that was inwardly focused on a disembodied self (Cottingham, 2001). In stark contrast to the religious dogma of the medieval and Renaissance world view, Descartes proffered the notion of the physical world in which we live as being explainable in terms of universal physical laws. In *The Enigma of Health* Gadamer (1996) set this view as the foundation of modern science:

> With the idea of the unitary method of the understanding, as formulated by Descartes in his Rules, the idea of certainty became the standard for all understanding. Only that which could be verified could have validity as experience (p.5).

Cartesian thinking was to prove a fertile ground that was ultimately to lead to the Enlightenment philosophies of Hume (Quinton, 2001), Kant (Gadamer, 1960/2003) and others who deified observable and repeatable science as the pinnacle of understanding in the physical world (Cottingham, 2001). In the metaphysical world, Enlightenment viewed moral and ethical judgment not in the context of a divine compass realized in the laws of the church, but raised the internal moral compass of the individual over God[16] in making sense of the world.

The underlying tenets of enlightenment philosophy were well illustrated in the 18th Century *Critique of Pure Reason* by Immanual Kant (1724-1804) that drew together the threads of Enlightenment thinking (West, 2004). In Kant, spirituality as part of the metaphysical world, was an illogical notion that had no basis in reason.

> It (Critique of Pure Reason) draws together most of the central issues of Enlightenment thought in a suggestive way…his critique of 'pure reason', which concerns the kind of knowledge of the external world most clearly demonstrated in the natural sciences, provides an imaginative synthesis of empiricism and rationalism, opposing camps in what was perhaps the central philosophical dispute of the period. (West, 2004 p.17)

Kant (1724-1804) attempted to ground our experience and knowledge of the world through systematic investigation. For him, understanding of all human knowledge was bound to an *a priori* synthesis of intuition and empirical concept to which all objects must conform (McNeill and Feldman, 1998). Pure knowledge (Intuition)

[16] Enlightenment philosophy viewed the existence of a God as being outside human experience and therefore without proof. Consequently God was subjugated to myth, and science and reason were proffered as the only 'true' means by which humanity could understand itself in relation to the inhabited world (Honderich, 2005).

involved an *a priori* (prior to experience) judgment of a *necessary* proposition and an understanding of experience as a comparative universal judgment rather than as a judgment of truth. Empirical knowledge on the other hand was bound *a posteriori* in experience.

In the writings of Descartes (1596-1650) and Kant (1724-1804) we observe a common thread that presented a particular attitude to the observable world. Both saw the world through the eyes of a distant and detached observer rather than as a participant in the world. The objective attitude thus took a position of authority over the subjective attitude and set in motion a dominant positivist world view.

This view was not shared by the researcher in this study. In the context of this study spirituality is an essential element in our relationship with the physical world. Humanity interacts with and ascribes meaning to the physical (natural world) through the emotional and spiritual connection of mind, body and spirit. It was from this viewpoint that philosophers began to argue against the supremacy of science in understanding the world.

A response to "enlightenment"

As indicated earlier in this chapter, the German philosophical tradition, of which phenomenology and Philosophical Hermeneutics form a part, was a product of the post 16th Century European socio-political landscape. As a product of this historical period Germanic philosophy evolved against a backdrop of enormous upheaval in

scientific, religious and political spheres. The reductionism of Enlightenment science altered the understanding of the world and challenged the primacy of the church.

Enlightenment philosophy, however, was not without its critics even among contemporaries of Kant (1724-1804). Jean-Jacques Rouseau (1712-1778) and Johan Gottfried Von Herder (1744-1803), while being critical of aspects of Enlightenment philosophy, were nevertheless proponents of many of its central themes such as its distaste for the adherence to "superstition, dogma and arbitrary authority" (West, 2004 p.27). Rouseau (1712-1778) did, however, rail against notions of modernity, suggesting that the evils of society were directly attributable to the socio-demographic development of society. He also noted that it was only within the constraints of a society that individuals could attain a purposeful, moral and rational existence. Herder (1744-1803) prefaced the centrality of language that was so dominant later in the writings of Gadamer (1976/2004). However, rather than adhere to the tendency of Enlightenment philosophies to view the world in terms of universal laws, Herder (1744-1803) intimated that our common humanity was understood relative to our language and culture. Of Herder, Gadamer (1976/2004) observed the following:

> That language is essentially human and that man is an essentially linguistic being, and they[17] worked out the fundamental significance of this insight for man's view of the world (p.61).

[17] Gadamer also alluded to the writing of Wilhelm von Humboldt (1767-1835) in this statement and acknowledged him as the founder of a philosophy of language.

The development of a philosophy of language through the works of Herder (1744-1803) and Humboldt (1767-1835) presupposed a philosophy of understanding. Language needed to be understood to be meaningful and this could only occur in the context of a common set of words and symbols. Interpretation of language was the task of hermeneutics and it was the development of the hermeneutic that occupied the writings of Friedrich Daniel Ernst Schleiermacher (1768-1834) and Wilhelm Dilthey (1833-1911) that were to prove influential to the philosophies of both Heidegger (1962) and Gadamer (1976/2004). The development of hermeneutics laid the foundation to understanding the philosophical position of Gadamer and its importance to the study presented here.

Hermeneutics

In its original sense within the Christian Church, hermeneutics was restricted to the interpretation of biblical texts and was therefore constrained to interpreting the divine word of God (Lundin, 1997). In its later use, however, hermeneutics set as its task the interpretation and understanding of phenomena that included the written and verbal word (Schmidt, 2006). In the 20th Century the hermeneutic task expanded to encompass the understanding of a work of art, other expressive media and indeed anything else that required interpretation. Hermeneutics was thus seen as a constantly expanding and changing discipline and was used in this thesis to understand spirituality and spiritual care in the deployed Australian military nursing context.

During the Enlightenment Schleiermacher (1868-1834) developed a universal hermeneutic that drew together a number of hermeneutical theories from which to

understand spoken and written language. For Schleiermacher the hermeneutic art[18] was universally applied to mediate the ever present misunderstanding of language (Schmidt, 2006). In seeking to understand language Schleiermacher divided the hermeneutic into a grammatical interpretation and a psychological interpretation.

In the grammatical interpretation Schleiermacher (1868-1834) suggested that one must understand the language of the author in order to authenticate the meaning of the text (Schmidt, 2006). Complementary to textual authentication, the interpreter used psychological interpretation to understand the developed thinking of the author and expression of this thought. According to Schleiermacher, however, neither was exclusive and the emphasis on either the grammatical or the psychological interpretation varied depending of the focus of the interpreter at the time.

> Hermeneutics requires both grammatical and psychological interpretation…If one is interested primarily in language as the means by which an individual communicates his thoughts, then the psychological will be more important. Whereas if one is interested in language as it determines the thinking of individuals at a particular time, then the grammatical side will predominate (Schmidt, 2006 p.12).

Other important hermeneutic notions that emerged from Schleiermacher's (1868-1834) work, although only the first point was used in the Philosophical Hermeneutic approach taken in this study, included:

[18] Schleiermacher alluded to the hermeneutic as an art but indicated that rules govern our understanding of language. However, he then suggested that interpretation in and of itself, like the application of art, cannot be rule bound as the mechanism of art is learned through rules but the application is a subjective and creative process.

- His use of the hermeneutic circle in which he posited the belief that there was a unity between the whole and the parts whereby the parts are understood in relation to the meaning of the whole and the whole was understood in relation to its parts (Lawn, 2006). This notion was taken up by Gadamer (1976/2004) in his Philosophical Hermeneutics and was applied throughout this study.

- His negative use of prejudice as leading to misunderstanding through the unintentional addition or omission of something due to an inherent want to impose our own perspective on the author's words (Schmidt, 2006). This claim was refuted by Gadamer (1976/2004) and prejudice was therefore identified as a precondition of understanding in the context of this thesis.

Dilthey (1833-1911) developed the ideas of Schleiermacher and advanced an empirical methodology for the human sciences termed *Verstehen* or understanding. However, rather than expand the context in which hermeneutics was applied Dilthey remained fixed on a narrow textual interpretation. The task of hermeneutics for Dilthey then was:

> The justification of understanding with reference to the written records of human existence where the life of human beings finds its complete expression (Schmidt, 2006 p.31).

Dilthey (1833-1911) separated the notions of *Verstehen* (understanding) and *Erklaren* (explanation) within the human and natural sciences respectively but also noted interdependence between the two. In this he suggested that the natural sciences were primarily concerned with explaining causal relationships while the human sciences

concerned themselves with the understanding and expression of "lived experiences" (Schmidt, 2006).

The next major developments in hermeneutics were arguably seen in Heidegger (1962) and culminated in the Philosophical Hermeneutics of Gadamer (1976/2004). These developments will not be explored in this section but rather left to the specific sections on Heidegger and Gadamer later in the chapter. What follows now is an exploration of the Germanic phenomenological tradition, its proponents and its influence on Gadamer and the philosophical approach taken in this research.

Phenomenology

Phenomenology evolved from the 19th Century German philosophical tradition and continually re-invented itself over the course of the past century. It represented a movement in continental European philosophy that sought to free itself from the objectification of positivist science that evolved from Cartesian and Enlightenment philosophies. The quest for phenomenology was to uncover the "lived experience" of our lives and the phenomena that we encounter relative to the world around us.

The origins of phenomenology are traced to the Edmund Husserl (1973) who began the phenomenological "movement"[19,20] with his entreaty to bracket our

[19] Edmund Husserl formalized the concepts that were to be accepted as the foundational tenets of phenomenology though much of the initial work was influenced by the work of Dilthy and Schleiermacher (Schmidt, 2006).

[20] While a 'movement' in phenomenology may conjure thoughts of a homogenous set of central tenets, this was not generally the case. Phenomenology developed through three quite distinct

presuppositions and return to the *things themselves*. Martin Heidegger (1962) moved the debate on in his "Being and Time", opening the discussion on hermeneutics derived from biblical exegesis. However, while the research presented in this thesis examined several phenomena and retained a flavour consistent with Heidegger's hermeneutic, it was not approached through the phenomenologies of either Husserl or Heidegger. The predominant influence in this thesis came from the writing of Hans-Georg Gadamer (1960/2003; 1976/2004). Gadamer was a former student of Heidegger, who posited the view that the understanding of a phenomenon can only be achieved through the interplay of ideas between actor and audience. Each individual brings their own historically contextual understanding to bear on the interchange.

Phenomenology, as indicated above, developed through a number of iterations since its early conceptual foundations with Husserl (1973) (Dowling, 2005). As a philosophical paradigm, phenomenology continued to develop through the work of such writers as Max Van Manen (1997/2007) and Linda Finlay (2003). As a philosophical movement phenomenology remained a mode of thought that directed its energies to understanding the "lived experience" of the individual in the world (Sokolowski, 2005; Van Manen, 1997/2007). Its intrinsic function was to interpret a phenomenon, though how this was achieved has been the subject of much debate between Husserl and his philosophical contemporaries and those that have followed (Finlay, 2009).

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movements that while still interested in the nature of phenomena, sought to understand phenomena in quite distinct ways. Husserl (1973) advocated bracketing our presuppositions to view phenomena from an *a-priori* standpoint. Heidegger (1962) rejected Husserl's bracketing and viewed phenomena in relation to our *being in the world*. Gadamer (1960/2003) approached phenomena through dialogue and sought truth in agreement.

Phenomenological purists, such as Michael Crotty (1996) argued that a true phenomenology was aligned with Husserl's (1973) view of a "bracketed" *a-priori* search for meaning. In this context Philosophical Hermeneutics as proposed by Gadamer (1976/2004) would not be considered as an evolution of Husserlean phenomenology. Rather, Philosophical Hermeneutics would be treated as a separate philosophical approach altogether. However, in the context of this thesis the author asserts that in the Post Modern world that strict adherence to a "purist" thought, while useful in focusing philosophical debate and providing a historical context to phenomenology, concerns itself too much in an argument of semantics and not enough with an acceptance that a "movement" can evolve beyond its origins.

Edmund Husserl (Back to the things themselves)

Edmund Husserl (1859-1917) built the foundation for the phenomenological movement when he published his *Logical Investigations* in 1900. In *Logical Investigations*, which comprised a series of volumes, Husserl attempted to have phenomenology accepted as a rigorous science. He used careful description to underpin the application of his *phenomenology* and proposed the suspension of our natural attitude to the world when approaching phenomena (McNeill and Feldman, 1998). Husserl suggested that to objectively understand phenomena that it was necessary for the researcher to examine phenomena from an unbiased view point. That is, there was a need to *bracket* our prejudices and return to an *a priori* and pre-reflexive position.

> By suspending the general positing function of consciousness, that is, by bracketing the affirmation of the actual existence of the world, Husserl restricted the task of philosophy to the correlation of phenomena in their

> essential nature with corresponding acts of consciousness in which they are constituted in their objectivity (Linge in Gadamer, 1976/2004 p.x1iii).

Husserl (1973) expressed the view that to truly understand a phenomenon it was necessary to *go back to the things themselves* and set aside our views and historical prejudices. In approaching research from an *a-priori* perspective one allowed the phenomenon to speak for itself. In proposing that all thought was suspended through *bracketing* Husserl (1973) asserted that understanding can only be true to the phenomenon when it was not coloured by the life lens of the researcher. This approach was of course a high ideal to achieve as other philosophers (Heidegger, 1962; Gadamer, 2003) would tell us we are indeed historical beings. Hence, to suspend our temporal closeness to the phenomenon, and our prior history in shaping that understanding, was a form of Utopianism beyond the grasp of mortal abilities.

> By leading us 'back to the things themselves' (zu den Sachen selbst) as they first become manifest to us, prior to the 'objectifying' constructions of our conceptual judgments, phenomenology aims to demonstrate how the world is an experience which we live before it becomes an object which we know in some impersonal and detached fashion (Kearney, 1991 p.13).

Husserl (1973) grounded his "phenomenology" in the experience of the *Lebenswelt* (life-world) from which he suggested objective truth was to be found. In this respect Husserl raised the notion of intentionality. Intentionality asserted that consciousness was always consciousness of something as an intentional object. In this way intentional objects, whether physical or not, could be proved or disproved by experience (Schmidt, 2006). Husserl thus aligned his thoughts with Descartes (1596-

1650) in seeking to raise philosophy to a rigorous science. However, Husserl then departed from Descartes' views by countering the claims of scientism by situating reason within the conscious experience of the "life world" (Kearney, 1991).

Intentionality was broken down into three equal parts: perception, imagination and signification. Through perception the object intended itself in its present reality. In the imagination the object intended itself in an abstract and symbolic form. Finally, in signification the object intended itself in a pure absence that left open our thinking to an expanding future (Kearney, 1991). Husserl (1973) therefore, attempted to re-integrate the objective and subjective experience into an ordered relationship that concerned itself with the here and now and the future intentionality. In this way we were no longer detached observers of our world but rather conscious and intentional participants in the world.

While the approach offered by Husserl to research phenomena was not used in this study his ideas were nevertheless the foundation for the phenomenological approaches that followed. One philosopher that built upon the foundation laid by Husserl was his student Martin Heidegger (1962) who developed Husserl's (1973) phenomenology by transforming the idea of an intentional consciousness of the world into a concept of "being-in-the-world" (Heidegger, 2007 p.20).

Martin Heidegger (Being in the world)

Martin Heidegger (1962) was a phenomenologist and a hermeneuticist who concerned himself with the question of "Being" as it related to our understanding of the world. In his seminal work *Being and Time* Heidegger (2007) explored "Being"

as an existential notion of *Dasein* that expressed "Being" not as an object but rather as an action. "Being" was considered as "Being-in-a-World" (Heidegger, 2007 p.55) and it was in this orientation to the world that we attempted to make some sense of our relationship to the world and our existence. What Heidegger posed was a fundamentally hermeneutic question that sought to understand "Being" within the context of our history and present. However, rather than follow the explicit aim of Husserl of creating a prejudice free *a-priori* rigorous philosophy, Kearney (1991) suggested that what Heidegger did was to break free of the constraints of Husserl's (1973) bracketing. Heidegger (2007) allowed existence to enter and emerge as openness to "being of being" (p.55) situated in its "life world". Heidegger, as will become apparent later, was the link that joined Husserl to Gadamer (1976/2004) in developing the hermeneutic of understanding that supported the researcher in this study.

The concept of "Being" was developed by Heidegger (1962) to: recover "Being" from its original Greek understanding as a universal, indefinable but self-evident concept; examine the nature of the essential structure of "Being"; and explore the ontological and ontic[21] nature (Heidegger, 2007) of "Being". Heidegger expressed the nature of "Being" as Dasein in the following way:

> Dasein, on the basis of its metaphysical constitution, on the basis of being-in-the-world, is always in its very possibility already beyond all being. And in this being-beyond it does not come up against absolute nothingness. Rather, on the contrary, in this very being-beyond Dasein

[21] Ontic knowledge pertains to a knowledge of "the distinctive nature of particular types of entity" (Mulhall, 2003).

> holds before itself the binding commitment as world (Heidegger in Rapaport, 1991 p.90).

Heidegger (2007) then proceeded to show that Dasein, as “Being-in-the-World” (p.20), was a constant and circular question of understanding and mis-understanding of our existence in the world. This questioning could be an intentional or an unintentional act, though what Heidegger suggested was that the unintentional act was really a pre-intentional act (Rapaport, 1991). As previously identified, Heidegger also situated the question of understanding “Being” as a historically effected hermeneutic. This position will be seen later as the bridge between the phenomenology of Husserl (1973) and the Philosophical Hermeneutics of Gadamer (1976/2004).

Heidegger (1962) introduced the concept of “facticity” to describe our “lived experience” of “Being-in-the-World” as a temporal mode of *Dasein*. He further developed this thought when he described the hermeneutics of “facticity” as a way of uncovering truth and meaning in what was concealed (Schmidt, 2006 p.54). The hermeneutic was therefore not presented in its original exegetical sense, but like Gadamer (1976/2004) later, in a more encompassing search for meaning. Hence, “the aim is to approach the objects of investigation “as they show themselves in themselves”” (Schmidt, 2006 p.57). The hermeneutic of Heidegger (1962) involved the concept of “thrownness” which presupposed a projected understanding of a phenomenon. The phenomenon or object was only ever understood through interpretation within the framework of our experience and language.

Much of Heidegger's (1962) phenomenological and hermeneutic approach presented above was appropriated by Gadamer (1976/2004). However, Gadamer expanded the hermeneutic task into his own Philosophical Hermeneutic which was further appropriated by the researcher in this study to interpret the spiritual phenomena under investigation. The next section will explore the Philosophical Hermeneutics of Gadamer (1976/2004) in order to make explicit the underlying philosophical assumptions that guided this research.

Hans-Georg Gadamer (Toward a Philosophical Hermeneutic of understanding)

Hans-Georg Gadamer was variously described as a phenomenologist, an aestheticist and a hermeneuticist (Hammermeister, 2002; Dorstal, 2002; Lawn, 2006). His magnum opus *Truth and method* (Gadamer 1960/2003) laid out the foundations of Gadamer's (1976/2004) hermeneutic thesis by seeking to show, through the media of art, game and language, how truth could be disclosed via a universal interpretation of phenomena. In disclosing this truth, however, Gadamer also demonstrated the limitations inherent in the methods of logical positivist thought that continued to dominate the field of scientific endeavour. Indeed, one of the major difficulties Gadamer had with the Enlightenment philosophies centred on the claim of truth in science through the control of prejudice and bias in research (Dorstal, 2002). Gadamer (1976/2004) asserted:

> The question arises as to how we can legitimate…hermeneutical conditionedness of our being in the face of modern science, which stands or falls with the principle of being unbiased and prejudiceless…The genuine researcher is motivated by a desire for knowledge and by nothing else. And yet, over against the whole of our civilization that is

> founded on modern science, we must ask repeatedly if something has not been omitted (p.10).

The "objective" attitude of science was exposed as somewhat restrictive by extolling a rigid adherence to method as the only pathway to understanding our experience of the world. Gadamer (1976/2004) indicated that hermeneutics provided a way in which to incorporate the subjective experience into our search for truth. Thereby it was possible to bridge the limitations of objective science without demonizing or downplaying the importance of the advances made by the natural sciences over the course of the past century.

> It (hermeneutics) is not concerned primarily with amassing verified knowledge, such as would satisfy the methodological ideal of science-yet it too is concerned with knowledge and with truth...The difference that confronts us is not in the method but in the objectives of knowledge (Gadamer, 1960/2003 p.xxi).

In *Truth and Method* (1960/2003) Gadamer formulated his earlier thoughts on the universal hermeneutic as an entreaty to honour a search for universal truth. The universal truth did not yield to a slavish adherence to the constraints of method proffered by science. This theme was carried through into the later work of Gadamer where David E. Linge (2004), in his editor's introduction to *Philosophical Hermeneutics* (Gadamer, 1976/2004), described his work as "ontological rather than methodological"[22].

[22] According to Linge (2004) Gadamer opposed a rigid adherence to method in understanding phenomena because; "The universality of the hermeneutical question can emerge…only when we have freed ourselves from the methodologism that pervades modern thought and from its assumptions regarding man and tradition" (p.xi). This is the ontological question of *being* in relation the world.

Throughout his life Gadamer (1960/2003) set in motion an ongoing critique of the "truth" claim that science made. He suggested that the natural sciences retained a legitimate place in our quest to understand the world. However, Gadamer (2006) asserted that the natural sciences could not possibly provide answers to the interpreted world of the human sciences in seeking answers to human problems such as life purpose, death and history. Truth in the human science context was not measurable and according to Gadamer (1960/2003) was always subject to our history and prejudices. The concept of a self evident interpreted truth is important to understanding the philosophical basis for this study.

As already alluded to, Gadamer (1960/2003) initially set out his concern with the "problem of hermeneutics" and truth in his treatise on *Truth and Method.* He saw the hermeneutic task as a need to go beyond the rigid methods of science and developed a universal hermeneutic that provided a basis for the interpretation and understanding of phenomena. In this endeavour he asserted that the claim of truth extended beyond the self-consciousness of method. Therefore, we seek to capture the essence of our connection with the immediate world through the lens of our historical horizons mediated in language through dialogue (Lawn, 2006). In doing so, we strive to find understanding and truth in the dialogue by being open to the viewpoint of the *other* and coming to a temporal moment of understanding as we enter a fusion of those horizons.

The ideas Gadamer presented in *Truth and Method* (1960/2003) were refined and expanded upon in his *Philosophical Hermeneutics* (1976/2004). Gadamer had already opened the understanding of Philosophical Hermeneutics in his earlier work

but it was in his later *Philosophical Hermeneutics* that Gadamer brought the threads of hermeneutics together into a more accessible and cohesive treatise.

In keeping with the Philosophical Hermeneutic approach to phenomena offered by Gadamer (1976-2004) the next section will explore the centrality of the researcher to understanding in the context of this study.

3.3 The Researcher

In the interpretive framework of Gadamer (1976/2004), used to guide this study, the *dogmatic objectivism* (p.28) of quantitative research was set aside to enable the personal history and understanding of the researcher to be brought into the interpretive gaze. In this way the preconceptions and biases were disclosed and became an integral part of the interpretive research process. The personal orientation to the phenomena under investigation in this study will be introduced below. The process of disclosure will allow the reader to understand the personal "horizons" of the researcher and how these "horizons" influenced the presentation of the data within the totality of this thesis.

In qualitative, interpretive research the researcher was acknowledged as having a "voice" within the research itself (Guba and Lincoln, 2005). No longer a detached observer in the quantitative sense, the researcher offered their own horizon and history to the interpretive process. This study was approached from the perspective of a Christian nurse who had practiced within the Australian military for over 23 years and who had deployed on several military operations. A military nurse who

understood the context of the military nursing setting and was therefore able to bring a personal perspective to the phenomenon under examination.

The personal horizons of the researcher influenced the interpretive gaze applied to this study from inception to completion. However, it would be self-indulgent to claim that the interpretation presented in this study was the only legitimate interpretation of the data possible. A view that was supported by Schmidt (2006), after Gadamer (1976/2004), who asserted that "the same subject matter comes into language in different, yet correct, interpretations" (p.125). Habermas (1971) accused Gadamer (1960/2003) of historical relativism[23] in expressing a view on multiple interpretive realities (Gadamer, 2006). However, each interpreter approaches the interpretation of an object, whether in art, text, dialogue, play or any other phenomenal form, from their own unique horizon and will therefore interpret the phenomenon in subtly different ways (Gadamer, 1976/2004).

> There cannot…be any single interpretation that is correct "in itself"…The historical life of tradition depends on being constantly assimilated and interpreted. An interpretation that was correct in itself would be a foolish ideal (Gadamer, 1960/2003 p.397).

The researcher developed an interest in spirituality and spiritual nursing care in the military context as a direct result of a deployment to Rwanda in 1994 (see Prologue and Chapter one for more detail). The deployment was as an Australian military nurse and peacekeeper to the United Nations Assistance Mission for Rwanda in the

[23] Relativism asserted that any interpretation of a phenomenon by an individual that the individual believes is true, was true for that individual and therefore had its own inherent legitimacy (Honderich, 2005, p.800).

immediate aftermath of the 1994 genocide in that country. As a Christian nurse caring for critically ill and injured patients, the researcher had always tried to provide care for the patient as a whole person. That is, caring for the physical, the emotional and the spiritual needs of the patient. Spirituality, therefore, sat at the core of the "*being-in-the-world* (Heidegger, 2007 p.20)" of the researcher and the nursing practice and research of the researcher was approached through that experiential lens.

After Gadamer (1976-2004), the history of the researcher was embraced in this study as integral to the interpretation of the transcripts. Spirituality, therefore, was imbued in all aspects of life and relationship to others who entered the "life world" of the researcher. As Denzin and Lincoln (2005) asserted, "there is no clear window into the inner life of an individual. Any gaze is always filtered through the lenses of language, gender, social class, race and ethnicity" (p.21). In this research, the approach also included a personal spiritual perspective and an "emic"[24] or "insider's" understanding of military nursing.

Following is a more detailed discussion on qualitative research.

[24] The term 'emic' is used extensively in ethnographic research to refer an insider's or actor's view of the research endeavour. "Emic refers to the local or native view derived directly from the people's language, beliefs and experiences" (Leininger, 1985 p.238). In this study the researcher is situated within the culture, practices and experiences of Australian military nurses who have deployed on military operations and therefore approaches the research as an insider.

3.4 Qualitative Research

Qualitative research paradigms[25] seek to interpret and describe the world in which we live (Denzin and Lincoln, 2005) through full and rich description. They are not a homogenous group of research methodologies, but rather an amalgam of multiple approaches that have included ethnography, critical theory, grounded theory, phenomenology, hermeneutics and deconstructive theory, to name but a few.

Qualitative approaches to research stand in stark contrast to quantitative research methods. Quantitative methods set as their task the uncovering of phenomena through the perfection of research design tools that are constantly being refined for precision and exactitude (Max Van Manen, 1997/2007).

Denzin and Lincoln (2005) in their *Handbook of Qualitative Research* offered a useful and broadly applicable definition for qualitative research:

> Qualitative researchers study things in their natural settings, attempting to make sense of, interpret, phenomena in terms of the meanings people bring to them *(2005, p.3).*

In qualitative research, therefore, the researcher was an active participant in the research process from beginning to end and an integral part of the data collection instruments, data analysis and research reporting (Hoffmann, 2004). The researcher

[25] Denzin and Lincoln (2005) described a "paradigm as a basic set of beliefs that guide action. Paradigms deal with first principles…They define the worldview of the researcher as interpretive-bricoleur."

attempted to interpret the phenomena under study in a way that captured the meaning ascribed by the research participants.

Creswell (1998) described qualitative research as a holistic field of inquiry that explored social and human problems in such a way that allowed the researcher to build a picture of often complex phenomena via detailed reports and analysis of data conducted in a natural setting. Based on the above descriptions the basic tasks of qualitative research were viewed as:

- The collection of data from research participants in a way that authentically captured the intentions of the participants words and actions in their natural setting;

- The interpretation of the data and its attached meanings and expressions via a process of early and ongoing inductive data analysis; and

- Reporting the research findings expressively, evocatively and persuasively (Hoffmann, 2004).

Roberts and Taylor (1998) broke qualitative research down into two main sub-types; *interpretive* and *critical*[26] research. They argued that interpretive research was

[26] Critical research explores the "how the social and political aspects of the situation shape the reality" (Merriam, 2002 p.4) and therefore how aspects of "power, privilege, and oppression play out" (Merriam, 2002 p.4) in social constructs. However, Denzin & Lincoln (2005) made the argument that all qualitative research, including critical approaches, was inherently interpretive. After Gadamer (1976/2004) this researcher supported the interpretive framing of qualitative research.

focused on deriving meaning from the data, whereas critical research sought to initiate socio-political change (Roberts & Taylor, 1998 p.16). In the context of this study the approach remained firmly planted within the interpretive paradigm. Accordingly, the researcher sought to attach meaning to the data through interpretation and present it in a way that expressed and situated its context within the milieu of human relationship with the world. The approach, therefore, was consistent with the attributes described by Creswell (1998) and was easily translated into the framework of Philosophical Hermeneutics to be described in depth later in this chapter.

In understanding the underlying assumptions of qualitative research it is useful to briefly examine the nature of knowledge and the truth claim that is made when undertaking qualitative research. These concepts are defined in the following ways:

- Epistemology describes the nature of knowing the world and our stance toward truth in that world (Roberts and Taylor, 1998; Denzin and Lincoln, 2005); whereas

- Ontology concerns itself with the nature of what it means to be or to exist in the world (Roberts and Taylor, 1998; Van Manen, 1997/2007).

The questions of qualitative research undertaken in interpretive paradigms are framed within philosophical thought processes. The researcher was primarily concerned with the validation of a “truth” in the interpretation and presentation of data and how this related to our knowledge of, and relationship to, the world in

which we existed. Within the context of this research the epistemological question was answered through a temporal dialogue that was implicitly bound to language as the medium for understanding. In the ontological sense, the research was focused on the *being* of the participants in relation to the phenomena as viewed through the researcher's *being* relative to the participants and the transcripts. On the question of truth, Gadamer (1960/2003 p.383) suggested that truth was to be found in an ontology of language, where a truth emerges when we allow language to work with us to arrive at an understanding of something.

Lastly, according to Cresswell (1998) qualitative research was characterized by the following traits:

- It generally described the *how* or *what* of a phenomenon rather than *why*;
- It explored meanings and interpretations in human experiences;
- It detailed a phenomenon at "close-hand" rather than distantly;
- It was written in a literary style and may introduce the writer into the narrative; and
- It emphasized the researcher as an active learner who works with the participants rather than standing in judgment over them.

The decision by the researcher to employ a qualitative research approach to this study was clearly supported in the preceding section. Interpretive qualitative research seeks to authentically capture phenomenal meaning through the active and involved interpretation of the researcher. This aim was consistent with the context and intent of this study and aligned with the Philosophical Hermeneutic approach that was taken throughout the research process. What follows is an exploration of the philosophical framework that sets the scene for the methodological approach used in this thesis. Denzin and Lincoln (2005) provided a fitting preface for the section that follows:

> All research is interpretive; it is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied (Denzin and Lincoln, 2005 p.22).

3.5 Philosophical Framework of the Study

The central aim of this thesis was to capture the essence of spirituality and spiritual nursing care as expressed by Australian military nurses within a deployed military nursing context. The foundation for the analysis and presentation of the data in this study was in the Philosophical Hermeneutics of Hans-Georg Gadamer (1976/2004). The Philosophical Hermeneutic approach expanded and reshaped classical hermeneutics and extended the hermeneutic notions posited by Martin Heidegger (discussed earlier) in his phenomenological Magnum Opus, *Being and Time* (Heidegger, 1962).

In Philosophical Hermeneutics, Gadamer (1976/2004) approached the act of understanding as a process that was mediated through language and dialogue[27]. Its task was presented as:

> The opening up of the hermeneutical dimension in its full scope, showing its fundamental significance for our entire understanding of the world and thus for all the various forms in which this understanding manifests itself: from interhuman communication to manipulation of society, from personal experience by the individual in society to the way in which he encounters society; and from the tradition as it is built of religion and law, art and philosophy, to the revolutionary consciousness that unhinges the tradition through emancipatory reflection (Gadamer, 1996/2004 p.18).

In the context of this study, Philosophical Hermeneutics provided a platform from which to gain an *entree* into the "lived experience" of the nurses who graciously agreed to be interviewed. However, rather than leave the researcher as a distant and unbiased observer, Philosophical Hermeneutics validated the voice of the researcher as an active participant in the dialogue[28]. In this way, Gadamer's (1976/2004) approach was anathema to the still quantitatively dominated world of "hard" science. Philosophical Hermeneutics railed against rigid method, embraced prejudice[29] in a positive manner and accepted that every moment of understanding was temporal and

[27] Philosophical Hermeneutics acknowledges that language is the medium for all understanding and that every interpretation is temporal in its essence (Gadamer, 1976/2004).

[28] Philosophical Hermeneutics embraces the tradition and prejudices of the interpreter in relation to the informants and the approach to the textual interpretation (Gadamer, 1976/2004).

[29] Gadamer (1976/2004) used pre-judice in the context of its original intent. In this context pre-judice is to be viewed in a positive light, not as a bias to our thinking but as recognition of the importance of our tradition in shaping the way that we interpret phenomena.

finite[30]. The approach to understanding offered by Gadamer (1976/2004), therefore, complemented the goal of this research in sensitively capturing the stories of the nurse participants in a way that was authentic in its rendering but acknowledged the effective history and consciousness[31] of the researcher in shaping that rendering.

Philosophical Hermeneutics captures elements of aesthetics, phenomenology and hermeneutics. Sokolowski (2005) argued that Philosophical Hermeneutics sits "on the margins of phenomenology" (p.224). It is the contention of the researcher that while Philosophical Hermeneutics reflected an intellectual and generational shift in phenomenological thinking it remained nevertheless an authentic phenomenology in the tradition of Husserl (1973) and Heidegger (1962). However, it set as its aim the capturing of phenomena as interpreted through the history[32] and horizons[33] of the researcher.

The researcher makes no claim of authority or primacy in presenting the stories of the nurses who participated in this research. The transcripts presented in this thesis represent an attempt to render the data in a way which is sensitive to the intent of the

[30] Understanding is temporal as it captures phenomena as a 'snap shot' bound to a defined moment in time. However, while our interaction with a phenomenon may continue and our understanding may grow, each moment of understanding remains bound to that moment in time and is therefore finite.

[31] Gadamer (1976/2004) suggested that the historical consciousness is the result of the fusion of the researcher's past and present horizons constituted in tradition (Lawn, 2004).

[32] Historicity is an element of tradition that proposed that our knowing is always a historical knowing as we always understand against the backdrop of our "own preconceived opinions and prejudices" (Matzavinos, 2005 p.50).

[33] Horizons are temporal understandings of the world constructed from our inherited prejudices. "In the process, our understanding of ourselves changes as we incrementally integrate current experiences with past memories" (Zuckert in Dorstal, 2002/2006 p.206).

participants at the time of interview. However, the data is presented as an interpreted rendering and not as a *verbatim* account (except where direct quotes are used). The interpretation could more accurately be described as reflections of an ongoing but temporal dialogue between the researcher and the transcripts (in keeping with the Philosophical Hermeneutics of Gadamer (1976/2004)) that are finite in and of themselves (see Chapter four for a deeper discussion on the methodical approach to data analysis). It is also an ongoing dialogue to which every reader will bring their own interpretive lens to the encounter with the text.

This study brings together the stories of military nurses who, while having some shared cultural experiences, told their stories from the perspective of quite divergent life histories. It is the hope of the researcher that the stories told will lay open the ground for others to gain an insight and deeper understanding of spirituality and spiritual nursing care as experienced by Australian military nurses with the deployed military nursing context.

The finitude of the researcher is expressed throughout this study in the reflective attitude that was applied to the transcripts and the process of writing. At all times the researcher was aware of their own limits of understanding in relation to the phenomena under investigation. Through the process of critical self-awareness interpreted meaning was ascribed to the phenomena and the available knowledge of the phenomena was expanded.

3.6 Summary of Chapter three

This chapter has brought together the philosophical and methodological threads that underpinned and guided the research process throughout this thesis. The researcher was an interpreter who came to the study within a tradition that necessarily brought with it certain assumptions and prejudices about the field of study. Situating the researcher within a particular tradition disclosed the prejudices and opinions that shaped the approach to the interpretation of the data contained in the transcripts. However, the lived experience of some of the traditions to which the participants were also a part, namely Australian military nursing and the experience of operational deployment, did not necessarily presuppose an identical understanding of those traditions. After Gadamer (1976/2004), both the interpreter and the interpreted retained unique horizons of understanding that despite common experiences led to differing meanings even being ascribed to the experience of same or similar life events.

A qualitative interpretive methodology was used to inform the research endeavour. Qualitative research does not seek to discover causal effects nor does it attempt to generalize findings across a population (Ezzy, 2002). The aim of this study was to understand the phenomena of spirituality and spiritual care as it related to a group of Australian military nurses who had deployed on military operations. The methodology was informed by the Philosophical Hermeneutics of Gadamer (1976/2004) and therefore sought to understand the experience of phenomena via the use of an ongoing language mediated dialogue. The dialogue was a process of genuine conversation with the interpreted object that found a temporal completion or

truth when the play of question and answer between the interpreter and the interpreted object came into a moment of agreement. However, Philosophical Hermeneutics did not provide the researcher with a structured method by which to analyse and thematise research data. What follows in Chapter four, then, is a detailed explication of the method that was used to thematically analyse and interpret the data in a way that remained faithful to the Gadamerian philosophical approach taken throughout this interpretive journey.

CHAPTER 4: METHOD

4.1 Introduction

The focus of this chapter is on the method used by the researcher to gather, analyse and interpret the study data. The data for this study were collected through in-depth phenomenological interviews with ten Australian military nurses. Analysis and interpretation of the data was conducted using a modified Colaizzi (1978) method in conjunction with Van Manen's (1997/2007) approach to phenomenological research. However, the Philosophical Hermeneutics of Gadamer (1976/2004) underpinned the interpretive process throughout the study (see Chapter three). The ultimate aim of the interpretive process, aided by the method detailed in this chapter, was to uncover the essence[34] (Van Manen, 1997/2007) of spirituality and spiritual nursing care as experienced by the participants within a deployed military nursing context.

This chapter will examine the analytical and interpretive method used in this study. In examining the method the researcher will reiterate the purpose of the study (4.2) and then introduce the general analytical approach (4.3) to the data. Data analysis (4.4) will then be discussed and the method of data generation (4.5) detailed. Participant selection (4.6) will be explored and a discussion on ethical considerations (4.7) will follow. The means for establishing rigour (4.8) will be examined before the chapter concludes with a summary of chapter four (4.9).

[34] According to Van Manen (1997/2007) phenomenology is concerned with the study of essences. The essence of a phenomenon is the fundamental quality or evident truth (Heidegger, 2007) that makes the phenomenon what it is and without which the phenomenon would not be the same.

4.2. Purpose of the Study

The main purpose of this study was to understand the experiences of spirituality and spiritual nursing care as expressed by Australian military nurses who had deployed on military operations. The researcher aimed to provide meaningful interpretations of the data that authentically represented the essence of the phenomena as experienced by the participants. However, the data were not a mirrored reflection of the nurses' experiences. The experiences of the participants were transformed (Van Manen, 1997/2007) and presented through the interpretive lens of the researcher. Gadamer (1976/2004) asserted that:

> The task of the translator…must never be to copy what is said, but to place himself in the direction of what is said (i.e. in its meaning) in order to carry over what is to be said into the direction of his own saying (p.68).

The transformed accounts were then contextualized within the shared understandings and culture of deployed military nursing. Philosophical Hermeneutics, as described by Gadamer (1976/2004), provided the methodological approach used and defended as the most appropriate interpretive approach to meet the research intent. The approach was initially a collaborative dialogue (Van Manen, 1997/2007) between the researcher and the participants and secondly, an interpretive dialogue (Gadamer, 1976/2004) between the researcher and the transcripts.

4.3 Analytical Approach

A number of different methods had been proposed and used by researchers in dealing with the analysis of phenomenological research data. Some of the most common methods for data analysis to be found within the phenomenological literature were those of Van Kaam (1966), Giorgi (1970), Colaizzi (1978), Moustakis (1994), Van Manen (1997/2007). Each of those approaches, to a greater or lesser extent, provided a structured way in which to analyse and thematically code phenomenal data for interpretation.

The approach taken in this study applied Colaizzi's (1978) method, in a modified form, to the first level descriptive process of data analysis. The second level interpretive data analysis was influenced by the phenomenological approach to researching lived experience of Van Manen (1997/2007) but retained its Philosophical Hermeneutic underpinnings (Gadamer, 1976/2004). Therefore, it was consistent with the notions of understanding, language, tradition, truth and time offered by Gadamer (1976/2004). The approach in this study took into account the philosophical attitude and interpretive framework of the researcher and was supported by the related literature.

The philosophical approach to any research undertaking should be consistent with the underlying intent of the research (Stern, 1994; Roberts and Taylor, 1998; Denzin and Lincoln, 2005). Therefore, the epistemological and ontological philosophical grounding must be appropriate for the research question that drove the study.

The philosophical position to which the researcher ascribed was one of approaching the interviews and the data from within his own traditions and those shared with the study participants (Gadamer, 1976/2004; Ezzy, 2002; Willis, 2002). In accordance with the philosophical position of Gadamer (1960/2003), the research was approached from within a tradition as "a genuine partner in dialogue" (p.358). Furthermore, Willis (2002) supported the argument that understanding the experiences of the participants "also requires an awareness of the social and cultural environment of the experience" (p.139).

As an Australian military nurse who had also deployed on military operations, the researcher understood the social and cultural context in which the participants practiced. The participants were all nurses who had practiced within the common cultural background of the military. Participants were asked to reflect on and describe their experiences of spirituality from the perspective of nurses who had firsthand knowledge of the deployed operational nursing setting. While the interpreted experiences were not generalisable, they were nevertheless able to be thematised according to evident commonalities between the stories of the participants (Van Manen, 1997/2007). However, the approach taken did not dismiss thematic notions that were offered by a single participant. Where a theme of significant value to the overall understanding of the phenomena was identified it was given similar weight to commonly ascribed themes. Lawn (2006) supported this approach when suggesting that "instead of emphasizing the repeatable, Gadamer, [1960/2003]…draws attention to the qualities of the non-repeatable and unique" (p.61-2).

In using an interpretive framework based on the Philosophical Hermeneutics of Gadamer (1976/2004), the interpreter could not be separated from the task of understanding. In this study the researcher was a military nurse and therefore was situated within the hermeneutic dialogue and the event of understanding occurred cognizant of that tradition. As previously stated, understanding occurred as transformed interpretations of the phenomena rather than as mirrored reflections of the participant experiences (Van Manen, 1997/2007).

Exemplars were generated from participant stories to support the emergent themes in the data. The themes were then merged with the contemporary literature on spirituality to mediate the process of understanding (Van Manen, 1997/2007). Van Manen (1997/2007) suggested that a lack of examples of experiences diminished the usefulness of the research. Therefore, the researcher argues that the appropriate use of exemplars to support emergent themes assisted in demonstrating the trustworthiness of the research. The next section examines the method used to explore the phenomena of spirituality and spiritual nursing care as experienced and expressed by the participants.

4.4 Data Analysis

The research design determined that data were generated through in-depth phenomenological interview. The underpinning methodological approach to the analysis was provided by the interpretive dialogical interaction of the researcher with the transcripts. The dialogue sought to understand the phenomena as the “lived experience” (Van Manen, 1997/2007) of the participants. However, as discussed in

Chapter three the data were presented as transformed, interpreted accounts influenced by the prejudices, historicity and finitude of the researcher (Gadamer, 1976/2004).

The analytical scheme used in this study applied two distinct but complementary analytic methods to the data. The first part of the section to follow, combining methods, will examine the synergies between the phenomenological data analysis methods of Van Manen (1997/2007) and Colaizzi (1978). The section will explore how the two methods were justified for use within the Philosophical Hermeneutic (Gadamer, 1976/2004) methodological framework that underpinned and informed the study.

The first analytical method to be examined in this chapter was derived from the interpretive approach to analyzing phenomenological data of Van Manen (1997/2007). This method did not provide a prescribed series of steps to be followed in analyzing the data but rather a general framework that assisted the researcher in the research endeavour. Van Manen (1997/2007) viewed the process of data analysis as a reflective, language mediated and temporal dialogue with the text at hand. The components of the method described by Van Manen (1997/2007) that were applied in this study were: Step 1 – Orienting the researcher; Step 2 – Reflexive analysis; Step 3 - Thematic analysis; and Step 4 – The process of writing. These steps are used as sub-headings in the first part of this data analysis section under the main heading of Van Manen's method for researching lived experience.

The second analytical method applied to this study was the descriptive phenomenological method of data analysis proposed by Colaizzi (1978). Colaizzi (1978) provided a seven step method for the analysis of phenomenological data. However, for the purposes of this thesis the method was reduced to six steps by omitting the final step of the method. The reasons for omitting the seventh step will become apparent as the data analysis method is detailed and presented in the second part of this section. The seven steps of the Colaizzi (1978) method will be explored under the main heading of Colaizzi's phenomenological method of data analysis as: Step 1 – Acquiring a feeling for each transcript; Step 2 – Extracting significant statements; Step 3 – Formulating meanings; Step 4 – Organising formulated meanings into clustered themes; Step 5 – Exhaustive description of the investigated topic; Step 6 – Describe the fundamental structures of the phenomenon; and Step 7 – Returning to the subjects.

Combining methods

The phenomenological research approaches of Van Manen (1997/2007) and Colaizzi (1978) both provided a structured way of dealing with phenomenological data that was consistent with the methodology that underpinned this research. What one approach brought to the analysis of the data, the other added to or strengthened. In combining the methods the researcher was able to more clearly demonstrate the research decision trail that led to the data analysis, description and interpretation that will be detailed in the findings in Chapters six and seven. A summary of the methods is provided at Table 4-1 below:

Analytic approach	Van Manen (1997/2007)	Colaizzi (1978)
Approach	Interpretive	Descriptive
Framework	General framework	Flexible but defined steps
Investigates	Interprets lived experience	Describes human experience
Orientation	Phenomenon	Phenomenon
Meaning	Grasped in reflection	Grasped in description
Fore-meanings	Made explicit	Brought into the open
Descriptions	Transformations	Transformations
Analysis	Reflexive	Reflexive
	Descriptive	Descriptive
	Thematic	Thematic
	Interpretive	

Table 4.1: Comparison of Van Manen (1997/2007) and Colaizzi (1978) approaches to phenomenological research

What became clear from the comparison of the two phenomenological approaches described above was that there were many commonalities in the approaches. However, more apparent was that Colaizzi (1978) provided a descriptive analysis that was well structured to inform a first level analysis of the data. Van Manen's (1997/2007) approach went beyond the strictures of description to provide a suitable method for a second level or interpretive analysis of the data. Accordingly, both

approaches were applied to each level of data analysis presented in Chapters six and seven. However, Colaizzi's (1978) method informed the analysis in Chapter six and Van Manen (1997/2007) provided the basis of the analysis in Chapter seven.

As identified in Chapter three, Gadamer (1977/2004) sought to understand the meaning of phenomena through a genuine hermeneutic dialogue. The act of understanding occurred by disclosing truth and was mediated in language through dialogue. Truth was not absolute but changed with each encounter and was therefore a temporal event. Gadamer (1976/2004) further asserted that understanding occurred cognizant of the historicity and prejudices of the researcher. Understanding was laden with the pre-understandings and fore-meanings of the researcher.

Gadamer (1976/2004) presented the researcher with an approach to understanding phenomena that was largely devoid of a structured method. Some researchers had applied Gadamer's (1997/2004) approach to their research without using a defined set of methodical steps (Morrell, 2003). However, it was apparent in the literature that a number of researchers who applied a Philosophical Hermeneutic approach to the research endeavour did employ a structured method (Hemsley, 2003; Williamson, 2005; Penman et al, 2013). In this study a combined data analysis approach was applied using both Colaizzi (1978) and Van Manen (1997/2007).

The use of Van Manen (1997/2007) in this thesis was justified on the grounds of its consistency of approach with that of the Philosophical Hermeneutics of Gadamer (1977/2004) (see comparison in Table 4-2 below). The phenomenological data analysis approach of Colaizzi (1978) has been more often applied to descriptive

rather than interpretive research approaches (Jones, 2001). However, Colaizzi (1978) suggested that "the research procedures…are by no means definitive [and]…should be viewed flexibly and freely by each researcher…depending on his [sic] approach and his phenomenon" (p.59).

Philosophical approach	Gadamer (1977/2004)	Van Manen (1977/2007)
Approach	Interpretive	Interpretive
Understanding	Temporal	Temporal
Mediated through	Language/dialogue	Language/dialogue
Method	A-methodical	Flexible
Fore-meanings	Embraced	Made explicit
Orientation	Interpreted meaning	Interprets lived experience
Validity	Self-evident truth	Truth through reflection

Table 4.2: Comparison of Gadamer (1977/2007) and Van Manen (1997/2007) philosophical approaches to phenomenon

Argued in this thesis is that the procedural steps were not the end point of the analysis but rather provided a pathway to interpretation. Therefore, the processes of describing and thematically analyzing using Colaizzi (1978) were viewed as the first level of analysis that provided the initial focus point for the research. The researcher was then able to use the interpretive approach of Van Manen (1997/2007) to return to the data in the second stage of analysis and in the process of dialogue build an interpretive understanding of the phenomena. However, while these two approaches

to data analysis are presented in linear steps their actual application was overlapping. The interpretive process began at the moment of data immersion. Indeed, Van Manen (1997/2007) drew on Gadamer (1986) when he alluded to two levels of interpretation. In *pointing to* the phenomena we described what the phenomena concealed from us and in *pointing out*, the researcher interpreted the meaning of what was *pointed to* (Van Manen, (1997/2007). The two data analysis approaches were therefore complementary to each other and consistent with the underlying methodological approach to this study.

Van Manen's method for researching lived experience

Van Manen (1997/2007) provided a general framework for analyzing phenomenological data rather than a distinct set of prescriptive methodical steps. While the analytical framework was not prescriptive it did provide some structure to the phenomenological research endeavour. Gadamer (1977/2004) suggested that truth was obscured by method (Lawn, 2006) and disclosed through dialogue. Consequently, Philosophical Hermeneutics did not offer the researcher a framework for data analysis. However, using a structured research approach assisted in constructing a systematic and auditable research trail (Van Manen, 1997/2007). Van Manen's (1997/2007) approach to data analysis in this study was consistent with the underlying methodology examined in Chapter three. Van Manen (1997/2007) proposed four steps in his approach to data analysis and these are detailed next.

Step 1 - Orientation to the phenomenon

Van Manen (1997/2007) proposed that the researcher must first orientate themselves to the phenomenon they seek to understand. The motivation behind this research endeavour has been highlighted throughout the thesis. Spirituality and spiritual nursing care remain at the core of the researcher's clinical practice. Accordingly, the interpretive horizon applied to this study was inextricably linked to the traditions and culture in which he and the participants were situated. The orientation in this study was therefore an "emic" or "insider's" orientation (see full explanation of "emic" in Chapter three). However, while shared experiences were identified with the participants, the interpretations presented in this research were not a replication of those experiences. What is offered is one possible transformed interpretation of the participant experiences, "coloured" by the prejudices, history and finitude of the researcher. The interpretation was developed through a process of reflexive analysis[35] and dialogue[36] with the text and was mediated through language in the process of writing (Van Manen, 1997/2007).

Step 2 - Reflexive analysis

Van Manen (1997/2007) used reflexive analysis as a language mediated process to grasp the essential meaning of a phenomenon as a lived experience. Through reflexive analysis the researcher was able to identify thematic structures emerging from the text (Van Manen, 1997/2007). Reflexive analysis was conducted against the

[35] "The purpose of phenomenological reflection is to try to grasp the meaning of something" (Van Manen, 1997/2007 p.77).

[36] "To understand a text is to come to understand oneself in a kind of dialogue [and]…a text yields understanding only when what is said in the text begins to find expression in the interpreter's own language" (Gadamer, 1977/2004 p.57).

backdrop of the assumptions, "pre-understandings and prejudices" (Cayetano-Penman, 2012 p.75) of the researcher. In the context of this study reflexive analysis was used to understand the influence that the tradition and effective historical consciousness of the researcher exerted on the interpretive gaze. Further, Van Manen (1997/2007) made the point that it was only in reflection that the meaning of lived experience could be grasped. It was through the act of reflexive analysis that themes emerged and textual meaning was understood.

Step 3 - Thematic analysis

Van Manen (1997/2007) stated that a "theme gives control and order to our research and writing" (p.79). He described themes as ideas generated from the data that captured the phenomenon and gave meaning to an experience (Van Manen, 1997/2007). Themes needed to make sense within the context of the study and be open to other interpretations. They were integral to the process of discovery and disclosure. The themes, then, provided the shape, structure and context to understand phenomena (Van Manen, 1997/2007). Further, themes reduced the notions uncovered in the analysis into manageable "sound bytes" from which to understand an aspect of the phenomena.

As discussed in Step two above, reflexive analysis was used to guide the generation of both primary and secondary themes[37] throughout this study (Van Manen, 1997/2007). Themes were primarily generated by reflecting on thick descriptions of

[37] Primary themes are those themes that capture the essential quality of the phenomenon and without which the phenomenon could not be what it is. Secondary themes support the primary themes but they do not alter the essential quality of the phenomenon (Van Manen, 1997/2007 p.107).

the phenomena within the transcripts. These themes were sourced from one or more participants but were not reliant on recurrence to be considered significant. However, themes were also generated from recurrent characteristics that presented themselves across the data (Van Manen, 1997/2007). Themes were generated in this study reflexively from both singular significant statements and from recurrent words or ideas presented by a number of participants.

Van Manen (1997/2007) identified three general approaches to thematic analysis, all of which were used to a greater or lesser extent in this thesis. The first was a *holistic approach* that looked at the meaning of the text as a whole. In this study the researcher transcribed the interviews and developed an understanding of the texts as a whole. This was a deductive or "top down" approach to thematic development that enabled the researcher to move "from a general rule to specific cases" (Ezzy, 2002 p.14). Meta themes were then developed that attempted to encapsulate the fundamental significance and meaning of the text as a whole (Van Manen, 1997/2007). An illustrative example from the thematic analysis in this study was: *A military nurse accepts and supports a patient's spiritual needs without imposing their own spiritual values and views.* The phrase encapsulated a general understanding of a phenomenal theme derived from the text as a whole.

The second approach that Van Manen (1997/2007) posited was a *selective approach* to uncovering themes. In this approach the researcher read or listened to the text several times and sought to find statements and phrases that revealed the essential nature of the phenomena (Van Manen, 1997/2007). At this point standalone themes were highlighted in the text but paraphrased for clarity. An example that was used in

this study related to the notion of the nurse being away from home for long periods on deployment: *When you're in a military situation…you've only got each other…you feel isolated from others and from…home* [Katie, 37/7-11]. This theme was reworked to say: *Military nurses on deployment support each other while away from home*.

The third approach to thematic development, and the one which was primarily used in this study, was the line by line or *inductive approach*. In this approach the researcher looked through each line or sentence and determined what that sentence revealed about the phenomena (Van Manen, 1997/2007). This approach was inductive as it "moves from specific cases to the general law" (Ezzy, 2002 p.14). A generalized example from this study was the clustering of words and phrases together that all related to the importance of connecting with the patient in order to provide meaningful spiritual care. Words such as *empathy, communication, touch, relationship* and short phrases such as *putting myself in that person's shoes* were all clustered under a the theme: *Spiritual nursing care in the Australian military nursing context on deployment is connecting with those in need – it is empathetic and is centred on communication*. How then do we present these themes?

Step 4 - The process of writing

Ezzy (2002) stated that "writing is at the heart of the research process" (p.138). Van Manen (1997/2007) proposed that the critical step after reflection and the generation of themes was to engage in the process of writing. Writing became a dialogue between the researcher and the text and also the method for fixing thoughts on paper. In the process of writing the researcher reflected on, described and interpreted the

experiences of the participants (Van Manen, 1997/2007). Understanding was mediated through language (Gadamer, 1997/2004) and “writing gives appearance and body to thought” (Van Manen, 1976/2007 p.127). The researcher asserts that writing fixed interpretation within a captured temporal moment of understanding. It was, therefore, one interpreted understanding and remained open to further interpretation (Van Manen, 1997/2007). The measure of success of the writing was how well it made the hidden meanings of the text recognizable to others (Van Manen, 1997/2007).

Next is an examination of Colaizzi’s (1978) method of data analysis that provided the step by step analytical method.

Colaizzi’s phenomenological method of data analysis

Colaizzi (1978) proposed a seven step method for the analysis of phenomenological data. Where Van Manen (1997/2007) provided a general framework for phenomenological research without prescriptive steps, Colaizzi (1978) offered a more rigid and systematic approach to data analysis. However, for the purposes of this thesis the method was reduced to six steps by omitting the final step of the Colaizzi (1978) method. The reasons for omitting the seventh step will become apparent as the data analysis method is detailed in the ensuing paragraphs. The phenomenological data analysis method of Colaizzi (1978) is detailed below with explanatory statements of what the step aims to achieve. A description has also been provided of how the steps have been applied within this research study.

Step 1 - Acquiring a feeling for each transcript (Colaizzi, 1978)

In this preliminary step of Colaizzi's (1978) method the researcher read all of the interview transcripts in an effort to understand the data as a whole. In this study each of the interview recordings was listened to and transcribed verbatim trying to retain the syntax, pauses and flow of the original interview. The process of transcribing the interviews enabled the researcher to acquire an overall feel for the data and develop and annotate some initial insights on the emerging themes.

Step 2 – Extracting significant statements (Colaizzi, 1978)

In the second step of Colaizzi's (1978) method of data analysis the researcher reviewed each transcript. In returning to the transcripts it was possible to identify and extract phrases or sentences "that directly pertain to the investigated phenomenon" (Colaizzi, 1978 p.59). Here the interview recordings were revisited and listened to several more times to build a stronger picture of the phenomena. Returning to the transcripts, specific sentences and phrases were identified that encapsulated the meaning of spirituality and spiritual nursing care to the participants. The statements were marked with a highlighting pen and comments placed into the margins of the transcript. This process was extended to the contextual phenomena that surrounded the experience of spirituality and spiritual nursing care. Significant statements relating to military nursing, operational deployment and the concept of family in the military were marked with different coloured highlighting pens.

Significant words and statements were cut and pasted into excel spreadsheets, retaining identifiers for the "transcript, page and line number" (Sanders, 2003 p.295).

While there were a number of computer assisted qualitative data analysis programs available, analysis in this study was conducted manually. Manual analysis ensured that the researcher remained immersed in the data throughout the research process (Borkan, 1999; Sanders, 2003).

Step 3 – Formulating meanings (Colaizzi, 1978)

The researcher examined each of the significant statements that were identified in Step two and sought to illuminate the meaning of each of those statements (Colaizzi, 1978). In this approach, statements, words and phrases were rephrased into formulated translations. Sanders (2003) suggested that the researcher should then "bracket" their presuppositions after Husserl (1960) to allow the meaning to speak for itself. This position was not supported in this study. Accordingly, the prejudices and history of the researcher formed an integral part of the constantly evolving horizon of understanding after the manner of Gadamer (1976/2004). The translations, therefore, were not mirrored reflections of the participant experiences, but rather transformed interpretations by the researcher of those experiences. However, Finlay (2009) cautioned the researcher "to avoid preoccupation with their own emotions and experience if the research is not to be pulled in unfortunate directions which privilege the researcher over the participant" (p.8).

Step 4 – Organise formulated meanings into clusters of themes (Colaizzi, 1978)

The formulated meanings identified in Step three were revisited and organized into *clusters of themes*. This phase allowed the researcher to look at the emergent themes for commonalities among the participants and thereby: (1) validate the themes within

the whole of the research; and (2) identify any discrepancies between the themes. Discrepancies and differences between participants did not, however, invalidate identified themes. As discussed earlier in this chapter the overarching criterion for determining the importance of a theme was not numerical affirmation, but rather the judgement of the researcher based on thick description and the "truth" value that emerged through the interpretive lens (Van Manen, 1997/2007).

Step 5 – Exhaustive description of the investigated topic (Colaizzi, 1978)

In this step the findings to this point were combined into an *exhaustive description* of the investigated phenomena. This was a preliminary statement of the phenomena under investigation that included all the elements of the themes and clusters that identified the phenomena as they presented. In the case of this study the statement presented itself through the interpretive lens of the researcher as a transformed rendering of the phenomenal experiences of the participants.

Step 6 – Describe the fundamental structure of the phenomenon (Colaizzi, 1978)

The final step in the analytical process was to break down the exhaustive description described in Step five into an *unequivocal statement* that represented the essence of the investigated phenomena. The statement unified the component parts into a whole that was dependent on the sum of its parts to provide meaning within the hermeneutic interpretive process. What is argued here, after Gadamer (1976/2004), is that this statement represented the fusion of the researcher's horizon and truth claim with that of the text. The statement provided a temporal closure within the hermeneutic circle of past and present horizons. However, the statement remained an

ever expanding circle open to the futurity of new interpretive horizons. “The hermeneutically enlightened consciousness seems to me to establish a higher truth in that it draws itself into its own reflection” (Gadamer, 1976/2004 p.94).

Step 7 – Returning to the subjects (Colaizzi, 1978)

The final step in the phenomenological method of data analysis of Colaizzi (1978) was that of returning to the participants to have them validate the exhaustive description of the phenomena. As indicated earlier in this chapter, this step was omitted from this analysis of the data. Gadamer (1960/2003) asserted that “understanding is, essentially, a historically effected event” (p.300). Therefore, to return to the participants to validate the essence of their experience of the phenomena under study was not a valid approach to this event of understanding (Flood, 2010). The researcher endeavoured to present the experiences in an authentic and meaningful way, but authenticity does not mean replication. The horizons of the participants were constantly expanding and their words were captured in a temporal moment. Their interpretation of the events and experiences that were discussed during the interviews would need to be re-interpreted against their present horizon. The interpretation presented in this thesis, therefore, claims its own truth value independent of the truth ascribed by the participants, and remains open to further interpreted truths in its reading and re-reading (Gadamer, 1976/2004).

4.5 Data Generation

In accordance with the qualitative research approach used in this study the primary source of data collection was interview. Merriam (2002) suggested that interviews

were a rich source of data when the researcher was "interested in the experience" (p.12) of an event or phenomenon. Interviews were conducted over a 12 month period. The researcher met with all the participants individually and at a time and location that they nominated that was convenient for them. Some of the interviews were conducted in the homes of the participants, others in a private area within their workplace and others in a quiet corner of a coffee shop. All interviews were tape recorded, transcribed and analysed by the researcher. The interviews lasted between one and two hours and the data were generated from eight women and two men. At the conclusion of each interview the participants were thanked, an initial review of the interview recording was undertaken that night and the process of transcribing the data from the digital recorder into Microsoft Word (2007) format begun. Data were tabulated into Excel spreadsheets and raw thematic analysis was conducted both manually and using a freeware mind mapping program (FreeMind 0.9.0). An interview lasting one hour generated around 40 pages of double spaced text. All interviews were conducted as in-depth phenomenological interviews[38] to "explore the complexity and in- process nature of meanings and interpretations" (Rice and Ezzy, 1999 p.53).

Interviews

Ten Australian military nurses were interviewed about their experiences of spirituality and spiritual nursing care in a deployed operational setting. All interviews with the nurses were recorded and their analysis is presented in Chapters six and

[38] In-depth interviews are a data gathering tool designed to elicit a rich description of a participant's knowledge and experience of a phenomenon (Minichiello et al, 1990).

seven. Some reflective notes were made after the interviews and where appropriate these are included in the analysis to follow.

Questioning

Phenomenological hermeneutic research seeks to describe and interpret the lived experiences[39] of a phenomenon (Van Manen, 1997/2007). Using this underlying philosophy the researcher sought to elicit the lived experiences of the participants. Questioning was conducted in a manner that maintained the focus of the participants on their experience of the phenomena under investigation, such as: *What is your experience of spirituality on deployment? Any experiences that come to mind? How did you feel about that? Can you describe your experience? What was it like for you?* Each interview began with some general discussion about the story of the participant as a nurse and then centred around four main thematic ideas: their experience of being a military nurse; their experience of nursing on operational deployment; their experience of spirituality and spiritual nursing care in the deployed environment; and their experience of the military family.

Along with the questioning about experiences, a number of prompts and paraphrases were used to guide the conversation and to clarify various points raised during the interviews, such as: *How did that experience in the Middle East differ from your experience in South East Asia? Talking about being able to smell the death in the air…what was that like for you? Have you experienced? Can you describe?* This

[39] Van Manen (1997/2007) and Gadamer (1960/2003) both alluded to the notion of lived experience (*Erlebnis*) in their writings. In lived experience "Every experience is taken out of the continuity of life and at the same time related to the whole of one's life" (Gadamer, 1960/2003 p.69).

approach accorded with the assertion of Van Manen (1997/2007) that "whenever it seems that the person being interviewed begins to generalize about the experience, you can insert a question that turns the discourse back to the level of concrete experience" (p.68). The interviews could be described as guided phenomenological rather than semi-structured[40]. However, this was only done to apply a distinctly qualitative term to this study as Rice and Ezzy (1999) suggested that "it is not very useful to describe qualitative interviews as semi-structured" (p.53). While Roberts and Taylor (1998) refuted the assertion that semi-structured interviews were not useful to qualitative research, Field and Morse (1985) supported Rice and Ezzy's (1999) view and suggested that guided interviews:

> Are used when information is required about a topic…it is useful because this technique ensures that the researcher will obtain all information required (without forgetting a question), while at the same time permitting the informant freedom of response (Field and Morse, 1985 p.67).

The use of in-depth phenomenological interviews provided the researcher with a large body (349 pages of interview transcript) of varying degrees[41] of rich descriptive data to analyse.

[40] Rice and Ezzy (1999) suggested that semi-structured interviews are more aligned with the quantitative research paradigm as there is an emphasis on the researcher to administer questions the same way each time. However, Roberts and Taylor (1998) viewed the semi-structured interview as a valid qualitative tool as "the researcher invites the participant to talk, encouraging a free flow of words and ideas, while at the same time keeping the person relatively on track in the conversation, if he or she has a tendency to wander off the point" (p.178-9).

[41] Varying degrees of rich descriptive data as each participant was able to articulate certain aspects of their experiences very well but other areas of discussion were not so easily articulated. Indeed, for one of the participants found the interview process challenging as the questions appeared to touch on deployed nursing experiences that were still quite raw for that individual.

4.6 Participant Selection

The study sample

The sample for this study were drawn from Australian Defence Force Registered Nurses who had deployed on military operations. The participants were either full-time or part-time (reserve) military nurses from the Australian Army or the Royal Australian Air Force[42]. Each of the participants responded to an expression of interest to be interviewed about their experiences of spirituality and spiritual nursing care on military operations. A total of ten military nurses agreed to be interviewed about their experiences and all ten were ultimately interviewed.

Sample selection

The sample selected for this study was purposive. That is, a sample chosen on the basis of a clear criterion that was directly related to the research question (Ezzy, 2002 p.74). This study sought to investigate the phenomena of spirituality and spiritual nursing care as it was experienced by a group of Australian military nurses in a variety of deployed operational settings. In order to investigate the phenomena identified it was necessary to define a sample that was best able to inform the research question. To achieve the aim of the study it was a precondition that the participants that were interviewed in this study were: registered nurses; members of the Australian Defence Forces; had experience in providing nursing care on operational deployment; and were able to relate their experiences of spirituality and

[42] As noted in Chapter five, while expressions of interest to be interviewed were forwarded to military nurses from the three arms of the Australian Defence Force, no Royal Australian Navy nurses responded to the request to participate.

spiritual nursing care in the deployed environment. Therefore, the process of sample selection was entered into in a purposeful manner and the participants were chosen based on the judgement of the researcher. The judgement exercised was historically situated and reflected the prejudices and opinions of the researcher in entering the research endeavour. Therefore, the judgement that was exercised in selecting participants remained consistent with the Gadamerian (1976/2004) approach taken throughout this study.

Sampling in qualitative research did not seek to be representative of a population. It referred to the non-randomised selection of participants based on certain criteria (Marshall, 1996; Endacott, 2005). Purposive sampling, also known as judgemental, subjective or selective sampling, was one of a cluster of sampling techniques used in qualitative research that included theoretical, convenience or snow-ball sampling (Roberts & Taylor, 1998). Theoretical sampling was derived from the *Grounded Theory* approach of Strauss and Corbin (1998). It gathered data based on "concepts derived from the evolving theory and based on the concept of "making comparison"" (Strauss and Corbin, 1998 p.201). Therefore, theoretical sampling is argued as not appropriate to this study because it did not seek to generate theory from the data but rather interpreted and rendered lived experiences of defined phenomena. The use of convenience and snowball sampling techniques was equally rejected in the context of this study as these techniques were based on ease of access for the researcher rather than providing the most appropriate informants to inform the research question (Ezzy, 2002). Purposive sampling was the most appropriate sampling technique for the context and aim of this study as it met the requirement to identify participants who were able to inform the research question.

4.7 Ethical Considerations

Koch (1993) stated that “ethical considerations pervade the entire research process” (p.159). While ethical issues may not be so readily identified in qualitative research (Lipson, 1994) it was incumbent on the researcher to make explicit any issues identified. Identification of actual or potential ethical issues was an important part of the researcher’s decision trail (to be discussed later) in establishing the credibility of the research. Ezzy (2002) noted that following guidelines set down by various ethics committees was important to the conduct of “ethical” research. However, he also asserted that this was only one part of the ethical picture:

> Ethical conduct of qualitative research is much more than following guidelines provided by ethics committees. It involves a weighed consideration of both how the data collection is conducted and how analysed data are presented, and will vary significantly depending on the details and particularities of the situation of the research (Ezzy, 2002 p.51).

Gaining approval

Approval for the study was initially gained from the Social and Behavioural Research Ethics Committee of Flinders University. Further approval was then obtained from the Australian Defence Force Human Research Ethics Committee prior to the commencement of the study. All participants in the study were made aware of the research approval process and were encouraged to either contact the researcher or either of the ethics committees if they had any complaints or concerns about the conduct of the research.

Informed consent

The collection of data for a research study demanded that the researcher obtained fully informed consent from the study participants (Lincoln and Guba, 1985). Informed consent ensured that participants fully understood the nature and intent of the research and could make a free and informed decision as to whether they wished to participate in the research or not (Polit and Hungler, 1995). Informed consent safeguarded the rights and privacy of the participants, provided for open disclosure, and helped develop the relationship between the researcher and the participants.

A formal request for expressions of interest to be interviewed was sent to the Director of Defence Force Nursing for distribution to all Australian Defence Force nurses. This request was accompanied by a package containing an introduction to the research (Appendix 1), information regarding the right of participants to refuse to participate and withdraw at any time, assurances of confidentiality and the contact details of the researcher for those expressing an interest in participating in the study (Appendix 2). Distribution of the call for expressions of interest and accompanying information were sent via the Australian Defence Force internal email system. Those nurses who indicated a willingness to be interviewed were contacted personally by the researcher to verbally confirm their continued willingness to be interviewed and interviews were organized. At the commencement of the interviews each participant had the purpose of the study explained to them, were informed that they could refuse to answer any question, and that they could withdraw at any time. Participants were asked to sign a consent form (Appendix 3) authorizing the researcher to record the interviews and to proceed with the data collection.

Confidentiality

Two main approaches were used to safeguard the confidentiality of the participants. Firstly, pseudonyms were used for all participants and secondly, the interview transcripts and the tapes of the interviews were stored securely in accordance with the National Health and Medical Research Council guidelines for research. Confidentiality was not only assured for the participants but also for any individuals named by the participants in the interviews. This approach saw the researcher blanking out the names of people named by the participants in the text. From an organizational perspective it was deemed prudent to refer to general geographic regions rather than specific locations of Australian Defence Force operations. The process of de-identification further reduced the chances of participants being identified and minimized any potentially embarrassing repercussions for the Australian Defence Force or other foreign military forces where participants had identified sensitive issues arising from particular deployments.

Other considerations

There was a real potential for participants to become distressed during the interviews in reflecting upon some of their experiences on deployment. Hodson (2002) in her PhD dissertation on Post Traumatic Stress Disorder among military peacekeeping veterans noted that one in five Australian veterans of the 1994 Peacekeeping mission to Rwanda experienced significant distress related to their deployment many years after their return to Australia. Statistics from the Department of Veterans' Affairs suggested that these figures were consistent with symptoms of distress experienced by Australian veterans of other high intensity military operations such as the Korean

War, the Vietnam War and the Gulf War[43]. The researcher made an offer to cease interviewing at any time that a participant became significantly distressed reflecting on their experiences and to refer to Australian Defence Force psychologists and medical officers if necessary for support and follow-up. While two of the nurses were clearly still distressed about some aspects of their deployment(s), these nurses were still willing to continue with the interviews and did not ask for assistance following the interviews.

The final area that needed to be addressed in the ethical considerations was that of potential accusations of coercion of participants due to the perceived power imbalance created by the hierarchical rank structures in the military. The researcher was a senior officer in the Royal Australian Air Force, and while two other participants were also senior officers, the majority of the participants were junior officers at the time of the interviews. To combat any perception of a power imbalance over the nursing officers junior in rank to the researcher, a number of steps were taken to minimize any potential for coercive authority being applied. Firstly, all nurses who participated were approached via a third party (Director Defence Force Nursing) to express an interest in being interviewed. Secondly, all participants approached the researcher to indicate their willingness to be involved in the study. Thirdly, all participants provided full, informed consent to be interviewed and were advised that they were able to stop the interviews or withdraw from the

[43] The Australian Korean War Veterans' Study (DVA, 2005) indicated an approximate 33% incidence of Post Traumatic Stress Disorder in the veteran population; The Morbidity of Vietnam Veterans' Study (AIHW, 1999) indicated an approximate 31% incidence of Post Traumatic Stress Disorder in the veteran population; and the Australian Gulf War Veterans' Study (Monash University, 2003), noted a higher incidence of Post Traumatic Stress Disorder than the control group but did not explicitly quantify the incidence.

study at any time without personal or career detriment. Fourthly, the researcher introduced himself to all participants by his first name and invited them to call him by that name. Fifthly, the interviews were conducted off military establishments where possible, and the researcher wore civilian clothing for the duration of the interviews. At no time was any nurse forced to participate in the study. Lastly, none of the participants were part of the direct chain of command of the researcher. Therefore, he had little or no influence over the career or work situations of the participants (Ormsby, 2001).

4.8 Establishing Rigour

In any research endeavour it is important for the researcher to clearly demonstrate the decision trail that led to the findings of the study. The decision trail makes explicit the process taken by the researcher to ensure that the data is trustworthy and credible (Koch, 2006). That is, the research examined what it purported to examine. (Sandelowski, 1986; Ormsby, 2003). Lincoln and Guba (1985) suggested that the researcher must establish trustworthiness to persuade the reader that the findings are "worth paying attention to" (p.290). The qualitative researcher is less concerned with the strictures imposed by the quantitative mantra of eliminating bias and replicating results. Indeed, Freshwater et al (2010) argued "qualitative research approaches… expect the enquirer to remain self-aware, reflexive and self-monitoring in order to maintain the rigour and credibility of findings" (p.498).

The qualitative researcher generally seeks to make explicit the biases inherent in the research process and authentically represent the data in either a descriptive, critical or

interpretive way (Roberts and Taylor, 1998; Rashotte & Jensen, 2007). In the context of this research the entire process was conducted through a Philosophical Hermeneutic lens (see Chapter three). An interpretive methodology was used that embraced the biases (effective historical consciousness) of the researcher, engaged the researcher in a dialogue with the participants and the transcripts, and ultimately presented the data and findings as a temporal representation of the phenomena under study.

Trustworthiness

There was no one method for establishing trustworthiness[44] in qualitative research (Roberts and Taylor, 1998; Rashotte & Jensen, 2007). Guba and Lincoln (1985) proposed that trustworthiness could be established through the notions of credibility, transferability and dependability. Sandelowski (1986) expanded on the ideas of Guba and Lincoln (1985) and suggested that credibility, fittingness, auditability and confirmability were the hallmarks of rigourous and trustworthy qualitative nursing research. Leininger (1987) applied the criteria of credibility, confirmability, meaning-in-text, recurrent patterning, saturation and transferability. It was clear that there were a variety of methods of establishing rigour and trustworthiness at the disposal of the qualitative researcher. Rashotte & Jensen (2007), when discussing the plethora of methods for establishing rigour in qualitative research, identified that the foundational criteria did not change between methods. They argued that "despite the label change, the central motive of evaluation remained virtually the same" (Rashotte

[44] Sandelowski (1986); Leininger (1987); Lincoln and Guba (1989); Denzin (1989); Beck (1993); Koch (1993); Koch and Harrington (1998); Strauss and Corbin (1998) are examples of just some of the authors who provide methods for establishing rigour and trustworthiness in qualitative research.

& Jensen, 2007 p.97). This study focused on one of the foundational methods of establishing qualitative validity (Leininger, 1987) to provide an auditable decision trail for the research (Koch, 2006).

The work of Leininger (1987) was used in this study to provide a guide for establishing the trustworthiness of the data. While Leininger (1987) applied her method to the field of ethnographic research its applicability will be argued, after Rashotte & Jensen (2007), as equally applicable to the Philosophical Hermeneutical methodology that underpinned this study. Armour et al (2009) also supported this approach when they noted that "there is an emerging and important consensus about the procedures necessary to ensure rigor" (p.105) that showed consistency across the foundational criteria for establishing rigour. As stated above Leininger (1987) proposed that rigour and trustworthiness be examined using the criteria of credibility, confirmability, meaning-in-text, recurrent patterning, saturation and transferability and these will be examined as individual criterion below.

Credibility

The credibility of qualitative research findings can be understood as the inherent believability of the data (Leininger, 1994). Credibility asserts itself as the truth value that is uncovered through a thick description of the phenomenon under investigation (Armour et al, 2009). The truth value of the phenomenological interpretation may be uncovered through a reflective process where the researcher recognizes their description as correct in the context of the interpreted interaction (Ray, 1994; Armour et al, 2009). In the case of this study, the interpreted interaction was between the researcher and the participants and then the researcher and the transcripts. The

credibility of the data was initially established by authentically describing the data as it presented *prima facie* to the researcher. That is, the data were rendered in a manner that preserved the original context in which it was conveyed. The researcher then engaged in a dialogical interplay with the data, not as a mirrored reflection of the conversations, but as an interpreted translation that was truthful to the historically effected interpretive lens of the researcher. The interpretation, consistent with the Philosophical Hermeneutic approach of Gadamer (1976/2004), was central to the data rendering as it staked its claim to being credible. It may, therefore, be argued that any assertions toward credibility in this study fall under the spell of relativism. Relativism often connotes a negative, anything goes attitude in the quantitative research domain (Smith and Hodkinson in Denzin and Lincoln (2005 p.921). However, this claim is countered by arguing after Gadamer (2006) that:

> From the standpoint of the philosophy of finitude, it's possible for us to acquire historical consciousness again without falling prey to historical relativism, exactly to the extent that we recognize the limits of all knowledge, which is bounded precisely by its own historical situation. This recognition gives us back the possibility of seeing past our historical perspective, a possibility that I call the "fusion of horizons" (p.29).

The interpretations presented in this study were bound by the researcher's own finitude and are, therefore, cognizant of the horizons of the researcher as an insider to the world of deployed military nursing. Gadamer (1976/2004) suggested that the researcher can never be value neutral in seeking to understand phenomena. The researcher was a military nurse of over 23 years service and had deployed on three operations. Therefore, he brought an intrinsic understanding of the culture and context in which the participants practiced and this "emic" view coloured the

interpretive gaze. The interpretations made explicit the moment at which the “aha” moment of truth (Strauss and Corbin, 1998 p.47) or “phenomenological nod” (Van Manen, 1997/2007 p.27) was uncovered that was mediated through dialogue with the transcripts. The interpretation of the data, however, did not end with the words that are presented on the page. As the task of phenomenological research is “to construct a possible interpretation of the nature of a certain human experience” (Van Manen, 1997/2007 p.41), the interpretation presented in this thesis is offered to the altar of reinterpretation by other readers.

Confirmability

Leininger (1987) argued that the researcher should return to the participants to confirm that the data obtained aligns with their experience of the phenomenon. However, as discussed in the section on Colaizzi (1978) this view was not shared by the researcher. Returning to the participants in a Philosophical Hermeneutic research endeavour was neither appropriate nor aligned with the underlying tenets of the research approach taken in this study. Interpreting the data through the interpretive lens of the researcher would have fundamentally shifted the temporal reality of the original interactions between the researcher and the participants. Further, the horizons of the participants at the time of the interviews would have shifted and would, therefore, be a transformed interpretation of the original data. Van Manen (1997/2007) confirmed this mode of thinking when he noted that “a phenomenological description is always one interpretation” (p.31). Any description or interpretation is a captured moment in time rather than a definitive interpretation. On the basis of the arguments presented the researcher chose not to pursue confirmability as a criterion in the context of this study.

Meaning-in-context

Meaning-in-context referred to making data understandable within the context of a whole (Leininger, 1987). The whole may be the situations, contexts or environments in which a phenomenon had been experienced by the participants. In the context of this study the phenomena of spirituality and spiritual nursing care by Australian military nurses could not be separated from the context in which it was experienced. That is, in an operationally deployed military environment. The context was inextricably linked to how the phenomena were experienced and described by the participants in this study. It is also important to note that the uniqueness of the research was found in the context of the study. Spirituality and spiritual nursing care had been explored in many nursing settings but the deployed military nursing environment remained unique. Leininger (1994) asserted that:

> This criterion [meaning-in-context] focuses on the contextualization of ideas and experiences within a total situation, context or environment. The significance of interpretations and understandings of actions, symbols, events, communication, and other human activities as they take on meanings to informants within their lived context or the totality of their lived experiences support this criterion (Leininger, 1994 p.106).

Recurrent patterning

Leininger (1987) referred to recurrent patterning as the fifth criterion for establishing rigour and trustworthiness in qualitative research. This view was supported by Braun and Clarke (2006) who suggested that the research endeavour began with a search of the data for patterns of meaning. Leininger (1994) stated that "repeated experiences [along with numbers of occurrences]…that reflect identifiable patterns…are used to substantiate this criterion" (p.106). She suggested that themes based on recurrent

patterns of ideas presented by participants strengthened the trustworthiness of research. However, unlike quantitative research that imputed the strength of a theme by its numerical attribution by participants, qualitative research was less concerned with numbers than it was with the significance of a theme to the research question. A richly described phenomenal attribute identified by only one individual may be provided equal weight with other phenomenal attributes identified across the study cohort.

In the context of this study the use of recurrent patterning, along with reflexive analysis, assisted in substantiating the truth claim to some of the themes that emerged in the data analysis. As noted above, the patterning assisted where significant commonalities were reported across the study cohort, but it did not invalidate significant themes identified by individual participants. Willis (2002) quoted Brookfield (1990) when he stated that “the phenomenological truth of an insight does not depend on the number of people who report its occurrence” (p.143). What Willis (2002) and Brookfield (1990) did was to underline the truth value of an individual response without invalidating the value of common responses. This was the approach taken in this study.

Saturation

Leininger (1987) referred to saturation as the sixth criterion in her approach to establishing rigour and trustworthiness in qualitative research. Saturation was alluded to earlier in this chapter as the point in the analysis at which no further information had presented itself to the researcher.

> Saturation means that the researcher has done an exhaustive exploration of whatever phenomenon is being studies…[and]…finds no further explanation , interpretation, or description of the phenomenon under study (Leininger, 1994 p.106).

Saturation was established when the researcher had been fully immersed in the data and knew it as thoroughly and completely as possible. It did not close the door to further interpretations as the researcher reached saturation within the temporal confines of their own finitude. The interpretation of spirituality and spiritual care that is presented in this thesis remains a "snap shot" of the interpretive horizons of the researcher at the time of writing. It is a product of the historicity of the researcher and was finalized in a fusion of horizons. "The principle of history of effect is always at work" (Mantzavinos, 2005 p.53) and remains open for reinterpretation by the researcher or the reader.

Transferability

The final criterion that Leininger (1994) used, after Lincoln and Guba (1985), to establish rigour and trustworthiness in qualitative research was that of transferability. Transferability was not to be viewed in the quantitative manner of generalization of findings (Armour et al, 2009). Rather, it referred to the ability to transfer knowledge gained from one study into another similar setting.

> Transferability refers to whether particular findings from a qualitative study can be transferred to another similar context or situation and still preserve the particularized meanings, interpretations, and inferences from the completed study (Leininger, 1994 p.106).

Armour et al (2009) suggested that the task of demonstrating transferability did not lie with the researcher. The researcher needed to provide a thick description of the phenomenon under investigation, the analytical process and the context of the findings. “Providing rich, ‘thick description’ allows readers to determine if the findings of a study are transferable to other groups and settings” (Armour et al, 2009 p.104). Therefore, this information is provided as part of the decision trail so that other inquirers are able to determine the applicability of the study to other settings.

4.9 Summary of Chapter four

This chapter set the scene for the data analysis and discussion of the findings to follow in Chapters five through nine. The researcher provided an analytical framework that was argued as consistent with the Philosophical Hermeneutics of Gadamer (1976/2004). However, where Philosophical Hermeneutics was largely a-methodical and unstructured, the researcher applied a structured approach to the process of data analysis through the use of the phenomenological data analysis approaches of Colaizzi (1978) and Van Manen (1997/2007).

The phenomenological method of data analysis of Colaizzi (1978) provided the basis for a preliminary descriptive analysis of the study data. This method of data analysis used a seven step approach to describing data and developing themes. What the researcher argued in this chapter, however, was that the final step of returning to the participants to validate the data was not useful or appropriate when applied to the Philosophical Hermeneutic methodology that suffused this study. Indeed, Sommers (2005) suggested that apart from the horizon of the participant having changed from

the time of interview that the “tyranny of niceness” (p.118) may have prevented participants from providing open and honest feedback to the researcher on the transcripts. Therefore, only six of the seven steps set out by Colaizzi were used to analyse the data.

The second level of analysis applied to this study was guided by the interpretive approach to analyzing phenomenological data of Van Manen (1997/2007). Van Manen did not advocate prescriptive steps to the analysis of data. Rather, he provided a general guide to be used by the researcher that was based around four flexible steps. The chapter then argued for the combination of the two methodical approaches to build a deeper understanding of the study data that was at all times cognizant of and aligned to the Philosophical Hermeneutics of Gadamer (1976/2004) that underpinned this study.

Data were generated through the use of guided phenomenological interviews with ten purposively sampled Australian military nurses who had deployed to military operations. The ethical considerations pertinent to the study were discussed. Finally, Leininger’s (1987) criteria for establishing rigour in qualitative research were examined and applied to this study. What follows in Chapter five is an introduction to the participants that provides the foundation for the data analysis to follow in Chapters six and seven in Part three of this thesis.

CHAPTER 5: PARTICIPANTS

5.1 Introduction

The focus of this chapter is to introduce the study participants to the reader. Demographic data were collected to provide some contextual understanding of the participants in relation to the research question. In Philosophical Hermeneutics each interpretation of a phenomenon is temporal and unique. Therefore, the demographic data were not used in this study to provide a platform for study generalisability or repeatability so often found in the quantitative research methodologies. The primary source of the demographic data was the transcripts generated from interviews with the ten participants.

The chapter will present a detailed account of the population demographics for the study participants. The first section will provide an overview of the participants as individuals (5.2). The second section will describe the participants as a collective (5.3). In the next section the researcher will be situating the nurses' spirituality (5.4) before providing a summary of chapter five (5.5).

5.2 Overview of the Participants - Individual

All ten nurses in this study were Australian Defence Force registered nurses who had deployed on one or more military operations, and were aged between 30 and 60 years. Pseudonyms were chosen for all participants in the study, and other identifying information changed, to protect the identities and confidentiality of the

nurses. While all the nurses identified as Australian Defence Force nurses, they were a mixture of permanent (full time) and reserve force (part time) nurses. The participants had varying levels of experience as registered nurses and as nurses within the military. The researcher knew or had been employed[45] with six of the ten nurses within the study group prior to the conduct of the interviews. What follows, then, is a brief introduction to each of the participants.

Katie (Participant one)

Katie was one of the least experienced of the nurses in terms of her time in the military having served less than five years in the Air Force. She had undertaken study in intensive care nursing while in the permanent Australian Defence Forces and had practiced these skills in the Middle East and in South East Asia. She admitted, however, that maintaining those skills had been problematic in that military nurses were often engaged in administrative rather than clinical roles when not deployed. Katie was forthcoming in discussing the issue of spirituality from her deployment experiences. The interview was conducted on the rear patio of her home with some infrequent interruptions as she tended to her baby. Katie expressed her spiritual views very broadly and was able to speak quite eloquently on the topic.

[45] As identified in Chapter four, the researcher distributed expressions of interest to be interviewed through a third party. Therefore, prior knowledge of the participants did not influence participant selection as all nurses who accepted the invitation for interview were interviewed. Noting the years of military service that the researcher had completed and the small size of the Australian Defence Force nursing services it was also highly likely that the researcher knew or had worked with a number of the participants.

Peter (Participant two)

Peter was a very experienced emergency nurse prior to joining the permanent Australian Defence Forces, though his time in the military was relatively limited compared to some of the other nurses. He was a very deep thinker who was quite philosophical in retelling his stories of spirituality in the deployed military context. Peter was interviewed in an office in his workplace about his experiences in South East Asia, the Middle East and the Asian Sub-continent. Peter was very congenial and the conversation very fruitful with deep insights into his experiences and understanding of spirituality in the areas to which he had deployed. His personal spirituality was grounded in Catholicism. Peter's views on spirituality were very liberal and accepting of the spiritual expressions of others to the point of having a thirst for understanding the *other*.

Jane (Participant three)

Jane was a nurse in the reserve forces who had considerable experience in the military and in emergency nursing in the civilian nursing sector. She was the second highest ranked nurse involved in the study and brought a very deeply reflective approach to the dialogue of her experiences in the Pacific Islands. The interview with Jane was conducted on the outdoor deck of an officer's mess just outside an Australian capital city. This was the first time the researcher had met Jane and she was open in her responses during the dialogue. Her personal spiritual viewpoint was founded in Catholicism. Jane indicated that she was accepting of spirituality of the *other* and the role of the nurse in supporting the person.

Colleen (Participant four)

Colleen was working in an *out of category*[46] job in the permanent Australian Defence Forces when she was interviewed. She was forthcoming with her views on spirituality and military nursing on deployment throughout South East Asia. The researcher met Colleen at her workplace but moved to a quiet corner of a coffee shop nearby to conduct the interview. She noted that she felt overwhelmed and/or constrained in some of her deployment experiences due to either the situation itself or the group dynamics in which she found herself. Colleen expressed a God based spirituality and an enquiring mind in understanding the spirituality of others, though she was clearly concerned by extremism in any purported religious organisation.

Brian (Participant five)

Brian had considerable experience in the Australian Defence Forces as a permanent and reserve member. He had worked as either a medical assistant or a nursing officer in Africa and the Middle East respectively. The interview was conducted in a relatively private location in his workplace. Brian reflected often on the "mateship" and support that he received and offered to others while on deployment and situated his experiences of spirituality well within that context. He offered his personal experience of spirituality as being a broadly based non-religious belief in God.

[46] Out of category jobs are those in which a person undertakes duties that are outside those for which they are formally qualified and employed for a defined posting period (usually 2-3 years). An example might be a registered nurse working as operations officer in a military headquarters.

Bridget (Participant six)

Bridget was interviewed in a private office where she was working. She was a very experienced military nurse with intensive care qualifications who had worked in two different arms of the Australian Defence Force. Bridget was an enthusiastic and thoughtful story teller. She was very reflective during the interview on her spirituality and experiences on multiple deployments through Africa, South East Asia and the Middle East and how it had changed her, remarking that *there is always a price to be paid* (Bridget, p13). Bridget had a very eclectic and accepting view on spirituality as it related to care of others.

Anna (Participant seven)

Anna was interviewed in her home and engaged the researcher in dialogue in her lounge room. Anna was a very positive individual who offered freely of her experiences on deployment. She was very open about her spirituality and how she cared for those needs in others. She had deployed to the South Pacific, South East Asia and the Middle East and had gained intensive care qualifications while in the Australian Defence Force. Anna was a very reflective informant who provided good insights into her experiences. She described herself as a very generic Christian who saw spiritual care as grounded in a connection with others.

Tracey (Participant eight)

Tracey was interviewed in a private office in her workplace. Tracey was often guarded in her reflections on her experiences. Like Brian she had worked as both a medical assistant and a nursing officer in permanent and reserve capacities. She had

worked in both South East Asia and the Middle East and held an intensive care qualification that she used in the latter deployment. The interview was often stilted as Tracey had difficulty expressing her views on spirituality and the researcher had to provide many prompts to draw deeper responses on a number of the questions. The responses reflected someone who was still coming to terms with some of the experiences she had encountered on her last deployment. She expressed a humanitarian understanding of her spirituality but thought that nursing had been dispossessed of its role in providing spiritual care.

Kerry (Participant nine)

Kerry had significant experience in the Australian Defence Forces as a nurse, and like Brian and Tracey had worked as both a medical assistant and a nursing officer. Kerry's interview was conducted in a private office in her workplace. She understood her spiritual reference point in a non church going religious sense, coming from a Seventh Day Adventist upbringing. However, while she felt providing spiritual care was important she thought that military personnel were largely un-spiritual. Kerry was intensive care qualified and had been deployed to the South Pacific and South East Asia.

Barbara (Participant ten)

Barbara was the first of the nurses that the researcher spoke to about her experiences in spirituality and spiritual nursing care while deployed on military operations to Africa. She was the most senior nurse interviewed in terms of military rank and experience. Barbara was very pleased to speak about her experiences and was the

most prolific speaker of the nurses interviewed. Barbara was interviewed in her home and spent some time reflecting on her experiences over her time in the military. She was very frank and sometimes controversial in her views during the dialogue on a range of topics in relation to military nursing across the span of her reserve and permanent career. Her personal spiritual values were situated within a Protestant religious framework and she was quite liberal in her views.

The chapter will now explore the background and experience of the study cohort as a collective of military nurses. Presenting the participants as a group will allow the researcher to unpack the information presented in Tables 5-1 and 5-2 (below) and discuss the relationships of the various population characteristics of the nurses.

5.3 Overview of the Participants – Collective

As discussed in Chapter four, all the nurses who participated in this study were Australian Defence Force nurses who expressed an interest in being interviewed about their experiences of spirituality and spiritual nursing care provision on deployment. The participants were from diverse backgrounds with varying levels of experience as registered nurses and as military nurses. They also demonstrated diversity in the types of military operations into which had deployed. Table 5-1 below graphically demonstrates the experiences and diversity of the participants who informed this research.

Demographic	Breakdown			
Gender (5.3.1)	Male	Female		
	2	8		
Years of military service (5.3.2)	5-9 years	10-14 years	15-20 years	>20 years
	2	1	4	3
Rank (5.3.3)	Junior officer	Senior Officer		
	8	2		
Service (5.3.4)	Navy	Army	Air Force	Combined
	0	3	6	1
Service type (5.3.5)	Permanent	Reserve	Combined	
	6	1	3	
Specialisation (5.3.6)	General	Intensive care	Emergency	Op theatre
	2	5	2	1
Deployment type (5.3.7)	Warlike	Non-warlike	Combined	
	4	1	5	
Number of deployments (5.3.8)	One	Two	Three	Four
	2	2	5	1
Deployment locations (5.3.9)	Pacific Region	SE Asia	Africa	Middle East
	Bougainville	East Timor	Rwanda	Iraq
	Solomon Islands	Sumatra		Various
		Bali		
		Malaysia		

Table 5.1: Informant background in the Australian Defence Force

Table 5-1 will now be unpacked to better understand the demographic and experiential background of the participants. The data will be examined in relation to the general Australian nursing context to note any differences that may be evident

between the two cohorts. It will also be examined against the general Australian Defence population to identify any similarities and differences. Lastly, the data will be used to demonstrate the diversity of military service and experience that presented across the participants.

Gender

The gender profile of the participants provided a way to compare the military nursing cohort against their civilian counterparts and those of the military to whom they belonged. The participants were predominantly female (80%) and this figure was relatively consistent with the current workforce breakdown of Registered Nurses within the Australian nursing profession. The Australian Institute of Health and Welfare reported in 2009 that male Registered Nurses comprised 9.8% of the Australian Registered Nurse workforce (AIHW, 2009). However, the female participation rate of 80% within the Australian military nursing profession was the reverse of the demographic of the Australian military in general which sat at 14% (DoD, 2013b) This finding was not surprising as the military traditionally attracts a large number of young males to direct combat roles[47] which until recently had been closed to females (DoD, 2013c).

Years of military service

Years of service as military nurses provided some clues to the age, seniority and military experience of the participants. The participants tended to be military nurses

[47] Direct combat roles include, but are not limited to clearance divers in the Navy, infantry and artillery soldiers in the Army and fighter pilots and airfield defence guards in the Air Force.

who had considerable deployment experience and who had been in the military for greater than 15 years (70%). Approximately 85% of Australian military personnel were under the age of 40 years with 65% of its total workforce below the age of 30 years (DoD, 2006b). The participants largely fell within the 85% Australian military age demographic. This figure reflected the need for Australian military personnel to meet ongoing medical and physical fitness standards.

Rank

Rank is necessary for the maintenance of discipline and provides a formal structure of command and control[48] from which the military organization can direct its functions and operations. The researcher included this demographic information to:

- Highlight the hierarchical nature of the Defence organization.

- Identify the rank spread of the participants and thereby demonstrate the breadth of military nursing experience and responsibilities of the participants.

- Highlight the potential power imbalance between the researcher and the participants (discussed in Chapter four).

Military nurses, in the Australian Defence Forces, are employed in the officer ranks of the military and therefore have varying levels of command authority over individuals depending on the rank that they wear. For simplicity, the nurses in this

[48] "Command and control is the system empowering designated persons to exercise lawful authority and direction over assigned forces" (DoD, 2009)

study were designated as either junior or senior officers. The nurses who were classified as junior officers ranged in rank from Lieutenant (equivalent) to Captain (equivalent) and those classified as senior officers ranged in rank from Major (equivalent) to Colonel (equivalent). The rank spread was generally indicative of the relative years of service in the military[49]. The range of ranks therefore represented the full spread of nursing ranks in the Australian Defence Force, with the exception of trainees, at the time that the interviews were conducted.

Rank in the military imparts authority which Gadamer (1976/2004) discussed, though not in a military application, as legitimacy through knowledge and openness to questioning rather than blind obedience. "True authority is neither blind nor slavish…because it is freely recognized and accepted" (Gadamer, 1976/2004 p.34). In the Australian military, authority is generally exercised within the lawful constraints of legislation and policy and the authority of the person who wears a given rank is legitimized by their knowledge and experience and is exercised according to the situated context of the person. In the critical discourse it may be argued that the imposition of rank sets up power imbalances within an organization that subjugate individuals. Therefore, in the context of this study it could be suggested that the researcher, as a senior officer, might have carried a coercive power imbalance over the junior officers that engaged in the dialogue on spirituality. However, this issue was addressed in the preceding chapters. What the rank spread did represent, noting the bias toward the junior officer ranks, was that spirituality was

[49] It is acknowledged that a number of the nurses in the junior officer ranks had extensive years of military service beyond that which their rank would indicate. The experience identified is largely due to those nurses having worked in the military prior to their nursing training either as medical assistants or in other non-officer job groups.

viewed as an important issue from the perspective of both junior clinicians and senior nursing clinicians and administrators.

Service

Identifying the service arm of the Australian Defence Force to which the participants belonged helped to establish the diversity of experience of the participants. The participants consisted of Army and Air Force nurses only. While no Navy nurses responded to the expression of interest to participate in the research the lack of a naval participant did not lessen the richness of the data that was available for analysis. Gadamer (1960/2003) argued that every interpretation was just one interpretation and was therefore limited by its own finitude. Hence, there was still an evident truth value to the analysis and interpretation of the transcripts in this research despite the lack of a Navy participant. Gadamer (1976/2004) later expanded on the concept of finitude when he stated “I have myself shown that understanding is always an event” (p.125). In expressing this view Gadamer inferred that the researcher did not seek to make generalizations from findings as each event of understanding was unique in and of itself. Therefore, in the context of this research it was more important to have informants that were able to speak to the question under investigation than to have a broadly representative sample.

The assertion by the researcher that the lack of a Navy participant in the research did not adversely affect the richness and relevance of the data was also supported by the nature of contemporary military deployment. Australian military nurses from the Navy, Army and Air Force often worked and deployed together. While the

fundamental service cultures and the primary focus of each military nursing service differed,[50] Australian military nurses did work together for long periods on deployment and so the cultural differences may blur over time (Anna, p.18-19). Therefore, as the research question was directed at deployed Australian military nurses as a whole it was appropriate to select participants around experiential rather than service criteria.

Service type

Service type referred to the status of the participants as either full-time (permanent) or part-time (reserve) Australian military nurses. It was relevant to identifying whether the participants were fully immersed within the culture of military nursing or had strong insights into both military and civilian nursing practice and could therefore make insightful comparisons between the two. Permanent force military nurses work full-time within the military but may undertake some outplacement to civilian hospitals to maintain acute clinical skills currency. Reserve force nurses volunteer part-time service to the military while continuing to work in full-time in the civilian nursing sector. The differences between service type effectively splintered the homogeneity of the nursing group when it came to deploying as a group to military operations. For example, reserve nurses might have minimal contact with the permanent nurses until they "force concentrate"[51] just prior to

[50] Navy, Army and Air Force nurses in the Australian Defence Forces maintain distinct identities that align with those of their parent 'Service'. These identities encompass some differences in work environment, the fundamental roles of each 'Service', and the focus of their nursing practice (e.g. Navy nurses focus on the maritime environment, Army nurses on the land battlefield environment and Air Force nurses focus on the aviation environment).

[51] The assembly of military personnel prior to deploying on active operations.

deploying. As will become apparent later, reserve force nurses offer greater currency of acute clinical skills when they deploy as they are generally employed day to day in major public hospitals. Given the relatively small size of the Australian Defence Force health services, the reserve forces are considered integral to the delivery of operational health services. The reservists provide niche capabilities and skills that are difficult to maintain in the permanent military nursing workforce.

Specialisation

The specialisation of the Australian military nurses provided information on the clinical work settings in which the nurses worked on deployment. This was important in the context of this research as the clinical setting influenced the ability of the nurse to provide spiritual nursing care while on deployment. Table 5-1 indicated that 80% of the participants had a clinical specialty above their general nursing qualification. However, evident in the transcripts was that some of the participants did not have specialist qualifications for all their deployments, gaining them over the course of their careers. Also of note was that some nurses that did have specialist qualifications were not required to use these skills when they deployed because of the nature of the deployment to which they were assigned. It could be assumed, therefore, that the clinical specialty of a nurse was likely to have a minimal impact on how they reported spiritual care across the span of operations to which they had deployed. Where the clinical context has influenced nursing care, this will become apparent during the exploration of the interview transcripts.

Deployment type

In the context of this research it was important to understand the nature of the operations to which the participants have been deployed. The deployment context was fundamental to understanding the research as the research focused on the experience of spirituality and spiritual nursing care in a deployed military nursing environment. The nurses had practiced in a variety of operational settings ranging from warlike[52] to non-warlike[53] to peacetime[54] operations with some having been involved in a combination of military operations. Warlike operations are considered high intensity and high risk offensive campaigns that have the potential to involve high numbers of battle casualties. Non-warlike operations are often lower risk and lower intensity peacekeeping campaigns where the expectation of battle casualties is low. Peacetime operations include humanitarian assistance and disaster relief activities that generally carry minimal risk of battle casualties but may have high environmental risks. All Australian Defence Force deployments carry risk and the classification of the operation is based on the relative risk to personnel from combatant activity and from more benign threats such as disease. It is important to note, however, that the exposure of military personnel to death and dying may not decrease with a change in the risk classification of the operation so much as the mechanism of injury.

[52] "War-like operations are those military activities where the application of force is authorized to pursue specific military objectives and there is an expectation of casualties" (DoD, 2012b).

[53] "Non-warlike operations are defined as those military activities short of warlike operations where there is a risk associated with the assigned task(s) and where the application of force is limited to self-defence. Casualties could but are not expected" (DoD, 2012b).

[54] "Peacetime operations are operations not declared Warlike or Non-warlike" (DoD, 2012b).

Deployment frequency

The frequency of the deployments provided information about the breadth of experience of the participants in providing patient care in different operational settings. Most of the nurses had deployed on more than one operation and into a variety of warlike, non-warlike and peacetime operations. The number of deployments that the nurses had been involved in was indicative of the high tempo under which the Australian Defence Forces have been operating for the past 20 years (Morrison, 2013). The span and frequency of operations provided a significant breadth of experience from which to inform the study intent, covering nursing care and experiences in low and high risk operations and dealing with a diversity of cultural/spiritual contexts. Each context brought with it its own challenges and opportunities to the provision of nursing care and ascribing meaning to spirituality and spiritual nursing care.

Deployment location

The location of the deployments to which the participants had been assigned further emphasised the spread of experience of the nurses in informing the research. Knowledge of the deployment locations also provided an understanding of the relative risks of the operations in which the participants practiced and the number and type of injuries that they had experienced. The participants in this study had deployed into almost every major operation that the Australian Defence Force had been involved in since 1994 with the exception of Afghanistan (Reid et al, 1999; Museum, W.A, 2013). Deployment locations were named by region in this study rather than actual location to minimize the chances of participants being recognized.

De-identifying deployment locations also reduced potentially damaging tensions arising with other nations with whom Australian nurses have deployed where controversial issues had been raised in relation to detainees and patient care.

The next section will situate the spirituality of the participants to provide a picture of the breadth of spiritual expressions found across the study cohort.

5.4 Situating the Nurses' Spirituality

In this section the personal spiritual expressions of each of the participants will be presented. Identifying the spiritual expressions of the participants provides some insights into the spiritual framework that each individual brought to their understanding of the phenomena under investigation. Table 5-2 summarises the different ways that the ten nurses frame their personal spirituality.

Spirituality		**Number**	**Comments**
Christian religious **(e.g. Catholic, Baptist, Seventh Day Adventist)**		5 nurses	Variety of religions
Non-Christian religious **(e.g. Muslim, Buddhist, Hindu, Indigenous)**		0 nurses	
Non-religious	Humanistic spiritual	1 nurse	Caring and doing right thing
	Non-religious God	2	Karma, many paths to God
Not sure	Understands spirituality	1 nurse	Not sure of own spirituality
Not defined		1 nurse	General approach

Table 5.2: Ten nurses spiritual expressions

The table indicates the breadth of spiritual expressions amongst the participants were relatively consistent with those found in wider Australian society. A lack of non-Christian religious affiliations was likely to be reflective of Australian society in general where less than eight percent of the population identify with a non-Christian religion such as Islam or Buddhism. The Australian Bureau of 2011 Census data (ABS, 2011) indicated that around 62% of Australians ascribed to a Christian religious association. Around 31% of Australians were also identified that either had no religion or did not state or provided insufficient information to determine their views. The participants, therefore, largely reflected the Australian society of which they were a part. This point was reinforced by one of the participants who stated that:

> Peter: *I think military probably mirrors civilian life in that regard, that you have a range of people who are either spiritual or…not (Peter, 20).*

Peter's view above was also consistent with the extant nursing literature on spirituality which showed a general lack of a coherent and inclusive definition of spirituality (see Chapter two) and an increase in non-religious spiritual expressions. Some approached spirituality from a religious framework, others situated themselves in more eclectic or humanistic terms and some did not have a defined spiritual framework. However, what will become apparent later in this thesis is that while the personal spiritual framework of the nurse may vary, there was an underlying thread that suggested that the manner in which the participants approached the spiritual care of their patients remained largely consistent across the group. Acceptance and tolerance for the spiritual views and expressions of the patient, and the non-imposition of the spiritual views of the nurse on others, were paramount to the

provision of inclusive and effective spiritual nursing care in the deployed military environment.

5.5 Summary of Chapter five

Chapter five introduced the participants as individuals and as a collective group of military nurses. Firstly, a general description of the researcher's interaction with the individual participants was described with some preliminary comments about their demeanour, ability to talk to their experience of the phenomenon and their background as military nurses. Secondly, demographic data on the participants were presented to aid the reader to understand the nurses as a group and make some comparisons with other military personnel and civilian nurses. This section also discussed the collective experience of the nurses as military nurses and the nature and diversity of the military operations to which they had deployed during their military service. Lastly, the chapter presented a summary of the personal spiritual expressions that the nurses identified during the interviews.

The demographic data provided an insight into the unique nature of Australian Defence Force nurses. What was apparent in these data was that the participants were quite diverse in their military service, their nursing careers and their perspectives on spirituality and spiritual nursing care in general and on deployment. However, while the backgrounds and career pathways of the participants were diverse they shared many common experiences and perceptions about nursing and the nature of the military and operational deployment. These common experiences and perceptions

will become more apparent in the subsequent chapters as the transcripts are analysed and the findings presented.

The thesis now shifts its gaze from the methodology and methods discussed in Part two to the analysis of the study data. Chapter six reflexively and descriptively analyses the data through phenomenological method of data analysis of Colaizzi (1978). Part three finds its completion in Chapter seven where an interpretative analysis of the phenomena takes place using Van Manen's (1997/2007) approach to researching lived experience to link the analysis in Part three to the discussion to follow in Part four.

PART THREE
The Hermeneutic Dialogue

> To understand a text is to come to understand oneself in a kind of dialogue. This contention is confirmed by the fact that the concrete dealing with a text yields understanding only when what is said in the text begins to find expression in the interpreter's own language. Interpretation belongs to the essential unity of understanding…The genuine reality of the hermeneutic process seems to me to encompass the self-understanding of the interpreter as well as what is interpreted (Gadamer, 1976/2004 p.57-58).

Part three details the reflective, descriptive and interpretive data analyses undertaken by the researcher in this study. The analyses will be detailed in the following chapters:

- Chapter Six – Reflection and description

- Chapter Seven – The interpreted meaning

CHAPTER 6: REFLECTION AND DESCRIPTION

6.1 Introduction

The focus of this chapter is to present and discuss the findings of the research as phenomenological descriptions[55] of the interview transcripts. The process leading to the phenomenological descriptions will be presented in a linked manner. Steps one through six of the Colaizzi (1978) approach will be used (sections 6.2 to 6.7) to examine the data and introduce emergent themes evident in the data. In the manner of Colaizzi (1978) the researcher will:

- (Step 1) Acquire a feeling for the transcripts;
- (Step 2) Extract significant statements;
- (Step 3) Formulate meanings;
- (Step 4) Organize formulated meanings into clusters of themes;

[55] It should be noted that Gadamer (1976/2004) did not explicitly bring description into his Philosophical Hermeneutic approach to phenomena. In borrowing the descriptive elements of Colaizzi (1978) and Van Manen (1997/2007) the researcher is acknowledging the need to provide structure to the process of data analysis. Further, and consistent with Gadamer, description can be viewed as a first level interpretive analysis. The researcher, therefore, asserts after Gadamer (1976/2004) that any description of a phenomenon is always an interpreted description that is subject to the history, prejudices and finitude of the researcher.

- (Step 5) Exhaustively describe the investigated topic; and

- (Step 6) Describe the fundamental structure of the phenomenon (Colaizzi, 1978).

Descriptions of the data, as interpreted through the researcher's horizon of understanding, were derived from a dialogical interplay between the researcher and the transcripts.[56] The focus of the descriptions was on the background of the Australian military nurses (participants) and their experiences of spirituality and spiritual nursing care (phenomena) on deployed military operations (context). The process of describing the transcripts was consistent with the Philosophical Hermeneutics of Gadamer (1976/2004) that asserted that understanding was a language dependent dialogue. "There is in fact an infinite dialogue in questioning as well as answering, in whose space word and answer stand" (Gadamer, 1976/2004 p.67). Using this approach the researcher was able to interrogate the essential meanings of the phenomena against their own evolving horizon of understanding.

Phenomenological description focused on elucidating the "lived experience" of phenomena as described by the participants (Van Manen[57], 1997/2007). The

[56] Gadamer (1960/2003) referred to dialogue "as the structure of verbal understanding…as a dialectic of question and answer. That proves to hold completely true for our "Being-toward-the-text"" (p.576).

[57] The researcher has drawn on Van Manen (1997/2007) to highlight the combined approach to data analysis used in this study. As detailed in Chapter four Gadamer (1976/2004) informed all aspects of the study. However, Van Manen (1997/2007) and Colaizzi (1978) were used in combination through the analysis chapters to provide complementary analytical frameworks to provide structure to the largely unstructured Philosophical Hermeneutic approach of Gadamer to understanding phenomena.

researcher sought to understand phenomena as experienced by the participants though the descriptions "are never identical to the lived experience itself" (Van Manen, 1997/2007 p.54). The processes of transcription, textual dialogue and description were all interpretive acts. Interpretation provided transformed rather than mirrored accounts of an experience but "transformation always establishes a relationship to what is meant, to the subject matter being discussed" (Gadamer, 1960/2003 p.391). This approach was taken in the descriptive analysis presented in this chapter. The approach aligned with Van Manen (1997/2007) but remained consistent with the *Philosophical Hermeneutics* of Gadamer (1976/2004).

As previously stated the primary data source for this research was interview. The researcher entered into a dialogue with the participants to grasp the essential meaning that they attached to the phenomena under investigation. The questions posed and the prompts provided to participants in the interviews are identified in Table 6-1 below. Interview prompts were used to delve more deeply into issues and themes raised in the interviews and to keep the dialogue both relevant and on course. The interviews were conducted in a guided manner and allowed to develop as open Gadamerian[58] dialogues between the researcher and the participants.

[58] Gadamer posited the notion that dialogue is essential to understanding and all understanding is necessarily interpretation that involves dialogue between the past, present and future "A dialogue with another in pursuit of understanding, and a common dialogue with the past as all interpretations in the past necessarily encounter, most significantly through language, the echoes of the past in tradition" (Lawn, 2006).

Topic Guide	Interview Question Guide and Sample Prompts
Background **Military Nursing** **Deployment** **Spirituality** **Spiritual Nursing Care** ***Typical Prompts***	*Can you tell me about your story as a nurse?* *What is it like to be a military nurse?* *What was it like to be deployed?* *What is your experience of spirituality?* *What is your experience of spiritual care on deployment?* *What was it like?* *How did it feel?* *Can you describe?* *Provide an example.* *How did you deal with that?*

Table 6.1: Interview question guide and sample prompts

The chapter will present a descriptive analysis of the phenomena under investigation. It will begin with an orientation to the phenomena (6.2) by describing and reflecting on the transcript data. The individual expressions of spirituality, spiritual nursing care, deployment and military nursing of the participants will be presented. Important phrases are underlined throughout the text to demonstrate how the researcher used of the second step of Colaizzi's (1978) phenomenological method of data analysis, extracting significant statements. *Formulated meanings* derived from the significant

statements will be presented that demonstrate “how a participant’s personal definition…can be formulated into a more explicit meaning associated with the phenomenon” (Sanders, 2003 p.297). A personal reflection on the phenomena is offered at the conclusion of each phenomenal description. The next section begins the process of thematic development (6.3). In this section formulated meanings identified earlier are grouped into *clusters of themes* from which an exhaustive description (6.4) of the phenomena will be offered. An unequivocal statement to describe the fundamental structure (6.5) of the phenomena will then be presented. The statement is used as an entrée to the interpretive analysis to follow in Chapter seven and concludes with a summary of chapter six (6.6).

6.2 Orientation to the Phenomena

Colaizzi (1978) proposed the first step in making sense of data was to acquire a feeling for it (Step 1). In this study, a preliminary feeling for the data was acquired by manually transcribing the interview transcripts. Engaging the transcripts in a dialogue, in the manner of Gadamer (1976/2004), allowed the preliminary feeling for the data to be expanded upon to reveal the essential meaning of the phenomena. The textual engagement was achieved through a process of reading, re-reading and reflection (see Appendix four for a sample preliminary thematic analysis).

The aim of this section is to orientate the reader to the phenomena. The phenomena are offered as interpreted descriptions transformed by the historically effective consciousness and interpretive horizons of the researcher (Gadamer, 1976/2004). Each participant transcript is described under the headings of spirituality, spiritual

nursing care, deployment and military nursing. These headings were chosen as they represented the four primary questions that the researcher sought to answer in this study and it was from within these questions that the themes were derived. Accordingly, the descriptions highlight the experiences that the participants ascribed to each phenomenon. The *significant statements* (Step 2) underlined in the text will be drawn together into *formulated meanings* (Step 3) at the end of each section. Formulated meanings emerged after the researcher eliminated similar statements and repetitions, and made generalized statements that "try to spell out the meaning of each significant statement" (Colaizzi, 1978 p.59). The formulated meanings are presented in tabular form to assist the reader to follow the themes emerging from the data. A reflection on the data is provided after each phenomenon is described to assist in drawing together the threads into an overall description of the transcripts.

Spirituality

The first question to be explored in orientating the reader to the study phenomena (per p.179 Para 3 above) is that of spirituality. The views of the participants on spirituality provided the foundation for understanding their attitudes toward the provision of spiritual care.

Katie (Participant one)

Katie provided a number of insights into the nature of spirituality, spiritual nursing care, deployment and the military nurse. She held the view that spiritual care was an integral part of providing holistic care to her patients. *As nurses, we're not just looking after the physical wellbeing…you're looking after their mental health, you're*

looking after their spirituality (Katie, p.9) and *it is the patient who suffers…if you can't provide that holistic care* (Katie, p.6). Despite having grown up in a Catholic religious household Katie did not couch her spirituality in religious terms. Rather, she believed that her spirituality was formed by *the sum of all* [her] *experiences* (Katie, p.28) and to her as a person and a nurse it was the *impact that you leave on other people, that…is important* (Katie, p.28).

Peter (Participant two)

Peter approached the phenomenon of spirituality from the perspective of someone who having deployed in Muslim areas wanted *to learn more about their culture, environment…their way of life* (Peter, p.18) including their religion. He found that in provided nursing care to Muslim communities that they were very appreciative of the care that they received. *It was interesting I think…being predominantly a Muslim culture… the locals embraced us very warmly… I think we reciprocated* (Peter, p.5). Peter stated that there was much that people can *learn from the Muslims in particular…they are very dedicated and committed…getting rid of that ignorance opens you up a little bit to be a bit more receptive* (Peter, p.18) to their faith. As a Catholic Peter found that there were many parallels between his faith and the Muslim faith and he found it affirming to see that the differences were smaller than he had originally thought. Peter believed that the nurse should not be judgemental about the faith of another and noted that he did not *tend to form judgements* (Peter p. 20). He also expressed a belief that there was a difference between spirituality and religion. Peter also offered a view that spirituality was more directly related to *the way people see…they fit into the bigger picture* (Peter, p.20) with military personnel reflecting the range of spiritual expressions found in contemporary Australian society.

Jane (Participant three)

Jane expressed her spirituality within a Catholic religious framework and attended church regularly. Spirituality was central to Jane's life and helped her to cope with whatever happened in her life. In this respect spirituality sustained Jane through the hard times and was the source of her resilience. *The only way I can…survive is to have a religion to support me especially when things are tough* (Jane, p.20). She believed faith helped people find acceptance in their personal situation. Jane felt sorry for people that did not have religion *that helps them through difficult times* (Jane, p.20) as God had always been there for her to talk to. Being on deployment was a time of spiritual renewal for Jane. To Jane having a religious based spirituality provided a person with a surety of what was to come after death and this was important for acceptance and made the caring role for the nurse easier.

> Jane: *It's always so much easier when they* [patients] *are religious or spiritual people because at least you felt that they were dying to go somewhere…but if they don't have any belief in a God or anything then it's really hard to…be there with them because you've got nothing to say* (Jane, p.21).

Colleen (Participant four)

Colleen couched her spiritual understanding in "faith" terms after growing up attending church. However, she stated that after joining the Defence Forces she got *out of the habit of…going to church* (Colleen, p.26). Despite no longer regularly attending church Colleen affirmed her faith and belief in God and that she still prayed regularly. While her personal spiritual beliefs were Christian religious based Colleen offered an acceptance to *all spiritual beliefs and faiths* (Colleen, p.26). Colleen was of the view that all faiths were similar in their belief in God but God

took on different forms in different cultural belief systems. She believed that acceptance and respect of belief systems of others was important. *They're all valid spiritual activities* (Colleen, p.28).

Brian (Participant five)

Brian expressed a God based non-religious understanding of spirituality. However, while Brian believed in God his view was that *I don't believe he can control everything* (Brian, p.17). He did not subscribe to any particular system of belief but indicated that he held firmly to what he did believe. Belief for Brian did not require a church or other building. Rather, the individual had to find their own spiritual reference point in life. *I believe that everybody has their own path they have to try and forge out, and they decide whether they go off that path or not* (Brian, p.17). Brian also believed in Karma as a cyclic system of cause and effect (Honderich, 2005). *If you do a good job in life…usually opportunity comes your way…and if you do something wrong bad will come back to you* (Brian, p.17).

Bridget (Participant six)

Bridget chose not speak directly to the question of her experience of spirituality in the interview. Rather, she concentrated her responses on the spirituality and spiritual care of others.

Anna (Participant seven)

Anna spoke to spirituality as a part of life that sometimes became more important to a person when they were in difficult situations. She cited her use of prayer as a

manifestation of her time on deployment noting that *I haven't done that before* (Anna, p.27). Anna described praying to and thanking God for her safety as a comfort to her that helped her to cope while she was deployed. Anna asserted that nurses needed *a level of spirituality…and be accepting of what the patient requires* (Anna, p.29). While she found spirituality *airy fairy* (Anna, p.30) she felt it was part of the human interaction and was therefore important to the care of her patients.

Anna was uncertain at times about whether the care she provided was helpful to the spiritual needs of her patients but noted that spirituality, though couched in religious terms, was as much about respecting a person's needs than knowing what specific spiritual care was needed. *You need to respect their religion, because there are specific things that you need to respect* (Anna, p.30). Much of Anna's framework around spirituality centred on religion and this was reinforced in her beliefs and the beliefs of others she had observed while on deployment. In working with military nurses from other nations Anna commented that while some professed strong religious beliefs this did not appear to manifest in their care of the patient. Of one nationality Anna noted that they were *very vocal about their spirituality, but I didn't see it cross over into their nursing* (Anna, p.27-28). However, in some of her Muslim patients she had seen a lived spirituality that resulted in the patients giving their situation over to God and accepting their lot if life. In this assurance Anna found comfort and encouragement along with a lifting of the pressure off her as a nurse.

> Anna: *I always remember, 'it was up to God', they always used to say…and just accept it* [death], *and I found that quite encouraging…to me that they knew that there was a higher power…so I actually felt there was a little less pressure on us* (Anna, p.29).

Tracey (Participant eight)

Tracey spoke only briefly about her experience of spirituality. What she highlighted, however, was that her own spirituality was humanitarian focused. She referred to religion when she noted that her spirituality was *not necessarily in any one religion* (Tracey, p.17) but did not elaborate any further. In her humanitarian spiritual framework Tracey believed that spirituality was about *caring about other people and doing the right thing* (Tracey, p.17). When she situated her spirituality in the context of deployment Tracey was clear that spirituality was about looking after each other.

Kerry (Participant nine)

Kerry related her experience of spirituality as being initially grounded in the Seventh Day Adventist Church but noted that she moved away from the church in her teens:

> Kerry: *My parents were…fairly devout seventh day Adventist, and brought us up that way, but I kinda rebelled at…about 15, didn't want to go to church anymore, wanted to hang out with my teenage friends, so I kind of busted out of there* (Kerry, p.21).

Despite her move away from the church Kerry still maintained a belief in God and noted *in the back of my mind, I guess, there's always been that underlying, you know, belief in God* (Kerry, p.21). Therefore, she described herself as *a Christian who doesn't go to church as often as she should* (Kerry, p.22). Kerry still prayed in thanks and gratitude for what she had in life but stated that she had to actively remind herself to do so. Spirituality for Kerry gave *a little bit of underlying comfort or reassurance* (Kerry, p.23) through the difficult times. In relation to the military Kerry

remarked that *everybody's quite…non-spiritual in the military except for the padres* (Kerry, p.22).

Barbara (Participant ten)

Barbara couched her personal spirituality in religious terms due to her Protestant views but was very broad and inclusive in her thoughts on spirituality in general. She talked about predestination where life is predetermined for an individual.

> Barbara: *I also believe that your life's predestined for you in some respects…and because I think we have free will...we can do certain things* [but] *I think things happen in your life that you have no control over* (Barbara, p.32).

However, in that statement Barbara also believed that people had a degree of choice and free will in choosing their individual paths within the confines of their predetermined destination. Barbara's philosophy in life was to treat each day as if it were your last and to *appreciate every day that you have* (Barbara, p.32). Barbara did not believe that Christianity and Islam were necessarily compatible in their world views. However, she was of the view that through respect *you can still get along with people that you just don't necessarily see it quite that way* (Barbara, p.37). Barbara described the sense of calmness that she had seen in patients who had a belief and that spirituality provided *the armour to be able to manage things* (Barbara, p.63). She also expressed her personal comfort in dealing with issues that were spiritual in nature whether they aligned with her views or not.

Formulated meanings of spirituality

Table 6-2 below details the formulated meanings extracted from the significant statements identified and underscored in the preceding descriptions. The focus of this section is on the appropriation by the researcher of the expressed experiences of the participants with spirituality. Note that while some formulated meanings had only one or two participants directly ascribing to them, the lack of numerical strength did not invalidate the importance of that formulated meaning. Colaizzi (1978) implored the researcher to "refuse the temptation of ignoring data or themes which don't fit" (p.61) while Braun & Clarke (2006) expanded on Colaizzi's statement and noted that "more instances do not necessarily mean the theme itself is more crucial" (p.82). Further, the researcher argues through his interpretive lens that other participants may have implied agreement to a meaning in their dialogue without explicitly referring to it in the interview transcripts.

Formulated Meanings on Spirituality
1. *Spirituality may or may not involve a belief in a God* (participants 2,3,4,5,7,8,9,10)
2. *Spirituality may be found in religious or non-religious expressions* *(participants1,2,4,5,7,8,9,10)*.
3. *Everyone's spiritual reference point is different* *(participants 5,7,10)*
4. *All spiritual views are valid for the individual and should be respected* *(participants 2,4,5,6,7,10)*
5. *Spirituality can be expressed anywhere* *(participants 4, 5)*
6. *Depth of spirituality is not dependent on involvement in organized faith groups* *(participant 5)*
7. *Spiritual practice and faith are deliberate attitudes that can vary at different points in a person's life* *(participants 1,3,4,6,7,9)*
8. *Expressed spirituality often increases in difficult circumstances such as deployment* *(participants 1,5,6,9)*
9. *Spirituality allows a person to find their fit in the 'bigger picture'* *(participants 2,9)*
10. *A person's spirituality reflects the sum of their experiences* *(participants 1,8)*
11. *Spirituality provides assurance, comfort, and encouragement and aids coping by building resilience as an armour against life's* *(participants 1,3,7,8,9,10)*

12. *The spiritual attitude is thankful and appreciates every day as if it is the last (participants 6,10)*
13. *Spirituality involves human interaction and leads to respect and care for others (participants 1,2,3,6,7,9,10)*
14. *Spirituality is often internally experienced but externally directed (participants 1,2,3,9,10)*
15. *Most spiritual world views help individuals to accept their lot in life (Participants 1,2,3,7,10)*
16. *There is much to be learnt from the spirituality of others (Participants 1,2,6,7,8,9,10)*
17. *Religious and spiritual differences can be overcome through acceptance, respect and a non-judgemental attitude (Participants 1,2,4,5,7,8,9,10)*
18. *Spiritual views in the military largely reflect those of broader society (Participant 2)*
19. *Christian spiritual views are dominant in the Australian military (Participants 1,2,3,4,9,10)*
20. *Life is predetermined but the path one takes on the journey is a free will choice (Participants 2,10)*
21. *God based beliefs are culturally different but the parallels are affirming (Participants 2,4,8,10)*
22. *A nurse needs a level of spirituality to understand other's spirituality (Participants 1,2,8,10)*
23. *Comfort in dealing with spiritual issues varies between individuals (Participants 1,2,3,7,8)*
24. *Spirituality is an integral part of holistic nursing care (Participants 1,2,3,9,10)*
25. *Strong personal spiritual beliefs do not necessarily flow into patient care (Participant 7)*
26. *The patient suffers if spiritual needs are not recognized (Participant 1)*
27. *Spirituality can be 'airy fairy' in its understanding and application (Participant 7)*

Table 6.2: Formulated Meanings on Spirituality.

Reflections on spirituality

This section concludes with reflections on the phenomenon of spirituality as expressed by the participants. The reflective attitude allowed the researcher to move beyond pre-reflective descriptions of data (Colaizzi, 1978; Van Manen, 1997/2007). The approach accorded with the third step of the Colaizzi (1978) method of phenomenological data analysis and assisted in distilling the essential meanings to be explored and interpreted in Chapter seven. The reflective approach is used at the conclusion of each of the subsequent sections on spiritual nursing care, deployment and military nursing to guide the reflective descriptions.

The participants identified spirituality in very broad terms throughout the interview dialogue. For example, Katie referred to spirituality as *the sum of all my experiences* (p.11), Brian suggested that *everybody has their own path* (p.17) and Peter stated that *you can be a very spiritual person and not necessarily be a religious person* (p.20). Personal spirituality was often framed in religious language such as church, God, faith and prayer, reflecting the religious identification of six of the participants. Eight of the ten participants expressed the view that spirituality encompassed religion. However, religion as a concept was not interchangeable with spirituality. Peter noted that *the older I get, the more I can differentiate between spirituality and God* (p.20). This notion was supported by the researcher and the contemporary literature where "religion can serve as vehicle for expressing spirituality" (Govier, 2000 p.32) but was only one of many expressions (Sawetzky & Pesut, 2005; Koren & Papamiditriou, 2013; Penman, Oliver and Harrington, 2013).

Spirituality was a faith attitude that allowed a person to make sense of their lives through a search for something beyond the self (Dyess, 2011). Peter affirmed this view when he stated that spirituality concerned *the way people see themselves…how in touch they are with who they are, what they're doing, where they fit* (p.20). That seeking may be for a God, in whom to find strength and meaning, or it may be for an accepting and thankful attitude that assisted a person in their interactions and relationships with others. Relationships were bound in trust, respect and acceptance of the views and beliefs of others. The participants captured this notion by suggesting that while the spirituality of an individual was an internally held belief, the outcomes of a person's spiritual attitude were often directed outward to their relationships with

others. *It's the impact that you leave on other people, that…is important* (Katie, p.28).

In the view of the eight of the participants (participants 1,2,3,4,5,6,7,9), spirituality was a constantly changing phenomenon. *Every experience makes you the person you are, because you stop, you reflect, you internalize, and come out slightly different somehow* (Peter, p.22). Spirituality, therefore, was expressed as a dynamic attitude that often increased in adherence and ascription during the difficult times in a person's life. For example, the participants suggested that the challenges faced by military nurses on deployment made them more acutely aware of the impact of the spiritual on their lives. Jane supported this when she stated that the spiritual growth on deployment *makes your mental and physical be sustained* (Jane, p.24). In contrast it could be assumed that once the threat or hardship was removed that the spiritual attitude became less important to an individual. However, this assumption was found wanting as some participants suggested that their spirituality was what anchored their lives at all times. *I'm still Catholic and still regularly, weekly usually attend church* (Jane, p.20).

The participant responses clearly expressed spirituality as a tool for building resilience against the challenges of life (participants 1,3,7,8,9,10). One of the participants talked about the notion of resilience as *the armour to be able to manage things* (Barbara, p.63). Barbara's terminology represented the Christian notion of spiritual armour found in the apostle Paul's letters to the Ephesians where he exhorted them to "put on the full armour of God so that you can take up your struggle against the devil's schemes" (NIV, 1983 p.1093). While the other

participants did not express this view in direct biblical terminology, they did speak about assurance and comfort in the face of adversity, encouragement in what they were doing, and coping with difficulties in life. Molzahn et al (2012) when commenting on the contemporary nursing literature noted that "authors provide many examples of how people with serious illness reflect on existential life questions, and spirituality is identified as helping people deal with their situation" (p.2348).

The last points reflected upon in this section related to military expressions of spirituality reflecting society and the centrality of spirituality to holistic nursing. Peter suggested that Australian military nurses were a subset of Australian society and therefore their expressed spiritual values reflected those of Australian society. *I think military probably mirrors civilian life in that regard, that you have a range of people who are either very spiritual or…not* (Peter, p.20). This view was confirmed in Chapter five where the spiritual expressions of the participants were shown to be largely reflective of those of broader Australian society (ABS, 2011).

Koren and Papimiditriou (2013) made the point that the "nurses work is spiritual in nature" (p.37). The participants identified the holistic nature of nursing and that spirituality formed an integral part of the holistic and spiritual care provided by nurses. They observed, however, that while Australian military nurses practiced their nursing in a holistic and inclusive way, other nationalities were more selective in their holistic care. Tracey discussed the practice of a group of non-Australian nurses she worked with on one deployment stating that they *didn't look at a holistic approach with their nursing* (Tracey, p.4).

In the researcher's view the assertion that some non-Australian nurses outwardly professed their religious faith, but did not apply their faith to their practice, highlighted one of three possibilities. The first was that some nurses may have viewed spirituality as a personal journey that was separate to their professional responsibilities and therefore did not apply spiritual care routinely to their nursing practice. The second was that the spirituality of the nurse influenced their patient care but the application of spiritual nursing care was not overtly visible to others. The third possibility was that the nurses may have applied spirituality in an uneven way. That is, they may have provided fully holistic care to their own soldiers within the constraints of the operational tempo but did not provide this level of care to foreign soldiers and civilians. Anna confirmed the latter view when she noted that *on one hand they are very vocal about their spirituality, but I don't see it cross over into their nursing* (Anna, p.28) when discussing the treatment of detainees. The participants, without defending the actions of the other nurses, referred to their understanding of why spiritual care might have been uneven among one group of non-Australian military nurses. Tracey summed up this view when she stated that *they were seeing a lot of their people getting hurt, which wouldn't have been nice for them* (Tracey, p.7) particularly when many of the local patients that they were caring for were insurgents who might have been responsible for the injuries to their own troops.

The main points to be drawn from the descriptive analysis of spirituality above can be summarized as follows. Spirituality was:

- a broad and encompassing term that may or may not involve religion;
- a faith attitude that provided meaning and a sense of place and purpose;
- bound in relationships and provided strength, acceptance, trust and respect;
- inwardly experienced but often outwardly directed;
- not constant and varied at different times in a person's life;
- a tool for building resilience to life challenges such as deployment;
- consistent in the military with Australian society; and
- part of the nursing role and was essential to holistic nursing care.

Spiritual Nursing Care

The second question to be explored in orientating the reader to the study phenomena is that of spiritual nursing care. Spiritual nursing care was understood as an outward expression of spirituality that was applied to the care of military patients on operational deployment.

Katie (Participant one)

Katie suggested that spiritual nursing care was part of the role of the nurse and was a role similar to that of a chaplain in the military.

> Katie: *It's part of the nurses job, whether the nurse realizes it or not…to…not just provide for the physical care, but those other aspects. The mental and the psychological and the spiritual* (Katie, p.32) *kind of like a chaplain* (Katie, p.36).

In providing spiritual nursing care Katie emphasized a need to empathize with her patients and put herself *in that person's shoes* (Katie, p.28) to guide her care. Her spiritual care incorporated touch, listening, talking, being present with the patient, soothing, reassurance and connection. Katie expressed a number of barriers to providing spiritual care on deployment such as language, cultural differences, the presence of guards with detainees and the available time. She noted, however, that despite the difficulties present on deployment it was still important to provide spiritual care and to treat everyone equally. *Treating them like you would treat anybody would help them…the nurse's role is really important* (Katie, p.33). The act of doing so made her feel good about herself and her role.

Peter (Participant two)

Spiritual nursing care for Peter encompassed an acceptance of the spiritual expressions of others and being *cognizant of not imposing our beliefs* (Peter, p.5). In respecting the beliefs of others there was much that the nurse could learn from their patients. Peter believed that spiritual nursing care happened *as a by-product* (Peter, p.21) and was often an unconscious act. In Peter's view spiritual care was a major

part of the holistic nursing care spectrum and had a large impact on the patient. *Sometimes you can do something extremely…what would appear to be small to us, but will have a significant impact...on people's spirituality* (Peter, p.22). Peter provided time for patients to listen and talk about their spiritual needs and felt the role of the nurse complemented that of the chaplain. *There is a big cross-pollination between the nurse and the chaplain* (Peter, p.22). Spiritual care involved developing a level of trust with the patient and it was important for the nurse to give of themselves in the dialogue.

Jane (Participant three)

Spiritual care to Jane was not restricted to caring for patients. *I suppose I feel like I'm a bit of carer, or a healer, or a fixer anyway so I take that role on wherever I am* (Jane, p.5*)*. Jane viewed the role of the military nurse as supporting everyone that needed care throughout the deployment including peers and chaplains.

> Jane: *Some of the chaplains that we were sharing our time with…just talking about anything, sometimes it was about God, sometimes it was about how you felt, sometimes it was about how they felt* (Jane, p.6).

In an interesting insight Jane also suggested that the nurse could also be supported spiritually by the local community. Jane suggested that nurses had *that innate ability* (Jane, p.23) to identify and care for the spiritual needs of their patients though she believed that training was important to assist the nurse to provide this level of care. The presence of the nurse with the patient, more so than with other professional groups, placed them well to care for spiritual needs. Jane took a direct approach to asking about spiritual needs in her patients and would sit with them, be present, talk

to them and *help them through whatever journey they're going through* (Jane, p.22). She saw the nurse as a pastoral carer that complemented the role of the chaplain as an important part of holistic nursing care. Jane suggested that it was important for her as a nurse to talk to God for her own spiritual support and care.

Colleen (Participant four)

Colleen viewed the nursing role in providing spiritual care to patients as being tolerant and respectful of the faith and needs of others.

> Colleen: *I quite respect that all the different groups have their own belief structure They might be different to mine, but it doesn't make them necessarily less valid, doesn't mean that they're not true…who's to say that I'm not quite on the right track* (Colleen, p.26).

She also indicated that as a nurse that she supported her patients in their spiritual needs and practices. Colleen proposed that having an understanding of the spiritual needs of her patients influenced the care that she provided and facilitated their spiritual practices. One point that Colleen was very adamant about was that the nurse should never impose their own beliefs on the patient. *Professionally we've got to respect our patient's needs and wishes* (Colleen, p.29).

Brian (Participant five)

Spiritual nursing care had a number of facets to Brian but the overriding view was that the nurse was *just a conduit* (Brian, p.27). In this respect he viewed the padres as a primary resource in providing care to the spiritual needs of patients. However, in some situations that Brian experienced on deployment the family of the patient, in

some cultures, took over most aspects of caring including their spiritual care. Brian, however, indicated that the role of the nurse in providing spiritual care was to provide a "sounding board" for the needs of the patient and do what they could *to help that person* (Brian, p.27). Importantly for Brian it was paramount that nurses did not impose their own beliefs on the patient. Spiritual care did not just extend to Brian's patients as he indicated that even the care givers needed spiritual care and cited his support to a colleague in crisis and a padre who he attended during a cardiac arrest.

Bridget (Participant six)

Bridget made a number of comments on some of the difficulties in providing spiritual nursing care on deployment. *You couldn't give your time to everybody…and you just did the best you could* (Bridget, p.17). To Bridget, spiritual nursing care was very much a nursing role but the operational environment limited the ability of the nurse to provide this level of care. Bridget utilized the services of the padres when they were available but noted that in some circumstances they were difficult to access and *a lot was left up to us* (Bridget, p.19). In the intensive care environment Bridget treated her patients as if they were awake and used a general approach to her spiritual care by touching and talking to her patients. She went on to identify the difficulty in facilitating the presence of a patient's family in their care in an operational setting, but used them where she could. In other situations she provided spiritual care directly or facilitated the presence of friends or colleagues to stay with the patient, talk to them or hold their hand. Bridget did not find spiritual care provision a burden but found the lack of time hindered her delivering the care that she wanted to provide. What she did suggest, however, was that she *couldn't do*

enough for them…we always did everything for them as much as we could (Bridget, p.19).

Bridget raised the issue of caring for military detainees on deployment and the difficulties that posed to providing spiritual care when the nurses were not supposed to talk to the patient who were often deprived of their senses. She provided an example when discussing prisoners who:

> Bridget: *weren't even really supposed to be spoken to…and they had bandanas across their eyes and they couldn't see us and we're not supposed to see them…and I found that quite difficult because they're a patient* (Bridget, p.19).

What Bridget did state, however, was that she and the other Australian military nurses treated the detainees *exactly the same* (Bridget, p.19) as their other patients.

Anna (Participant seven)

Anna viewed spiritual care as being a part of her normal care of the patient and as *an integral role* (Anna, p.31). She approached spiritual nursing care from an empathetic view point and attempted to understand what it was that the patient needed so that she could provide for that. Anna spoke to her patients about their beliefs, sometimes through an interpreter, and did what she could to accommodate that. *Talking to the interpreters all the time or talking…about their beliefs, then I'd try and accommodate it…I never came up against things that I felt hard to deal with* (Anna, p.28). However, Anna noted that available time in a busy deployment did create barriers to providing spiritual care, but *we always just did everything for them as*

much as we could (Anna, p.19). One of the other barriers that Anna identified was in providing care to detainees on deployment who were not supposed to be spoken to but *we treated them exactly the same* (Anna, p.19). Her views on providing spiritual care revolved around talking, empathizing, respecting, supporting, understanding and accommodating needs, and being open to the *other*. Anna stated that *you try and compartmentalize the spiritual side but you actually realize you are doing it along side your clinical stuff* (Anna, p.29). Finally, Anna talked about the difficulty in measuring whether the care the nurse provided actually met the needs of the patient or whether the care was right for a particular patient.

Tracey (Participant eight)

Tracey felt that spiritual nursing care was still part of the holistic caring role of the nurse *to a certain extent, but spirituality isn't as big a role in nursing as it used to be (Tracey, p.19).* However, she noted that like other facets of nursing spiritual care had been largely outsourced to other professional groups. *A lot of that* [spiritual care] *has been taken away from nurses and given to other professionals* (Tracey, p.18). Tracey suggested that a result of outsourcing was that nursing had changed and the spiritual caring role had decreased to a point where nurses did not think about it very often. *From my experience you don't think about it* [spiritual care] *much* (Tracey, p.19). However, she raised the point that nurses still facilitated care through referral to chaplains and other religious and social workers. Tracey still believed that *we would always try and provide some sort of spiritual support for people* (Tracey, p.18) but she suggested the ability of the nurse to provide spiritual care was *based on experience and what sort of person you are* (Tracey, p.17).

Kerry (Participant nine)

Spiritual care took on more than just one dimension for Kerry. It could be directed to the patient but could also be directed back from the local community to the nurses. On one deployment she had an experience with the local Indigenous spiritualities, complete with a "witch doctor" that provided support to the military personnel who were helping the community. S*he just came from nowhere and come straight up, and she started delivering all this sort of deep and meaningful, spiritual sort of wisdom* (Kerry, p.14). Spirituality in this context was about support and imparting wisdom and left Kerry with a sense of being aware of the world around her and thankful for what she had. *It gives you a greater appreciation for…the other world, for life, for how other people live, what's important* (Kerry, p.14). In the other dimension, spiritual care formed part of day to day holistic care of the patient. It focused on an empathetic attitude to the patient and involved genuine interaction, drawing on personal emotions, the use of touch, and talking to the patient. One thing that Kerry did raise was that time poor nurses may not be able to provide spiritual care.

Barbara (Participant ten)

Barbara did not provide much information on her experience of spiritual care on deployment. She did, however, provide a couple of short exemplars that hinted at supporting and respecting the beliefs of others. One example involved the death of the baby of a local couple and the way the experience led Barbara to understand the spiritual world view of the community into which she had deployed.

> Barbara: *I said to her that her beautiful little baby had a comfortable night but finally passed away…that the baby was much loved by the staff*

and she just said...it's' god's will…that really blew me away…but that allowed me to appreciate how they saw things in a country (Barbara, p.58).

Formulated meanings of spiritual nursing care

Table 6-3 below details formulated meanings derived from the significant statements extracted from the participant interview transcripts. The focus of this section is on presenting the expressed experiences of the participants in spiritual nursing care.

Formulated Meanings on Spirituality Nursing Care
1. *Spiritual care is a normal and integral part of the holistic caring role of the nurse* *(Participants 1,2,3,4,6,7,8,9)*
2. *The nurse's spiritual caring role complements that of the chaplains to whom they often refer* *(Participants2,3,6,7)*
3. *An empathetic attitude is essential to understanding and meeting a patient's spiritual needs* *(Participants 1,9,10)*
4. *Good listening skills are essential to spiritual care as the nurse is often a 'sounding board' for the patient's needs* *(Participants 1,2,3,7,9)*
5. *Touch is an important spiritual caring tool for the nurse* *(Participants 1,3,9)*
6. *Genuine human connection is essential to providing spiritual care* *(Participants 1,6,9)*
7. *Spiritual care incorporates being present with the patient in their need* *(Participants 1,3,7)*
8. *Spiritual care provides reassurance, comfort and soothing for the patient* *(Participants 1,3,5,6,7,9,10)*
9. *Spiritual care can be either direct or indirect in its application* *(Participants 1,2,3,4,5,6,7,8,9)*
10. *Talking to patients and asking them about their beliefs is important to understanding and supporting a patient's spiritual needs* *(Participants 1,2,3,6,7,9)*
11. *The nurse often acts as a conduit to spiritual care by facilitating patient access to chaplains, family and peers where possible* *(Participants 1,2,4,5,6,7,8,9)*
12. *Spiritual care should be provided equally for all patients* *(Participants 1,6)*
13. *The nurse needs to be accepting of the 'others' needs when providing spiritual care to the patient* *(Participants 3,7,10)*
14. *The nurse needs to be respectful and tolerant of a patient's spiritual needs and not impose their own beliefs* *(Participants 2,4,6,7,10)*
15. *Spiritual care is often an unconscious act that occurs as a by-product of normal nursing care* *(Participants 2,8)*
16. *The nurse can positively and strongly impact the patient by providing appropriate and sensitive spiritual care* *(Participants 4,10)*

17. *Spiritual care is dependent on trust, being open to the 'other' and often involves the nurse giving of themselves and their emotions* *(Participants 2,3,7)*
18. *It is important for the nurse to try to understand the patient's spiritual needs and support them in whatever way they can to support that need* *(Participants 1,5,6)*
19. *The nurses' ability to care for spiritual needs varies for individuals from innate to marginal depending on their background and experiences but it is acknowledged that all would benefit from training in spiritual care* *(Participants 1,2,3,9,10)*
20. *Nurses help patients on whatever spiritual journey they are going on in providing spiritual care* *(Participant 1,3)*
21. *Spiritual care is multi-faceted and needs to be tailored to each individual* *(Participants 4,8)*
22. *The effectiveness of spiritual care is difficult to measure* *(Participant 7)*
23. *There are a number of barriers to spiritual care including: available time; language; culture; the operational environment; detainees and the presence of guards, but it is important to provide spiritual care despite the barriers* *(Participants 1,2,4,6,7,8,9,10)*
24. *Spiritual care is not restricted to patients as it can also aid peers or be directed back to the nurse from peers, local culture or community and God* *(Participants 2,5,10)*
25. *Spiritual care is just as important for care givers to aid coping* *(Participants 2,3,5,9,10)*
26. *Spiritual care is never a burden* *(Participants 2,7,8)*

Table 6.3: Formulated Meanings on Spiritual Nursing Care.

Reflections on spiritual nursing care

This section concludes with a reflective description of the phenomenon of spiritual nursing care as interpreted by the researcher through a dialogical interplay with the text (Gadamer, 1976/2004).

While reflecting on the formulated meanings derived from the significant statements on spiritual nursing care the researcher determined that each of the formulated meanings could be grouped into one of five different categories. The first of these categories described the definitional expressions of the participants toward spiritual nursing care. The participants described spiritual nursing care as a relational act that was grounded in genuine human interaction and was a normal part of the holistic

caring role of the nurse. *It's not just a nursing role…you have to be able to listen to people, and empathise with people* (Katie, p.37). Chung et al (2007) expressed that spiritual care was as much about our relationship with our own thoughts and feelings as it was about our interactive relationships with others including God or a higher being "expressed through activities such as reflection, meditation, prayer, art, music and natural appreciation" (p.161). Viewed in this way nurses needed to be present with patients and engage them in discussion about their personal spiritual framework and needs because *it's human interaction* (Anna, p.31). Without taking the time to develop a trusting professional relationship with their patient it was difficult for the nurse to understand the spiritual needs of the patient and assist them to meet them.

The second category to be described provided an insight into the scope of spiritual nursing care. The participants did not focus on any one mode of spiritual need but took a very eclectic view of what might be included as spiritual care. Spiritual care could be directed to any activity or expression that the patient viewed as spiritually important to them because *they're all valid spiritual activities and…I think they should all be respected* (Colleen, p.28). To achieve a tailored and sensitive approach to spiritual care the nurse strived to understand the spiritual needs of the patient. By understanding the needs of the patient the nurse was able to assist the patient on their spiritual journey free of judgement and imposition of their own personal views. *We certainly were very cognisant of not imposing our beliefs* (Peter, p.5).

The third category of spiritual nursing care explored the expressed spiritual nursing care practices of the participants. Like the scope of spiritual caring the practices were very diverse and were seen as directly or indirectly supporting the needs of the

patient. *There's some things I couldn't really relate to…but most of the time I just tried to accept what they actually needed…it's being open to that I think* (Anna, p.29). The researcher suggests that due to the enormous variability in spiritualities that it was difficult for the nurse to have one defined approach to providing spiritual care. *I always talk to them and I think it's that general approach* (Bridget, p.18). In this respect it was important for the nurse to be able to assess the unique spiritual needs of their patients so that they could understand and provide appropriate and sensitive spiritual care (Ennis and Kazer, 2013).

The participants identified their modes of spiritual care as practices that brought reassurance, comfort and soothing to the patient. These practices included facilitating the involvement of family, peers or chaplains and it was in this area that Tracey despaired in the view that nurses outsourced spiritual care rather than dealing with it themselves. *A lot of that has been taken away from nurses and given to other professions* (Tracey, p.18). The researcher suggests that referral to other professionals to support the spiritual needs of the patient was appropriate in many circumstances and was not an abrogation of responsibility on the part of the nurse. The participants highlighted touch, active listening and dialogue as part of their spiritual caring tool box but were careful to note that whatever care was provided it needed to be tailored to the needs of the patient. They also noted that spiritual care could be directed back to the nurse.

The fourth category presented the attitude required of the nurse in providing spiritual nursing care. In the view of the participants the nurse needed to adopt an empathetic attitude to the care of the patient and retain openness to the needs of others. *By*

putting myself in that person's shoes, I can get more empathy for someone and…that kind of guides the way I look after someone (Katie, p.28). To do so the nurse was required to subjugate their own personal views and focus their attention on the patient.

> Colleen: *I really don't think that imposing personal views onto a patient is the role of a nurse in any situation…the patient's needs and requirements are paramount* (Colleen, p.29).

Spiritual care became an attitude of acceptance, tolerance and respect and this was true across the full spectrum of patient care. The final word in the opinion of the researcher was the view that Bridget took that spiritual care was never a burden as it was an extension of normal nursing care. *It certainly wasn't a burden but it was a strain on us…because we'd like to spend more time with them but it was hard* (Bridget, p.19).

The final category that the researcher will discuss in this section related to the barriers that existed to providing spiritual nursing care. The participants identified a number of barriers to providing spiritual nursing care. These included: available time; language; cultural differences; the operational environment; and the difficulties in caring for detainees. Despite the barriers identified the participants were strongly of the view that spiritual care was important to patient care and therefore barriers could and should be overcome.

> Katie: *The language barrier and having two guards standing at the foot of the bed…that kind of discouraged any rapport that you had built with*

> *the patient…I made an effort to touch the patient…just for the sake of it* (Katie, p.30).

The main points to be drawn from the descriptive analysis of spiritual nursing care above can be summarized as follows. Spiritual nursing care was:

- enacted in relationship built on genuine human interaction;
- broad and eclectic in its delivery but tailored to the needs of the patient;
- not judgmental and did not impose the views of the nurse on the patient;
- reassuring and comforting to the patient and may be directly or indirectly provided;
- provided in an empathetic, open, respectful and accepting manner;
- able to be provided despite the barriers that existed to its delivery; and
- not just directed to patients but also to military peers and nurses.

Deployment

The third question to be explored in orientating the reader to the study phenomena is that of deployment. Deployment was arguably the primary distinction between

military nurses and their civilian nursing counterparts and provided the unique context in which spiritual care was experienced in this study.

Katie (Participant one)

Katie talked at length about her experiences of deployment as a military nurse. She viewed deployment in a very positive light when she stated that *I'm really proud of it* (Katie, p.20). Katie considered herself fortunate to have had the experience of deployment. She noted:

> Katie: *I'm so fortunate to have been able to have experienced these things, and go to these places where these unfortunate people who live there every day and never have the things that I have and all the opportunities that I have and I can maybe make a difference to them* (Katie, p.20).

However, she identified some factors that could negatively impact on a nurse who was deployed. She spoke about the guilt associated with being away from home for a long period noting *I kinda feel guilty when I'm away especially when I ring up and I'm having a good time* (Katie, p.24). She also alluded to the adjustment of homecoming and the impact that losing colleagues had on the deployed nurse which she described as *a terrible way to end the deployment* (Katie, p.15). Despite the potential negative impacts of deployment and the dangers that she faced with regular mortaring, Katie relished the ability to work in teams, to *do something* (Katie, p.13) to help others, to work in a variety of roles and get to know and share experiences with other military health professionals. Katie noted that the working hours were long and arduous on deployment and there was nowhere to retreat from those around

you as everyone worked and lived in close proximity. As such the military nurses had to learn to get along and respect one another for the good of the mission.

> Katie: *When you're on deployment, living in each other's pockets for 24 hours a day, you really get to…to know what gives you the shits and what works, and you also learn to tolerate people, you know, that you probably wouldn't do it outside* (Katie, p.21).

Peter (Participant two)

Peter highlighted the good and the bad aspects of deployment including the good clinical challenges and the difficulties inherent in long and often indefinite periods away from home:

> Peter: *The good thing about that I think from a clinician's perspective, you want to be challenged, and you want to do it in an austere environment, outside of your comfort zone* (Peter, p.4).

However, the downside of that deployment was that:

> Peter: *We were there initially for 90 days, which went out to 120 days, which ended up being 150 days, so 5months, we came back. And that was probably the biggest challenge from a nursing perspective* (Peter, p.6).

He viewed himself as being very fortunate to have had the experiences that he had but noted that some deployments were more satisfying than others. Deployment was often associated with austere and difficult living and working conditions:

> Peter: *We lived on the side of a mountain for four months in tents while it was snowing and…the environment was harsh…lived on rat packs*[59] *for four months…that was bloody awful* (Peter, p.5).

Peter suggested that deployments were rewarding not just for the work but also because of the sense of community, camaraderie, common bonds and shared experiences that characterized the deployment experience. *When you do go away for six months, you do forge very strong, intimate relationships with people* (Peter, p.11). While there were many demands and constraints on those that deployed Peter still believed that every deployment was an opportunity for personal growth and the desire to deploy was ever present. *You just sit back and watch and learn and absorbed it's just a life experience* (Peter p.18). Peter discussed the dangers and risks involved with deployment that were driven home when colleagues were killed or injured but noted that *there has to be a degree of risk taking in your personality to enjoy what we do* (Peter, p17).

Jane (Participant three)

Jane's experience of deployment was overwhelmingly positive and it was a part of her life as a nurse that she felt *at home with* (Jane, p.3). Jane equated her experiences on deployment with those that she saw on the television show MASH.

> Jane: *I loved the show MASH…I can understand why they got so close because they were all in it together, they were away from home but they made their family the group they were with…but I think that it's through that family relationship that actually helps them…in the hard times…I think in a small way that's what we do in Defence* (Jane, p.4).

[59] Peter was referring to combat ration packs in his reference to "rat packs". Combat ration packs are 24 hour individual field rations designed to be carried by military personnel in their field kit.

Jane viewed the group of military nurses and other personnel who deployed together as being *like minded people…who…make their family where they are* (Jane, p.3). Jane elucidated on the theme of family on deployment and suggested that the family relationship that developed on deployment helped people to cope with the rigours and hard times experienced while away from home (see MASH example above). This assertion appeared to be related to the shared experiences of military life and deployed life:

> Jane: *I think you're more in a family with Defence and I think that probably makes it stronger with a relationship because you're like a family and you can share the experiences of what's happened to you on the Defence deployment* (Jane, p.15).

Deployment helped Jane to reflect on and find some perspective in her life but she noted that the adjustment home after deployment was a difficult period for her:

> Jane: *When I came back to Australia I had great difficulty settling back even after three months…I just I'd go to the shops, to the shopping centres, and I absolutely hated all these people wasting money and all these people have got nothing* (Jane, p.13).

Colleen (Participant four)

Colleen related some of her experiences on deployment as having been very challenging clinically and stated that at times *it was scary…it's not like looking after someone in a controlled hospital* (Colleen, p.6). Despite the clinical challenges Colleen still viewed deployment as an exciting activity to be part of.

> Colleen: *I guess if you're away from home for an extended period of time, and you really rely on the people you're living with…I look back, and the professional experiences were great…like the clinical experiences I had, you couldn't have gotten anywhere else* (Colleen, p.23).

Nursing on deployment required a flexibility in skills to be able to overcome the austerity of the environment and the paucity of equipment that the nurses had available to them for patient care. Simply put, Colleen stated that *you've got to apply your skills in all sorts of situations and…do the best with what you've got* (Colleen, p.8). Colleen discussed the dangers that military nurses faced on deployment including potential terrorist threats in some parts of the world. The dangers did not just present a threat to the nurse, however, as they also posed a threat to military aircraft in which they may have been providing patient care. Colleen discussed the difficulties for the families that were left behind when a military nurse deployed especially if the nurse deployed at short notice.

> Colleen: *There are some spouses over there that really aren't coping, and their spouses will…well the partner overseas will then worry about that and it'll effect how they do their job* (Colleen, p.16).

She also discussed the bonding amongst the people that deployed together. Colleen remarked on the sense of family that existed in the military and made a comment that when *something happens to one person in the military, it affects everybody* (Colleen, p.18).

Brian (Participant five)

Brian presented a number of ideas when he spoke about his experience of operational deployment. Firstly he talked about the anticipation of going into the unknown and noted *that you always expect the worse* (Brian, p.7). After talking about the unknown he moved on to speak about the reality of arriving in the operational environment in Africa. *You were hit with the reality of it…you could smell death in the air…vehicles were bombed out…villagers…with amputations…from…bomb blasts* (Brian, p.9). Arriving on deployment did not scare Brian but gave him a heightened sense of awareness of what was around him and the dangers with which he was confronted. Brian identified thoughts of not seeing his family again, the dangers of carrying a weapon loaded with live ammunition that might need to be used, and the ever present threat of land mines. He also conveyed a story of seeing a man being hacked by a machete. Brian remarked on the longer term effects of his experiences with flashbacks of events and having to deal with the emotions and guilt related to another incident.

> Brian: *One of the guards had a machete, we were standing probably 300 metres away…the man walked up handed out his paper. We saw a bit of an argument and the guard then got his machete and struck the other man… we found out later that…they were brothers. …I couldn't get over the fact that brothers were doing this to each other…I had a lot of trouble caring for the bloke…mainly because I kept picturing my brother on the bed…that I couldn't deal with the fact that I was going over there and treating this person and I was seeing my brother and treating my brother* (Brian, p.18-19).

> Brian: *I've just burst through the door and looked down…and saw it was the Padre…and I remember very, very vividly, saying it can't be him. He is the one that supports us…I was praying while I was working on this bloke thinking you've got to pull him through…God you've got to pull him through…I was involved in getting his family over…'cause I felt*

> *guilt…when I found out he had died…everything came back…all of the emotions…I had been going to see the padre on base for eight months afterwards, trying to explain the guilt that I still had* (Brian, p.23-24).

Brian remarked on the austere environment and arduous living conditions often encountered on deployment:

> *Showers were a bucket of water…we were doing 18 hour days and if you were unlucky a piquet*[60] *on top of that…walls were scrubbed down to get the blood off* (Brian, p.15).

What Brian also referred to was that the people with whom he deployed bonded very quickly in much the same manner as brothers and sisters and with one "mate" in particular he placed him *on the same level to…my brother* (Brian, p.13).

Bridget (Participant six)

Bridget viewed deployment in a very positive way and highlighted the excitement she found in deploying, stating that her deployment to the Middle East *was the highlight of my career* [and] *what you get trained for* (Bridget, p.12). She found that because of her intensive care skills that she was very much in demand. Bridget suggested that each deployment was different and brought with it its own challenges. Being on deployment made Bridget *appreciate what we've got back home* (Bridget, p.8). However, the challenges of deployment had taken a toll on Bridget. This toll was evidenced when she stated that despite the good aspects of deployment that *you never come back the same* [because] *there's always a price to be paid* (Bridget, p.13). Bridget highlighted the sacrifices that the nurse and their families made when

[60] Piquet in the context that Brian is referring to is a guard duty shift at either the hospital or within the grounds of the accommodation compound that usually last around one hour.

the military nurse deployed, identified the dangers, and also hinted at the difficult environment and the arduous working hours and conditions that the nurses endured when deployed.

Anna (Participant seven)

According to Anna *on deployment it's expected that you're going to be sort of stripped bare* (Anna, p.19) emotionally and the people that a nurse deployed with saw them at their best and their worst. Deployment helped Anna to *reconnect with the human side of nursing* (Anna, p.13). However, Anna stated that *we are a family* (Anna, p.19) and therefore the family supported its members throughout the deployment and beyond because of the shared experiences. Anna sought support from *like minded people and who I can talk to…normally its same rank or maybe one above or…you know…someone who I can be really honest with and pour my heart out* (Anna, p.20).

In terms of support Anna talked about the group of deployed nurses nurturing one another and regularly debriefing to cope with the demands of the deployment. Anna also spoke of the physical and emotional drain of deployment when she said *sometimes you're just absolutely shagged both physically and mentally* (Anna, p.9). Anna talked about the conditions experienced on deployment with separation from family, eating unpalatable food, being "pissed off" with the chain of command and using toilets that *the majority of Australians wouldn't use* (Anna, p.23). In this experience that all military personnel had to endure was a common bond and understanding that helped the nurse connect quickly with their peers and patients:

> Anna: *There's a certain mind set in a military person…it does extend into our private lives as well…so military nursing is…to actually experience the military life actually contributes to the way we nurse our military patients, 'cause we can relate* (Anna, p.33).

Finally she addressed the dangers experienced on deployment when she spoke about regular mortar and rocket attacks on the compound in which she lived on one deployment and seeing the mass casualties constantly coming in on helicopters from the battlefield.

> Anna: *We were in the emergency department…and anytime there was a mass casualty…we were really just hanging around waiting for the onslaught…'cause they'd either stay in emergency or get shipped to surgery first…so we'd always go in and help…there was a large room, and it was basically just pain relief and if they were quickly assessed in pain relief, and maybe just dressing checks and antibiotics and line them up ready for surgery* (Anna, p.5-6).

Tracey (Participant eight)

Tracey referred to her experience of deployment in language that indicated that it was a difficult and arduous time for her. In one section, Tracey noted that her time in the Middle East *cured me of my need for deployments well and truly* (Tracey, p.21). In relating to her experiences Tracey discussed the living and working conditions and demands placed on her as a military nurse. Tracey described working 12 hour shifts and being on call constantly for casualty call outs and noted that *clinically it was an experience you'd never have anywhere else* (Tracey, p.11). She went on to say that *I've never worked so hard in all my life* [and] *it makes me appreciate how easy you have it back home in your nursing* (Tracey, p.11).

Tracey discussed the dangers, death and destruction that she had to deal with as a nurse while deployed. She described the working environment where helicopters were coming and going day and night and machine gun fire and explosions became a constant part of the background noise. She expressed this experience as *a bit surreal to start off with and then after you've been there a while…it becomes the normal environment that you live in* (Tracey, p.5). Tracey identified that the environment was about as far as a nurse can get from working in a civilian hospital in Australia. The nurses were living and working together in tents and mass casualties formed part of the daily workload with one example being 40 or 50 casualties coming into the hospital in one night just after she arrived on the deployment. She discussed her experience as *seeing so much death and destruction* (Tracey, p.12) and not feeling like she was really achieving anything. Tracey talked about only people who had been in the type of deployed environment into which she had worked understanding what the experience was like. She also discussed the after effects of the deployment when she said *you have memories of…some pretty horrific things that you don't want to talk about all the time* (Tracey, p.9) and those memories remained for a long time. On the positive side of the deployment Tracey remarked about the closeness and cohesiveness of the people who deployed together and the team work and support that each provided for the *other*.

> Tracey: *After being there together a week or two, you've become a fairly…cohesive team, because…you're working…so closely together and living together…became very close...and I think every group forms subgroups, and you have your own little…family* (Tracey, p.10).

Kerry (Participant nine)

Kerry expressed her experience of deployment in positive and enduring terms. *I think the military nurse on deployment has the potential to be far more rewarding and stay with you* (Kerry, p.29). Kerry went on to say that *I think deploying is exciting…that's probably why most people join the army* (Kerry, p.12). To Kerry the excitement was derived from going overseas and doing adventurous activities. One of the rewarding experiences that Kerry related was that of interacting with other cultures. She also stated that deployment was full of life experiences *that kind of touch our heart because you're living there* (Kerry, p.29). Kerry concluded by highlighting some of the realities of deployment. She discussed the long hours on deployment and that the nurses did not get to go home. There was very little personal time or time off during a deployment because they were confined to a barracks area and constantly on call for any occurrences.

> Kerry: *On deployment you don't get to go home. There's no…knock off time…but…you haven't really got much elsewhere to go, so I think people tend to work longer hours, so you're around…to do what you can do if you need to do it* (Kerry, p.27).

Barbara (Participant ten)

Barbara discussed her experiences of deployment as a rewarding but very challenging time. *I think for me personally* [Africa] *was very significant* (Barbara, p.27). In talking about the significance of the deployment, however, Barbara noted *that was the only UN operation I went on and after that I was happy to never go on another one* (Barbara, p.27). She remarked on how the deployment experience had changed her in both positive and negative ways. *I learnt to swear and all those sorts*

of things…and…I came home feeling incredibly empowered (Barbara, p.28). Barbara highlighted the shared experiences of the deployment that *binds you for the rest of your life* (Barbara, p.40). However, Barbara noted that even in shared experiences in the same war each individual experienced an event differently. *You can all go to the same war but have completely different experiences* (Barbara, p.40). Barbara then discussed one of the major long term effects that she observed from Africa where *one in four of our colleagues over that twelve month period have got some form of PTSD and they really need help* (Barbara, p.28). About going on deployment Barbara remarked that no one really had any idea of what was ahead of them but there was a sense of anticipation and excitement. Lastly, she remarked on the rewarding aspect of working with local people to help them achieve their potential as nurses without imposing our own values.

> Barbara: *Working with the local people to fulfil their potential…not imposing our thought processes on them but allowing them to work within and offering them some assistance along the way* (Barbara, p.45).

Formulated meanings of deployment

Table 6-4 below details formulated meanings extracted from the participant interview transcripts and focuses on expressed experiences of deployment. Deployment did not attract the same number of formulated meanings as spirituality and spiritual nursing care. However, the contextualization of these phenomena within the deployment was important to understanding the setting in which they occurred.

Formulated Meanings on Deployment
1. *Deployment is generally a positive experience for the military nurse (Participants 1,2,3,4,5,6,7,9) though for some nurses there is a price to be paid (Participants 8,10)*
2. *There are many physical and emotional dangers to be faced on deployment (Participants 1,2,3,4,5,6,7,8,9,10)*
3. *The camaraderie and shared experiences of deployment help military nurses to bond very quickly (Participants 1,2,3,5,6,7,9,10)*
4. *Deployment generally involves extreme hours and arduous working and living conditions (Participants 1,6,7,8,10)*
5. *The sense of a military family is reinforced on deployment (Participants 1,2,3,4,5,6,7,8,10)*
6. *Deployment can negatively impact some nurses (Participants 1,2,3,4,5,6,7,8,9,10)*
7. *Military nurses may have to deploy at very short notice for many months (Participants 2,4,5,6,7,8,10)*
8. *Deployment is what military nurses train for (Participants 1,2,3,4,5,6,7,8,9,10)*
9. *The challenging environments of deployment necessitate flexibility and independence on the part of the military nurse (Participants 1,2,4,5,6,7,8,9,10)*
10. *Deployment is physically and emotionally draining (Participants 1,2,4,5,6,7,8,9,10)*
11. *Only people who have deployed can understand the experience (Participants 1,2,3,5,6,7,9,10)*
12. *The expectation of deployment always differs from the reality (Participants 1,4,5,8,10)*

Table 6.4: Formulated Meanings on Deployment.

Reflections on deployment

Deployment was an experience that military nurses prepared for and anticipated with great excitement. The researcher's own experiences on three separate deployments affirmed the views of the participants in this respect. For many the opportunity to deploy presented a pinnacle in their military careers but the realities of deployment did not always match the idealized expectations (participants 1,4,5,8,10).

Deployment presented many clinical challenges to the military nurse. The nurse needed to be adaptable to working in austere environments with limited clinical backup, equipment, medical consumables, and often restrictive avenues of resupply (all participants). Equally the military nurse faced many personal challenges when

deployed into operational areas gripped in the aftermath of war, famine or natural disaster or actively in the throes of conflict. The views of the participants were supported by Kelly (2010) who noted that military nurses who were deployed may work in:

> Extreme high or low temperatures, and could also be under enemy fire from missile attacks…and would…have the uncertainty about medical supplies being replenished (p.637).

Therefore, the personal challenges took the form of physical and emotional dangers. Physical dangers came from exposures to disease, gun fire, mortar and rocket attacks, aircraft crashes, improvised explosive devices or any other immediate threats to life that occurred in the countries to which they deployed (participants 1,2,3,4,5,6,7,8,9). Emotional dangers might not manifest immediately but could remain with a person for life. Exposure to death, inhumanity and destruction could all adversely impact the ability of a person to synthesize and cope with abnormal experiences. Military nurses were not immune to the potential effects of psychological trauma and some suffered any number of Post Traumatic Stress Disorders or depressive illnesses (participants 3,7,8,9,10). The following extract from a study by Hodson (2002) into key indicators for post-traumatic symptomatology in military peacekeeping veterans attested the views of the participants on this point:

> The research showed that Australian military peacekeepers that deployed to Rwanda were exposed to multiple potentially traumatic events, some of which included witnessing human degradation and misery on a large scale, seeing dead bodies, and fear of injury or death. Data revealed that most personnel coped with this exposure, but one in five were still

> experiencing significant levels of distress six years after the deployment (Hodson, 2002 p.102).

The experience of deployment was unique to those that had shared in the experience (participants 1,2,3,5,6,7,8,9,10). Deployment brought people more closely together into a military family that supported and nurtured its members through the good and the bad times (participants 1,2,3,4,5,6,7,8,10). This view of the military family supported the outcomes of the earlier Master's level findings (Ormsby, 2001) of the researcher. The earlier study highlighted the centrality of the military family to meeting the emotional and spiritual needs of the military member while separated from their normal family and peer support networks in Australia (Ormsby & Harrington, 2003). There was a camaraderie that quickly developed amongst the nurses who deployed and this camaraderie also extended to other members of the military. The artificial divisions that existed between different military professional groups and service groups gave way to the bonds borne of shared experience and the mission objectives that all military personnel had in common.

The main points to be drawn from the descriptive analysis of deployment above can be summarized as follows. Deployment was:

- highly anticipated and sought after by military nurses;

- experienced as a dynamic tension between expectation and reality;

- the defining characteristic of military nursing;

- often experienced in austere, challenging and dangerous environments; and

- physically and emotionally demanding and only understood by those who had deployed through the sharing of common experiences.

Military nursing

The final question to be explored in orientating the reader to the study phenomena is that of military nursing. Military nurses are a sub-category of the Australian nursing profession. However, the environment in which they work imposes expectations on them that civilian nurses do not generally have to contend with in their professional practice.

Katie (Participant one)

Katie was proud to be a military nurse and felt that she had an enriched life because of her experiences. *I feel like I've lived a hundred lives and just had the most amazing experiences* (Katie, p.21). She felt that she was able to make a tangible difference to the lives of others particularly when she was on deployment. *I think…that when I do go to places like that that I make a difference* (Katie, p.20). Katie suggested that the bonds between nurses in the military were much tighter than those of their civilian counterparts because they relied so heavily on each other:

> Katie: *It's a job with a difference…the culture's different…I think your bonds with people are a lot tighter in the military than they if you're in a*

> *civilian environment…the experiences that you go through together…living in each other's…pockets for 24 hours a day, you really get to…know what gives you the shits and what works, and you also learn to tolerate people…that you probably wouldn't…outside* (Katie, p.21).

As a military nurse Katie belonged to the military culture and identified a common bond between its people. There was a shared sense of belonging in the military that was infused throughout its culture. *When you're treating, you know, soldiers or airmen or sailors, you know, from your own country…I definitely have a closer bond* (Katie, p.22).

Peter (Participant two)

Peter viewed his transition from civilian to military nursing as being very easy noting that both nursing cultures were very hierarchical. The main difference that Peter offered was that military nurses were often *put in situations…you probably would choose not to go into* (Peter, p.9). The political views of the military nurse were subordinated to the military mission as the nurses had a job to do regardless of the environment and their personal political views. *One of the big things is that in this job you do what you're told…whether that conforms to your political beliefs or not* (Peter, p.9).

Jane (Participant three)

Jane did not talk at length about military nursing as a discrete phenomenon. However, she did refer to the two distinct roles for military nurses. The deployed military nurse with the excitement and fulfilment that brought and the military nurse within Australia who spent more time on administrative than clinical tasks.

> Jane: *There's probably two different things…there's the deployment and there's working in the role that I work as now…and when I think about it the deployable part of me in Defence is the part that I like…or the real part of me in Defence is the part of me that I like better than the administrative paper work side* (Jane, p.3).

Jane did offer an insight into the military from her experience when she stated that *it's more than the uniform…I think you feel…an ability to a share a bit more of yourself…than you do when you're in a fake life that we live in* (Jane, P4).

Bridget (Participant six)

Bridget was quite effusive about her life and career as a military nurse. She found nursing in the military was an exciting life. *I guess it's the excitement, it is going away on deployment too because every deployment is very different* (Bridget, p.3). Bridget very much enjoyed deploying on operations and training exercises and having the opportunity to do things *you sometimes could not do in civilian life* (Bridget, p.3). She also relished the responsibilities that came with being a military nurse and an officer in the military where *you have to be well rounded* [and] *you can't rely on anybody else* (Bridget, p.3).

Anna (Participant seven)

Anna talked at length about military nursing and the often self imposed expectations that were placed on the nurses to appear strong in the face of some difficult circumstances. She related these expectations to her own view of her senior officers. *I've expected them to be so perfect to the point that they can't make any mistakes* (Anna, p.22). Military nurses needed to be strong team workers who were flexible enough to work with very scarce resources and be able to be *a Jack of all trades*

(Anna, p.16). Anna was very proud of her military service and noted that military nurses had a *can do attitude* (Anna, p.33) that could only be understood from within the profession. Anna agreed with the assertion of the researcher that the military tended to attract like minded people into an organization that was pervasive through the work and private lives of its members.

> Anna: *I don't think that civilians truly can understand what it's like to be in the military…there's a certain mind set in a military person…it does extend into our private lives as well…so military nursing is…to actually experience the military life actually contributes to the way we nurse our military patients* (Anna, p.33).

In that remark Anna also noted that military nurses connected well with their military patients because they came from the same culture and therefore understood one another.

Tracey (Participant eight)

Tracey did not speak at length about her experience of military nursing aside from the deployment experience. However, she noted that military nurses needed to be rounded in their clinical skills and had to have some different skills and competencies to their civilian counterparts, although she did not elaborate. *You have different skills and competencies that you have to keep up with and…a lot more discipline I guess as a military nurse* (Tracey, p.2). Tracey talked about the Australian military nurses as being multi-skilled in their practice. She contrasted this to some of her overseas counterparts who tended to be good at one task rather than many.

> Tracey: *They don't multi-skill like the Australian nurses did, so…I think they found…that was sort of really different for them, but they didn't appreciate our skills and the way that we could look after the whole patient* (Tracey, p.4).

The last point she made was that in being a military nurse, she was also a military officer and was afforded greater respect in her role than was the case in her civilian nursing practice.

> Tracey: *I think that military nurses are probably respected by the people they work with and in the environment they work in a lot more because they're…commissioned officers as such. Whereas civilian nurses probably aren't treated quite as well by their peers, including the medical officers* (Tracey, p.3).

Kerry (Participant nine)

Kerry related military nursing to other areas of the military. She highlighted the common understanding of military life that military nurses shared with their colleagues across all military groups in relation to *the constraints of the military…the hardships* (Kerry, p.2). Kerry raised the issue of camaraderie among military nurses and personnel and that this camaraderie flowed over into caring interactions with military patients. *You have the camaraderie and the general understanding, you know…even across the services* (Kerry, p.2). She went on further to state that *we definitely would have a camaraderie with the patient. Could definitely have more of a camaraderie with a military patient than with a civilian patient automatically* (Kerry, p.17). Kerry was quite direct when stating that *there are things about military nurses that civilian nurses would never know or understand* (Kerry, p.6) like the dangers of practicing nursing on deployment.

Barbara (Participant ten)

Barbara viewed military nurses as a very professional group of nurses who went beyond what was expected of them to achieve their objectives despite the circumstances that confronted them:

> Barbara: *Each and every one of them…tried really hard under really difficult circumstances… and they did the best they could given the circumstances* (Barbara, p.38).

When she described military nurses Barbara noted that:

> Barbara: *military nurses can be plucked and put anywhere…they're not going to have a structure that supports them necessarily and they'll be quite independent* (Barbara, p.37).

As a group they also shared certain traits that were common to military personnel such as independent personalities and an ability to socialize easily. Military nurses also shared the experience of deployment, frequent moves and long separations from their families. Barbara also stated that military nurses had the *versatility and the knowledge to support what you are doing in any environment* (Barbara, p.38). She then concluded that the military tended to attract people with similar attitudes and values, noting that *in the Defence forces…we have to get along and we have to do things together and often it's in close quarters…often in really stressful situations* (Barbara, p.73).

Formulated meanings on military nursing

Table 6-5 below details formulated meanings extracted from the participant interview transcripts and focus on expressed experiences of military nursing. Exploring the formulated meanings that the participants ascribed to military nursing provides the reader with an understanding of the unique characteristics of the study sample.

Formulated Meanings on Military Nursing
1. *Military nurses are proud of what they do and achieve* *(Participants 1,4,7,10)*
2. *Military nurses have a great camaraderie and a sense of belonging to the military culture that flows into their care of military patients* *(All participants)*
3. *Military nursing is about more than just the uniform and can only be understood from within the culture* *(Participants 1,5,9,10)*
4. *Military nurses share in experiences and bonds that are unique to military life* *(All participants)*
5. *Military nursing tends to attract 'like minded' individuals with similar traits and values* *(Participants 2,3,4,5,10)*
6. *Military nurses need to be flexible and versatile in their practice* *(Participants 1,6,7,8,10)*
7. *Military nurses feel they make a tangible difference to the lives of others* *(Participants 1,6,9)*

Table 6.5: Formulated Meanings on Military Nursing.

Reflections on military nursing

Military nursing presented itself as a unique part of the broader military culture. The participants (participants 2,3,4,5,10) suggested that military nurses shared a number of traits that set them apart from their civilian counterparts. The traits that they identified included: independence (participants 4,6,10); an ability to socialize easily (participants 1,2,4,8,10); strong camaraderie (all participants); and a heightened

sense of belonging to a pervasive military culture (all participants). While some of the traits could not be argued as exclusive to military nurses they were argued by the participants as being more uniformly found amongst military nurses as the profession attracted “like minded” people who shared common traits and values (participants 2,3,4,5,10). The participants also highlighted that military nurses wore two professional hats (participants 4,5,6,7,8,9,10). The participants were not just nurses within the military they were also military officers and accepted the responsibilities that were incumbent in that role. This view was supported by Griffiths and Jasper (2007) who identified the “double hat” nature of nursing in the British military.

Military nurses expressed pride in the work that they did (participants 1,4,7,10). In this respect most of the military nurses with the exception of Tracey indicated that the work that they did made a tangible difference to the lives of those that they helped (participants 1,6,9 explicitly and participants 2,3,4,5,7,10 implicitly). Tracey felt that she made a difference to individuals but did not believe that the work that she did when on deployment changed the circumstances or difficulties for those that were caught in the conflict. In expressing this view Tracey indicated that a perceived lack of control over what she experienced on deployment left an indelible scar on her coping abilities and desire to deploy again. The researcher suggests that military nursing largely evoked positive experiences and responses from its members. While all the participants agreed on the positive aspects of military nursing some nurses, when faced with overwhelming events such as deployment, experienced negative outcomes and feelings about their military service (participant 8).

The main points to be drawn from the descriptive analysis of military nursing above can be summarized as follows. Military nursing was:

- part of a broader military culture that set it apart from civilian nursing;
- practiced in a setting that imparted a sense of belonging and camaraderie;
- based on dual healer and warrior roles where nurses were military officers in addition to professional nurses;
- imbued with a sense of pride in making a difference to the lives of others when deployed on military operations; and
- experienced in a positive way by nurses, however there may be long-term negative consequences to nurses resulting from their deployment experiences.

6.3 Thematic Development

In undertaking a descriptive analysis of phenomena Colaizzi (1978) did not stop at the point of pure description. Phenomenological descriptions "depend on the extent that they tap the subjects' experiences of the phenomenon as distinct from their theoretical knowledge" (Colaizzi, 1978 p.58). The task of the researcher then was to describe phenomena in such a way that the reader understood the lived experience from the perspective of the participants. This study sought to achieve this in part by presenting an interpreted description of the phenomena. However, as "every

understanding is only “underway”” (Gadamer, 1976/2004 p.211) the description is left open for the reader to reinterpret from within their own horizon of understanding.

What the previous sections have done is to present the phenomena under investigation as significant statements and formulated meanings through reflection and description. In using the phenomenological data analysis method of Colaizzi (1978) it was necessary for the researcher to move beyond the descriptive statements and formulated meanings and begin the process of thematic development. Therefore, the focus of the next section is on drawing together the emergent themes into clusters of themes (Step 4).

Clusters of themes

The fourth step of Colaizzi’s (1978) phenomenological method of data analysis required the researcher to “organize the aggregate formulated meanings into clusters of themes” (p.59). Themes that were common to all the subjects emerged as the researcher returned to the formulated meanings to reflect on the data. Contradictory themes and singular themes also became apparent that required a value judgement to be made on their validity to the emergent thematic constructs. Contradiction and singularity did not invalidate a thematic idea. However, Colaizzi (1978) suggested that the researcher validated themes by referring them back to the original transcripts to ensure alignment and inclusiveness. In this way the themes should appear as self-evidentiary and present their own truth value (Gadamer, 1960/2003).

In this study there were 62 significant statements identified for spirituality which were brought together into 27 formulated meanings. A further 104, 83 and 32 significant statements were identified for spiritual care, deployment and military nursing respectively. Those statements were refined into 26 formulated meanings for spiritual care, 12 for deployment and a further seven for military nursing. Table 6-6 below provides an example of the process of descriptive analysis that the researcher followed throughout this chapter to develop the themes that follow.

Significant Statements	Formulated Meanings	Emergent Theme
6. Spirituality provides the armour for coping with life. 7. Spirituality provides a sense of calm. 14. Spirituality provides comfort and reassurance. 24. Spirituality involves assurance, comfort and encouragement. 35. Praying to God provides comfort and aids coping with life. 53. Spirituality sustains and provides resilience to cope with life. 54. Spirituality helps a person cope with life.	11. Spirituality provides assurance, comfort, and encouragement and aids coping by building resilience.	Resilience.

Table 6.6: Example of Thematic Development from Significant Statements to Emergent Themes.

The researcher repeated the steps outlined in Table 6-6 for all the significant statements and formulated meanings. Formulated meanings were clustered to reveal 14 emergent themes through which to describe the phenomena under investigation

and these are presented in Table 6-7 to follow. The process of revealing emergent themes aligned with the notion of a game posed by Gadamer (1976/2004) where he referred to “the constant movement back and forth between discovery and concealment” (p.51). In this way the researcher became engaged in an active dialogue with the text to uncover concealed themes as understood through their interpretive horizon. In the event of the game there were moments of clarity and temporal understanding as the researcher’s horizon of past fused with the horizon of the present in its futurity.

Emergent Themes
Emergent themes for the lived experience of spirituality
Search for meaning
Resilience
Relationship
Differential
Emergent themes for the lived experience of spiritual nursing care
Integrated holistic care
Facilitator and collaborator
Non-judgmental care
Touching the spirit
Symbiosis
Barriers

Emergent themes for the lived experience of operational deployment
Mismatch
Scars
Emergent themes for the lived experience of military nursing
Camaraderie and family
Pride

Table 6.7: Emergent Themes in Descriptive Analysis.

6.4 Exhaustive Description

The penultimate step (Step 5) in applying the phenomenological method of data analysis of Colaizzi (1978) to this study was to "integrate all the resulting ideas into an exhaustive description of the phenomenon" (Sanders, 2003). The integration of ideas can be presented as a narrative or as a series of separate but thematically connected points. However, to meet the aim of an exhaustive description it was necessary for the researcher to ensure that the description captured the essence of the phenomenal experience in all its dimensions (Sanders, 2003). In this study the researcher will present the phenomena in a series of short narrative descriptions that encapsulate the emergent themes and their derivative elements into a descriptive whole.

Spirituality will be presented as the fundamental element from which the other phenomenal descriptions in this study emerged. Conceptually, therefore, spirituality encapsulated all the other elements into a phenomenal whole. Throughout the following exhaustive description it will become apparent that each participant

expressed their personal spiritualities in very individualized ways. What will also become apparent is that each participant identified the essence of spirituality for their patients within a broadly inclusive and eclectic understanding which may or may not have accorded with their own spiritual views. The operational setting in which the spiritual care was provided was also quite diverse and the experiences of spirituality and spiritual care varied according to the deployment location and type. Therefore, while military nurses remained a sub-set of the wider Australian nursing profession their military role and the unique influences this had on their personal and professional lives set them apart from their civilian counterparts.

Emergent themes described

The fourteen emergent themes that evolved from the textual dialogue will be summarized below. The themes provided the meaning structures from within which the fundamental structure of the spiritual phenomena will be presented as a discrete statement.

Emergent theme one - search for meaning

Spirituality emerged as a broadly holistic notion that was used by individuals to find their unique sense of self and place within society and the world in which they lived. The search for meaning was not restricted to the transcendent context of a God, religion or higher being but did not exclude the religious-spiritual realm as a valid expression of the spiritual. For many the religious expression provided a concrete spiritual reference point and moral framework from within which to live their lives. For others spirituality was expressed within a more humanistic search for purpose

and connection with the world without reference to the transcendent. However, the spiritual language often reflected the religious influences of the culture in which the individual lived.

Emergent theme two - resilience

Spirituality provided a person with shelter and comfort in difficult times. It may not completely protect an individual from the impacts of life but it could assist in bringing order and perspective in overwhelming circumstances and even in the mundane. In this way a strong foundation in the spiritual built resilience, enhanced coping, and acted as armour against hardship.

Emergent theme three - relationship

Spirituality involved relationship and interaction with others. It was within relationships that the spiritual self was shaped. For the military nurse the relationships were expressed in family, friends, peers, the military, God (through prayer) or any other significant individual, deity or group with whom the individual found support and a sense of belonging. In interacting with others in relationship there was a sense of giving of oneself to the relationship and of being open and accepting of the *other*. Relationships were built on trust, respect and acceptance and it was within this framework that genuine interaction occurred.

Emergent theme four - differential

Apparent differences in spiritual expression were often measured in degrees of difference rather than absolutes. The individual may find the differences and the

similarities evident among the array of spiritual and religious expressions either challenging or affirming to their own spiritual expression, faith and belief. Often the differences were viewed as cultural points of departure. In this perspective there were many pathways that led to the same end point of spiritual fulfilment. Spirituality, therefore, was a journey of self discovery and presented choices that might change at various times in a person's life.

Emergent theme five - integrated holistic care

Spiritual nursing care was a natural extension of the personal spirituality of the nurse and their broader holistic nursing practice. It integrated the mind, body and spirit into a whole from which to assess, support and treat a patient. Spiritual nursing care could occur as a deliberate act of caring but it was more often seen among the participants in this study as an unconscious by-product of the caring encounter with the patient. In this respect spiritual care was often realized in reflection rather than contemporaneously with the provision of care.

Emergent theme six - facilitator and collaborator

The nurse had a primary a role in the provision of spiritual care within their holistic practice. While this care was provided in isolation in some circumstances it was very often given in a process of collaborative caring. In this way the nurse shared the act of spiritual caring with other health and spiritual professionals on one level and with the peers, family and unit of the patient on another level. The nurse was a conduit or facilitator of spiritual caring who attempted to ensure the spiritual needs of their

patients were met regardless of the status of the patient, their own spiritual values, or the situation in which the patient found them self.

Emergent theme seven - non-judgemental care

Meaningful spiritual caring could be achieved through both direct and indirect means. It was very much a product of the caring attitude of the nurse in relationship with the patient. The nurse sought to be present with the patient in a non-judgemental, respectful and accepting way where the needs of the patient were the focus of attention. Imposition of the attitude or spiritual framework of the nurse at the expense of the needs of the patient was counterproductive to the caring relationship. The caring relationship was one of trust and allowed the nurse the opportunity to understand and meet the spiritual needs of their patients at whatever point they were on their spiritual journey.

Emergent theme eight - touching the spirit

Direct spiritual care incorporated human interaction in the most basic of ways in an attempt to touch the spirit of the person in need. The caring attitude may involve a prayerful interaction with or for the living, the dying, the dead or their relatives, friends or peers. It complemented the role of the military chaplain but was not reliant on the presence of clerics or others to be effective in meeting the needs of a patient. The nurse interacted with their patients through an ongoing relationship that developed through active listening, talking, touch, presence, trust, acceptance and giving of oneself. It did not discriminate in its provision and was dependent on the

nurse doing whatever they could within the constraints of the deployment to meet the unique spiritual needs of the patient.

Emergent theme nine - symbiosis

Spiritual care on military deployment was not restricted to nurse patient relationships. It extended to caring for the needs of peers and other care givers and was even directed back to the nurse. There was often a symbiotic relationship between the nurse and the military chaplains as each care giver cared for each other within often difficult circumstances separated from their normal support networks. The military nurse also received spiritual solace in the care of the local community into which they deployed.

Emergent theme ten - barriers

There were many barriers to spiritual care identified by the participants. Barriers were not, however, viewed as arbitrary and unassailable walls to spiritual care but rather as constraints to be recognized and overcome. The most dominant barriers for deployed military nurses were those of time, operational intensity, language and cultural and religious differences.

Emergent theme eleven - mismatch

Operational deployments were the career pinnacle for military nurses and were the reason why they joined the military and what they trained for once a part of the military. Each deployment brought with it a great sense of excitement and anticipation for the challenges that lay ahead. However, the reality of the deployment

often did not match the expectation. The expectation-reality mismatch had negative impacts on some military nurses but was generally well tolerated and did not detract from the positive experiences of deployment for most nurses.

Emergent theme twelve - scars

Deployment was an inherently dangerous part of the military nursing job. The often unrelenting pressures of separation from family, close, arduous and austere living and working conditions, and the constant threat of harm adversely impacted many nurses. Wounded warriors emerged while on deployment or after coming home where adjustment back into normal home life could be a difficult and long road. Nurses were not immune to the dangers of emotional, psychological and spiritual stresses and many carried the unseen scars for many years. The physical dangers were ever present but varied between deployments. It was not uncommon for nurses to be exposed to disease, rocket and mortar attacks, the threats from improvised explosive devices, gun fire, machete attacks, anti-personnel land mines or to aircraft accidents.

Emergent theme thirteen - camaraderie and family

Deployment was viewed by the participants as a unique experience that could only be understood by those who had lived through it. The common understanding and camaraderie that developed between military nurses who had experienced deployment provided an enduring bond. The nurses identified a sense of belonging to a military family where each supported the other through the good and bad experiences. Deployment forced people together for long periods in difficult

circumstances and it was within this context that the nucleus of the military family was formed. Peers bonded quickly and took on the role of siblings within the family and they looked to their senior officers for guidance and strength in a pseudo parental role. The military family supported the nurse in all aspects of their lives, including the spiritual, when they were separated from their normal family and peer support networks.

Emergent theme fourteen - pride

Military nurses were proud of their service and felt a strong sense of association with those that had shared their experiences of service life. They viewed themselves as comrades in arms who worked together toward a common goal. The goal was based on military objectives but had a human dimension for the nurses as they sought to help not only their own sailors, soldiers and airmen/airwomen, but also those of other military forces and civilians who were impacted by the events that surrounded them. Military nurses were part of the military structure and were expected to undertake all the military roles expected of an officer though the participants did not believe this unduly affected their caring role. The military tended to attract “like minded” individuals who shared common values that set them apart from their civilian colleagues.

6.5 Fundamental Structure

The final step that the researcher used of Colaizzi’s (1978) approach to phenomenological descriptive analysis was to make an “unequivocal a statement of identification of its (phenomenon) fundamental structure as possible” (p.61). The

unequivocal statement distilled the thematic threads detailed above into a coherent and thorough, but succinct, statement of the phenomena. In this study the statement was used to encapsulate the essence of the phenomena in preparation for the detailed interpretation and discussion to be explored in the next chapters. The statement is presented in italics to better delineate it within the process of descriptive analysis that underpinned this chapter.

Spirituality is a very personal concept that involves a person's search for meaning and sense of self and place within the world that they inhabit. It is more than a religious expression but may be found in religion or other practices or rituals that involve a transcendent relationship with a God or higher being. Each individual has their own spiritual journey and a choice on which life path they wish to follow. Spirituality provides a shelter against the storms of life and is central to developing resilience and coping. Spirituality is an inherent part of a person's humanity to others. Despite the differences in spiritual expression there is no invalid spiritual framework and it is in this realization that the nurse understands the importance of respect and tolerance in faith and belief. Spirituality provides a point of reference from which spiritual nursing care is practiced by military nurses on deployment and is therefore pervasive throughout the act of caring.

Understanding their own spiritual framework assists the nurse to assess and meet the spiritual needs of patients. While many nurses may have an innate ability to deal with spiritual issues there is a level of spiritual maturity and training required for most nurses to provide this level of holistic nursing care sensitively and with a degree of comfort. Spiritual care touches the spirit of the individual and is at its most

meaningful when provided from within a trusting, open and respectful relationship of care. Therefore, human interaction and relationship are at the core of spiritual care provision and are dependent on the caring attitude of the nurse. The nurse is a spiritual facilitator in care and may assist the patient to meet their spiritual needs through indirect and direct means. Referral and facilitated spiritual nursing practice, for example providing a quiet space for prayer, are equally as valid as more direct practices such as prayer, touch, presence, listening and talking in meeting the expressed spiritual needs of patients. In this way the nurse adopts the role of a spiritual midwife and the act of spiritual caring occurs naturally as a by-product of well considered holistic nursing care. Spiritual care requires acceptance, respect and a non-judgemental attitude on the part of the nurse. Spiritual care can also be directed to supporting peers, family or even be directed back to support of the nurse who also has spiritual needs that need to be met on operational deployment.

The contextual framework within which the military nurse practices may affect the delivery of spiritual care. Nursing on operational deployment brings with it many challenges that are not experienced within the day to day practice of military nurses when in Australia. Deployment creates barriers that need to be recognized and overcome by the nurse in providing spiritual care. Language, cultural and religious/spiritual differences and the handling of detainees can complicate the process of communication and the ability to understand the spiritual needs of the patient. The largest barrier for the participants, however, remains the time available to be present with patients. Deployment is demanding for the nurse in terms of the arduous working hours, the lack of privacy and separation from the environment, the

tempo and number of casualties and the austere and often dangerous working and living conditions. All these factors can influence the emotional reserves of the nurse and tolerance of events and relationships with peers and patients. However, the nurses share a common bond in these experiences and support each other through the creation of a military family. The military family provides an ongoing de-facto support network of people who understand what each other has endured while deployed. Despite the challenges posed by deployment it remains sought after, valued and highly anticipated. Deployment is the raison d'être for the military nurse and is one of the main reasons why military nurses are proud of their service and consider themselves as more than nurse in uniform. Military nurses are military officers and leaders who understand the dangers inherent in their role but are willing to do it anyway.

6.6 Summary of Chapter six

This chapter detailed the analytical approach used to describe the phenomena of spirituality and spiritual nursing care as expressed by a population of Australian military nurses who had deployed operationally. Analysis was guided by the phenomenological data analysis method of Colaizzi (1978) and remained philosophically aligned with the Philosophical Hermeneutics of Gadamer (1976/2004).

The chapter provided an orientation to the phenomena under investigation. This was achieved by reflectively describing the phenomena through the interpretive gaze of the researcher. The phenomena were examined under four main headings for simplicity of understanding. Firstly, the main elements of spirituality, as identified by

the participants, were explored. Secondly, spiritual care was described in its component parts. An emerging model of spiritual care will be presented in Chapter eight. Thirdly, the views of the participants on deployment were examined as the unique context in which spiritual care was practiced in the military. Lastly, the researcher described military nursing as the population under investigation.
At the end of each section significant statements were drawn from the reflective descriptions. Formulated meanings were then provided to underpin the emerging themes that presented themselves from the data. The chapter finished with the researcher presenting exhaustive descriptions of the fourteen emerging themes that provided the basis for the fundamental structure of the phenomena.

Chapter seven will move the analysis from the descriptive phase into one of explicit interpretation. The emerging themes from Chapter six will be further defined and preliminary definitions of spiritual care, deployment and the military offered to capture the essence of spiritual care in the unique deployed military context.

CHAPTER 7: INTERPRETIVE ANALYSIS

7.1 Introduction

This chapter examines the second phase of analysis undertaken in this study. The purpose of this chapter is to present the findings derived from the interpretive analysis of the data. The chapter moves beyond the reflection and description used in Chapter six to examine the phenomena of spirituality and spiritual nursing care in the deployed Australian military nursing context through an interpretive lens. Using Gadamer (1976/2004), the researcher engaged in hermeneutic conversations with the participants and the transcripts. Hermeneutic conversations were used to develop transformed representations of the data as interpreted through the history, prejudices and horizons of the researcher.

The fourteen emergent themes identified in Chapter six are transformed throughout this chapter into five essential[61] themes. The essential themes represent the lived experiences of the phenomena as expressed by the participants. The themes were derived from a circular dialogue of question and answer between the researcher and the text (Gadamer, 1976/2004) and were captured in the process of writing. "Human

[61] Van Manen (1997/2007) suggested that "the essence or nature of an experience has been adequately described…if the description reawakens…the lived quality and significance of the experience in a fuller and deeper manner" (p.10). The researcher adopts Van Manen's description of essences and further asserted that the essential meaning of a phenomenon is that quality that without which, the phenomenon would lose its significance and unique nature (Gadamer, 1960/2003).

science research is a form of writing" (Van Manen, 1997/2007 p.111). The phenomena, therefore, will be presented in part as verbatim accounts of participant experiences but also as interpreted meanings as understood through the interpretive horizon of the researcher.

The chapter begins by exploring the mode of thematic analysis (7.2)[62] used to interpret the data and uncover essential themes in this study. The fourteen emergent (descriptive) themes[63] identified in Chapter six will then be revisited during the thematic analysis and explicitly interpreted. The emergent themes are then grouped together and collapsed into essential themes (7.3) under the headings of spirituality, spiritual care, deployment, military nursing and family. Grouping the themes under the these headings was consistent with the four primary questions that were asked of the participants: *What is your experience of spirituality?*; *What is your experience of spiritual care on deployment?*; *What is it like to be deployed?*; and *What is it like to be a military nurse?* The headings also recognise the importance of the notion of family, drawn from the researcher's earlier study into spirituality (Ormsby, 2003) and re-encountered in this data, to spirituality and spiritual care in the military. Supporting examples are provided from the transcripts and the literature. Part three of the thesis concludes with a summary of chapter seven (7.4).

[62] Thematic analysis refers to the process of identifying themes and making sense of their meaning through the interpretive act (Van Manen, 1997/2007).

[63] Descriptive themes simply describe the nature of a phenomenon objectively as it presents. However, the researcher agrees with Gadamer's (1976/2004) assertion that description is of itself a form of interpretation and therefore the process of description is always influenced by the researcher's own interpretative horizons.

7.2 Thematic Analysis

Willis (2002) proposed thematic analysis as a way to approach phenomenological data to uncover "those elements that constitute the phenomenon as experienced" (p.182). According to Van Manen (1997/2007), thematic analysis questioned the meaning of phenomena and therefore focused the quest for understanding. The researcher used the search for phenomenal meaning to build upon the themes identified in Chapter six (pages 233-234), and presented in Table 7-1 below, to describe the fundamental structure of spirituality and spiritual care by Australian military nurses in a deployed military nursing context. The researcher will interpret their significance to the essential nature of the phenomena under study.

Emergent Themes from Chapter Six – Reflection and Description	
Theme 1.	Search for meaning.
Theme 2.	Resilience.
Theme 3.	Relationship.
Theme 4.	Differential.
Theme 5.	Integrated holistic care.
Theme 6.	Facilitator and collaborator.
Theme 7.	Non-judgmental care.
Theme 8.	Touching the spirit.
Theme 9.	Symbiosis.
Theme 10.	Barriers.
Theme 11.	Mismatch.
Theme 12.	Scars.
Theme 13.	Camaraderie and family.
Theme 14.	Pride.

Table 7.1: Emergent Themes from Chapter Six – Reflection and Description.

The main sources of data used to inform the interpretive and thematic analyses in this chapter were the interview transcripts and the phenomenological descriptions

discussed in Chapter six. The themes resulted from a combination of reflection, textual dialogue, description and interpretation. They reflected the personal interpretive horizon and judgement of the researcher on their "fitting" to the phenomena (Gadamer, 1960/2003). The judgement did not attribute significance to a theme on the basis of data frequency alone. Rather, it was concerned with the significance of a theme to describe the essential meaning and structure of phenomena[64] (Colaizzi, 1978, Van Manen, 1997/2007).

Interpretation, using Van Manen's (1997/2007) approach to researching lived experience, required the researcher to be constantly engaged with the data. Engagement with the data in dialogue allowed the researcher to reveal and understand the essential structures of meaning contained within the text. Gadamer (1976/2004) suggested that interpretation "takes place whenever we "understand," especially when we see through prejudices…that hide reality" (p.32). The data are presented in this chapter as interpreted phenomenal essences derived from the researcher's dialogue with the transcripts through a process of reflective reading and re-reading. The dialogue continued until there was nothing more to be said (Van Manen, 1997/2007) and was "a circle closed by the dialectic of question and answer" (Gadamer, 1960/2003 p.389).

[64] Van Manen (1997/2007) identified that commonality and recurrence of ideas in data may give rise to themes. However, he noted that a single occurrence of a significant idea that is essential to the phenomenon under investigation is also a valid theme and can stand alone without further instances apparent in the data. Significant meaning, therefore, can be ascribed to a phenomenon based on its own truth claim as interpreted by the researcher engaged in dialogue with the text (Gadamer, 1976/2004).

Emergent themes interpreted

The next section revisits the fourteen emergent themes identified in Chapter six, and restated above in Table 7.1, and interprets their meaning in relation to the research question that drove this study. Common thematic threads identified within the interpretation of the emergent themes will be combined into essential themes in the section to follow. The essential themes will provide the foundation for a new model of spiritual care that will be presented in Chapter eight. The first emergent theme to be interpreted is the search for meaning.

Emergent theme one: search for meaning

Theme one identified a search for meaning as central to understanding spirituality. Peter was the only participant who directly addressed this theme. However, his views were supported by Jane, Colleen and Brian. Theme one related to Peter's view that spirituality concerned an individual's fit in the world.

> Peter: *Spirituality to me is more to do with the way people see themselves…how in touch they are with who they are…where they fit into the bigger picture, the role they play within that* (Peter, p.20).

Peter's view was reinforced by Koren and Papamiditriou (2013), in their study on the spirituality of staff nurses, where they identified spirituality as "the pursuit of meaning and purpose in life" (p.37). Spirituality from this perspective sought to establish a point of focus in which to direct one's energies. In the researcher's view Peter was explicitly expressing spirituality as a search for meaning in life. The search for meaning was supported by a developed sense of self, purpose and fit in the world.

In their study on religious and spiritual plurality in health care, Reimer-Kirkham et al (2012) noted that:

> for many patients and staff, their religiosity and spirituality provided a compass for how they confronted and negotiated the diverse and complex terrain of healthcare contexts (p.209).

Spirituality, therefore, sought religious or secular life meaning and provided the framework for living life in relationship to the world and others. *I think you can be a very spiritual person and not necessarily be a religious person* (Peter, p.20).

Brian followed on the notion of spirituality as meaning when he expressed the need for individuals to find their own spiritual path in life:

> Brian: *I believe that everybody has their own spiritual path they have to try and forge out and they decide whether they go off that path or not* (Brian, p.17).

Brian identified multiple pathways to find meaning in the spiritual life of a person and included the Eastern spiritual notion of karma alongside a non-religious belief in God. Karma in the Hindu and Buddhist religions implied that:

> every act has certain consequences…There is nothing that can break this connection…for the law of karma carries over into the next incarnation (Erickson, 1995 p.611).

Spiritual meaning for Brian encompassed a journey that had multiple departure points depending on the circumstances of the individual at various times in their life.

Each diversion from the spiritual path and each act and decision had life consequences. Therefore, the journey was a journey of choices that helped define who that individual was in relation to the world of which they were a part (Dyess, 2011).

Peter and Brian's statements revealed a breadth of understanding that could be applied to spirituality as a search for meaning, self and place in the world. Spirituality was seen as a personal pathway that focused the individual on their "fit" within the world in which they lived and engaged. The individual decided for themself the spiritual path upon which they walked. The "spiritual walk" could be religious or secular in nature but ultimately centred the individual on what was important to them in their lives.

The other participants (participants 1,3,4,6,7,8,9,10) did not directly address the search for meaning in their transcripts. However, they did infer multiple religious and secular pathways that situated the individual in relation to their lived world. Participants identified their personal spiritualities within either religious (participants 2,3,4,7,9,10) or secular frameworks (participants 1,5,6,8). All participants, however, subscribed to the view that regardless of whether their spiritual views aligned with those of their patients that the personal spiritual framework of the patient remained at the centre of their nursing care. Jane and Colleen provided good evidence of this view:

> Jane: *I can accept that other people will have their own belief systems…and…they need to be respected* (Jane, p.23).

> Colleen: *I really don't think that imposing personal views on a patient is the role of a nurse…the patient's needs and requirements are paramount* (Colleen, p.29).

Jane also reinforced Peter and Brian's arguments regarding the search for meaning as an essential spiritual theme. When asked at interview about the spiritual role of the nurse in helping patients find a sense of meaning in their lives Jane, Katie and Peter agreed that spiritual care was an important facet of the nursing role: a view that was also supported by Colleen, Bridget, Anna, Tracey and Kerry.

> Jane: *Yes…I think if we can do that as nurses we're actually doing a good job* (Jane, p.20).

> Katie: *It's* [spiritual care] *part of the nurses job , whether the nurse realizes it or not* (Katie, p.32).

> Peter: *The nature of our work is that we do deal with spirituality all the time* (Peter, p.21).

The search for meaning was an important facet of the views of the participants on spirituality. Spirituality provided a sense of purpose, self, fit and place in the world and the individual had a choice on which spiritual pathway they chose for their lives. Those pathways could be framed within religious or secular meanings and it was the role of the nurse to assist the patient to meet their spiritual needs. The spiritual needs of the patient superseded the spiritual views of the nurse and were to be respected. A sense of meaning was an essential quality of spirituality and gave rise to resilience in individuals coping with significant life events such as illness, injury or deployment.

Emergent theme two: resilience

Resilience was the second theme to emerge from the study that related to spirituality. The literature noted that resilience allowed people to develop coping against "stressors, adversity, change, or opportunity in a manner that results in the identification, fortification, and enrichment of protective factors" (Richardson, 2002 p.308). Richardson (2002) also alluded to the notion that resilience was enhanced by "spiritual sources of strength" (p.319). Indeed, resilience through spirituality was the foundation for coping for Jane, Anna, Kerry and Barbara and was described by Barbara as *armour to be able to manage things that are a bit outside of the norm for you* (Barbara, p.63).

Hodson (2002) suggested that resilience was a protective psychological factor:

> that will impact on the individual's ability to adapt to the traumatic stressor, by impacting on the individual's ability to deal with the distressing symptomatology (p.34).

Cayetano-Penman (2012) identified and acknowledged the psychological view of coping. However, she added the notion that a God dimension was a valid form of coping among her study participants in a palliative care environment. "In spiritual coping, God is the focal point in the changes made, action/s taken and relief of distress" (Cayetano-Penman, 2012 p.107). The researcher suggests that limiting spiritual coping to a focus on God, while valid for some individuals, is too restrictive an interpretation of spirituality in a world view context. *The older I get, the more I can differentiate between spirituality and God* (Peter, p.20). In this respect spiritual coping could be religiously or God based but also included those broader life factors

that brought meaning, purpose and fulfilment to the individual (Moberg, 1979; Ormsby and Harrington, 2003; Koren and Papamiditriou, 2013).

Jane, Anna, Kerry and Barbara also approached resilience from both personal and patient perspectives. An important distinction was made here that while patients had challenges to cope with created by injury and illness, nurses had their own challenges with which to cope. These challenges included separation from home, austere and often hostile working conditions, the prospect of injury, illness or death to themselves and exposure to large scale disaster or war related death, injury, suffering and destruction. Gibbons et al (2012) suggested that military health care providers suffered similar psychological trauma to military combatants. Accordingly, they noted that the:

> presence of a strong sense of meaning and purpose, within a supportive environment appear to help mediate the impact of these dangerous and stressful events (Gibbons et al, 2012 p.3).

The military nurse, therefore, assisted the patient to cope with their needs while facing challenges to their own resilience.

Barbara reinforced the view that patients needed a personal pattern of belief through which to build their resilience to life's challenges:

> Barbara: *I think if you don't have some set belief patterns that you are comfortable with. It doesn't necessarily give you the armour to be able to manage things that are a bit outside of the norm for you* (Barbara, p.63).

The extract below from Jane's transcript builds upon the assertions that Barbara made and alludes to resilience and coping strategies in both patient and participant populations. While phrased within a religious paradigm it still provided a framework that stressed that giving over problems to something beyond ourselves aided coping and therefore was a valid resiliency factor:

> Jane: *I feel really sorry for people who have no religion that helps them through difficult times and I think you can more easily talk to your God when things aren't so good* (Jane, p.20)…*I think my spiritual beliefs and my emotional integrity and my resilience probably got me through and that's why I'm still standing today…wiser and probably a little bit more burnt but probably stronger too from it…I think that is probably a lot to do with my beliefs* (Jane, p.25).

Anna talked directly of her spiritual needs when she was deployed to the Middle East. The stresses of deployment focussed Anna on her need to give over her problems to something beyond herself in the way that Jane remarked above. In Chapter five Anna identified herself as a generic Christian who had focussed her need for strength and reassurance on a Christian God, despite not having prayed previously. Puchalski (2001) supported Anna's notion of coping through spiritual strategies such as prayer. She suggested that:

> when people are challenged by something like a serious illness or loss, they frequently turn to spiritual values to help them cope with or understand their illness or loss (Puchalski, 2001 p.354).

A relationship with God provided Anna with comfort and helped her to cope with her situation:

> Anna: *I used to pray to God a lot when I was over in* [the Middle East]*…I haven't done that before. I used to talk to myself and actually before I went to sleep I used to thank Him for you know, for just keeping us safe, and that actually just comforted me…helped to cope* (Anna, p.27).

Kerry continued on the notion of prayer providing comfort and reassurance while deployed. She noted that prayer enabled her to cope with the situations that confronted her. Kerry also suggested that her beliefs were reinforced through prayer and that the situations that she faced invariably had good outcomes as a result of prayer:

> Kerry: *I find myself…going, "just say a prayer and forget about it, and deal with it when you get there", and invariably, everything works out alright, so…that's what I do* (Kerry, p.22)*…I think it gives a little bit of underlying comfort or reassurance* (Kerry, p.23).

Religion and non-religion based spirituality, enacted through prayer and strong models of belief in God, were strongly ascribed among the participants (Participants 2,3,4,5,7,9,10). Religion/faith based coping strategies appeared to be significant factors in building resilience against the challenges of the deployed military nursing setting. Prayer, spirituality and religion were cited by Chambers (2013), in a study of wives of deployed soldiers, as being significant "problem-focused coping strategies" (p.36). This view accorded with those of the participants cited above.

Resilience was a form of spiritual coping. The literature defined resilience as:

> response flexibility in the face of ever-changing situational demands, including the ability to recover from negative and stressful experiences and find positive meaning in seemingly adverse situations (Maguan et al, 2008 p.7).

Anna spoke about the Muslim patients that she had cared for and their trust and relationship with God. Simmons (2012) in a study on resilience in active duty soldiers noted that "those who were considered resilient described a healthy relationship with God, which they relied upon to get them through hard times" (p.38).

The notion of resilience through flexibility was supported by Peter who raised the prospect of resilience and coping changing and developing with each deployment:

> Peter: *I think every time you go into a different environment, you develop new coping mechanisms…you learn from previous experience, and there's always bits that you can pull from your previous experience to help with a current situation* (Peter, p.8).

Peter's view indicated that an individual may learn to cope better over time and with multiple exposures to deployment. However, this view did not hold true for all military personnel when rates of Post Traumatic Stress Disorder and other psychological trauma resulting from deployment were considered (Hodson, 2002). Tracey provided a good example of the difficulties some military personnel faced when she talked about feeling lost and without purpose after returning from deployment:

> Tracey: *You feel a bit lost…you've lost your sense of purpose as well, 'cause you sort of felt like you had a good sense of purpose in a place like that where you were doing something, although, I didn't feel like I achieved a lot really in the end* (Tracey, p.6).

The researcher suggests that multiple factors contributed to resilience beyond exposure, religion and spirituality. These factors included family support, peer support, resilience training and a sense of purpose to name but a few (Cohn and Pakenham, 2008; Maguen et al, 2008; Chambers, 2013). Tracey, Anna and Barbara alluded to peer support and debriefing as being critical factors in coping:

> Tracey: *Talking to your mates that you worked with…has been more useful to me than anything else, and they say the same thing* (Tracey, p.9).

> Anna: *We need regular debriefing to actually nurture ourselves…because sometimes you're just absolutely shagged both physically and mentally and if you don't have that time out…people going down the drain 'cause they're not recognizing in themselves that they need to debrief* (Anna, p.9).

> Barbara: *Important to debrief people after everything and we used to debrief people all the time…now we're told we shouldn't do that…but it seemed okay at the time…so I felt that given the circumstances, and nothing was ideal… if we could get people together and allow them to work through some of their things, that might help them* (Barbara, p.61).

Debriefing, whether formal or informal amongst peers, was clearly expounded by the participants as a way of coping with abnormal circumstances on deployment. Anna noted that it was often difficult for the nurse to recognise signs of stress in

themselves due to the extreme fatigue frequently associated with deployment. It was in these moments that peers often stepped in through debriefing to highlight and help the nurse deal with problems. Researching the wives of deployed soldiers Chambers (2013) supported the importance of social support networks in helping a person deal with confronting issues. While study by Chambers (2013) did not directly relate to the support for the deployed military personnel, it did have cross applicability between the populations. This view was affirmed by Agazio (2010) in her study on nursing practice challenges on humanitarian and wartime missions.

Anna provided a fascinating glimpse into the use of humour and flippancy as a way of coping with the stresses of deployment. She noted on one deployment that she became inured to the dangers that she faced each day. As a result she developed a skewed view of situations that would unnerve most people if confronted by them. Edward and Welch (2011) supported the use of humour as a resilience tool in mental health when they noted that "resilience qualities involve having hope, faith, having a sense of spirit, courage and optimism…at times, being the fool" (p.168). Humour was used as a way to make light of otherwise overwhelming situations.

> Anna: *There was* [a] *girl lying on one of the stretchers absolutely balling her eyes out and she had just like, 3 bandages on her fingers…so I'm like 'she's over the top balling her eyes out', and I was half way through my deployment and I said to the LCDR, I said 'Oh my God, what's wrong with her?'…'cause like she's sobbing and there's all these people around her and she said 'oh, she said a rocket came through one of the buildings on base and landed on her keyboard while she was typing on the computer (laughs) and didn't explode…and it actually made me realize that I'd been there too long…that I became so flippant…she just had 3 bandaged fingers, she wasn't blown to bits (laughs), but she'd had the*

> *most absolute shocking experience, you know a rocket coming through, landing on her keyboard and didn't explode* (Anna, p.25).

Resilience was an important factor for military nurses on deployment. It was aided by many factors, though the participants all noted that a personal spiritual belief system, whether religious or secular in nature, was pivotal to coping for themselves, their peers and their patients. Resilience was aided for some individuals who used each deployment experience as a growth opportunity. Professional and peer debriefing after traumatic events were major tools in building resilience among deployed military personnel, however humour and human relationships were equally important in maintaining a sense of self and perspective.

Emergent theme three: relationship

Relationship was the third theme to emerge from the data on the phenomena of spirituality but also related to spiritual care in a deployed military nursing context. In this study relationship included a connection to God, patients, family (as both conventional and military family constructs) and peers. Relationship was an essential spiritual trait that concerned the humanity of nursing through the development of trusting, open, accepting and giving interaction (Penman et al, 2013). The building of relationship was a pivotal step in the therapeutic environment and was alluded to by all the study participants. Of note, however, was that relationship was equally important to all of the participants in coping with their own spiritual needs when deployed away from their normal family support networks.

Spirituality was experienced in relationship and enacted in nursing care through human interaction within that relationship (Chung et al, 2007; Dyess, 2011). Relationship was an important facet of coping and was used by military nurses on deployment to help them build a connection with those in the caring relationship. According to Anna, developing a close caring relationship with one of her patients, a female insurgent, helped her to reconnect with her humanity and the reason she had deployed. That was, to care for the sick and injured irregardless of the circumstances or the setting. The relationship developed with her patient touched the spirits of both Anna and her patient.

> Anna: *She was pretty much the same age as me…and she was building a bomb and it actually blew when she was actually building it…she had significant injuries…so initially I wanted to look after her out of absolute fascination…when her face improved she was stunningly beautiful and I remember cutting her hair…I just wanted to look after because I thought 'wow, this girl's just like me'…and it actually made me think…what happens if I was a 26, 27 year old who was married and I had these beliefs would I actually be like that…at the same time I thought this woman's done the wrong thing…she was actually contributing to this conflict and…but then I thought well, that actually helped me to look after her, because I connected with her* (Anna, p.11).

Spiritual relationship can, therefore, be viewed as an extension of social relationships that can "provide both support and a sense of connectedness" (Williams and Sternthal, 2007 p.S48). The example provided by Anna may not have been typical of patient interactions and relationship through connection. What it did highlight, however, was that in the act of caring for someone, regardless of the circumstances, the nurse could make a spiritual connection with their patient. Anna provided care without judgement and was able to build a trusting and mutually beneficial

relationship with her patient. There was genuine humanity in her care and she was able to reconnect with her own humanity:

> Anna: *She was just so human to me… and it actually made me reconnect with the human side of nursing… she really sort of touched that human element in me and why we were actually there* (Anna, p.13).

Relationship, therefore, was built on trust and trust was a central feature of spirituality that "involves both giving and taking responsibility…and acknowledges the dangers…of life, yet affirms the individual's…coping with them" (Solomon, 2002 p.49). Peter talked about building trust with the people he supported on deployment, including peers and patients. Without trust, openness to the *other* and giving of oneself it was very difficult to establish a genuine therapeutic relationship to deal with issues of spirituality.

> Peter: *If you are perceived as someone that is trustworthy, who can listen, is willing to take time, and give of yourself, then you're more likely to be targeted with that sort of role informally* (Peter, p.23).

Relationship was also dependant on notions of acceptance and respect for the spiritual point of view of others (participants 2,3,4,6,7,10). Peter, Colleen, Anna and Barbara commented on the need for acceptance and respect in the relationship between nurse and patient. In expressing the need for acceptance and respect, the participants also raised the need for the nurse to not impose their own beliefs on their patients. Colleen summed up this view when she stated that:

> Colleen: *I really don't think that imposing personal views onto a patient is the role of a nurse in any situation…that the patient's needs and requirements are paramount* (Colleen, p.29).

The following extracts encapsulate the views of the participants on acceptance and respect.

> Anna: *There is a level of spirituality that you require in your nursing and you have to be accepting of what that patient requires* (Anna, p.29).

> Colleen: *I can accept that other people will have their own belief systems as well, and that yeah, they need to be respected* (Colleen, p.26).

> Barbara: *It's respecting the opportunity that people have to have this thought processes and their beliefs* (Barbara, p.37).

> Peter: *I'd been brought up, to respect people…to…that you don't impose yourself on them. That they can offer you far more than what you can offer them in terms of that cultural exchange* (Peter, p.17).

Based on the words of the participants above, the researcher suggests that the interaction between nurse and patient in relationship was one of mutual trust and benefit. In its spiritual context, relationship involved an essential connectedness to someone or something beyond the self. Spiritual relationship in the nurse-patient interaction needed openness, trust, acceptance and giving to the relationship. Relationship involved the development of a connection between the parties that aided coping and resilience in the individual. Finally, the nurse needed to focus their attention on the needs of the patient without imposing their own beliefs.

Emergent theme four: differential

The fourth spiritual theme to emerge from the data focussed on the apparent differences between expressed spiritualities. These differences were not viewed in this study as absolute points of departure, but rather as different gradations of the same hue. Peter emphasised this view when he discussed the similarities that he observed between Muslim and Christian beliefs. He stated that *it's affirming in a way that essentially, with a slightly different focus, they believe what I believe* (Peter, p.19). For Peter there were differences in approach between the world religions, but these were neither large nor insurmountable.

As discussed in Chapter six, differences in religious and spiritual outlook were viewed as cultural phenomena by some individuals. "The meanings attached to the word "spiritual" vary considerably from one context of use to another" (Moberg, 1979 p.2). There were a huge array of spiritual expressions and faiths. Each brought with it a sense of its own unique character but also elements that were either universal or at least shared by a number of spiritualities among the plethora of beliefs evident today. Solomon (2002) referred to spirituality as "ultimately social and global, a sense of ourselves identified with others and the world" (p.6). In this respect, spirituality among the participants (see Chapter five) was expressed initially from their own diversity of world views (e.g. Christian, Karma, humanistic/eclectic). However, spirituality was also expressed in relation to the diversity (all participants) found among the different world views of those that they had cared for when deployed on military operations (e.g. Muslim, Buddhist, indigenous, Christian, Hindu).

The following extracts emphasise the diversity of religious and spiritual expressions identified in the study and the impact these had on the spiritual caring provided by the participants.

> Peter: *From a religious perspective…I'm a Catholic, and very interesting learning more about Muslim faith, because there were so many parallels* (Peter, p.18).

> Jane: *I don't know whether it was his spiritual beliefs…but I'll (sic) forget how quickly they…get over things and they seem to have real trust…in God and what will be will be…they never complain about anything they just accept it and get on with it* (Jane, p.11).

> Colleen: *I tend to have a bit of a loose belief that there is a God and that different ways of believing and having that faith have been divided up and the fact that we've got Allah, and we've got God to the Jews, we've got God to the Christians, we've got Buddha, they are all fairly similar…belief systems…who's to say that it isn't just the one overruling being God, who's just been believed in differently by different cultures through the years* (Colleen, p.26).

Peter found his faith affirmed by the diversity of religious expressions that he experienced on deployment. He saw strong parallels between the main world religions demonstrated by his experience of Catholicism and caring for Muslim patients. Bourg (1979) supported the notion of diversity and collectivity[65] among religions. Learning about the faith of others opened the opportunity for understanding, respect and appropriate care for the individual. Importantly for Peter,

[65] Bourg (1979) alluded to the diversity of global religions. She then illustrated the collectivity, or common elements that link those religions, through a discussion on the diverse traditions of the Catholic Church. While Bourg did not explicitly link the collectivity to non-Christian religions the researcher implied this from his reading of the text.

spiritual maturity through time and engagement with other faiths brought into relief the differences between spirituality and religion. Religion was expressed in a large variety of organised practises and rituals but spirituality encompassed a considerably broader array of expressions and life philosophies that transcended the strictures of organised religion (Salmon et al, 2010; Dyess, 2011; Koren and Papamiditriou, 2013). *I think you can be a very spiritual person and not necessarily be a religious person* (Peter, p.20).

Jane experienced spirituality amongst a group of local civilians that she engaged with and cared for on one deployment. Like Peter, the experience was couched in religious terms, with a belief in God providing an anchor for acceptance of life and death. Spiritual care was made easier for Jane by understanding the spiritual beliefs of her patients:

> Jane: *Its always so much easier* [when dealing with patients facing death] *when they are religious or spiritual people because at least you felt that they were dying to go somewhere …but if they don't have any belief in a God or anything then its really hard to in a way be there with them because you've got nothing to say* (Jane, p.21).

Colleen maintained an eclectic view of spirituality that supported the notion of diversity in faith. In this respect, Colleen suggested that a God based system of belief was the common point of understanding among the world religions. However, the diversity of faith based spiritualities lay in the effect of the culture in which individuals were immersed. The researcher supports Colleen's view of culturally effected religious diversity but suggests a broader application in other spiritual

perspectives. A search for God in a religious context invoked a sense of relationship and a search for fit and meaning in life. In the broader understanding of spirituality, the individual sought a relationship with the world rather than God but still sought meaning and fit in their lives. This view was supported by Koren and Papamiditriou (2013) who noted that spirituality was:

> the pursuit of meaning and purpose in life and the shared interconnections with the world, with a Higher Power, and with other persons who share this world. It can also, but not always, be transcendence to another level of being (p.37).

Based on the transcripts, the researcher suggests that the diversity of spiritualities should be viewed as a series of variations on a theme. Whether religious or more broadly based, each type of spirituality contained as many points of commonality as it did points of difference. The diversity of spiritual expression was more often viewed in relation to cultural influences. Understanding these differences helped in caring for the spiritual needs of patients and identifying common spiritual characteristics was affirming to the belief systems of nurses. Spirituality, whether religious or humanistic, involved a relationship with a God, the world or something else beyond the self and revolved around a person's fit in that world and a search for meaning in life. Spiritual care integrated the mind, body and spirit into the holistic caring act.

Emergent theme five: integrated holistic care

In the context of this study, integrated care not only referred to the holistic aspects of mind, body and spirit in the caring act (Carson, 1989; O'Brien, 1999; Reimer-

Kirkham et al, 2012), but also to how the spirituality of the nurse pervaded their nursing practice. Spiritual care was viewed by the participants (Katie, Peter, Bridget, Tracey, Kerry, and Barbara) as an essential element of their holistic nursing practice as *we do deal with spirituality all the time* (Peter, p.21). However, what Peter and Tracey made apparent from the data was that spiritual care was often only realised upon reflection. *It's not something that I'm cognoscente of doing, I think it's something that just happens…they're issues that you certainly reflect on* (Peter, p.21-22). Spiritual care could be a deliberate part of holistic nursing care, but was more frequently, to the participants at least, an unconscious by-product of the caring act with the patient.

The following extracts provide evidence to support the theme of "integrated care".

> Katie: *As nurses, we're not just looking after the physical wellbeing, we're looking after a lot of things…their mental health...their spirituality…and…if you don't look after them, who will…provide that care for them* (Katie, p.9).

> Peter: *The nature of our training is that we are taught to look at the person as a whole and their environment, rather than disease processes… its probably not something you're conscious of* [spiritual care] *it is a by-product. …I think that is probably one of our key roles* (Peter, p.25).

> Barbara: *You need to look at the patient from that total holistic perspective* (Barbara, p.51).

Katie identified the significance of the mind, body, spirit inter-relationship in holistically caring for her patients. She also drew attention to the detrimental impact on the health of a patient if they were not cared for holistically:

> Katie: *It is the patient who in the end suffers…and misses out on you know whatever…at a better chance at life or a quicker recovery…if you can't provide that holistic care* (Katie, p.6).

Conversely, what Katie implied was that good holistic nursing care had a positive impact on patient outcomes in the act of caring. Williams and Sternthal (2007) supported the positive impact of spirituality on health when they concluded that "most studies had found a positive association between religion and physical and mental health" (p.S47). The other point that Katie raised was specific to the deployed military nursing environment. In this context Katie identified the importance of the nurse providing holistic care that included a spiritual component, as there might not be anyone else available or able to provide that level of care.

Peter indicated that the nurse was well placed to provide fully holistic care to their patients and this attitude was a by-product of nursing training. However, Peter went on to indicate the spiritual aspects of holistic care were often provided unconsciously as a natural extension of the holistic caring act. This perspective did not exclude conscious spiritual care from the armoury of the nurse, but suggested that in the unconscious act the nurse had fully integrated holistic care into their day to day practice. Swinton and Pattison (2010) reinforced the view that spiritual care was often subconscious in its attendance. However, they advocated raising spirituality into the holistic consciousness as a way of improving spiritual care to patients. Gadamer

(1976/2004) posited the possibility that consciousness was transcended when the conscious act "can barely be surmised and no longer spoken" (p.80). In this respect it could be inferred that in raising spirituality into the consciousness of the nurse, the nurse ultimately integrated spirituality into an ingrained unconscious holistic view of the patient.

Tracey, Kerry and Barbara supported the integrated care notions suggested above by Katie and Peter. The participants also all agreed with the researcher when spiritual care was presented as an often unconscious act that was only realised on reflection. The views of the participants aligned with notion by Gadamer (1976/2004) that "reflection…brings before me something that otherwise happens behind my back" (p.38). Spiritual care, therefore, was integrated holistic care that was realised in both conscious and unconscious caring acts. What was also inferred from the transcripts was that integrated holistic care encompassing the spiritual needs of the patient was important to the nursing role. Anna supported this idea when she stated that spirituality was *an integral role* (Anna, p.31).

Emergent theme six: facilitator and collaborator

The next theme to emerge from the data centred on the notion that nurses were primary providers of spiritual care to their patients. This notion carries through into the next three themes, which also focus on the delivery of spiritual care. In providing spiritual care the nurse often became a facilitator by assisting the patient to meet their spiritual needs, as well as a collaborator in working with others to aid this process of care. Brian described the nurse as *just a conduit* (Brian, p.27) to facilitate spiritual care. Reimer-Kirkham et al (2012) identified the facilitative aspects of care when

they noted “how caregivers facilitate sacred spaces (p.206). Peter referred to the *cross pollination between the nurse and the chaplain* (Peter, p.22) in the collaborative caring environment on deployment. This view was supported by Koren and Papamiditriou (2013) who stated that “chaplains become a part of the health care team and thereby promote more collaboration between nurses and chaplains” (p.43).

Eight of the participants (participants 1,2,3,4,6,7,8,9) referred directly to the importance of the role of the nurse in providing spiritual care. Peter intimated that the nurse supported the spiritual needs of patients by facilitating appropriate care to meet those needs. The other seven participants agreed with Peter’s assertion, with Tracey noting it was important for the nurse to accommodate the spiritual needs of the patient where possible. *We would always try and provide some sort of spiritual support* (Tracey, p.18). Facilitation, therefore, involved direct spiritual assistance but more importantly involved the nurse assisting patient access to chaplains, religious or spiritual leaders, friends, peers and family as appropriate and available in the deployed operational nursing setting. Bridget touched on the point of access when she stated:

> Bridget: *Its very hard in a setting on an operation when you can’t really get the family involved because there’s no family there…so you do the best that you can and often its either yourself treating them but you’re treating them as the nurse or you find who are their friends* (Bridget, p.18).

The point that Bridget made was very relevant to the care of injured and ill military personnel on deployment. It was in this context that the extended military family

(Simmons, 2012), including unit members or the military nurse, took on the role of carer and support for the spiritual needs of individuals within the military. A point that both Jane and Peter affirmed and which was well illustrated in Jane's words that *they're happy to have you as pastoral care, sit with them and be present and help them through whatever journey they're going through* (Jane, p.22).

Military nurses had more opportunities to facilitate spiritual care for the civilian patients that they cared for on deployment than they did military patients. Brian spoke of one deployment in which the predominant culture of the civilian patients dictated that much of the care of the patient, including spiritual care, was attended to by the family of the patient:

> Brian: *In a way that had their beliefs in who should take care of who…we were foreigners but we were caregivers, but they still would not let us have anything to do with their family... that was their role, that was their belief* (Brian, p.22).

However, Bridget identified that in some deployed settings it was difficult to involve the family in patient care, but this was facilitated when ever possible. *It's very hard in a setting on an operation when you can't really get the family involved because there's no family there* (Bridget, p.18). Anna continued Bridget's line of thought by highlighting the important clues that the nurse could gain about the spiritual needs of their patients from interactions with the family when available. She noted that the nurse could use the family of a patient to gauge their care *because how you are actually approaching that patient, and seeing how the family responds to them and attending to their needs as well* (Bridget, p.30). In this way, the nurse was not only

facilitating the presence of the family but also collaborating with the family in meeting the need of the patient for spiritual care. To facilitate and/or collaborate in spiritual care the nurse had to respect the needs and beliefs of the patient and remain open to those spiritual needs. Openness to the *other* required an attitude that did not judge, despite potential differences in spiritual expression between nurse and patient, and accepted and supported the specific needs of the patient.

Emergent theme seven: non-judgemental care

Non-judgemental care was the next theme to emerge from dialogue and engagement with the participant transcripts. Trust was more easily built on a foundation of acceptance of the spiritual views of others than in imposing the views of the nurse on the patient (Reimer-Kirkham et al, 2012). Casarez and Engebretsen (2012) noted that "health professionals should be supportive resources for patients through establishing trust…and being neutral and sensitive toward spiritual issues" (p.2103). Non-judgmental care recognised that the nurse and their patient could have very different spiritual views, however, acknowledged that in the respectful caring act the views of the patient were paramount (Timmins and McSherry, 2012). Therefore, the nurse was not in a position to judge the needs of the patient but to support them as best they could within the constraints of the health care setting.

Peter identified the need for the nurse to *respect people…don't impose yourself on them* (Peter, p.17) when discussing his experiences of deploying into predominantly Muslim cultures. This view was shared by Colleen and was supported by Reimer-Kirkham et al (2012) when they wrote about providing sacred spaces for patients to be able to practice their religious or spiritual rituals. Colleen went on to note:

> Colleen: *It impacts on how you look after somebody, having an appreciation for why they do something and why they need to do something and just doing it, or respecting it, doing it, leave and get on with whatever they have to do, it's just a part of looking after that patient* (Colleen, p.28).

Colleen focused on the nurse seeking to understand the spiritual framework of the patient in order to better meet those needs. In her view, respecting the spiritual needs of the patient was a professional obligation on the nurse. Anna supported Colleen when discussing the spiritual needs of her patients from a religious perspective. She stated that *you need to respect their religion, because there are specific things that you need to respect* (Anna, p.30). Anna was referring to the rituals that needed to be observed in many religions. However, by extension the researcher suggests that the nurse needed to remain mindful of supporting whatever spiritual ritual, practice or need in which the patient found meaning.

Spiritual care, as implicitly or explicitly expressed by all the participants, was about meeting the needs of the patient at whatever point in their spiritual quest they were, and in a way that was meaningful to them. Jane expressed this view quite clearly when she noted that the nurse needed to help the patient *through whatever journey they're going through* (Jane, p.11). Jane did not judge the needs of her patients but accepted, respected and supported those needs in whatever way she could. She advocated sitting with the patient and listening to their needs. In the "present act", *just being there* (Katie, p.33) as Katie referred to it, the nurse was able to grasp the spiritual meaning that their patient attached to their situation in life at the time of the

nurse-patient encounter. In this way the nurse was able to touch the spirit of their patient in an open, trustful and genuine manner.

Emergent theme eight: touching the spirit

The eighth theme to emerge from the data referred to the way that the nurse had the ability to touch the spirit of a patient in the caring act. By touching the spirit of the patient, the nurse was able to build a trusting relationship in which spiritual needs could be met in a meaningful and directed manner. Carron and Cumbie (2011) reinforced this view when they exhorted nurse practitioners "to reach out from their spiritual base and touch the spiritual base of others" (p.554). This statement supported the notion that there was a convergence of spirits in the holistic caring act[66].

Katie questioned how she would feel if she was *in that person's shoes* (Katie, p.28) to guide spiritual care in an empathetic way. Empathy was noted as a key attribute of spiritual care that allowed the nurse to better understand the spiritual needs of their patient (Meehan, 2012). Kerry reinforced Katie's view of the importance of empathy when she noted that she felt *quite empathetic to patients* (Kerry, p.24). From Katie and Kerry's perspectives the empathetic attitude enabled the nurse to "touch the spiritual base of others" (Carron and Cumbie, 2011 p.55).

[66] The convergence of spirits can also be referred back to Gadamer (1976/2004) as the fusion of horizons between the nurse and the patient, or whoever the subject of the caring act, was directed through a genuine dialogue that sought meaning in interaction.

It is the view of the researcher that the nurse could touch the spirit of their patients in a variety of other ways that varied between individuals. An empathetic attitude was supported as an important factor in spiritual care by Katie, Kerry and Barbara. However, empathy was a pathway to more direct spiritual caring practices that included prayer, listening, talking, touch, presence, acceptance and giving of oneself to the spiritual caring interaction. The participants subscribed heavily to the active caring practices listed above with six (Katie, Peter, Jane, Bridget, Anna and Kerry) of the nurses directly referring to several or all of the practices.

The extracts below support the theme relating either directly or indirectly touching the spirit:

> Katie: *I like to think that if I can make a difference to that person by…sitting and listening to them for 5minutes longer or…making them a bit more comfortable in the bed or just talking to them…that I might help them a little bit more* (Katie, p.29)…*you have to be able to listen to people, and empathise with people* (Katie, p.37).

> Peter: *If you are perceived as someone that is trustworthy, who can listen, is willing to take time, and give of yourself, then you're more likely to be targeted with that sort of role* (Peter, p.23).

> Jane: *They're happy to have you as pastoral care* [with the chaplains], *sit with them and be present and help them through whatever journey they're going through* (Jane, p.22).

In a religious spiritual context, prayer was still recognised as an important spiritual caring tool (Sessanna et al, 2011). Brian alluded to prayer as a spiritual support tool

for his patients. Peter spoke about the importance of prayer for some patients and the obligation on the nurse to support those needs. Jane, Colleen, Brian, Anna, Kerry referred to prayer as a spiritual caring tool for their own needs when on deployment. Colleen supported the notion of prayer as an ongoing part of the faith that helped her cope with the challenges of life and deployment. Anna on the other hand found prayer a comfort on deployment but noted that she *used to pray to God a lot when I was over in* [the Middle East]…*I haven't done that before* (Anna, p.27). For Anna, prayer became a spiritual support against the dangers that she faced on deployment despite not having used prayer in the past. Wester (2009) supported Anna's experience when he cited a study by Pomeroy (1946) that indicated that a large percentage of soldiers prayed more following their experience of war than before they went to war.

The participants (Katie, Peter, Jane, Bridget and Anna) supported the spiritual work of the nurse on deployment as a discrete but complementary role to that of the military chaplain. In the deployed environment, therefore, spiritual care became a collaborative effort to meet the needs of patients. However, spiritual care was not only provided to patients, it was extended to self, peers and even to the chaplains in an often symbiotic relationship.

Emergent theme nine: symbiosis

The ninth theme described the symbiotic relationship developed between the nurse and the chaplain in the deployed environment. Symbiosis also extended to the spiritual care found in the local communities into which military nurses deployed and to their direct peer supports. Peter raised the idea that the nurse could provide support to the chaplain when he noted that when he was deployed with a chaplain that *I think*

I became his sounding board, because obviously they get a lot of shit piled on them, and they need some sort of relieve valve (Peter, p.22). In Peter's view, the chaplain was in the same situation as the other military personnel on deployment. They all shared the deployment experience, the dangers, and the separation from home and normal support networks. The chaplains, as spiritual carers, often did not have a chaplaincy peer in whom to confide or deal with their own issues. The nurse was well positioned to take on a spiritual caring role in this situation by listening and supporting the chaplain in much the same way that the chaplain helped them.
Jane talked about the support that she and her military peers received from the chaplains while deployed to the South Pacific while still supporting Peter's notion of care for the chaplain by nurses. For Jane spiritual care was not necessarily overt but revolved around issues of importance for her when dealing with the stresses of deployment:

> Jane: *The chaplains that we were sharing our time with…were really good because they'd often be there to…see how you felt, and I think some of the memories of just sitting there at sunset just talking about anything, sometimes it was about God, sometimes it was about how you felt, sometimes it was about how they felt…was really interesting because there wasn't always the people who shared their religion or whatever* (Jane, p.6).

Jane and Peter both alluded to the symbiotic relationship of the caring professions on deployment. The chaplain was seen as a religious guide but the spiritual support of the chaplain extended beyond denominational religion. The nurse provided spiritual care in a less overt manner than the chaplain, but in the view of the researcher the role that each played in the spiritual support of deployed military personnel was equally

important. The support that the chaplain and the nurse provided to each other was related to the third spirituality theme in which relationship provided the foundation for spiritual caring. Peter talked about the amount of spiritual support provided as dependent on the maturity and the receptiveness of the individuals involved in the relationship. In this regard, a symbiotic relationship required trust, openness and respect for the individuals.

> Peter: *The roles themselves come down to, I think, the personalities. You can have someone whose role it is to foster the emotional wellbeing of people, but if they're a dickhead, no one's going to talk to them* (Peter, p.22).

Anna supported the notion that spirituality was about human interaction and therefore could support both the patient and the nurse in the deployed nursing environment. She noted that *they've touched me as well, that's right…'cause it's human interaction* (Anna, p.31). She continued by highlighting what she viewed as the important role that the nurse and chaplain had in working together for the benefit of the patient. In her view, the role of the nurse, in concert with the Chaplains, was to *nurture our soldiers and to give them that strength to do what they do every day…and it's great having that role* (Anna, p.31).

Kerry related a story of being provided with spiritual support from the local community into which she had deployed in the South Pacific. She attended local Christian church services and noted that *a lot of the locals came along and they…they were very, very compassionate towards us* (Kerry, p.13). While she experienced spiritual caring in the Christian context she was also exposed to the Indigenous

beliefs that provided her with a different spiritual perspective on life. Following the death of a soldier in a lagoon she found great spiritual comfort from the words of a local "witch doctor":

> Kerry: *This lady came up to me and then she started...talking to me…and she started delivering all this sort of deep and meaningful, spiritual sort of wisdom…it was stuff about… the spirits…they've left his body…she just sort of picked me up and started saying all these things…every day I come home and take my shoes off, and I feel the earth under my feet, and the whole thing just was so moving to me* (Kerry, p.14).

Kerry found spiritual comfort in the everyday act of living and took stock of her life and surroundings while deployed. Spiritual care on deployment, therefore, developed from the symbiosis of relationships between carers and patients, carers and carers, carers and local communities and peers. Importantly, spiritual care was directed back to the military nurse on deployment. This point will be further explored in Chapter eight. However, the nurse also encountered a number of barriers to providing spiritual care in the deployed military nursing environment.

Emergent theme ten: barriers

Casarez and Engebretson (2012) in a paper on the ethics of providing spiritual care in health care practice noted that there were several barriers that existed for health care providers in incorporating spiritual care into their practice. They suggested that barriers to spiritual care existed due to differing belief systems, the importance ascribed to spiritual care in practice, a lack of training and ability to provide spiritual care, spiritual care not being part of the job, a lack of time, space or priority, and the reluctance of patients to talk about their spiritual needs (Casarez and Engerbretson,

2012). The findings of this paper supported the applicability of most of the barriers presented above to the context of deployed military nursing practice. However, the participants also partially refuted some of the barriers identified by Casarez and Engeretson (2012) by suggesting that barriers to spiritual care were not fixed and immovable objects. *We always just did everything for them as much as we could* (Bridget, p.19). Kerry noted that:

> Kerry: *you've got a lot of people who…need more…holistic care, or they need to just sit down and talk to the nurse, and the nurse just hasn't got time* (Kerry, p.26).

This view of time being a barrier to spiritual care was supported by Katie and Bridget. Bridget, however, noted that while providing spiritual care was never a burden in a busy operational nursing setting, time was often at a premium and therefore *it was a strain on us…because we'd like to spend more time with them but it was hard* (Bridget, p.19). In the broader nursing care context on deployment, Bridget summarised her desire to holistically treat all patients to the best of her ability within the constraints that the operational setting imposed:

> Bridget: *It doesn't matter where you are in the country in the world…a patient is a patient…you know if that was your mother lying there or you lying there you would still expect the highest possible care for them…and it was particularly hard when…there was such a mass amount* [of casualties]*…you just did the best you could and you didn't have time to be sad* (Bridget, p.17).

Time and operational priorities were seen as situational barriers to spiritual care provision in the examples provided above. The participants also noted that the

medical evacuation system removed military patients from the area of operations within 12 to 72 hours (Stephenson, 2008). Early evacuation of severely wounded patients minimised the opportunities for the military nurse to provide comprehensive spiritual care for their patients. However, while the participants identified that the evacuation system decreased opportunities to explore spiritual needs in military patients, they did note that they had more extensive time to deal with spiritual issues with civilian casualties in their care. The civilian patients tended to remain with the deployed military hospital for longer and often until they were fit enough to be discharged, transferred to local health facilities or transferred to detention centres, in the case of detainees.

Caring for the needs of civilian patients also presented a number of barriers to spiritual care on deployed operations. Katie noted that language and security were potential barriers to spiritual care when she stated:

> Katie: *The language barrier and having two guards standing at the foot of the bed, that kind of discouraged any, rapport that you had built with the patient* (Katie, p.30).

The participants indicated that they were able to overcome language barriers through the use of interpreters (Peter, Anna, Kerry and Barbara). However, what Katie also raised was the issue of caring for detainees who were sensorially deprived. Katie indicated that often the only way to connect spiritually with detainees was to squeeze their hand or talk to them in a soothing voice *so they didn't feel so threatened* (Katie, p.30). Bridget, Anna and Tracey all supported Katie's view on the treatment of detainees and stated that they treated all their patients the same regardless of their

status as either friendly or enemy forces. Katie summarised how she and the other Australian nurses cared for the detainees:

> Katie: *I over compensated…what I observed, was that the Australians would really make an effort when they did have…prisoners to look after…they would go the extra mile…these patients can't do anything for themselves. They can't move…see…speak the language that we speak and…even to go to the toilet…they're absolutely, completely dependent on you to provide their care* (Katie, p.19-20).

Colleen, Anna, Peter and Barbara all expressed a belief that working with different cultures on deployment had its challenges. However, all agreed that learning to understand other religious and spiritual perspectives was affirming for the nurse and was overcome as a barrier by *being accepting of what that patient requires* (Anna, p.29). The last barrier noted was the lack of nursing training for the nurse in dealing with issues of spirituality in patients. Only two of the participants (Katie and Jane) indicated that they did not have any formal training in dealing with spiritual issues, though Jane was of the opinion that nurses *have that innate ability* (Jane, p.23) to provide spiritual care. Peter disagreed with Katie and Jane and noted that *the nature of our training is that we are taught to look at the person as a whole and their environment, rather than disease processes* (Peter, p.25). The researcher inferred care for the spiritual as a normal part of holistic nursing care.

The participants identified a number of barriers to spiritual care but noted that the barriers were not insurmountable, even in detainee patients on deployment. Operational priorities, time, language, culture, lack of training and detainees were all viewed as potential rather than real barriers for the participants in this research.

Emergent theme eleven: mismatch

A famous Prussian general of the First World War, Helmuth Von Moltke, is often quoted in military fora for suggesting that a plan will only survive until the first contact with the enemy (Moltke, 1871). Theme eleven related to Von Moltke's (1871) assertion above by identifying the expectation-reality mismatch that often occurred upon deployment into an area of operations. What a military nurse trained for in peace did not always match the reality of the operational situation into which they deployed. In this respect the military nurse needed to be flexible to the ever changing operating environment of military deployment.

Bridget and Barbara indicated that *every deployment is very different* (Bridget, p.4) and therefore came with different expectations and operational realities. Some deployments were relatively benign in their direct risk and the type of work that the nurse undertook. However, what the nurse experienced in the cultural, political and geographic landscape could be very different to what they expected prior to entering the deployed environment. This view was supported by Agazio (2010), who in a study of Army nursing practice challenges noted that "the level of injuries and intensity of the daily pace required a stamina and mental preparation not expected at the time of deployment" (p.173).

Brian alluded to the reality and challenges of deployment when he spoke of his experiences going into a deployed location in Africa:

> Brian: *It's daunting the fact that you always expect the worse when you go on a deployment…but you hope that you are not going to be confronted by the worst* (Brian, p.7). *Getting there was a complete shock,*

> *an eye opener, I'd never been involved in any sort of trauma to the degree…that I was exposed to* (Brian, p.8). *You were hit with the reality of it…there were vehicles on the side of the road that were bombed out. The villagers were walking by, some with amputations obviously from…bomb blasts* (Brian, p.9).

For Brian, the expectation of the deployment was challenging, but the reality was very sobering and extended him beyond anything that he had previously experienced. Anna, on the other hand, when deployed to the Middle East experienced something in her patients that was very foreign to her thinking. She was shocked by the bravado and excitement displayed by many of her military patients from coalition forces who had returned injured from major battles:

> Anna: *These guys were laughing…and flashing their gunshot wounds…they didn't want us to give them sympathy…they wanted to tell us their triumphs* (Anna, p.6)…*It shocked me at first but…part of my nursing is…to listen to them and support them, so if they want to talk to me about…how many people they've killed, I can't just turn around and say 'ah, that's disgusting'* (Anna, p.7).

Anna spoke about the need for spiritual care of deployed soldiers and the need to also care for the spiritual needs of non military patients. What she found challenging, however, was that the soldiers wanted to tell the story of the battle they had just been involved in. It took Anna some time to come to terms with this need for some patients to "boast" and vent about their conquests. What she did relay in her interview was that *there's some things I couldn't really relate to…but most of the time I just tried to accept what they actually needed…it's being open to that I think* (Anna, p.29). To Anna, care was about what the patient wanted and not what the

nurse expected the patient wanted, a situation that could create an expectation-reality mismatch for some people.

Barbara took a different direction in discussing the expectation-reality mismatch when she identified a paucity of information that preceded deployment. In her view it was difficult for the nurse to develop a realistic expectation of the deployed environment when scant information was available about the circumstances to be confronted. A lack of knowledge set up unrealistic expectations, however, as knowledge of the operational setting improved so did the situational awareness of what the nurse might expect to be confronted with on deployment. In the researcher's opinion knowledge did not necessarily negate the expectation-reality mismatch but may have reduced it.

> Barbara: *None of us had any idea of what was ahead of us…we knew we were going somewhere…and I guess most of us didn't even know where […] was until we were told we were going there and had to look it up on the map…and then we were eager to find out lots about it* (Barbara, p.41).

Tracey presented a slightly different view again when she spoke of the surreality of the deployment as it challenged the sense of what was normal and expected:

> Tracey: *It seems a bit surreal to start off with, and then after you've been there a while, you sort of just get used to it, and it becomes the normal environment that you live in, and then once you've left again, its surreal again, because you sort of miss that level of noise and whatever you were doing* (Tracey, p.5).

For Tracey reality was not fixed but rather changed with the challenges the nurse was confronted with. Over time what was abnormal in one environment was gradually accepted as the norm in another environment and context. What Tracey did note was that once the nurse returned to the environment that they were in prior to deployment that it seemed foreign and surreal, but was also eventually normalised. However, Tracey and four other participants (Brian, Bridget, Kerry and Barbara) indicated that despite the normalisation of environment, the nurse was fundamentally changed by the deployment experience as their horizons of understanding were challenged (Gadamer, 1976/2004). In this respect, the nurse often carried scars with them out of deployment and for some these were permanent.

Emergent theme twelve: scars

It was well documented (Hodson 2003; DVA 2005; Maguan et al 2008; Gibbons et al, 2012) that many military personnel suffered from long term physical and psychological trauma as a result of their experiences on deployment. Gibbons et al (2012) raised the notion that these same effects had not been studied in military health providers. They noted that while resiliency factors may be higher in health care providers there was still significant risk of Post Traumatic Stress Disorder in this population. The findings in this study supported the results of Gibbons et al (2012) that indicated that military nurses who had deployed did not come back the same as when they left. Indeed 50 percent of participants directly commented on the enduring personal cost of deployment.

Psychological dangers of deployment - The psychological scars of deployment result from a number of factors. The dangers evident in the deployed environment

were significant contributors to the scars of deployment. However, other factors also came into play such as the sight of death, dying and destruction (Gibbons et al, 2012), feelings of helplessness in not being able to change the circumstances of those that the nurse was deployed to help (Maguan et al, 2008), personal resilience (Wester, 2009) and going into the deployed environment with unrealistic expectations of what could or could not be achieved over the course of the mission (Simmons, 2012).

Peter alluded to the need to remain realistic about what the nurse could achieve on deployment despite its inherent frustrations.

> Peter: *I knew the limitations we were working within…you do your best within those constraints and…if you beat yourself up because you are working in those constraints it's not productive…there's no point…in trying to do things that are unrealistic and are outside your boundaries of experience* (Peter, p.27).

Peter's view was that trying to over achieve against the constraints of deployment was counter productive to the sense of perspective of the nurse. Tracey appeared to find herself in this position when deployed to the Middle East when she noted that despite the effort she put into caring for patients, she never felt like she had achieved much. Tracey said *it's a bit disheartening that you are working so hard and not achieving a lot* (Tracey, p.11). For Tracey, the deployment was personally challenging and negatively impacted her resilience. During the interview it was evident to the researcher that Tracey still had unresolved issues from the deployment.

Bridget noted that deployment fundamentally changed a person due to the experiences encountered. She related this effect to her own experience when she stated:

> Bridget: *I've always said that whenever you go away you never come back the same…there is some part of you that gets left behind and it changes you in some way…it's changed me…when I first went away…I was just a kid and I grew up very fast after seeing what I saw…and it made me very independent, very strong…sometimes maybe too strong and you have to learn to survive when you are on your own overseas* (Bridget, p.13-14).

Bridget viewed the changes evident from deployment as generally positive in building her character and resilience. Indeed Bridget remarked that deployment made her appreciate the fragility of life and the need to enjoy the life that you had. *You appreciate what you have here but life can be taken away so, so quickly and that I think you should smell the roses* (Bridget, p.14). The researcher suggests that the experiences that overwhelm one person may provide a platform for positive growth in another. However, while a positive attitude to deployment and a strong system of beliefs were seen as protective factors against Post Traumatic Stress Disorder and other adverse outcomes (Gibbons et al, 2012) they did not completely inoculate people from these types of psychological manifestations presenting even decades after a deployment. O'Brien (2004) identified that around 15 percent of Australian Vietnam veterans were affected by Post Traumatic Stress Disorder with a further 15 percent having some of the associated symptoms and Hodson (2002) referred to the often delayed onset of the condition.

Physical dangers of deployment - Beyond the psychological trauma that might occur to a military nurse on deployment was the very real risk of illness, physical injury or death. Military deployments were inherently dangerous situations whether from disease, direct offensive attack, indirect attacks (e.g. mortar and rocket fire), aircraft crashes, land mine and improvised explosive devices, gun fire, machete attacks or any other of the multiple modes of combat threats. The participants were unanimous in stating the dangers that military nurses faced on deployment. Peter summed up the views of the other participants when he exclaimed that *shit, we're in a dangerous job here* (Peter, p.16). The researcher suggests that while nurses recognised the dangers of their deployed roles they were prepared to accept the risk as a normal part of their employment. Despite having lost friends (a medical officer, a nursing officer and a medical assistant) in a helicopter crash on one deployment Peter noted that if asked to go on the next mission in a helicopter would not hesitate to accept the mission as *those are the risks that we're prepared to take to do what we do* (Peter, p.17). Military nurses on deployment could therefore be viewed as mission focussed.

Katie noted that when she returned home from deployment that she was pleased that she was *not getting mortared every day* (Katie, p.17). Brian identified the risk of land mines when he stated that *unless I knew for sure that there was nothing underneath the ground…I didn't walk there* (Brian, p.10). The researcher experienced the enduring effects that living with constant physical threat had on nurses in his journal. Readjustment to normal life, as discussed above, away from the deployment can be affected by unconscious habits. The researcher, for example, unconsciously avoided walking on dirt and grass for two to three months after returning to Australia from

Africa because of the constant threat of land mines on that deployment. The physical risks of deployment were real and they often went together with psychological trauma. Only individuals who had experienced the challenges of deployment really understood what confronted a military nurse on deployment. It was from within a community of military personnel with shared experiences that the military nurse found comfort and support while on deployment.

Emergent theme thirteen: camaraderie and family

Camaraderie - Seven of the participants (participants 2,3,4,5,6,7,10) identified camaraderie as an important facet of the military community on deployment. Camaraderie referred to the "intimacy, mutual trust, & sociability, of comrades" (Oxford, 1975 p.171). In the context of this study, camaraderie was a mutual trust developed between comrades in the profession of arms (the military) especially while on deployment. Camaraderie was developed through the shared sense of purpose and shared experiences that occurred on military operations. While military nurses were considered non-combatants under the Geneva Conventions (ICRC, 2014) they did work alongside military combatants though did not engage in hostile actions or patrol with offensive forces. Therefore, the researcher suggests that the participants understood the nature of the duties, hardships and risks that military combatants were exposed to and had an immediate connection with their military patients. Peter referred to the connection when he stated:

> Peter: *I guess there are things that you have in common which automatically gives you some sort of…a bond or a commonality that…you tend to….it's like a familiarity without even knowing people* (Peter, p.13).

The sense of camaraderie also extended beyond the clinical boundary and the link between the military nurse with their patients. Katie alluded to the camaraderie that was evident between the military nurse and their peers when speaking about deployment. *When you're in those situations, you share a lot about your personal lives, and so you kind of develop a bond even if you don't…not aware of it* (Katie, p.26). In Katie's view, military nurses developed camaraderie within the deployed community by developing bonds of friendship through the sharing of personal details about their lives. The researcher suggests that in sharing about their personal lives, the participants felt a connection to the deployed community. Camaraderie, then, extended to military patients, other health professionals and the non-health peers that the nurse deployed with and became a barometer of the cohesiveness of the community. In some situations, however, opportunities existed for the nurse to connect with local communities in deployed locations.

Local community – Jane referred to the support provided to her and her military peers by the local community on one peace monitoring mission to which she had deployed. *They don't have much but they have so much…the way they shared with us, their honesty and their love and there was just something beautiful* (Jane, p.10). Jane then spoke about the uplifting support she received from the local church community that directly impacted her spiritually while on deployment:

> Jane: *It really did lift you, lifted you to heaven and some of the people that you'd cared for would be there and…it was just beautiful, they entered into such a community together…it gave you a real feeling like you were a part of the place as well…you cared for them in health but they were also caring for us in a spiritual way* (Jane, p.17).

Kerry experienced a similar sense of community and the support that it provided her. She noted that following the death of one of the deployed military personnel that *at the service, a lot of the locals came along and they…they were very, very compassionate towards us* (Kerry, p.13). The researcher suggests that despite only two of the participants directly speaking about the support they received from the local communities on deployment, that when it was appropriate to interact that the community, that it could be a great source of spiritual support. It is important to note that most of the participants did not deploy into environments that facilitated easy interaction with local communities and this was reflected in the small number of participants that directly addressed this issue (participants 2,3,9,10).

Community provided an environment that was conducive to spiritual care in the deployed context whether directed to patients, peers or to the military nurse and was supported by the camaraderie of the deployed group. However, while community provided support to military personnel, including nurses, it was within the closer relationships developed in family that most effectively supported spiritual need.

Traditional family - In the sociological sense, family tends to denote "a social group of two or more people related by blood, marriage, or adoption who live together. Family life tends to be cooperative" (Macionis, 1989 p.370). While the notion of a traditional family had changed over time it nevertheless remained pivotal to the spiritual support network of individuals. The traditional family concept provided the basic family structure that was referred to by the participants who spoke of parental and sibling relationships within the deployed environment. The family that was left behind when the military nurse deployed remained important to all of the

participants. Five of the participants (participants 1,2,4,6,7) referred directly to the impact that deployment had on the families of military members that remained at home.

Katie further alluded to the impact of deployment on the military personnel. When military nurses were separated from family some people *missed their family, but they were getting on with their job and stuff, and then there were people who were almost acopic they were missing their family so much* (Katie, p.23). While advances in communication technologies had improved, the ability for military nurses to remain in contact with their family at home remained limited. Military patients were further disadvantaged because a lack of access to their families at home could further exacerbate the feelings of isolation that were an inherent part of deployment. It was on these occasions that the military family became an important part of the care and support of a military member while deployed.

Military family – A concept of a military family that existed outside the traditional family was an essential element to understanding family for military nurses. Eight participants spoke directly to the concept of a military family and the remaining participants agreed to its importance to military nursing on deployment.

> Jane: *I think you're more in a family with Defence and I think that probably makes it stronger with a relationship because you're like a family and you can share the experiences of what's happened to you on the Defence deployment* (Jane, p.15)

Ormsby (2001) identified the *de facto* family dynamic that developed in the military in response to separation from home. The military family, developed through a sense of belonging to a community with shared experiences and expectations, did not replace the traditional family, but adopted some of the supporting functions that were normally provided for within the family unit. The support provided, extended to the delivery of spiritual support. However, when a member was displaced from their military unit due to injury or illness the military nurse entered into relationship with the member to support their spiritual needs. Jane suggested that the military nurse *can do a lot to support the family…you get to know people a lot better in this sort of Army lifestyle* (Jane, p.3). In this way the military nurse adopted a conscious caring role to the military personnel with whom they interacted, whether patients or peers.

The participants in this study led the researcher to further develop the concept and understanding of the military family. The concept of a military family was no longer limited to a generic group understanding. The discussion, following the lead of the participants, now centred on the structure of the military family. Indeed, the participants suggested that a military family contained parental and sibling relationships that developed within the deployed group. Peter suggested that he felt like the *senior family member* in the group with which he deployed (Peter, p.15). The researcher suggests that Peter was adopting a parental role within the group and providing support to those for whom he was responsible. Jane supported this view when she suggested that *when you're away you've got a combined goal to keep your team OK* (Jane, p.5). Brian identified the development of a sibling like group dynamic when he stated that the deployed group had a *family dynamic in such a way that there was a lot of siblings. No one took the mother or father role* (Brian, p.12).

Unlike Peter and Jane's experience, however, it was evident that the parental role was not actively sought after. This view may reflect the relative age, seniority and maturity of Peter, Jane and Brian when they deployed.

Anna viewed the family as *sort of like siblings, and like siblings the junior officers, troops and Senior NCOs can also play up and be naughty* (Anna, p.20) but who still looked after one another. *The experiences that you go through together…living in each other's pockets for 24 hours a day you…learn to tolerate people…that you probably wouldn't…outside* (Katie, p.22). In this respect, the senior officers in the group provided the authority and parental guidance that ensured the cohesiveness of the siblings. *You do look to your senior officers to assert authority in certain situations…'cause…they're like the parents and we're the siblings* (Anna, p.22). Despite the tensions that sometimes emerged between siblings who were constantly living and working together, Jane noted that it was *nice to be part of a group of like minded people or people who are far away from home and make their family where they are* (Jane, p.3). The family dynamic that the military nurse experienced on deployment helped define their unique practice context. The next section will further define what it means to be a military nurse.

Emergent theme fourteen: pride

The fourteenth theme provided a framework for understanding military nursing through the pride that nurses expressed in their work regardless of the challenges of military life. Katie, Anna, Colleen and Barbara referred directly to the pride that they experienced as military nurses. Katie stated *that I'm really proud of it…I love telling people that I'm a nurse in the military* (Katie, p.21). This sentiment was shared by

Anna who noted *I think that there's a lot of pride in military nursing and we all rejoice in people's successes* (Anna, p.17-18). The four participants each indicated that the unique challenges that military nurses faced when deployed distinguished them from their civilian counterparts. Much of the pride that they expressed stemmed from a tenacity to "get the job done" despite the circumstances that deployment presented:

> Anna: *That's the reason why I'm still in…it's…a 'can do' attitude and we will absolutely do our darndest to do what we have to do…I think it comes from the culture within military nursing, and it's not until you're embedded in that culture that you truly understand it* (Anna, p.33).

Kerry spoke indirectly about what motivated her to remain a military nurse when discussing the rewarding nature of military nursing:

> Kerry: *I think military nursing, on deployment has the potential to be far more rewarding and stay with you…for life. The experiences that kind of touch our heart, because you're living there, you're part of the…situation* (Kerry, p.29).

Pride, therefore, was a defining element of military nursing in the collective view of the participants. The researcher suggests that pride evolved from a strong sense of worth and belonging to an organisation. Within the military, the participants shared a common military objective, sense of purpose and experience when deployed on military operations. The cohesiveness of the group, developed through the concepts of community and family, provided fertile ground for the participants to feel pride in their achievements individually and collectively.

The participants identified a number of elements that they considered were unique to military nursing when compared to their civilian counterparts. These included: a greater degree of teamwork (participants 1,3,8,9); working with a lack of resources (participants 1,4,7,10) in austere environments (participants 1,4,5,10); the tight bonds of shared experience on deployment (participants 1,2,4,6,7,8,9,10); the constant need to remain ready to deploy for several months at short notice (participants 1,4); being placed in operational situations that nurses would not choose to go (participants 1,4); the wider role of the military nurse that included the responsibilities of being a military officer (participants 4,5,6,7,8,9,10); the inherent dangers of deployment (all participants); and the family dynamic that developed in a deployed military environment (participants 2,3,4,6,7,8,9,10). The researcher suggests that while some of the elements listed above were not exclusive to military nursing, collectively they were defining qualities, unlikely to be matched by their civilian nursing counterparts. Most of these qualities were supported by the research into military nursing contexts by Kavats et al (2001); Griffiths & Jasper (2008); and Agazio (2010). Indeed Griffiths & Jasper (2008) supported the duality of the military nurse and military officer roles when they stated:

> 'That Double Hat' illustrates the nature of simultaneously being a member of two professions. Participants acknowledged their duality, in terms of their roles, authority, responsibility and accountability (p.95).

So how is military nursing defined? Barbara provided the answer to that question and concludes this exploration of the six essential themes that constituted the context, population and circumstances that combined to influence the delivery of spiritual care by Australian military nurses on deployed military operations:

> Barbara: *Military people are…different and I think the reason they are different is they're forced to be…separated from their families…have multiple postings…go to places…they have to be independent individuals who are able to socialise fairly effectively and easily because they are going to be lobbed in with a group of people they've never met before* (Barbara, p.33-34)*…military nurses can be plucked and put anywhere…and they're not going to have a structure that necessarily supports them*(Barbara, p.37)*…military nursing for me is being able to give best care you can to whomever or wherever and whatever the climate might be and recognizing that you might not have all the latest equipment, recognizing it might only be an aspirin to someone is dying that doesn't recognize they're dying and having the versatility and the knowledge to support what you're doing…in any environment whatsoever* (Barbara, p.38).

The section to follow will draw together related emergent themes under group headings that will redefine them collectively as essential themes. The essential themes are interpreted rather than verbatim accounts and serve as an entrée to the discussion to ensue in the following chapters.

7.3 Essential themes

The emergent themes presented above helped define the nature of spirituality and spiritual care within the context of military nursing on deployed operations. Reflection on the data, however, identified that the emergent themes could be grouped according to their common points of focus. For example: the search for meaning helped define spirituality; resilience was positively affected by spirituality; spirituality was sustained through relationship; and the differential between spiritual views emphasised the diversity of spiritual meaning. Collectively, the four emergent themes identified all focused on spirituality. Indeed, collapsing the fourteen emergent themes into five essential themes (Table 7.2) provided a foundation for a new model of spiritual care (to be discussed in Chapter eight). Each theme was considered

essential to understanding the context, meaning and practice of spiritual care and retained the central elements of the emergent themes. The essential themes are summarised interpretations of the data presented above that will be expanded upon in the discussion chapters to follow.

From Emergent to Essential – Thematic Development			
Emergent Themes		**Essential Themes**	
Theme 1. Theme 2. Theme 3. Theme 4.	Search for meaning. Resilience. Relationship. Differential.	Theme 1.	Spirituality
Theme 5. Theme 6. Theme 7. Theme 8. Theme 9. Theme 10.	Integrated holistic care. Facilitator and collaborator. Non-judgmental care. Touching the spirit. Symbiosis. Barriers.	Theme 2.	Spiritual care
Theme 11. Theme 12.	Mismatch. Scars.	Theme 3.	Deployment
Theme 13.	Camaraderie and family.	Theme 4.	Family
Theme 14.	Pride.	Theme 5.	Military nurse

Table 7.2: From emergent to essential – thematic development

Essential theme one - spirituality

As noted above, the search for meaning, resilience, relationship and the differential between spiritual views all focused on the meaning and understanding of spirituality. The core task of spirituality was to make sense of our existence as humans. It went beyond the simple understanding of the physical world to encompass the intangible aspects that made us who we are. Spirituality sought to answer the existential

questions of our lives in relation to the seen and the unseen. It also situated who we were ontologically relative to the world and provided the moral and ethical compass that guided our actions and interactions.

There were multiple spiritual paths that an individual could take in life (secular and religious) and the path one followed varied at different points in the life of an individual. Spiritual meaning could be found in: relationship to the natural world through a sense of connectedness with nature; the human aspects of life that brought meaning, purpose and fulfilment to a person; and/or transcendent understandings relating to a God, higher being or universal life force. Our spiritual world view, therefore, shaped how we saw the world and formed an essential element of our horizon of understanding.

Military personnel, including military nurses, are often exposed to confronting and negative life events on deployment and a strong spiritual understanding helps them to cope. Spirituality helped an individual to make sense of the world that they inhabited. Consequently, spirituality had a protective effect against the challenges in life and built resilience in an individual. Resilience could be enhanced through: religion or other belief systems (giving the problem over to God or something beyond the self); a sense of purpose (spiritual perspective); and/or relationship with family, peers and others (sharing the burden). It was in relationship, however, that our humanity was expressed and our spirituality formed and supported. Therefore, relationship was also essential to spiritual care.

Essential theme two - spiritual care

Essential theme two encompassed the emergent themes that focussed on the provision of spiritual care: integrated holistic care; facilitator and collaborator; non-judgmental care; touching the spirit; symbiosis; and barriers. Spiritual care was essential to the provision of integrated holistic care to patients in the military deployed environment. It could be delivered as a deliberate act of care but was more often provided as an unconscious by-product of the caring act that was only realised on reflection. Spiritual care, therefore, should be an ingrained part of normal nursing care of the patient. In the deployed environment, where patients were disconnected from family, peers and other spiritual supports, failure to provide spiritual care could be detrimental to the physical, emotional and psychological well-being and recovery of the patient.

The nurse was an essential provider of spiritual care in the deployed environment. However, the military nurse also facilitated access to other formal and informal spiritual care providers such as military chaplains, local spiritual leaders and family, friends and peers (where available) to deliver spiritual care. In this respect the nurse was also a collaborator in spiritual care. Spiritual care, however, was not just directed to patients. In the context of deployment it could also be provided to military peers including chaplains. More importantly in this thesis, however, was that spiritual care could also be directed back to the nurse who was coping with the same issues associated with deployment as their peers and military patients. Consequently, spiritual care was understood in symbiotic relationships between the care giver and the care recipient.

Spiritual care was delivered via direct (prayer, touch, discussion, etc) and indirect (facilitative) care pathways. However, it could only be delivered effectively in open, respectful and trusting relationships that accepted the needs of the care recipient as central to the caring act. Spiritual care should be non-judgemental and must be mindful of not imposing the personal spiritual views of the care giver on the care recipient. It was empathetic to the needs of the *other* and strived to touch the spirit of the care recipient in a meaningful and genuine interaction. Despite the barriers that existed to the provision of spiritual care on deployment, the nurse always sought a way to connect with those in need of spiritual care. Accordingly, spiritual care should always be delivered equally and to the best of the ability of the nurse within the constraints of the deployment.

Essential theme three - deployment

Deployment incorporated the emergent themes of mismatch and scars and provided the unique context in which the participants, as military nurses, provided spiritual care. Understanding deployment was essential to understanding the distinctive context in which the military nurse practiced and provided spiritual care. Spiritual caring practices for military nurses did not differ significantly from those provided by nurses in Australian civilian healthcare settings. However, the deployed operational environment provided the military nurse with some unique barriers to care and challenges that civilian nurses did not generally have to face in their practice. These included: long periods of separation from family, friends and normal spiritual support networks; long and arduous hours of work without days off for weeks on end; the carriage and use of weapons and live ammunition; austere living

and working conditions; the constant threat of injury, illness and death due to attack from enemy forces, high risk activities such as low level flying and endemic disease threats; and living and working in close quarters without opportunities for personal time and space.

Deployment opportunities were keenly sought by military nurses as they were viewed as a validation of their military training. However, each deployment was different and brought its own challenges and expectations. The expectation of a given deployment also did not necessarily meet the reality of what the military nurse experienced once they arrived. Accordingly, the military nurse needed to be flexible to a dynamic operational environment and realistic about what could be achieved within the constraints of their situation.

Deployment was inherently dangerous and involved a large number of risks to the military nurse. The risks were not just physical and included short and long term psychological impacts on the life of an individual, with Post Traumatic Stress Disorder being a reasonably common sequelae of deployment. Experiences on deployment that initially appeared surreal became normalised over time. Consequently, for many military nurses deployment fundamentally changed their horizon of understanding (Gadamer, 1976/2004) in relation to their being in the world. The shift in horizon was most acutely experienced when the military nurse was re-integrated into normal life post deployment.

Essential theme four – family

Military nurses operated within two distinct family structures that provided support for their psychological and spiritual needs. The traditional family, that the military member left to deploy on operations, was the primary source of support and nurturance for the military nurse and other military personnel. It was from within the traditional family of spouse, parents, significant others and community that military personnel including nurses defined and supported their spirituality and spiritual needs. Once deployed, however, access to the traditional family was no longer directly available to the military member.

The military family, which comprised the unit and peers of the military member, adopted a *de facto* support role for the military member that included support to their spiritual needs. The camaraderie of shared experiences bonded the unit personnel and they supported one another as if within a family unit. When the military member was ill, injured or dying, however, it was the responsibility of the military nurse, as part of their caring role, to provide spiritual care to their brothers and sisters in arms. To the military nurse the military family comprised parental like authoritarian figures in the senior officers who were responsible for their safety, health and well-being. However, the military family was made up of siblings who shared with the nurse through the highs and lows of deployment and provided the support that their traditional family normally provided.

Community was also an important structure from within which spiritual care took place when on military deployment and complemented the family roles identified

above. There were two levels of community experienced by the military nurse when on deployment. The first was the community that was formed by comrades in arms who deployed together as a group and in which military family units existed. The community was brought together through shared purpose and allowed military personnel to work cohesively to meet the operational objectives of the mission. The second level of community was that which was offered on some deployments where the operational risk was low. Interaction and identification with the local communities into which military nurses deployed provided another avenue for spiritual nurturance.

Essential theme five – military nursing

Military nursing was a unique practice context within the broader nursing profession in Australia. While military nurses shared common practice boundaries with their civilian counterparts there were many elements of their practice that differed significantly. They were often risk taking individuals who shared personality traits similar to their other military counterparts and were mission focused and committed when on deployment. The military nurse worked in austere and resource constrained environments while separated from the normal family and peer support networks for extended periods.

The military nurse maintained an operational readiness posture to deploy at very short notice. They were military officers who were required to perform the same command functions that their non-health peers were required to do. They were subject to military discipline and law and were required to carry weapons into often hostile and

dangerous environments. The participants were proud of their military service and felt that they positively influenced their patients and those with whom they shared the deployment experience.

7.4 Summary of Chapter seven

Van Manen's (1997/2007) approach to researching lived experience was used by the researcher throughout Chapter seven to provide an interpretive analytical structure to the Philosophical Hermeneutics of Gadamer (1976/2004). The chapter validated the data analyses detailed in Chapter six. However, it moved beyond mere description to interpret the essential meanings of the phenomena, as expressed by the participants, through the interpretive horizon of the researcher. The phenomena were interpreted through fourteen emergent themes that were then collapsed together into five essential themes that form the basis of the new model of spiritual care to be introduced and examined in detail in Chapter eight. The essential themes were: *spirituality*, *spiritual care*, *deployment*, *military nursing*, and *family*.

Throughout the chapter, the researcher attempted to remain faithful to Gadamer's (1976/2004) Philosophical Hermeneutic approach to phenomena. In this way, the themes were developed through the hermeneutic dialogue until the inherent truth claim of the phenomena became evident. However, rather than presenting the interpreted data as fixed outcomes they were offered as time bounded representations that remained open to re-interpretation by others.

Spirituality and spiritual care were presented and defined within the context of the military nurse practicing in a deployed operational environment. The care context

provided the unique nature of the study that set it apart from other research conducted within civilian care environments. The military nurse practiced in dynamic, austere and confronting circumstances with minimal support. They performed the roles of military officers while separated from home, family and significant others for periods extending to several months. Nurses often deployed at extremely short notice and remained constantly postured to do so. Military nurses were exposed to the same dangers as other military personnel and often carried the physical and psychological scars of deployment for many years. However, the common bonds of experience led to the development of a strong camaraderie and enduring family like relationships that supported not only the patients in their care, but military peers and the nurses themselves. Spiritual self-care, therefore, was an essential element of deployed military nursing.

PART FOUR
The Fusion of Horizons

> A hermeneutical situation is determined by the prejudices that we bring with us. They constitute, then, the horizon of a particular present, for they represent that beyond which it is impossible to see. But now it is important to avoid the error of thinking that the horizon of the present consists of a fixed set of opinions and valuations, and that the otherness of the past can be foregrounded from it as from a fixed ground. In fact the horizon of the present is continually in the process of being formed because we are continually having to test all our prejudices… understanding is always the fusion of these horizons supposedly existing by themselves (Gadamer, 1960/2003 p.306).

Part four begins by bringing together the thematic threads identified in Part three into a cohesive discussion (fusion of horizons) of spirituality and spiritual care as expressed by Australian military nurses within the context of deployed military operations. A new model of spiritual care as interpreted by the researcher will be introduced through a discussion of the five essential themes introduced in Chapter seven that define the unique nature of the spiritual phenomena. The chapters that follow will examine the new model of care in depth to demonstrate the significance of the findings, provide recommendations for further research and then conclude the thesis. These final chapters will be presented as:

- Chapter Eight – Discussion

- Chapter Nine – Conclusion and Recommendations

CHAPTER 8: DISCUSSION

8.1 Introduction

This chapter will discuss the findings of the research. The discussion draws together the themes identified in Part three into a coherent whole, consistent with the Philosophical Hermeneutic approach described by Gadamer (1976/2004). The chapter aims to answer the research question that provided the impetus for this study. The research question asked: *how do Australian military nurses experience spirituality and spiritual nursing care on deployed military operations?*

The research question will be answered through a combination of discussion and diagrammatic representation. The findings are synthesised in a new model of spiritual care. The model incorporates elements of the researcher's earlier (Masters) conceptual model of spirituality (Ormsby, 2001) and the five essential[67] themes that emerged in Part three. Each element identified in the model influences the delivery of spiritual care in a deployed military nursing context. The essential themes identified in Chapter seven were: *the military nurse; deployment; family; spirituality;* and *spiritual care*.

In presenting the findings, the researcher returned to the data. Transcript excerpts are included in the discussion, where appropriate, to support the essential themes and the

[67] As previously stated in Chapter four, essential themes are those themes that are so fundamental to the nature of a phenomenon that the phenomenon would not be what it is without it (Van Manen, 1997/2007).

model of care, and will be further supported by contemporary nursing literature. The essential themes will be offered as interpretations of the thoughts and reflections of the participants.

The central argument of this thesis is not that there are significant differences between civilian and military nursing settings in the way in which spiritual care is delivered. Rather, the context of operational deployment for the military nurse posed unique challenges to the delivery of spiritually directed care that were not considered elsewhere. Indeed, the literature was a *tabula rasa* with respect to spirituality and deployed military nursing, confirming that this study is both unique and original.

The discussion begins by exploring the essential themes (8.2) that emerged from the data analysis. Theme one (the military nurse) and theme two (deployment) provide the context in which spiritual care occurs in the deployed Australian military nursing setting. Theme three (family) and theme four (spirituality) identify the support structures that underpin spiritual care and define the nature of spirituality in this unique environment. Theme five (spiritual care) is the culmination of the previous four themes and provides the basis for building a new model of spiritual care (8.3). Section (8.3) briefly describes the transition of the family and spirituality concepts initially introduced in the researcher's earlier model of spirituality (Ormsby, 2001), into the new model of spiritual care (8.4). The application of the new model of care is then examined through the phases of deployment: pre-deployment, deployment and post-deployment, before a summary of Chapter eight (8.5) is offered.

8.2 Essential Themes

Theme one: the military nurse

Military nursing is a unique subset of the Australian nursing profession. To understand spirituality and spiritual care in a deployed military nursing context it is essential to capture the experiences of military nurses. It is also necessary to understand the unique nature of military service.

Hodge (1997) contended that military service is unique because it requires individuals to:

- accept the risk of serious injury of death in defence of the country;
- train for the application of extreme violence;
- accept lawful direction without equivocation; and
- forego any right to withdraw labour or refuse a task (p.36).

While this study affirms the view offered above by Hodge (1997), it is argued here that Hodge (1997) only provided part of the picture in relation to the uniqueness of military service for the nurse. The unique nature of military service influences every aspect of military life (Scannell-Desch, 2005) and is what differentiates military nursing from civilian nursing. Therefore, what follows is a discussion on nursing within a military setting that provides the foundation for the new model of spiritual care in the military that is offered in this study.

Unique nature of military service

Healer and warrior. Embedded in the military culture are a multitude of demands placed upon nurses in both peacetime and operational service. These demands are often viewed as idiosyncratic by people outside of the military (Keighly, 2003). However, being a part of the military culture allows nurses to understand the nature of military service and the risks and privations that other military personnel endure on operations (Agazio, 2010). Further, Scannel-Desch (2005) noted "that the rigors and demands of military nursing are very intense, and that it is a way of life rather than just a job" (p.605). This view was strongly held among the participants.

Apparent in the commitment of military nurses to the demands of service, is the unique context in which spiritual care takes place. Argued here is that the demands of military service generally exceed those imposed upon civilian nurses who are usually able to leave work and go home at the end of their work day. Indeed, Hodge (1997) supported this view when noting the pervasiveness of military culture to all aspects of the life of the individual "including his (sic) family" (p.36).

Since 1999 the Australian military has been constantly deploying to warlike, peacekeeping, boarder protection and humanitarian assistance and disaster relief operations (Morrison, 2013). Fifteen years of high operational tempo means that military nurses are often deploying on multiple occasions. This point was driven home by the participants who had, at the time of interview, deployed an average of 2.5 times each with six having deployed three or more times. The significance of the high rate of deployment cannot be overstated as it means a military nurse may spend

years of their career away from home[68]. There can be a hidden cost (to be discussed in more detail later) to the demands of military service in terms of family and relationship issues and mental health problems that can impact life well beyond an individual's military career (Agazio, 2010; Sixsmith et al, 2013). Of the hidden cost, Maguan et al (2008) noted:

> Military medical personnel may arguably face additional risks, above and beyond those experienced by other military personnel, because of their dual and complex roles of healer and warrior (p.1).

The unique nature and demands of military service differentiate the military nurse from their civilian nursing colleagues. Griffiths & Jasper (2007) called the military nurse a *warrior nurse* (p.92) in recognition of the duality of their roles as military and nursing professionals. This was confirmed at interview where it was acknowledged that the role of the military nurse as an officer took primacy over their professional nursing role. However, while nurses were military officers this should not be seen as diluting the nursing role. Indeed, Agazio (2010) noted that traditional civilian nursing practices are the cornerstone of military nursing practice but they must be adapted to the operational role. She remarked:

> The traditional practice of nursing, consisting of care, comfort and cure, must be adapted by Army nurses as their practice takes them between fixed facilities in a garrison environment to a tent set up under harsh

[68] Operational deployment, as will be seen later, demands extended periods away from home and family. However, this does not take into account training course, attachments to locations away from home for supplemental staffing duties or commitments to exercises that in some instances can add up to several months of away commitments per year. These factors are collectively referred to as "inherent requirements of service" (DoD, 2013a).

> conditions in a remote location in a Third World country (Agazio, 2010 p.168).

While the healer and warrior concept is subsumed as a sub-theme within the unique nature of military service it is, nevertheless, a very important finding of this study. Not only does the duality of roles represent a distinct point of difference between military and civilian nurses, it also presents some potential moral dilemmas for deployed nurses. Baumann (2007) argued that the two roles were opposed in their philosophies. From this viewpoint the healer focuses on the sustainment of life while the warrior prioritises the mission over their caring role. What the findings of this study suggested, however, was that military nurses did not appear to be morally conflicted about their dual roles. Indeed, pride in the military role as an officer was universally expressed by the participants. The healer and warrior concept is a recurring sub-theme through the military nurse and deployment themes.

Officer first. This section elaborates on the notion argued above that Australian military nurses are considered to be officers first and nurses second (Bridget, p.2; Griffiths & Jasper, 2007; Maguan, 2008). Under the Geneva Conventions military nurses are considered non-combatants (ICRC, 2014).[69] They are, however, still required to undertake the same general military training as other personnel within the

[69] The International Committee of the Red Cross stipulates that under the Geneva Conventions and Hague Regulations that military medical personnel are non-combatants. "Rule 3. All members of the armed forces of a party to the conflict are combatants, except medical and religious personnel" (ICRC, 2014). In this context military nursing personnel may only use their weapons to defend themselves or their patients from acts of violence and violation of this rule will lead to forfeiture of protected status. "Rule 25. Medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. They lose their protection if they commit, outside their humanitarian function, acts harmful to the enemy" (ICRC, 2014).

respective military Service to which they belong whether Navy, Army or Air Force. General military training consists of officer training school, weapons handling, laws of armed conflict, leadership, discipline, drill, combat manoeuvres, fitness testing and a multitude of other military officer development courses (ADFA, 2014). Accordingly, military nurses are required to act in the capacity of military officers through the application of command[70] and discipline[71] to subordinate military personnel. Agazio (2010) noted that in addition to receiving their general military training nurses also regularly refreshed their weapons, protective equipment and common military skills prior to deployment.

Griffiths and Jasper (2007) argued that "military nurses belong to two professions, those of caring and the military, and embrace the ethos of both" (p.93). The data supported this notion and the assertion made above that the dual professional associations and responsibilities that the military nurse carries sets them apart from their civilian nursing counterparts (Griffiths & Jasper, 2007). Within a critical discourse the command and discipline responsibilities of the military nurse could be seen as counter productive to spiritual care as they perpetuate an inequality of power (Kincheloe & McLaren, 2005). However, this study asserts that the common bonds

[70] Command in the Australian Defence Force is the authority to commit personnel and resources to achieve military objectives (DoD, 2009). Australian military nurses as officers of the Australian Defence Force may be delegated the responsibility for the command of health assets and personnel both in Australia and on overseas operations.

[71] Discipline in the Australian Defence Force is enforced through the Defence Force Discipline Act 1982. All members of the Australian Defence Force are subject to the Act and military nurses, as with any military officers, are required to act on any breaches. "Offences by ADF members are prosecuted under the DFDA, within the military justice system, when the offence substantially affects the maintenance and ability to enforce Service discipline in the ADF. Otherwise, criminal offences or other illegal conduct are referred to civil authorities, such as the police" (DoD, 2013a).

of experience that military nurses share with their military peers and subordinates, particularly on deployment, appear to supersede the effects of authority when providing spiritual care in an open, respectful and accepting manner. Keighley (2003) confirmed this point when she discussed the extended military family (to be discussed later) of which military nurses are a part. Further, Griffiths & Jasper (2007) noted that "rank and the associated position in the military is considered to be subordinate to the overriding caring ethic" (p.96). The researcher asserts that because the military nurse is seen as someone outside of the direct command of many of the military personnel that they are confided in and trusted to provide spiritual care.

Readiness. Associated strongly with deployment is the unique readiness posture that military nurses must adopt as part of their normal military roles. Readiness in the military refers to the ability to deploy, with the necessary skills, competency and currency, into an operational scenario within a defined timeframe (Tricarico, 1998; Kovats et al, 2001). Depending on where the nurse is in the readiness cycle they may need to be postured to deploy within hours to weeks.

Military readiness is unique because the nurse may be required to leave home at short notice and may not return home for several months[72]. Kennedy et al (1996) noted that "readiness is the single variable that distinguishes military nursing from civilian nursing" (p.33). This view was supported by Kovats et al (2001) in discussing readiness in active duty and Army reserve nurses and Agazio (2010) when

[72] It was noted in Chapter two that civilian health agencies are increasingly posturing for short notice deployments into humanitarian assistance and disaster relief scenarios (NCCTRC, 2014). However, they are unlikely to be deployed into active conflicts or where there is a significant risk of death or injury and in general they will not deploy for the same extended periods as military personnel.

reviewing the practice challenges for United States Army nurses on deployment. Viewed against the statements made by the participants it is clear that readiness remains a critical defining feature of military nursing.

What is also asserted here is that the actual experience of deployment, to be discussed separately as an essential theme, is also critically important to understanding the unique nature of military nursing. Noting the dual nurse and warrior role it is argued that while readiness differentiates military nurses from civilian nurses, it aligns them with their military peers. In this way military nurses share common experiences with the broader military population of which they are a part (Griffiths & Jasper, 2007). The military nurse approaches care of their military peers understanding the environment and experience of deployment. The common experience, therefore, becomes an *entrée* to the delivery of spiritual care.

Common experiences. Military nurses share many common experiences and traits with the general military population with whom they serve (Stanton et al, 1996; Ormsby & Harrington, 2003). Together they deploy into austere and dangerous environments with a lack of resources. They share the experience of long separations from their family and friends and are often caring for people that they know through their military careers (Biedermann, 2001). Also noted was that military nurses tend to be risk takers (Peter, p.17) and are part of an organisation of like minded people (Stanton et al, 1996). In this way there is a strong sense of camaraderie of which the nurses are active participants (Simmons, 2012). However, what is also suggested is that common experience does not infer that individuals experience events in exactly the same way. After Gadamer (1976/2004), it is argued that each individual brings

their own “horizon” of understanding to an event and will therefore interpret the event differently.

Theme two: deployment

Kennedy et al (1996) suggested above that “readiness” defined the unique nature of military nursing. This finding supported the earlier study by Ormsby (2001) where readiness for deployment was considered a uniquely military quality. However, while this point is not disputed here, readiness has as its primary concern preparedness to deploy. Kovats et al (2001) suggested that the primary role of military nurses “is to be prepared to support deployed forces during military operations” (p.30-31). In the context of this study, and as evidenced in the data, readiness is superseded by deployment as the defining characteristic that separates military nursing from civilian nursing. Therefore, the next theme to be discussed is the unique contextual setting of the military deployment that defines this thesis.

Deployment in context

Agazio (2010) asserted “that the military is an organization well prepared and experienced in the rapid mobilization and deployment of large volumes of personnel, equipment and supplies” (p.167). Understanding deployment is central to our understanding of spiritual care in the military nursing context. Every deployment presents different challenges to the military nurse in providing nursing care, inclusive of spiritual care, and also to their own personal resilience (Griffiths & Jasper, 2007; Agazio, 2010). The austere conditions, inherent dangers and separation from home

all combine to fundamentally alter the personal horizon of understanding of the nurse (Gibbons et al, 2012).

Deployment was a constantly recurring theme within the data and is the *raison d'être* of the military. The Australian Defence Force is an instrument of Government that is primarily concerned with the security of Australia (Brown, 2013; Morrison, 2013). Beaumont (2013) remarked:

> Driven by the notion that it is better to face adversaries abroad than in one's own territory, expeditionary warfare is seen by many militaries as a manner by which sea, air and land capabilities can be employed to address the challenges of contemporary strategic conditions (p.95)

Arguing along the point made by Beaumont (2013) it is clear that deployment suffuses all aspects of military nursing as nurses deploy with military forces. The researcher acknowledges Gadamer's (1976/2004) assertion that the recurrence of a theme does not necessarily provide it greater value than a non-recurring theme. However, as this study examined spiritual care within a deployed military nursing context, the significance of the theme cannot be overstated. So what defines the unique nature of deployment as a characteristic of military nursing?[73] The focus of the discussion to follow is on what the researcher interpreted as the most significant elements of deployment. The elements represent the reflections and thoughts of the participants that emerged from an ongoing dialogue with the data. As interpreted by

[73] The researcher has deliberately identified a nexus between military nursing and deployment as one is generally synonymous with the *other*. For the sake of clarity of understanding, however, the two related concepts are discussed separately and adjoin each other in the new model of spiritual care.

the researcher, because according to Gadamer (1976/2004) a "text begins to find expression in the interpreter's own language. Interpretation belongs to the essential unity of understanding" (p.57).

Physical dangers of deployment. Deployment was the focal context within which spiritual care took place for this study and is argued as what makes military nursing unique. According to Gadamer (1976/2004) our experiences and effective history are always at play in our interactions and form the horizons from which we understand phenomena. Like any member of the Australian military, the nurse is asked to make sacrifices in support of Australian Government directed tasks (Reid et al, 1999). Morrison (2013) noted the respect afforded Australian military personnel "who have put service before self at their nation's call in war and peace" (p.11). This view was reinforced as an inherent requirement for service in the Australian Defence Force (DoD, 2013a).

Australian military nurses have deployed to every major military operation in which the Australian Defence Force has been involved (Reid et al, 1999). While nurses are not involved in any of the war fighting activities they are nevertheless still exposed to many of the same dangers and risks as other members of the Australian Defence Force. Indeed, Stanton et al (1996) noted for a group of Vietnam veteran nurses:

> Personal dangers varied from chemical warfare and contracting topical diseases to being wounded by enemy fire or by weapons found on wounded soldiers…For many nurses in the field hospitals, there was the constant danger of being wounded or killed (p.5).

In Chapter two it was noted that more than 100 Australian military nurses had lost their lives in military service (Reid et al, 1999). To reinforce the inherent dangers military nurses face in their service to Australia one only needs to remember the massacre of 21 Australian Army nurses on Bangka Island by the Japanese Army following the sinking of the *SS Vyner Brooke* in World War Two (Norman & Angell, 2000). More recently, in 2005, was the death of a Royal Australian Air Force nurse (along with eight other Australian Defence Force personnel including doctors and medics) in the Sea King accident on the Island of Nias when providing post earthquake humanitarian relief support to Indonesia (Bosca in Hansard, 2005). Inferred above is that the risk of physical danger is no less present in a humanitarian assistance mission than it is in a war like deployment. Danger, therefore, is an inherent part of military service (Hodge, 1997).

What also became apparent when interviewing the participants was that the death of any Australian Defence Force member on deployment is keenly felt across the Australian Defence Force. Stanton et al (1996) reinforced this notion when they alluded to the close bonds with their military patients that "was nourished by the fact that they were "all in this together"" (p.5).

Psychological dangers of deployment. Hodson (2002), Friedman (2004), Scannell-Desch (2005), Gibbons et al (2012) and Simmons (2012) all highlighted the potential psychological trauma[74] that may emerge in a nurse who had deployed either during

[74] Psychological trauma needs to be differentiated from spiritual trauma in the context of this research. However, the two concepts do overlap to the point where a negative impact on one will ultimately adversely affect the *other* (USDVA, 2011).

or after they have deployed. Civilian nurses, particularly those working in trauma departments, are often confronted with tragedy and dreadful injuries in their patients. However, they may not see the volume of casualties that some military nurses are exposed to in high intensity offensive military operations (Scannell-Desch, 2005; Beidermann et al, 2001). Further, they do not generally work in environments that are high risk to themselves and from which they cannot retreat even after hours. It is to these environments that the military nurse must develop resilience (to be discussed below) so that they may effectively care for their patients.

Psychological trauma is not a new sequelae from deployment on military operations. However, psychological trauma has gained increasing visibility in the literature, not only for nurses in general but within the military psychology (Hodson, 2002) and military nursing (Gibbons et al, 2012; Simmons, 2012) literature. The latter was very pertinent to the context of this study as nurses are no more immune to the psychological trauma of deployment than their other military peers. This view was supported by Agazio (2010) in Chapter two where she noted that military nurses may be more at risk of psychological trauma due to the nature of their duties. Gibbons et al (2012) also argued this view when they suggested that:

> healthcare providers, who had the most contact with death and body handling were more likely to demonstrate psychological ill health than other service members (p.16).

Inherent in the notion of persistent exposure to death was that military personnel, including nurses, were at high risk of developing psychological trauma to the events of deployment. Therefore, there is a need to develop resilience in military nursing

populations against the insults of deployment to the emotional and spiritual reserves of the individual.

Resilience to deployment. The data supported the view that deployment challenges and sometimes exceeds the spiritual resilience of military members, and by extension military nurses (Simmons, 2012). It is, therefore, no less important for the nurse as a carer to have some mechanism to be able to synthesise what they experience on deployment. In this context the nurse needs to be able to self care or seek care from their peers or others with whom they engage in the deployed environment. Indeed, Wester (2009) argued that "for Soldiers, resiliency includes not only sustaining themselves physically and emotionally while in combat but also coming home fit" (p.17). The point that Wester (2009) made is important in the context of this study, as the social and personal cost to the military member and their family from psychological and spiritual trauma can be significant and enduring. Wands (2013) identified an increased incidence of suicidal ideation in returned soldiers and Rivers et al (2013) noted the impact of deployment on the longer term well-being of military personnel and the stability of their relationships. The latter point was well illustrated by Bridget who related how she experienced a marriage breakdown as a result of long separations from home due to deployment.

The literature indicated that spirituality had a positive correlation with building resilience in military personnel against the confronting and sometimes traumatic experiences of deployment (DoD, 2011b). However, while Simmons (2012) noted that "spirituality was found to be significantly related to resilience" (p.132) against the immediate effects of deployment, she suggested that the protective factor against

depression and Post Traumatic Stress Disorder was relatively low. The data in this study supported the view that while spirituality may not completely inoculate the military nurse against the adverse outcomes of deployment it remained a strong resilience factor. The view was further supported in the literature by Wester (2009) and Gibbons et al (2012) who identified a positive correlation between spirituality (or religion in the case of Gibbons et al (2012)) and resilience to wartime experiences and the development of Post Traumatic Stress Disorder.

While spirituality was cited in the literature as a protective factor against the stresses of deployment (Wester, 2009; Simmons, 2012) there were other factors that appeared to improve resilience[75] in military populations. The majority of the participants (eight of ten) indicated that their experience of the military and deployment was very positive, with four of them noting that they were proud of their service. Indeed, Maguan et al (2008) stated:

> Positive military experiences before deployment also played an important role in predicting positive affect, with the establishment of trust, support, pride, and belonging being an important foundation that helps military members thrive and feel part of a larger mission and purpose. These positive military experiences are also likely related to fostering strong cohesion and morale, which are associated with fewer post-deployment PTSD symptoms and overall well-being (p.7).

Argued here is that by identifying positively with their deployment experiences, the nurse is better able to adapt and cope with the stressors to which they may be

[75] Resilience was defined by Maguan et al (2008) as "response flexibility in the face of ever-changing situational demands, including the ability to recover from negative and stressful experiences and find positive meaning in seemingly adverse conditions" (p.7).

exposed. This observation was borne out when reflecting on the researcher's interview with Tracey who appeared to have unrealistic expectations of what she could achieve on deployment. A strong sense of personal spirituality and a positive outlook, along with good self and peer support mechanisms, were fundamental to the resilience of Australian military nurses on deployment in this study (Maguan et al, 2008; Gibbons et al, 2012; Simmons, 2012).

Austere conditions. The military nurse needs to be flexible and adaptive to the environment into which they may deploy. Biedermann et al (2001) suggested that the experience of Vietnam nurses was immediately transferable to the present military nursing experience and noted military nurses worked in "situations in which they were forced readily to adapt. For many nurses, it meant that they need rapid acquisition of knowledge" (p.548).

Military nurses may have to work and live for several months in very difficult and austere circumstances (Parish, 2007; Wilgus, 2011). Agazio (2010) noted in a study of practice challenges for deployed military nurses that the "nurses were challenged physically and mentally, living and working under austere conditions, especially in the initial stages of a deployment" (p.173). It is not uncommon for military nurses to work in tented, makeshift or hardened facilities and quarters within a secure compound while under constant threat of mortar, rocket or other modes of attack (Stanton et al, 1996; Griffiths & Jasper, 2007; Agazio, 2010). The latter point was underscored by Anna at interview when she spoke of a person at her deployed location that had died from enemy attack just prior to her arriving.

This study acknowledges that some civilian nurses may also work in austere environments, if working with overseas aid organisations (NCCTRC, 2014). However, civilian nurses are not bound by the strictures of military service. Military nurses may have to apply lethal force to protect themselves or their patients and may be placed into environments that place their lives at risk from enemy combatants (Hodge, 1997; Reid et al, 1999; Biedermann, 2001).

Healer and warrior. Griffiths & Jasper (2007) alluded to the warrior-nurse dichotomy (also discussed in Theme one above) when they noted that military nurses were "able to exercise their rights as a soldier, which allowed them to use their weapons for protective purposes" (p.96). It should be noted, however, that the participants overwhelmingly accepted the risks inherent with deployment as a part of their job and indeed, it was not a deterrent in most cases to their desire to deploy. Baumann (2007) raised the spectre of a moral conflict between the aims of nursing and those of the military. Interestingly, however, was that the participants in this study did not express any moral conflict in the dual roles of nurse or warrior or in the delivery of spiritual care.

The data suggested that the need to be flexible and adaptive to a constantly changing operational environment is a further characteristic of military nurses. Keighly (2003) identified the need for military nurses to display initiative. Griffiths & Jasper (2007) identified the requirement for military nurses to be "multi-skilled to respond to the dynamic environment of a conflict zone…a practitioner must be adaptable and flexible" (p.97). Deployed military nurses are accepting of the often austere conditions in which they have to live and work. They also accept the dangers and

challenges of the deployed nursing environment in which they may be called upon to apply lethal force, within the rules of the Geneva Conventions (ICRC, 2014), to protect themselves or their patients. These unique deployment challenges are viewed and accepted as inherent parts of the deployed role of the military nurse. They are unique to the military nurse and provide a clear delineation between military and civilian nursing practice.

Re-integration. The austere conditions often experienced on deployment create challenges for the military nurse though most accept and adapt to the challenges. This point was supported by the data. However, in adapting to the challenges of austere and inherently dangerous environments nurses can experience issues in re-integrating to normal home and work life when they return from deployment (Simmons, 2012; Rivers et al, 2013). Reflecting on the experience of the researcher returning from Africa in 1995 it became apparent that tolerance for minor ailments in non-deployed military members had decreased following exposure to horrendous injuries and atrocities in the aftermath of a genocide. Further, the researcher did not walk on grass or dirt for several weeks after deploying due to an unconscious adaptation to the constant threat of land mines. What this experience illustrates, and this is supported by the experiences of the participants, is that exposure to the challenges of deployment change the horizon of understanding for the military nurse. Indeed, the literature strongly identified the challenges of re-integration of military personnel back into normal life (Stanton, 1999; Scannell-Desch, 2005; Gibbons et al, 2012; Chambers, 2013). Gibbons et al (2012) advocated strongly for the introduction of re-integration programs targeted at military healthcare providers following deployment.

Separation from family. Military nurses may deploy on military operations for many months and may do so on multiple occasions across a career (see the military nurse above). The ability for nurses to communicate with their families has improved over the past decade through the advent and improvement in various form of electronic media. However, while communication home is certainly more robust than during previous conflicts such as the Vietnam War (Biedermann et al, 2001), contact with family remains relatively short and infrequent and may be constrained by operational security requirements of certain deployments (Chambers, 2013).

Separation from family is difficult for the military nurse and denies them part of their normal support network (Hodson, 2002). However, for many it is easier for the military nurse to cope with the separation from family than it is for their family left at home. At first view this situation seems a paradoxical statement but is clarified in the understanding that the military nurse develops close bonds of camaraderie and support with their peers through shared experience (Stanton et al, 1996). Chambers (2013) writing on the impact of deployment on military families noted:

> Four of eight (50%) military brides, isolated from extended families and a military base, depended on absent partners for guidance, and, unaware of support resources, experienced more difficulty adapting during the long war-imposed cycle (p.45).

Hodson (2002) suggested that it was also necessary to understand the impact that dislocation from military comrades may have on military members when they return home. This point was largely "due to the fact that on deployment peers are the primary form of support but on return to Australia this often transfers back to the

family" (Hodson, 2002 p.106). The military spouse on the other hand, as a result of regular location moves that occur during a military career, may not have set up their own support networks in the new area to which they have moved. Separation from family may impact the military nurse directly or indirectly, but the important point in this study is that separation from family due to deployment does have a significant effect on the nurse and their family.

Theme three: family

Conceptually a family represents a social structure of people who live in relationship to one another whether through marriage, blood, or adoption (Macionis, 1989). The nuclear structure of the family has undergone some change over the course of the past several decades. Qu & Weston (2008) in a study on couple formations in Australia, remarked that "couple formation patterns have changed dramatically in Australia and other Western countries" (p.5). However, family relationships, whether in a traditional nuclear or an extended family construct that includes community, are argued here as fundamental to our understanding of spirituality. Family provides the individual and collective support structures from within which spiritual care may take place at home or on deployment. Dislocation from normal family support structures can, therefore, have a deleterious impact on military personnel and it is with this understanding that substitute social and family support networks fill the void.

Constructing notions of family

In the context of this thesis spirituality and spiritual care are understood and provided within a family-like framework. Military personnel, including nurses, generally come to develop and express their individual spirituality within a core or extended family structure. Their spiritual needs are usually supported by family, peers and significant others (Ormsby, 2001) when at home. This view was supported by five of the participants. However, when military personnel deploy they do not have ready access to their normal spiritual/family/community support networks (Stanton et al, 1996).

Discussing nurses in a hospice setting Harrington (2003) noted that "the networks established within their employment provided an extended family for…people of like mind…[who] nourished their own spirits" (p.317). In the deployed environment nurses rapidly develop relationships that support them through the challenges of deployment (Stanton et al, 1996; Scannell-Desch, 2005). Spirituality for military personnel is often supported by military peers who adopt relational roles akin to those found within traditional and extended families. A major outcome identified in this study is that in the military family peers may be viewed as siblings and commanders as parents within the family unit. The military is an extended family to which military personnel, including nurses, become adopted members. The discussion on family will begin by recapping the earlier findings of the researcher in relation to family constructs in the military (Ormsby, 2001; Ormsby & Harrington, 2003).

Earlier concept of family. In the researcher's earlier study on spirituality (Ormsby, 2001) family was identified as pivotal to understanding the nature of military nursing

in the Royal Australian Air Force environment (see Chapter one for a more thorough description). The findings determined that spirituality was grounded and found support in the construct of a traditional family, which included peer and friendship support networks. The military nurse identified with the values and spiritual expressions of their family. Further, the identification with family values carried over with the nurses into the military environment onto deployment. This view was supported by Stanton et al (1996) in relation to deployed nurses caring for one another in Vietnam. They noted "it was like having an extended family…we were always sharing and watching out for each other…their closeness made it easier to cope" (p.346). The most significant finding of the previous research, therefore, was that spirituality found expression and support in a military family construct and this support was amplified when nurses deployed.

The military family acted as a *de facto* family to provide spiritual support and care to the military member when separated from their normal family and peer support networks. In this way military personnel were able to receive spiritual care from the members of their unit who substituted as family during the time of their deployment. Of importance to this current study was the finding that the nurse acted as a proxy for the injured, ill or dying sailor, soldier or airman/airwoman's military family (usually identified as their military unit) when that person was hospitalised. Therefore, the military nurse had a pivotal role in providing spiritual support as part of their normal caring role. As discussed previously, the caring role was made easier for the nurse due to the common bonds of experience that were shared between the patient and the military nurse (Stanton et al, 1996; Scannell-Desch, 2005). This finding remained valid within the context of this current study. However, the participants further

defined the military family construct within the context of their own experiences on deployment.

Expanding the concept of family. In this current study, family was a critical influence on the delivery of spiritual care on deployment. The characteristics of the military family had evolved from the researcher's previous research to include sibling and parental like relationships within the military family. However, the definition of the traditional family and its importance to spirituality and spiritual care remained consistent with the earlier research. The researcher acknowledges the societal shifts that are currently challenging traditional views of family within Australian society, but will leave the discussion to another forum.

The military family. The notion of a military family was well illustrated in a quote from the movie *We Were Soldiers* (Wallace, 2002). The movie was based on an episode in the life of LTCOL Hal Moore, a deeply religious and highly decorated United States Army commander during the Vietnam War, who rose to the rank of Lieutenant General during his long and distinguished career. In that movie the narrator spoke directly to the notion of a military family and the close bonds of kinship that were developed between the members of that family:

> Some had families waiting, for others their only family would be the men they bled beside, there were no bands, flags no honor guards to welcome them home, they went to war because their country ordered them to, but in the end they fought not for country or their flag, they fought for each other (Wallace, 2002).

The tight bonds of deployment that build a sense of belonging and community also lead the military nurses to a family-like dynamic within which they support and find support on deployment. Stanton et al (1996) supported this view when they noted amongst a group of Vietnam Veteran nurses that "the social context of war included unique relationships in a war-time environment" (p.349). In his recent book *The Crossroad,* Mark Donaldson VC (2013) spoke of his comrades in the Special Air Service as a brotherhood. Indeed, of family he wrote in his dedication: "This is dedicated to my family by choice, my family by blood and my family who I've fought alongside" (Donaldson, 2013). To the members of the Australian Defence Force the people that fight along side are a family, a spiritual home, in which each supports and looks after the interests of their brothers and sisters in arms.

In the context of this study, the military family was a fundamental element to understanding the unique nature of military deployment for the participants (Griffiths & Jasper, 2007). Military personnel on deployment are separated from their normal family and peer support networks. Scannell-Desch (2005) noted that while maintaining a connection with home was important, the development of trusting relationships was a crucial supporting factor on deployment. As noted earlier contact with family has improved for deployed members over the past decade. However, the short and infrequent electronic contact with family at home and operational security constraints can limit the ability of the military nurse to effectively deal with issues at home or to meet their own spiritual needs.

Chambers (2013) addressed this issue in her study of the wives of deployed military personnel. She noted that the infrequent and short electronic contact available on

deployment could not fully address family needs and issues (Chambers, 2013). It is within this context that the military family takes on a critical support role over and above that experienced by civilian nurses. It is acknowledged, however, that the *de facto* family supports that deployed military personnel develop do not assist the families during the period of separation. This point provides an important distinction between the support available to traditional families and the military family and is worthy of further research.

The participants overwhelmingly identified that the military family had a similar dynamic structure to that of a traditional family. The similarities drawn between military and traditional families appear to be based on relative levels of authority and the working relationships of the military nurses. Indeed, it is paramount in the military environment to retain a hierarchical structure akin to a parent/child relationship for the maintenance of discipline (DoD, 2009). In this way, the military family presents itself as a structure of parents and siblings with the latter having a stratified hierarchy based on experience. It is through this structure that military personnel find direction and also support for their personal needs on deployment (Keighly, 2003). Noted here also is that the concepts of siblings and parents have not been identified elsewhere in the military nursing literature surrounding deployment or spirituality and are therefore new concepts.

Parents. Brian noted that most people considered themselves siblings and did not want to take on a parental role within the family structure. However, the participants generally agreed that senior officers within the command structure provided the parental oversight that the family sometimes needed. The researcher asserts that by

deferring to those in command for guidance the nurse is able to gain support and sense of perspective on the stressors that they deal with on a day to day basis while deployed. Indeed, Wester (2009) quoted from a speech by General George C. Marshall of the United States Army that:

> It is the duty of commanding officers in every echelon to develop to the highest degree the conditions and influences calculated to promote health, morals, and spiritual values of the personnel under their command (p.2).

The *parent*, therefore, is able to provide some control and structure within the otherwise abnormal experience of deployment and indeed this is an expectation of their role as commanders (DoD, 2009). It is the researcher's thesis that the *parent* is to be viewed as a disciplinarian who exercises authority over those within their charge on deployment and this finding is unique to the context of this study. However, in exercising authority the *parent* also cares for the welfare of those under their command and can be artificially placed on a pedestal by their subordinates. In the latter context, a lapse in judgement in disciplinary, administrative or operational decision making by the commander could be detrimental to the morale of the family group by making the commander appear vulnerable.

The *parent* within the family group is a role model for the people under their command. The senior nurses and other military personnel who take on the parental role are expected to be distant from the other deployed members to assist the maintenance of discipline within the group. Barbara noted as a senior nurse on a deployment to Africa that the parental role could be very lonely and isolating. The

senior nurse may not have the same opportunities within the deployed group to find peers in whom to confide and seek support. However, while the participants implied that the *parents* within the group needed to distance themselves from their subordinates Anna also suggested that it was useful for the *parents* to open up to the group about their own feelings on deployment. The *parents* within the group were then able to be humanised by the group and the group was able to learn from the experiences of deployment and separation from home of a more experienced and senior nurse. The researcher suggests that the *parents* provide guidance, direction and discipline to the group (Wester, 2009), however, they also provide nurturance and support to those under their command as they are responsible for the "health, welfare, morale and discipline of assigned personnel" (DoD, 2009 p.2-1).

Siblings. The next level of meaning ascribed to *family* by the participants was that of the *sibling* relationships within the deployed group. The *siblings* were equated to any group of *siblings* within a traditional *family* structure. Some *siblings* may have stronger bonds than others within the family. In this way, each member may have different levels of influence within the *family* with senior *siblings* often providing comfort and guidance to the others around them. Equally, the *family* dynamic within a deployed group may change over time as new members are brought into the group. Stanton et al (1996) noted that newcomers to a unit were often viewed with suspicion until they had been working in the environment for some time. Acceptance into the group, however, is rapid as the common bonds of military service and the deployment create the environment for integration into the *family* (Scannell-Desch, 2005). Anna noted that military nurses get stripped bare emotionally and in

supporting each other an enduring bond develops between the nurses and other military personnel who deploy together (Stanton et al, 1996).

The *family* group of *siblings* provide direct peer support to one another to meet emotional and spiritual needs. The *siblings* or peers may be other nurses or health personnel, military chaplains, or other military personnel deployed in operations with the nurse. Jane (p.4) drew an analogy with the family-like dynamic of support that shone through the television show M.A.S.H. that depicted a United States Army surgical unit during the Korean War. To Jane the family-like relationships that were demonstrated in M.A.S.H. were also relevant to the Australian military nursing experience on deployment (a point that was supported by Stanton et al, 1996 in relation to a group of nurses who were veterans of the Vietnam War). Each member of the *family* hurts when another hurts, each member supports another in need and each develops bonds borne out of experience that endure for a lifetime (Stanton et al, 1996; Beidermann, 2001; Griffiths & Jasper, 2007). One additional factor identified by Brian about *sibling* relationships was that they would share the burdens of the other to the point of sacrificing themselves for the *other*.

Community. The military nurse belongs to a military family who as a group of like minded individuals are collectively also seen as a community. Community can be defined as a group of people who share a common background, attributes or interests (Oxford, 1975; Honderich, 2005). Therefore, belonging to a community provides a sense of shared purpose and support for its members. The researcher asserts that military nurses, as part of a military community, find support from within that group and this view is supported by eight of the participants. However, of interest is that

Peter (p.3), Jane (p.10&15), Anna (p.13) and Kerry (p.14) also alluded to the support that can be provided in being accepted by the local communities into which military nurses deployed.

Returning to the Stanton et al (1996) study of the shared experiences and meanings of Vietnam Veteran nurses, it was apparent that the social and community structures that exist in the modern Australian military had been evident in military populations for many years. They noted that:

> a strong and lasting sense of camaraderie existed among the nursing personnel…Nurses watched out for each other and developed a sense of camaraderie and belonging that often continued after return to civilian life (Stanton et al, 1996 p.352-353).

It is the researcher's thesis that a sense of belonging to a military community, as part of the broad military family, is pivotal to understanding the military nurse and their context of care on deployment. Military nurses, therefore, feel a sense of community and belonging due to the bonds of military service developed through common experience (Griffiths & Jasper, 2007). The sense of community is strengthened beyond those found in civilian nursing and extends beyond just the nursing or other health professions. As members of the profession of arms, each member has a unique and important role to play in the successful execution of the military mission on deployment. In sharing these experiences the military nurse develops tight bonds with those with whom they deploy. Once again it is clear that the bonds of shared experience are influential in the building of relationships from within which the

military nurse and their military comrades may find nurturance and support. This support extended to the provision of spiritual care to others and to the self.

In relatively benign deployed military settings the nurse may have a greater degree of freedom of movement (Agazio, 2010). Chapter six[76] peacekeeping operations are a good example of a non-warlike operation where military nurses may be able to interact with the local communities. Risk still exists for the peacekeepers but the risks are not as acute as those found in defined offensive, peace enforcing or war-like operations. Jane (p.10&15), Kerry (p.14) and Peter (p.3) all spoke of the importance to them of interacting with the local communities of some areas into which they deployed. Military nurses may find support, emotional and spiritual, in their engagement with the local communities. This support may be found in attendance at local church services or through acceptance into the community

Contended here is that, where appropriate and available, the support of the local community can be a rich source of spiritual support for military personnel, including military nurses, and can provide a sense of belonging, acceptance and normality within an abnormal environment.

Theme four to follow addresses the question of how spirituality is contextualised in the deployed military nursing setting.

[76] In Chapter Six peacekeeping operations the United Nations sets down a requirement for internal disputes that threaten international peace and security to be negotiated to peaceful resolution (UN, 2008). An example of Chapter Six peacekeeping operations was OPERATION BELISI in Bougainville where the United Nations was attempting to broker a peace between the Government of Papua New Guinea and the Bougainville Revolutionary Army.

Theme four: spirituality

Spirituality is the fourth essential theme within the circle of understanding that informs spiritual care on deployed operations. An understanding of spirituality and what it may mean for both the nurse and the patient is essential to providing spiritual care in the deployed environment. Indeed, understanding how nurses define and contextualise spirituality is important to the delivery of spiritual care in any nursing context (Clarke, 2009).

Spirituality in context

Spirituality, whether consciously acknowledged or not, suffuses all aspects of the experience of military nurses in providing holistic care to their patients and even their peers. A review of the transcripts revealed that for the military nurse spirituality was often founded in family and supported though family and community in the deployed nursing context. The researcher's thesis, therefore, is that spirituality is at play throughout the act of caring for patients and others and has a direct influence on the delivery of spiritual care, whether directed outward to others or directed inward to meet the spiritual needs of the nurse (Fisher & Brumley, 2008; Ekhadahl & Wengstrom, 2010; Shinbara & Olson, 2010).

Engagement in a hermeneutic dialogue with the transcripts affirmed that spirituality was a broadly encompassing phenomenon. For example, spirituality was expressed by the participants in both religious and non-religious ways. This view was strongly supported in the literature where definitions of spirituality had become very inclusive (Dyson et al, 1997; Clarke, 2009; Swinton & Pattison, 2010; Reinert & Koenig,

2013). McSherry & Cash (2004) counter argued that “there is a danger that the word may become so broad in meaning that it loses any real significance” (p.151) when discussing current definitions of spirituality. However, Swinton & Pattison (2010) noted that “it is in fact the vagueness of the concept that is its strength and value” (p.226). The participants identified that spirituality could not be defined in any formulaic way in their patient populations. However, the data suggested that it did not matter how spirituality was expressed. It was more important that the nurse understood and accepted the diversity of spiritual expressions without trying to confine spirituality within their own spiritual framework. A number of factors emerged from the data that influenced the understanding of spirituality for the individual and these are discussed below.

Earlier concept of spirituality. In the researcher’s earlier study, spirituality was described as having vertical and horizontal dimensions (Ormsby, 2001). A model of spirituality proffered by Moberg (1979) was modified to illustrate how a group of military nurses conceptualised spirituality in the Royal Australian Air Force. The vertical dimension described concepts of spirituality in which individuals sought to answer the existential questions of life. Meaning was found through belief in a God, a higher being, a universal life force or through religion and contained a transcendent quality in reaching for something or someone beyond the self.

The horizontal dimension of spirituality described a striving for meaning, purpose and fulfilment in the life of an individual through humanistic means such as self-actualising activities, art, music, career, money and nature (Moberg, 1979; Stoll, 1989). Spirituality in the horizontal dimension was internally focused and sought

tangible ways of ascribing meaning through the *seen world* (Ormsby, 2001 p.184). The two dimensions of spirituality, however, were not mutually exclusive. It was noted that "many people find their spirituality may be enmeshed within both dimensions" (Ormsby, 2001 p.184). Therefore, the importance ascribed to each spiritual dimension varied according to the personal circumstances and stage in life of an individual.

Crucially, spirituality in the military found its expression in a sense of belonging to both a traditional nuclear family and a non-traditional military family (discussed above under family). Like the vertical and horizontal dimensions of spirituality, the importance that a military member attached to either the traditional or the military family to provide spiritual support, was dependant on their personal circumstances and whether the individual was at home or deployed overseas. Further, the military nurse had a role in providing spiritual care as a *de facto* family member when the individual was separated from their military unit due to illness or injury. The common bonds of service and deployment enabled the nurse to connect with their patient quickly (Stanton et al, 1996; Scannell-Desch, 2005). While the vertical and horizontal dimensions of spirituality remained valid in the context of this study the discussion on spirituality had moved on since the earlier study (Moberg, 2011).

Expanding the concept of spirituality. Spirituality, like family, was a critical influence on the delivery of spiritual care on deployment in this study. As will be seen below, definitions of spirituality had become more pluralistic over the past 20 years (Moberg, 2011; Ronaldson et al, 2012) though there had been some resurgence in religion recently (Ammerman, 2013). The use of spirituality to improve resilience

to the challenges and long term psychological effects of operational deployment was an important finding of this study and had support in the contemporary literature (Wester, 2009). What was also noted below is that there is still no universal definition of what constitutes spirituality. The researcher offers the view that the lack of a universal definition may assist the delivery of spiritual care by not constraining spirituality within a particular paradigm (Swinton & Pattison, 2010)

Spirituality is diverse. The findings suggested that spiritual expressions differ between individuals (Tanyi, 2002). Therefore, the nurse should strive to understand the differences in spiritual expression to assist them in better tailoring care to the individual for whom they are caring. Religious differences also fell into the spectrum of spiritual diversity and the practices and rituals pertaining to different religions should be respected and catered for as well as military operational considerations allow (Gulam, 2003). Argued in this study is that acceptance of the spiritual needs of another, even when disparate from the views of the nurse, is a necessary precondition to meaningful and respectful nursing care to be discussed later under the heading of spiritual care. This point was supported by Ferrell & Baird (2012) in the context of spiritual care for family care-givers and Kevern (2012) when discussing who could provide spiritual care.

Expressions of spirituality are also influenced by the cultural norms of the countries into which military nurses deploy (Gulam, 2003; Lovering, 2008; Nabolsi & Carson, 2011). Lundberg & Kerdongfag (2010) affirmed the culturally sensitive nature of spiritual care when they noted “spiritual needs depend on ethnic, religious and cultural backgrounds” (p.1127). Definitions of spirituality will, therefore, vary from

country to country. For example, in many countries to which military nurses deploy, such as Afghanistan and Indonesia, culture cannot be separated from religion (Lovering, 2008; Mahmoodishan et al, 2010). The view expressed in this study is that religion helps define the framework for providing culturally sensitive spiritual care in these cultures. However, the researcher asserts that spirituality cannot be delimited in its definition by any single expression or understanding. This view was supported by Swinton & Pattison (2010) who argued that "it is…unreasonable to expect that the practises and concepts associated with the emergent term, spirituality, will be lapidary, coherent, and universally valid" (p.227). Accordingly, spiritual definitions must include religion as an element. Religion, however, should not be viewed in an inclusive definition as the predominant notion of spirituality.

Resilience. Simmons (2012) defined resilience "as rebounding from adversity without acting in "dysfunctional or harmful ways"" (p.18). This study suggests that spirituality provides a framework in which some individuals may develop their psychological and emotional resilience to the challenges of life. Wester (2009), commenting on soldiers in a combat zone noted a positive correlation "between an individual's level of spirituality and two other constructs: ethics and resilience" (p.3). The data supported this view, with nine of the participants directly referring to the positive effect of spirituality on their resilience to the personal impacts imposed by deployment.

Resilience, therefore, is offered as an effect of spirituality rather than an essential element that defines spirituality. However, what is also argued here is that resilience is important to our understanding of spirituality as it reinforces the longer term

protective effects of spirituality to an individual. This view was well supported in the psychology and nursing literature (Wester, 2009). Simmons (2012), however, identified spirituality as a way of coping with Post Traumatic Stress Disorder in military personnel rather than as a protective factor.

Resilience is a by-product of spirituality but is intricately linked to any definition of spirituality for military nurses on deployment. What is important to note is that resilience developed through spirituality has positive long term benefits for both military personnel and Australian society. Indeed, it may be impossible to completely inure military personnel from mental health disorders resulting from deployment. However, the development of a spiritual resilience training program as part of a broad approach to deployment preparation would have two benefits: reducing the social cost of deployment sequelae to individuals, families, the military and society; and minimizing the financial cost of treating Post Traumatic Stress Disorder.

Sense of self and purpose. The common factor that drew the diverse expressions of religious and pluralistic spirituality together in this study was a need for individuals to make sense of the world (Moberg, 2011). Spirituality provides an anchor for a person to explore their sense of self and place in the world. Therefore, the spirituality of an individual is a focal point for finding meaning even in the face of difficult circumstances (Chung et al, 2007; Penman et al 2013). This is a factor that is particularly pertinent in a deployed environment where a person's perceptions of the world are challenged.

Spirituality, then, refers to any aspect of a person's life that brings a sense of purpose within the context of their existence. Gibbons et al (2012) identified a sense of purpose as being a protective factor against Post Traumatic Stress Disorder for military healthcare providers. For some of the participants spirituality was focused on religion, but for others spirituality was focused on more humanistic world views that may or may not have involved a God aspect. Indeed, a resurgence of religious spirituality was identified in Chapter two (Smith, 2009; Ammerman, 2013). However, what was important to the participants was that they agreed that spirituality meant different things to different people. Indeed, Pesut et al (2008) argued that "an important characteristic of this emerging understanding of spirituality is that it is a uniquely individual experience" (p.2804). The existential search for meaning in existence, in whatever form that takes, is a central feature of spirituality. Therefore, spirituality is argued as being focused on a sense of self and a sense of place in relation to the lived world, regardless of whether it is framed within religious or humanistic terms.

Theme five: spiritual care

Argued in this study is that spiritual care, as the central focus of the new model of care, is a relational activity that is most effective when care is provided in an atmosphere and attitude of acceptance, tolerance, respect and trust (Keeling et al, 2010; Barss, 2012; Meehan, 2012). Spiritual care supports the needs of the person who is the focus of care and subordinates the views of the care provider. Keeling et al (2010) noted a need for care givers "to be respectful of their [the patient] spirituality and not impose…issues onto them" (Keeling et al, 2010 p.238). Further,

when describing spiritual care Keeling et al (2010) suggested that health providers and patients are partners in a spiritual dance.

Spiritual care in context

In the context of this study, spiritual care is a reciprocal activity due to the nature of the relationship between military personnel, including nurses. The shared bonds of experience developed in military service and deployment engender close working relationships that extend into and beyond the nursing care setting (Biedermann et al, 2001; Scannell-Desch, 2005). Indeed, in the camaraderie evident in the military environment, the focus of spiritual care may be the patient, military peers or the military nurse.

By-product of care. Spiritual care is an integral part of the holistic nursing spectrum (Shelly & Miller, 1999; Moberg, 2011; Meehan, 2012; Ronaldson et al, 2012). Argued in this study is that the nurse should strive to include spiritual care as a natural extension of their normal nursing care of the patient. This point is important because care that ignores the spiritual needs of the patient is only addressing part of their needs (Pesut, 2013). When spiritual care is fully incorporated into holistically caring for others on deployment, its provision may be an unconscious by-product of normal nursing care. Indeed, on reflection the participants realized that the care that they did provide contained a spiritual caring element.

It is the researcher's view that spiritual care should be an ingrained activity that is provided as part of a normal *caring event* in the same manner as physical, psychological and emotional care. Timmins & McSherry (2012) argued:

> This means spirituality and the provision of spiritual care are embedded within the fundamental and core values of everyday nursing ritual and practice. It is not something that is added to nursing because it is interwoven within the entire fabric of nursing history, culture and values –one cannot be a nurse without encountering or caring for the human spirit at some point (p.955).

Spiritual care may then be delivered either consciously or unconsciously but always in accordance with the needs of the patient. Therefore, the focus of spiritual care in the nursing interaction with the patient must always be on the needs of the patient. To understand the needs of the patient, however, the nurse needs to engage them in a genuine dialogue. Understanding is always a language bound act that seeks, through the question and answer of the participants, to find meaning in the event of the conversation (Gadamer, 1976/2004).

The other's shoes. Spiritual care is always an empathetic act between the nurse and the patient. Empathy is described as sharing "the feelings or outlook of another" (Honderich, 2005 p.242). The military nurse strives to understand the spiritual needs of their patient (*the other*) through an interpretive empathetic act[77]. While seven of the participants spoke about the need for empathy in providing spiritual care to their patients Katie referred to empathy as placing herself in the shoes of her patients. For Katie understanding the experiences and needs of the patient was an important part of her spiritual caring tool box. Empathy enables the military nurse to understand those needs in relation to their own interpretive horizon (Gadamer,

[77] The researcher proffers the view that empathy is an interpretive act that seeks to understand the point of view of the *other*.

1976/2004). Through dialogue with their patient the military nurse ensures that the spiritual care that they provide is better targeted to meet the needs of the patient.

Acceptance and respect. The next elements that influence spiritual care on deployment are those of acceptance and respect for the spiritual point of view of the *other*. Only four of the participants directly addressed acceptance and respect for the patient and their specific spiritual needs and worldview. However, the data suggested that the military nurse needed to accept the spiritual view of the person to whom they are directing their care. Further, the nurse should support those needs in whatever way they can within the constraints of operational deployment. Acceptance leads to respect for the *other* and helps the development of a trusting therapeutic relationship on deployment.

Respecting the spiritual point of view of the *other* is vital to the caring relationship. In being respectful it is also important that the military nurse does not impose their own beliefs on the patient. Any attempt to impose a personal spiritual view at the expense of the beliefs and needs of the patient will degrade the trust developed in the therapeutic relationship and this view was supported by seven of the participants. The nurse has a moral and ethical responsibility to do what is right for the patient and subjugate their own views to the needs of the patient.

It is the researcher's thesis that acceptance and respect for the spiritual needs of the patient are central to meaningful spiritual care in the clinical environment on deployment. However, these attributes are also relevant to the nurse-peer interaction whether this is directed to the peer or back toward the nurse.

Spiritual caring practices. Spiritual caring practices are as diverse as the individual expressions of spirituality. These practices may be direct and deliberate or indirect and unconscious. They may include praying with a patient, providing a quiet place for meditation or reflection, facilitating the involvement of chaplains, Imams or other spiritual carers, or being present as a spiritual support during a time of spiritual need. The most important points to be considered, however, are that a spiritual need should not be ignored and the focus of the care should always be directed toward the person in need and not distracted by the personal views of the carer. A number of spiritual caring practices were identified in this study that were common throughout the participant transcripts. These practices were also well supported in the spiritual nursing care literature (Carson, 1989; Govier, 2000; Harrington, 2003; Sawatzky and Pesut, 2005; Casarez and Engebretson, 2012; Cayetano-Penman, 2012) and are summarized in table 8.2 below.

SPIRITUAL CARING PRACTICES	
• Talk about beliefs/needs	• Give time
• Be present	• Refer
• Actively listen	• Assist their journey
• Touch	• Support practices
• Facilitate	• Respect needs and wishes
• Reassure	• Pray for
• Connect	• Involve family
• Empathise	• Nurture

Table 8.1: Spiritual Caring Practices

Effective spiritual care is borne out of human interaction and relationship. Military nurses are better equipped to provide spiritual care in an environment of open and

trustful communication. It is through effective dialogue[78] that the nurse begins to understand spiritual needs from the perspective of the patient. There was nothing new or revelatory about the views of the participants on spiritual practices in this study. However, the participants unanimously agreed that spiritual care was an important part of the nursing role and should not be abrogated despite the challenges to providing this aspect of holistic caring practice in a deployed military nursing context.

Barriers to spiritual care. Military operational considerations constitute one of the major barriers to spiritual care on deployment. In situations where there are high numbers of military casualties arriving in the military health care facility it may not be possible for the nurse to assess or understand the specific spiritual expression and needs of the individual in the immediate high intensity period.

Kerry's experience on a deployment where the risk of casualties and the operational risk for the nurse was much lower than that experienced by Bridget indicated more time to focus on the spiritual. In this environment the nurse may have more time to dedicate to providing adequate and targeted spiritual assessment and care. The researcher suggests that operational tempo and intensity can have a direct impact on the ability of the nurse to provide spiritual care. However, the participants agreed that spiritual care was a nursing job and should be provided despite the operational constraints.

[78] Gadamer (1976/2004) asserted that meaning is only possible in genuine dialogue. The researcher supports Gadamer's notion but notes that genuine dialogue requires both parties to enter into the conversation and this is the point at which relationship needs to be built.

The most interesting barrier to spiritual care that the participants raised was related to a very specific operational constraint. Providing care for detainees[79] presented a number of barriers that were unique to the military nursing context and very difficult to overcome. Some of the military nurses deployed into multinational health facilities in which detainees were frequently brought into wards or intensive care units for care during or prior to incarceration. The participants stated that all patients needed to be treated equally and with dignity. In their opinion Australian military nurses did not dilute their care of the spiritual and other care needs of the patient on the basis of nationality, religion, political affiliation or insurgent/terrorist activities.

The difficulty for the Australian military nurses was that detainees were often sensorially deprived and tethered to the beds they were in. They did not speak the same language as the nurse and were generally distrustful of foreign military nursing personnel caring for them. Spiritual care is hindered in such situations but its delivery is not impossible even in the most trying of circumstances. The use of interpreters and providing support that is humane and touches the spirit of the patient is a valid spiritual caring practice. Spiritual care, therefore, is a relational activity that is cross cultural and can be provided meaningfully despite the circumstances of a deployment.

Self-directed care. One of the most significant aspects of the spiritual care described within this thesis is that of the need for the nurses to deal with their own spiritual

[79] In contemporary conflicts detainees may be brought into military hospitals for care due to injury or illness. The detainees are most often members of insurgent or terrorist groups that are actively involved in offensive operations against the population of the country they are in and/or the military forces that are attempting to neutralise the insurgent activities.

issues. Deployment places many expectations, challenges and stressors on the military nurse and they are not immune to spiritual distress. It is important for the nurse to have a mechanism for processing the often confronting circumstances of deployment. Hodson (2002) clearly identified the high risk of psychological injury that Australian military personnel have experienced in peacekeeping operations. However, nurses were no less at risk of spiritual injury than were other military personnel on deployed operations. As Barbara identified earlier, of the nurses that she deployed with on one military operation, one in four suffered from Post Traumatic Stress Disorder.

The participants identified a number of different coping strategies for dealing with the stresses of deployment. For some these strategies revolved around their religious faith while for others the ability to rely on peers to talk through their spiritual issues was more relevant. However, there was a tacit understanding among the participants that the ability to talk through their issues within a construct of shared experiences was an important element of self care.

The findings suggested that within the group dynamic the mutual support provided to individuals by other members of the deployed military family was a crucial factor in spiritual coping. The friendships and bonds developed within the peer groups and military units facilitated the avenue for nurses to process their feelings. The peer relationships became a safe haven for the nurses within which they could express and have their spiritual needs met by their military family.

The nurse may also have some personal spiritual coping strategies that they use in addition to group support to meet their spiritual needs while deployed. It is the opinion of the researcher that every individual is an inherently spiritual being that seeks and finds support in someone or something beyond themselves. Individuals that are able to hold firmly to their system of belief appear to cope better with circumstances that are beyond their normal experience to deal with emotionally and spiritually. For the deployed military nurse holding firm to their system of belief may be as simple, yet significant, as believing in the inherent good of humanity to overcome circumstance despite the horrors that they may witness. However, religious belief, faith and prayer remain comforting factors for many military nurses, even those that do not necessarily ascribe a religious spiritual world view. Perhaps there is an element of truth in the remark by American priest William Cummings (Oxford, 1992, p.229) that "there are no atheists in foxholes."

The final area of spiritual self-care to be discussed is that of support from the local community into which the nurse may deploy (see community above for further discussion on this topic). While some deployments may not be conducive to seeking spiritual support from local communities due to the operational risk, there are some deployments where this is both possible and a valid form of spiritual nurturing. Nurses may seek spiritual nurturing within the religious services of a local church or a community of believers that is relevant to their spiritual beliefs. Alternatively, the nurses may find spiritual support offered by local communities in ways that they do not expect. This support may be in the form of wisdom or support from Indigenous spiritual leaders such as shamans or witchdoctors. In this way external spiritual

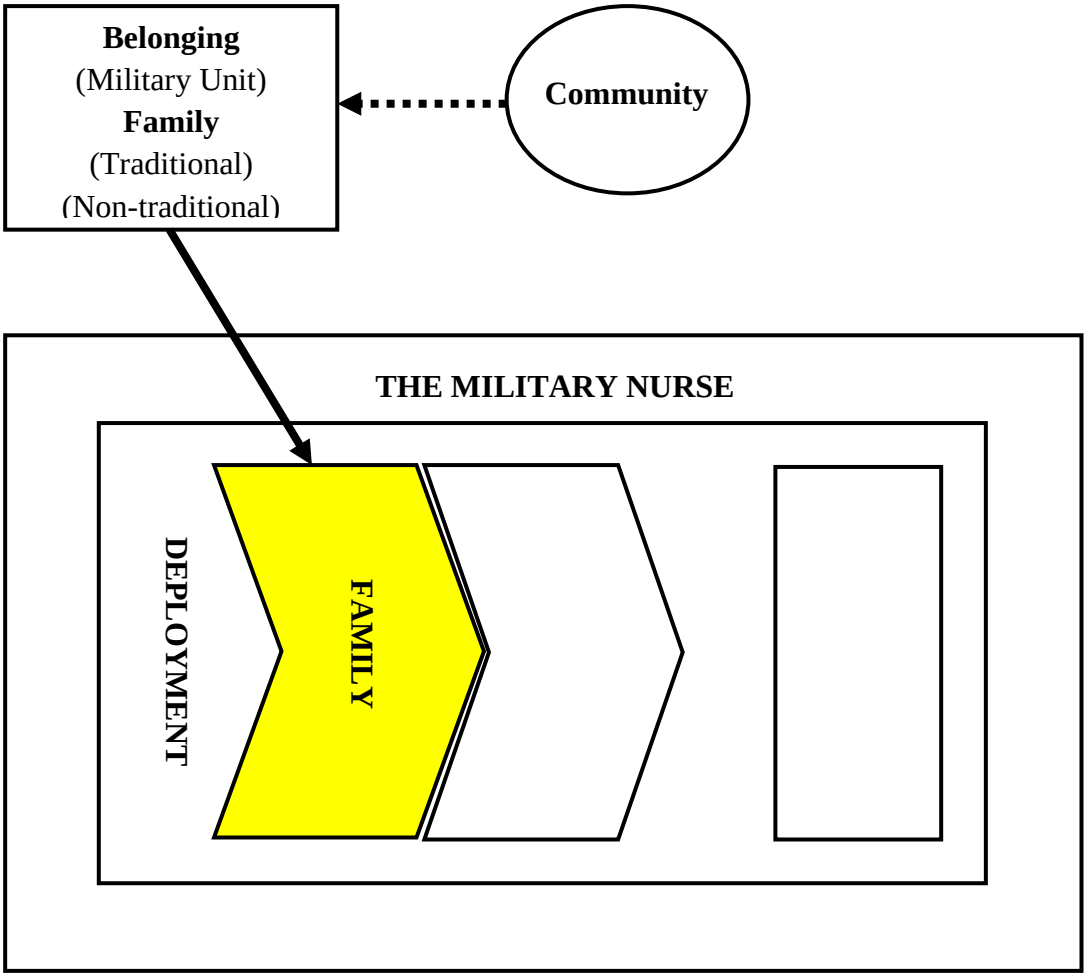
support for the self-care of the nurse may be unexpected but meet the spiritual need of the nurse at that particular time and place.

The remainder of the chapter introduces the new model of spiritual care that centres on the fifth essential theme: spiritual care.

8.2 Building a new model of spiritual care

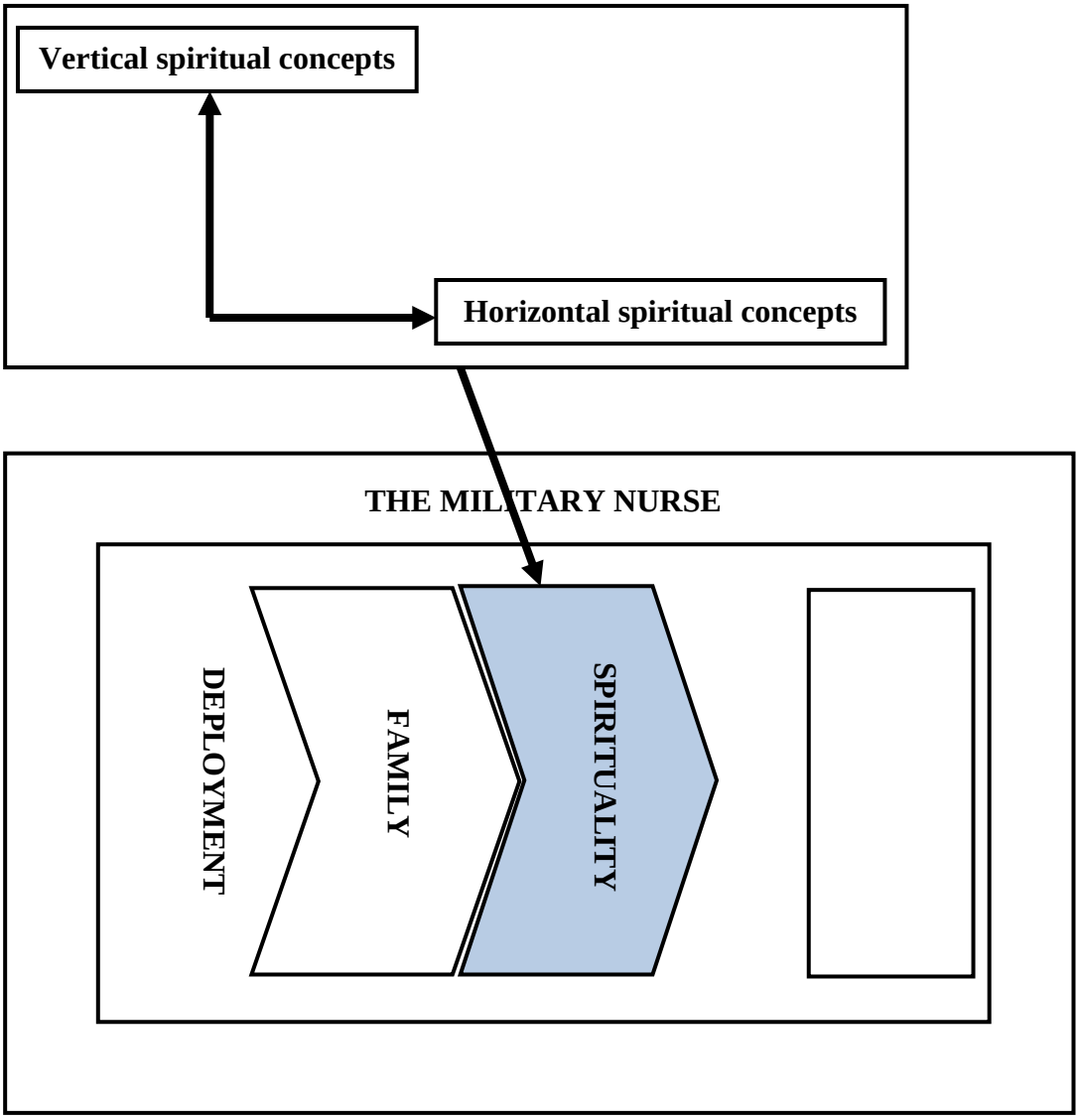
The new model to be examined in section (8.3) of this chapter uses elements of the researcher's first model (Ormsby, 2001) in which a sense of belonging to a family was central to spiritual care. In building the new model of care, family remained an essential element of spiritual care but was extended to include sibling and parental relationships and community. However, rather than being situated at the axis of the horizontal and vertical aspects of spirituality (see Chapter one discussion) family is now placed within a contextual framework that includes the military nurse and deployment. Further, belonging, family and community are collapsed under the single heading of family.

Figure 8.1: A new model of spiritual care part one (family)



2001). The horizontal and vertical concepts of spirituality (see Chapter one discussion) that saw their foundation in a sense of belonging to family and community are now collapsed into the contextual framework in which the relationship between the military nurse, deployment and family are understood to influence the delivery of spiritual care.

Figure 8.2: A new model of spiritual care part two (spirituality)



8.3 A New Model of Spiritual Care

To assist the reader to understand the unique nature of spirituality and spiritual nursing care in the deployed Australian military nursing context, a new model of spiritual care is offered. The model represents a caring interaction in which spiritual care may occur from or toward the nurse while on military deployment.

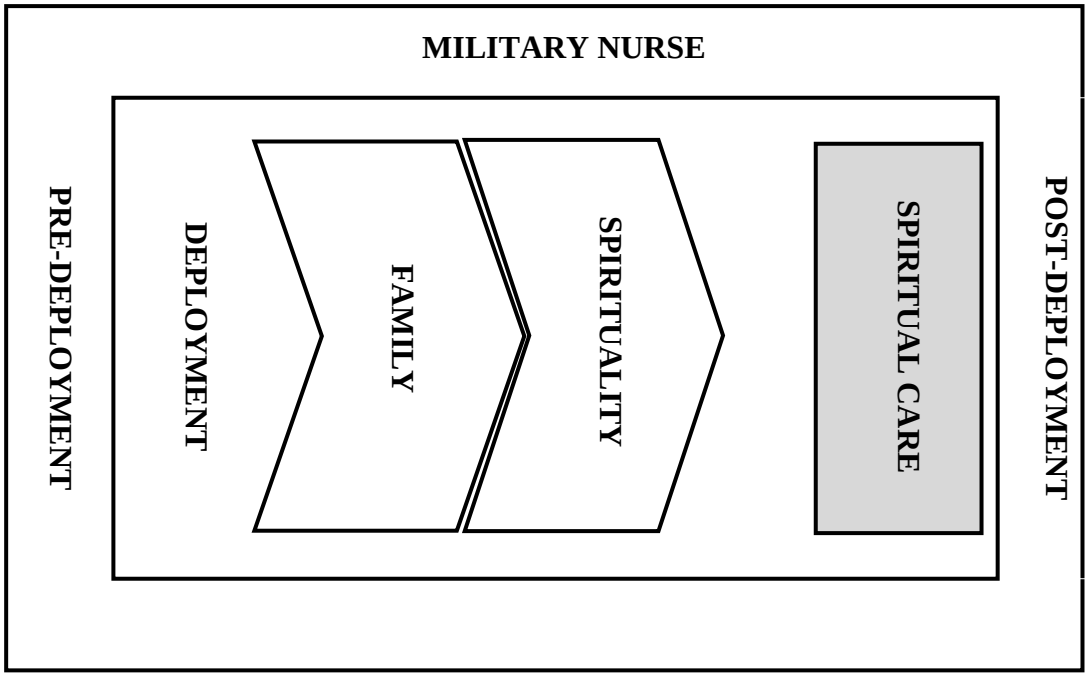
The new model provides context and meaning to the understanding of spiritual care. Each element of the model is presented as a foundation for the next level of the model. The outer layers of the model represent the context for understanding spiritual care from the perspective of military nurses on military deployment. The inner arrows highlight the relationship of the essential themes that combine to influence the provision of spiritual care.

The discussion of the model begins by examining spiritual care as a continuum through the three phases of deployment (pre-deployment, deployment and post-deployment). Pre-deployment (the preparatory phase of deployment) is the phase of operations where the mission is set and military personnel begin to draw focus away from normal home life in readiness for the actual deployment. Deployment (the execution phase of deployment) is the phase of operations where military personnel are entirely focussed on the circumstances of the mission. Post-deployment (the re-integration phase of deployment) is the phase of operations where military personnel return home, re-adjust to life away from the demands of operations and attempt to make sense of their experiences.

The model presented in Figure 8.3 below, is the culmination of the researcher's dialogue with the participants and the transcripts. It represents spiritual care through the interpretive horizon of the researcher in which spiritual care stakes its truth claim[80].

[80] According to Gadamer (1960/2003) the truth claim of a text is uncovered when the "text can present itself in all its otherness and thus assert its own truth against one's own foremeanings" (p.269).

Figure 8.3: A new model of spiritual care



The phases of deployment

The exploration of the new model of spiritual care (Figure 8.3) to follow will be broken down into three discrete sections that align with the stages of operational deployment. As identified above, operational deployment generally follows a linear pattern of pre-deployment preparedness, deployment and then a post-deployment phase of operations.

Pre-deployment

The pre-deployment phase of operations is centred on ensuring that military personnel, including nurses, are prepared and ready to deploy to military operations anywhere in the world (Kovats et al, 2001). The Australian Defence Force places a strong emphasis on mental and emotional resilience in preparing personnel

throughout their careers for the rigours of deployment. However, there is a deficit in programs that extend into spiritual resilience. Drescher et al (2007) suggested that spiritual awareness programs and care provided in collaboration between chaplains and health care providers is one way to address this gap.

This study advocates for the inclusion of spiritual resiliency training as a normal part of operational preparedness. Its inclusion would: de-mythologise spirituality from the sole domain of religion; help increase spiritual awareness as a mode of self-care; and assist in opening a dialogue that provides a framework of meaning in the face of the challenges of deployment (e.g. separation from family, the possibility of death or injury, the need to apply deadly force, or the viewing of dead bodies). While the Faith Under Fire program (DoD, 2011b) run by the Australian Defence Force Chaplaincy Service partly addresses the issue of individual spiritual resilience from a Christian perspective it does not form part of the preparedness training for military personnel. Further, the program does not address the issue of education of nurses or other health care providers in the provision of culturally sensitive and pluralistic spiritual care that can be applied on deployment. Indeed, after Baldachinno (2009) the findings suggested that spiritual awareness training "supported by education" (p.280) was a necessary component of competent spiritual care delivery by nurses.

The provision of spiritual awareness training in the pre-deployment phase of operations is important because military nurses provide care to military personnel on military bases in Australia. In most instances, when in Australia, military personnel meet their spiritual needs from within their traditional family and community structures. However, there is an opportunity for nurses to develop a rapport, through

common military experiences, with the military personnel with whom they will also deploy. Hodge (1997) noted that military personnel, and often their families, have a primary affiliation with the military and are "bound to others by the common cause and conditions under which they all service" (p.36).

Deployment

Operational deployment "to defend Australia" (DoD, 2002 p.1) is the *raison d'être* of the military and provides professional validation for the training that military personnel undergo. Opportunities for Australian military nurses to deploy to operations were scarce in the thirty years following the withdrawal of Australia from the Vietnam War in 1972 (Morrison, 2013). However, since the first Gulf War in 1990 and more recently since the involvement of Australia in East Timor, Afghanistan and Iraq, commencing in 1999, 2001 and 2003 respectively, Australian nurses have been continuously involved in military operations. On this point Morrison (2013) noted that the Australian military has "been exposed to sustained operations across the spectrum, from warfighting…to peacemaking…as well as pure humanitarian relief" (p.11) since East Timor.

In the contemporary Australian military environment deployment is experienced by most personnel, including nurses. The current operational tempo is significant to this study as it indicates that nurses have been actively providing care inside war zones continuously for over fourteen years. Argued in this thesis is that the duration, frequency and type of deployment will have a significant impact on the emotional and spiritual resources and resilience of these individuals both now and into the

future. This assertion was strongly supported by the literature (Hodson, 2002; Friedman, 2004; Sixsmith et al, 2013). Indeed, Gibbons et al (2012) suggested:

> military healthcare providers are not immune to deployment stressors and the current military climate with multiple redeployments into high intensity combat and terrorist regions requires a closer look at the exposure of healthcare providers and their personal and professional risk (p.4).

The pre-deployment phase of military life has been argued as important for establishing the framework and relationships in which spiritual care takes place. The deployed phase of operations, however, is the time when spiritual care of the individual is transferred from family and community to the military organisation. Hodson (2002) noted:

> Military populations may also have a greater dependency on intimate relationships and peer networks, due to the mobile nature of Defence families and a lack of access to extended family networks (p.110).

Care, therefore, is delivered through the connections developed within the military unit that are responsible for the welfare of its members and adopts a family like role (Beidermann et al, 2001). It is important to note that the military family does not replace the traditional family. Rather, it supplements the traditional family during times of separation when contact with home is often brief and sporadic (Chambers, 2013). Therefore, the role of the nurse in the delivery of spiritual care to military personnel is at its most apparent during deployment. Deployment is the time when the nurse has the greatest contact with patients. It is also the point at which nurses need to be most attuned to the spiritual needs of others through verbal and physical

language clues to be able to effectively provide spiritual care for those under their care. Accordingly, the nurse, through the rapport they have with military patients and the constant care they provide, remains central to the delivery of spiritual care as a professional and peer support within the military family. Moreover, in the context of this study the need for spiritual self-care is at its most acute during deployed operations as it prepares them for their reintegration to home life post-deployment.

Post-deployment

On return to Australia and the normal home environment, military personnel begin to readjust to life away from the challenges of deployment. In the post-deployment stage of operations, the primary spiritual caring role is handed back from the military family to the traditional family and community of the individual. It is important to note, however, that the bonds of shared experience for military personnel who have deployed together often endure as part of the ongoing support network of veterans of military operations (Scannell-Desch, 2005) upon return to home. However, it is often in the aftermath of deployment that the "ghosts" of war surface and present challenges to the spiritual resilience and the mental health of military personnel including nurses (Friedman, 2004; Drescher et al, 2007; Gibbons et al, 2012; Sixsmith et al, 2013).

Military nurses are no less impacted by the experience of deployment than other members of the military (Stanton et al, 1996; Gibbons et al, 2012). Indeed, Stanton et al (1996) noted that many nurses "tended to deny feelings and pretend "everything was all right". Many have denied feelings to the point of emotional illness" (p.346). In denying their own feelings in the act of caring for others, the researcher suggests

that nurses may be at more risk of spiritual, emotional and psychological injury than many of their military peers. Spiritual resilience, therefore, may provide part of the answer to inoculating nurses and other military personnel from the adverse outcomes of war such as Post Traumatic Stress Disorder. Gibbons et al (2012), while not directly referring to spirituality, found that "social support…and a sense of purpose" (p.15) were protective factors against the long term effects of deployment.

Viktor Frankl (2004), in writing about his experience of imprisonment in a number of concentration camps during the Second World War, confirmed the value of meaning and purpose to survival during wartime. On this point, Frankl (2004) remarked that "striving to find a meaning in one's life is the primary motivational force in man" (loc.1280). He continued by noting the resilience and meaning to be gained from a strong spiritual sense of self:

> In spite of all the enforced physical and mental primitiveness of the life in a concentration camp, it was possible for spiritual life to deepen (loc.545)…Only in this way can one explain the apparent paradox that some prisoners of a less hardy make-up often seemed to survive camp life better than did those of a robust nature (Frankl, 2004 loc.547).

Discussing spirituality and its effects on military veteran adjustment following deployment, Drescher et al (2007) also identified the protective effects of a sense of purpose within a spiritual caring framework. They stated that "religious beliefs and practices (spirituality)…provide an avenue for coping with difficult life events" (Drescher et al, 2007 p.432). In the context of this study, spirituality was also viewed by the participants as a way of making sense of the events that they experienced on deployment.

Sixsmith et al (2013) identified other resilience factors in World War Two wartime experiences:

> The binding together of the wartime generation comprised elements that could not be replicated in other historical niches: the comradeship of brothers-in-arms; the emotional and practical coping strategies for dealing with adversities, loss and deprivation…neighbourhood and family (p.22).

Noting the prevalence of mental health disorders, such as depression and Post Traumatic Stress Disorder as well as alcohol misuse post deployment (Hodson, 2002; Hoge et al, 2004; Drescher et al, 2007), it is vital that spiritual resilience programs are implemented in the Australian military as part of an overall resilience training strategy. Spiritual resilience in combination with strong peer support networks within the military family may reduce the incidence of the mental health disorders often precipitated by deployment to military operations (Drescher et al, 2007). Also argued is that organisational resolve is required to improve the holistic management of the mental, emotional and spiritual health of current and ex-serving military veterans post deployment. Combining spiritual resilience strategies with other emotional resilience programs will help reduce the cost: to the member by minimising the incidence of psychological trauma; their family by limiting negative coping behaviours in military personnel; the military by decreasing attrition of the trained workforce through medical discharge from service; and the community through a lesser reliance on the health system.

Drescher et al (2007) began to address the use of spirituality to improve the long-term resilience and coping strategies for veterans of conflicts in war zones. They

advocated for the use of spiritual care collaboration by chaplains and mental health teams to:

- Reduce negative and destructive patterns of behaviour such rage and revenge seeking;

- Recover meaning through modified ways of thinking;

- Reduce stress and increase resilience to life challenges; and

- Develop positive coping resources (Drescher et al, 2007).

The findings of this study suggested that military nurses also had an important role in the provision of spiritual care to patient and peer populations post-deployment. Further, spiritual awareness, resilience and self-care may assist nurses to cope with the long-term impacts of deployment on their own psychological, emotional and spiritual health and well-being. Gadamer (1976/2004) referred to the changing horizons of understanding in individuals. Deployment fundamentally changes individuals that experience it in ways that may be deleterious for military personnel and their families, who are often left to pick up the broken pieces. Spirituality and effective spiritual care in combination with other coping strategies may help to minimise the negative impact of deployment to military operations on military personnel including nurses.

> There are so many questions of how to recover a war veteran's emotional health and spirituality…The anguish of war is forever with the soldier. He has lost part of himself in the war when he became a trained and experienced killer. The combat soldier's world-view is shattered because no place is safe without a gun to protect himself, even after arriving at home (Paquette, 2008 p.143-144).

8.4 Summary of Chapter eight

Chapter eight discussed the five essential themes that culminate in the delivery of spiritual care in the deployed military nursing context. Through the text a new model of spiritual care was gradually built around the five themes that extended on the researcher's previous Master's Degree spiritual model (Ormsby, 2001).

The military nurse was presented as central to understanding spiritual care in a military care setting. The unique nature of military service was argued as a defining characteristic between military and civilian nursing. The duality of the warrior and nurse roles provided challenges to the delivery of spiritual care. Readiness provided a major defining characteristic of military nursing along with the relationship and connectedness found in the common experiences of military service. Military nurses are an integral part of the military culture and therefore provide the foundation layer for building a new model of spiritual care in conjunction with the unique context of operational deployment.

Deployment was presented as the most critical defining feature of military nursing and provided many challenges to the delivery of spiritual care. Nurses deploy at the behest of governments to support war fighting forces and to meet national security objectives. There are significant physical and psychological dangers inherent in

military service on deployed operations and nurses need to develop resilience to these factors. Separation from family and re-integration into normal life post-deployment are seen as two of the most significant challenges for military personnel including nurses.

Notions of family were central to the researcher's earlier study (Ormsby, 2001) and remain relevant to the current research. Indeed, the earlier concepts were combined with community as social, emotional and spiritual support structures and collapsed into a discrete element within the new model of care. Family in the military context is understood in terms of traditional family and social support networks, military family and peer support and community. Community encompasses local and Indigenous social networks when operational considerations allow. The military family was redefined to include a hierarchical structure of parents and siblings in which individuals find a spiritual home, camaraderie and a sense of community.

Spirituality was examined in terms of patient care, care to peers and as an instrument for self-care for the nurse. It was argued that spirituality suffuses all aspects of caring relationships in the military, consciously or unconsciously, and is integral to spiritual care on deployment. Spirituality was reviewed in its vertical and horizontal dimensions and these were brought together into another discrete and important influence, along with family, of spiritual care in the military. Definitions of spirituality need to be inclusive and diverse to meet the increasing secularisation of society of which the military is a part. Spirituality was argued as another protective factor in building resilience against the traumas often experienced on deployment

that may manifest in Post Traumatic Stress and other mental health disorders for military personnel including nurses.

Finally, a new model of spiritual care was introduced. The context and nature of spiritual care on deployed military operations was examined through the elements of spirituality identified in the model and through the three phases of operational deployment. Spiritual care was presented as a normal by-product of holistic nursing care that was empathetic, respectful and accepting to the needs of others above those of the nurse. Further, spiritual care practices were discussed and barriers identified to the delivery of such care by the nurse. Most importantly, however, was the finding that spiritual care was equally important for the deployed military nurse in dealing with their own experiences of the unique challenges of deployment.

CHAPTER 9: CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

Spiritual care is not the unique or exclusive domain of military nursing. It is, however, necessary for military nurses to understand the factors that influence spiritual care delivery in their practice setting. Drescher et al (2007) pointed out "spirituality may play as a healing resource for those recovering from the warzone trauma" (p.432). Consequently, nurses need to be cognisant of the importance of spiritual care in the deployed military context, not only for their patients and colleagues, but also for themselves. Spirituality, therefore, is argued here as a protective factor against the challenges and consequences often associated with deployment. Well developed spiritual resilience may assist in ensuring that military personnel return home emotionally, psychologically and spiritually "fit".

In this study military nurses were integral to the care of the wounded, sick and dying on military operations and associated strongly with the military personnel with whom they deployed (Griffiths & Jasper, 2007). The close connection with their military colleagues places the nurse well to provide spiritual care while deployed. The practice context is what sets this study apart from other studies and defines it as an original contribution to the nursing literature. The focus of this thesis, therefore, has been on how military nurses understand spiritual care in the context of deployed military operations.

This chapter is the culmination of this thesis and true to Gadamer (1976/2004) closes the hermeneutic circle of understanding in relation to the phenomena under investigation. Philosophical Hermeneutics provided a means through which the data could be explored and the meaning and truth claim of the findings disclosed. Gadamer (1976/2004) suggested that the history, prejudices and horizon of the researcher and the *other* (participant, care giver and care recipient) are integral to the research endeavour.

The following pages will:

- (9.2) Briefly revisit Gadamer;
- (9.3) Offer conclusions to the research; and
- (9.4) Make recommendations for further research.

It is fitting that the chapter begins by revisiting Gadamer before closing out this thesis.

9.2 Gadamer Revisited

Every aspect of this study from inception to completion has been approached through the Philosophical Hermeneutic lens of Gadamer (1976/2004). Accordingly, it is appropriate that the thesis now returns to Gadamer's themes to assist in bringing the threads of this thesis together. What has been attempted here is to faithfully represent

the thoughts and experiences of the participants on spirituality and spiritual care in the context of a deployed military nursing setting. The account presented, however, was not a verbatim retelling of the participant stories, as "understanding is not a mere reproduction of knowledge" (Gadamer, 1976/2004 p.45). Rather, it was an interpretation based on the researcher's understanding of the hermeneutic conversations where prejudices:

> Are biases of our openness to the world. They are simply conditions whereby we experience something – whereby what we encounter says something to us (Gadamer, 1976/2004 p.9).

The history and biases that we bring to the interpretive act constitute our horizon of understanding. Through genuine dialogue we seek to understand the interpreted world of the *other*. Gadamer (1976/2004) argued that "when a dialogue has succeeded, one is fulfilled by it" (p.66). It is in the fulfilment of the dialogue that the horizons of the interpreter and the interpreted are fused. Therefore, in seeking to understand the spiritual experiences of the *other* (participant) in this study the interviews and transcripts were approached openly but cognisant of the personal experiences that had shaped the horizon of the researcher. Those experiences included the common culture and language of the military, nursing and deployment that were shared with the participants.

Gadamer (1976/2004) asserted that "understanding is language-bound" (p.15). Indeed, without language dialogue would not be possible. It could be assumed, therefore, that without a common language that there could be no understanding. What Gadamer (1976/2004) argued, however, was that when two people enter a

dialogue "they speak the same language…But each person also speaks his own language[81]" (p.56). The fusion of horizons is the merging of the language of each individual into a common understanding. This point is important to note in the context of this study. When nurses entered into conversations on spirituality, they did so openly and genuinely to find a common language that facilitated spiritual care to their patients, their peers and themselves. The extracts from the transcripts in the previous chapters confirmed the openness to the dialogue. The nurses identified the requirement for spiritual care to be open to the needs of the care recipient without imposition of the personal spiritual views of the care-giver.

Gadamer (1976/2004) also likened the act of dialogue to the form of a game. He asserted that "the back and forth movement of the game has a peculiar freedom and buoyancy that determines the consciousness of the player" (Gadamer, 1976/2004 p.53). This study was approached throughout both the interviews and the transcripts via the back and forth flow of dialogue. In this way, "word and dialogue…include within them an aspect of the game" (Gadamer, 1976/2004 p.56). The game, therefore, represented the process of question and answer that occurred between the interpreter and the interpreted that led to agreement. The truth claim of the interpretation was disclosed in reaching agreement (Gadamer, 1976/2004) but

[81] Argued here is that Gadamer (1976/2004) was not making a literal statement when he alluded to dialogue being carried by the "same language". Rather, his meaning was to enter into a dialogue genuinely to find agreement. If taken literally it would not be possible for the military nurse on deployment to understand the spiritual needs of patients from other countries that do not speak English. In speaking "their own language" Gadamer referred to the internalised influences that shape the experiences of the individual. Their own language is the effective history and biases that form an individual's horizon of understanding.

remained open to its own futurity. That is, the interpretation was temporal and open to re-interpretation by others. On this point Gadamer (1976/2004) asserted:

> Nowhere does understanding mean the mere recovery of what the author "meant," whether he was the creator of the work of act, the doer of a deed, the writer of a law book, or anything else. The mens auctoris does not limit the horizon of understanding in which the interpreter has to move, indeed, in which he is necessarily moved, if, instead of merely repeating, he really wants to understand (p.210).

9.3 Conclusion

This research began with an aim to better understand the nature of spirituality and spiritual care from the perspective of military nurses who had practiced within a deployed operational setting. Consensus on a singular definition of spirituality remained elusive, though an operational definition was provided based on the findings of this study. What was sought from the study was to uncover the expressions and lived experiences of the nurses as they applied to spiritual care within a unique and under-researched area of nursing practice.

To achieve the aims of the study, ten Australian Defence Force nurses were interviewed as part of a Philosophical Hermeneutic endeavour. Philosophical Hermeneutics (Gadamer, 1976/2004) seeks to uncover the interpreted meaning of an object through the medium of language in dialogue. The findings represented a fusion of horizons (Gadamer, 1976/2004) between the researcher and the transcripts that contained the personal language and expressions (horizons) of the participants relating to the phenomena under study.

The researcher's journey began with a deployment as a military nurse to Rwanda in 1994, advanced through a preliminary study into military spirituality in 2001, and culminated in this current thesis. The overt aim of this study was to expand the current knowledge and understanding of spirituality and spiritual care within a unique deployed military nursing context. This aim was achieved through an interpreted view of the stories and experiences of the participants as Australian military nurses. Moreover, in engaging with the nurses and the data, the researcher was able to reflect on his own practice as a military nurse. The voice of the researcher was also established in relation to the application of spiritual care in nursing practice and the benefits to be derived from spiritual engagement in the deployed military setting.

Apparent throughout the research journey was that the application of spiritual care in the patient care setting by military nurses did not differ greatly from that provided by civilian nurses. Indeed, even spiritual care directed back to the nurse (reciprocity) or as a means of self-care (coping) were not new concepts. However, the impact of deployment on military nurses and the wider military population ensured that the significance of spirituality and spiritual care on this cohort had more immediate and tangible outcomes due to the relative isolation that military personnel experience while on deployment. Isolation from home and normal family, peer and community support networks for extended periods while working in often austere and dangerous circumstance ensured that resilience, both spiritual and emotional, were acute requirements to ward off the long term impact of deployment such as depression, Post Traumatic Stress Disorders, alcohol and drug dependency and social dislocation. A major finding of this study, therefore, was that improving spiritual

resilience in deploying personnel may have a protective effect against the negative sequelae of deployment.

In representing the experiences of the nurses in this study a new model of spiritual care was developed that encapsulated the five main themes that were disclosed within the data. In the first theme (the military nurse) the participants found a home in the context, culture and values that pervaded life as a nurse in the military. Not only did the nurses provide care to others they were an integral part of the military organisation that presented personal and professional challenges that generally exceeded those experienced by civilian nurses. In this respect the military nurse shared a common bond of experience with their patients and peers, who could also be their patients, that provided them an entrée to the provision of spiritual care.

Deployment (theme two) was an experience unique to the military and represented the *raison d'être* of the military nurse. It could be argued that some civilian nurses also deploy, however, throughout this thesis it was apparent that the nature of military deployment was significantly different from civilian deployment. A warrior-healer dichotomy existed in providing care to the wounded and ill under threat of military action. That the nurse was also being expected to apply lethal force if required, had no direct civilian parallel. It was within this environment that the enduring bonds of camaraderie found their foundation. The participants understood the austere working and living conditions, the dangers to life, limb, mind and spirit that accompanied war, the separation from home and the visual horror that conflict presented. Therefore, nurses were not immune from the same issues that their war

fighting colleagues endured both during and after deployment. Indeed, the nurses expressed a common view that deployment fundamentally changes a person.

The military was described as a family (theme three) that supported its members through the continuum of service. When deployed, the military family stepped into the *de facto* role of carer for its members due to the absence of traditional support networks. Adding to the uniqueness of military service was the view presented by the participants that they found their own spiritual support within the military family that provided substitute siblings and parents in whom they could confide and trust. Particularly important was the finding that the bond of camaraderie was so strong that family members would either share the burden of deployment or willingly lay their life on the line for their brothers and sisters in arms. The altruism evident in the military family took on a distinctly spiritual quality when viewed from the perspective of the sacrifice of self for the benefit of others.

The fourth theme (spirituality) indicated a pluralistic view of spirituality that centred on a search for meaning, purpose and place in the world. Religion remained important as an expression of spirituality, however, the language and experience of spirituality were uniquely individual. How the nurses conceptualised spirituality for themselves and their patients directly influenced their delivery of spiritual care on deployment. The major point to emerge from the understanding of spirituality presented here was that the participants suggested that spirituality may provide resilience against the immediate and long term negative impacts of deployment. Deployment raised many questions for nurses in relation to their spiritual sense of self and presented challenges to the delivery of spiritual care.

Spiritual care was the fifth theme to be presented in the new model of care. The nurse directed spiritual care to patients or peers. Conversely, the nurse received spiritual care from the same people that they cared for in a reciprocity of care. Of particular importance to this study, however, was that the nurse may undertake spiritual self-care. The provision of spiritual care was aided by the common bonds of experience that existed in the military and should be viewed as a by-product of normal patient care. Empathy, respect, acceptance, tolerance, relationship and trust toward others provided the fertile ground from which appropriate and understanding spiritual care took place. It was only when engaged in meaningful dialogue, in an effort to understand the *other*, that spiritual care truly engaged the spirit of humanity in its fullness.

Tanyi (2002), Timmons & McShery (2012) and Wright & Neuberger (2013) all argued that spirituality was an essential part of our being. Wright & Neuberger (2013) also identified, as did the nurses in this study, that spiritual care should be a normal part of nursing practice. Indeed, the recognition and support of nurses to the effective delivery of spiritual care was beneficial to patient well-being and resilience in the face of life challenges (Keeling et al, 2010; Pargament & Sweeney, 2011; Penman et al, 2013). The study confirmed the centrality of the military nurse, throughout the continuum of deployment (pre-deployment, deployment and post-deployment), to the delivery spiritual care. Further, it identified the reciprocal nature of spiritual care (Harrington, 2003) that assisted the nurse to also cope with the stressors of deployment (Gibbons et al, 2012).

This research journey remained grounded in the Philosophical Hermeneutic approach of Gadamer (1976/2004) throughout. The data interpretations and the writing reflected a temporal moment of unconcealed truth that remains ever open to reinterpretation by others from within their own historical horizon of understanding. As Gadamer (1976/2004) argued, “every understanding is only “underway”; it never comes entirely to an end” (p.211).

Throughout this thesis the reader has been engaged in a hermeneutic dialogue, mediated through language, into the nature of spirituality and spiritual care in a deployed military nursing setting. The study has unfolded through four parts that have introduced the participants, the data and the discussion before culminating in a fusion of interpretive horizons between the text and the researcher. This thesis represents a starting point from within which an understanding of spirituality has been introduced for others to continue to develop into the future. The benefits to both the military patient and the military nurse in better understanding the nature of spirituality and spiritual care are evident throughout this study.

9.4 Recommendations

The findings of this study are applicable to all levels within the military from the policy makers to the nurses providing care. The research has focussed on understanding spirituality and spiritual care in the deployed Australian military nursing context. However, the findings added an extra perspective to the ongoing conversation on spirituality and nursing in the Australian and international healthcare

literature. Recommendations are provided in Table 9-1 below for consideration in nursing policy, nursing care practice and education, deployment and research.

RECOMMENDATIONS

Nursing Policy

- Review and redevelop Australian Defence Force nursing policy to:
  - affirm the importance of spiritual care to holistic nursing practice; and
  - identify the role and duties of nursing in providing spiritual care.
- Develop nursing guidelines for the delivery of spiritual care both within Australia and overseas on deployment that includes:
  - tools for pluralistic spiritual assessment;
  - guidance on collaborative spiritual caring practice

Nursing Care Practice and Education

- Integrate spiritual care into the introductory courses for new Australian Defence Force nursing officers to:
  - facilitate a wider understanding of the role of spirituality to resilience and well-being in military patients;
  - engage the Defence Chaplaincy service to assist in the delivery of spiritual specific training for nurses;
  - increase personal spiritual awareness in nurses to improve their comfort in spiritual care delivery through normalisation into practice; and
  - highlight the relevant codes of conduct relating to the need for the delivery of spiritual care in a respectful manner.

Deployment

- Provide spiritual resilience training for military personnel deploying on overseas operations in addition to emotional resilience training to:
  - improve spiritual literacy;
  - improve comfort in discussing spiritual issues through normalisation;
  - encourage spiritual self-reflection to aid in coping on deployment; and
  - minimise the long term impact of deployment on the military member,

their family, the Australian Defence Force and society through improved resilience.
Research
• Noting the lack of research on spirituality in military populations, focus research on: o developing a better global understanding of spirituality in military populations; o the effects of the military family on spiritual care and resilience outcomes in deployed military populations; o the impact of spiritual nursing care on resilience in military personnel; o spiritual resilience in military nursing populations; o better defining spirituality and spiritual care from a military nursing perspective; o the collaborative linkage between military chaplains and nurses; o the delivery of effective spiritual care on deployment; and o understanding the perceptions of military personnel on the role of the nurse and their effectiveness in delivering spiritually directed care on deployment.

Table 9.1: Recommendations

APPENDIX 1:
LETTER OF INTRODUCTION

Dear Sir/Madam

This letter is to introduce Andrew Ormsby who is a PhD student in the School of Nursing & Midwifery at Flinders University. He will produce his student card, which carries a photograph, as proof of identity.

He is undertaking research leading to the production of a thesis or other publications on the subject of a Study of Spirituality in Military Nursing Practice.

He would be most grateful if you would volunteer to spare the time to assist in this project, by granting an interview and/or agreeing to observation which touches upon certain aspects of this topic. No more than one hour on one occasion would be required.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since he intends to make a tape recording of the interview, he will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed, and that the recording will not be made available to any other person. It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on 08 8201 3483, fax 08 8276 1602 or e-mail ann.harrington@flinders.edu.au

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on
8201 5962, fax 8201-2035, e-mail sandy.huxtable@flinders.edu.au.

Thank you for your attention and assistance.

Yours sincerely,

Dr Ann Harrington RN DNE B.Ed M.Ng PhD FCN FRCNA

Senior Lecturer, School of Nursing & Midwifery

APPENDIX 2: INFORMATION SHEET

INFORMATION SHEET

A STUDY OF SPIRITUALITY IN MILTARY NURSING PRACTICE

I am a Registered Nurse in the Royal Australian Air Force and have an interest in holistic nursing practice within the military nursing services. Holistic nursing practice includes not only care of the physical and psychological needs of patients, but also care of their spiritual needs.

This study seeks to understand how military nurses provide for the spiritual needs of their patients when deployed on military operations. In doing so it will also examine how military personnel who become patients within a deployed military hospital express their spirituality and respond to spiritual care provided by military nurses. Your participation in this study will help Australian Defence Force nurses gain a better understanding of the nature and significance of spiritual nursing care and the level to which it is provided to military personnel on military operations.

To gain a deeper understanding of your experiences of spiritual nursing care on deployment, as either a nurse or a patient, I seek your permission to interview you. If you agree to be interviewed, I will ask you to sign a written consent form. The interview would last around 1 hour and would be conducted at a mutually convenient time. It will be recorded by audiotape and be transcribed by an independent person and myself. Your confidentiality will be protected by the use of a false name during the interviews and transcripts will be coded to ensure that you can not be identified in the data. Audiotapes and transcripts will be stored securely and kept confidential.

You are free to decline this invitation or withdraw from the study at any time. No further attempt will be made to contact you and this will not impact on your care in this unit or your career in the military.

As an Australian Defence Force member you will be considered to be ‘on duty’ while participating in this survey.

There is no risk of harm to you from participation in this research. However, if you require support services, either directly or indirectly as a result of the research, I will stop the interview and you will be offered professional counselling through either the Defence psychology or Defence chaplaincy services.

If you wish to inquire further about this study, you may contact the researcher directly or address any concerns to either the Australian Defence Medical Ethics Committee or the Social and Behavioural Research Ethics Committee of Flinders University Adelaide Australia at the following addresses:

Australian Defence Human Research Ethics Committee
CP2-7-66
Department of Defence
CANBERRA ACT 2600
Telephone: (02) 6266 3837
Email: ADHREC@defence.gov.au

Secretary Social and Behavioural Research Ethics Committee
Flinders University Adelaide Australia
GPO Box 2100
ADELAIDE 5001
Telephone: (08) 8201 5962, Fax (08) 8201 2035
Email: sandy.huxtable@flinders.edu.au

This study into spirituality in a military nursing setting accords with the ethical guidelines of the National Health and Medical Council of Australia – NH&RMC. It is conducted under the auspices of both the Australian Defence Human Research Ethics Committee and Social and Behavioural Research Ethics Committee of Flinders University Adelaide Australia. In effect this means that Participants in this research have recourse to both ethics bodies.

When you have read this information I (Andrew Ormsby) will discuss it with you further and answer any questions you may have. If you would like to know any more at any time, please feel free to contact me in the unit.

This information sheet is for you to keep.

WGCDR Andrew Ormsby RN BN MNsg

PhD Student, Faculty of Health Sciences

Flinders University, Adelaide, South Australia

Telephone: (08) 8393 2258

APPENDIX 3:
CONSENT FORM

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(by interview)

I ….....

being over the age of 18 years hereby consent to participate as requested in the Information Sheet for the research project on **Spirituality in Military Nursing Practice**.

1. I have read the information provided and have had explained to me the aims of this research project, how it will be conducted and my role in it.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation being recorded on tape
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I am cooperating in this project on condition that:
    - The information I provide will be kept confidential.
    - The information will be used only for this project.
    - The research results will be made available to me at my request and any published reports of this study will preserve my anonymity.
6. I understand that:
    - I may not directly benefit from taking part in this research.
    - If I choose not to participate there will be no detriment to my career or future health care.
    - I am free to withdraw from the project any time and am free to decline to answer particular questions at any time with no detriment to my career or future health care.
    - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

I have also been given a copy of ADHREC's *Guidelines for Volunteers.*

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….

Researcher's signature……..Date…….

NB. Two signed copies should be obtained.

Should you have any complaints or concerns about the manner in which this project is conducted, please do not hesitate to contact the researcher in person, or you may prefer to contact either the Australian Defence Human Research Ethics Committee or the Social and Behavioural Research Ethics Committee of Flinders University Adelaide • Australia at the following addresses:

Executive Secretary
Australian Defence Human Research Ethics Committee
CP2-7-66
Department of Defence
CANBERRA ACT 2600
Telephone: (02) 6266 3837
Facsimile: (02) 6266 4982
Email: ADHREC@defence.gov.au

Secretary
Social and Behavioural Research Ethics Committee
Flinders University Adelaide • Australia
GPO Box 2100
ADELAIDE 5001
Telephone: (08) 8201 5962,
Facsimile: (08) 8201 2035
Email: sandy.huxtable@flinders.edu.au

APPENDIX 4:
SAMPLE THEMATIC ANALYSIS

PARTICIPANT ONE (KATIE) – PAGE 22

How do you see from your own experiences, the sort of, the differences

between your civilian nursing practice and your military nursing practice.

Do you see much difference sort of culturally between the two?

Um…yeah, uh, there is. How. Why. Um, I think it definitely; you have much more of an emphasis on team work in the military…military nursing, because you haven't got the resources…um…whether that be equipment or manpower or whatever, or just the environments you work in, so you need to depend upon each other a lot more than what you would in civilian life. Um, when you work in…I've worked in hospitals, you know, civilian hospitals…you turn up for work, you do your shift and you go home, and if you socialize outside that it's up to you, but certainly it's viewed as more of a…it's a job and um…I know a lot of people in the military…military nurses view it as a job, I mean…me I view it as a job as well, but um, it's a job with a difference, and…so I think that, the culture's different. Um, I think your bonds with people are a lot tighter in the military than they if you're in a civilian environment.

Team emphasis in the military with lack of resources

Unique work environment

Dependence on each other

Cultural differences military vs civilian

Greater bonds between people in the military nursing sphere than in the civilian workplace

Can you expand on that at all?

Well, the experiences that you go through together um, living in each other's…when you're on deployment, living in each other's pockets for 24 hours a day, you really get to…to know what gives you the shits and what

Cultural differences - living in each other's pockets 24/7 on deployment

Learn to tolerate people more than you would outside the military

works, and you also learn to tolerate people, you know, that you probably wouldn't do it outside, you know, you'd just write them off, but because you are in that environment, you have to get along…you have to…well as much as you can…you have to kind of see past those differences, so it encourages you to um…to get along with people and respect those…well, even though you have differences, to respect them, because, you know, it's bigger than just two people.

Learn to respect differences in others even when difficult to do so

Possible Themes:

- Relationship with others (Dependence, tolerance, bonds, team)
- Culture differences (military versus civilian nursing)
- Deployment (unique environment, living in each other's pockets 24/7, lack of resources, culture, bonds, shared experiences)

P22 L18-22 Katie	the experiences that you go through together um, living in each others…when you're on deployment, living in each other's pockets for 24 hours a day, you really get to…to know what gives you the shits and what works, and you also learn to tolerate people, you know, that you probably wouldn't do it outside	You have to learn to get along and tolerate people on deployment	Living in each other's pockets 24/7	**Deployment** shared experiences - close living - tolerance
P22 L23-27 Katie	you have to get along…you have to…well as much as you can…you have to kind of see past those differences, so it encourages you to um…to get along with people and respect those…well, even though you have differences, to respect them, because, you know, it's bigger than just two people.	You have to see past those differences	It's bigger than just two people	**Deployment** Have to get along - encourages respect

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