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Understanding Spiritual Intelligence in Healthcare – Raising Awareness Among Practitioners

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Abstract.

Spiritual Intelligence (SQ) is important in contributing to high quality, holistic care. It promotes communication between staff, and between staff and patients.
While emotional (EQ) and cognitive intelligence (IQ) currently informs staff interactions, there is an increased interest in the role of spiritual intelligence in mediating intra-staff communication.
This study will develop a framework to support the discussion of spirituality among healthcare practitioners using spiritual intelligence as a framework.
The proposed framework highlights three elements of spiritual intelligence, which are meaningfulness, the differences between religion and spirituality and the importance of value systems, all of which have practical application for better practice.
The study used a mixed method exploratory sequential methodology, with a convenience sample of 31 healthcare leaders. Phase One involved the completion of Wigglesworth's SQ 21 assessment tool. Nine of those that completed the SQ21 were interviewed for Phase Two. Data were analysed using mean rankings and a modified thematic analysis, using interpretive phenomenological analysis.
Phase One findings found that increased SQ facilitated making a difference at work and helped identify elements that made work meaningful. The second finding was that SQ provided an additional perspective that added to the EQ and IQ viewpoints. The third finding was that articulating the difference between religion and spirituality in a formal structure provided security for staff to discuss issues with confidence.
Emergent themes from the semi-structured interviews highlighted the difference between spirituality and religion, the importance of values and the need for a clearly articulated value system, the role and characteristics of spiritual leaders that influenced healthcare delivery and meaningfulness. There were barriers identified to discussing spirituality which included difficulties in communication, environment, fear, lack of knowledge and false assumptions.
Elements informing the understanding and application of spirituality and spiritual intelligence have been identified, and a framework to raise awareness among all levels of staff has been developed. Further research with the use of this framework with different staff groups providing feedback for its efficacy and usefulness is suggested.

Keywords: Spirituality, Spiritual Intelligence, Meaningfulness, Values, Mixed Methods.

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CHAPTER ONE.

1.1 Introduction.

The world is viewed through many different lenses which provides a unique perspective on life. Some lenses might include age, experience, education, gender and professional qualifications and background (Colyer, 2004). How the world is perceived is dependent in part on self-awareness and awareness of others and the interaction between the two (Morin, 2011). Spiritual Intelligence is a lens through which the world is viewed, particularly when used alongside three other lenses of physical, cognitive and emotional intelligence.

Spiritual Intelligence (SQ) is vital in healthcare contributing to high quality, holistic care. It helps to promote communication between staff and between staff and patients (Kaur, Sambasivan and Kumar, 2013; Zamanzadeh, et al., 2015; Sunaryo, Nirwanto and Manan, 2017).

This study aims to develop a framework to support the discussion of spirituality among healthcare practitioners using spiritual intelligence as a foundation.

1.2 Background.

The relationship between spirituality and health has been widely explored in the literature (Coyle, 2002; Koenig, 2012; Puchalski, et al., 2014a; Zimmer, et al., 2016; Wattis, Curran and Rogers, 2017). Oman and Syme (2018) have reviewed more than 100 meta-analyses and systematic reviews of the relationship between religion/spirituality (R/S) and health that have been published in refereed journals. They concluded that *'collectively, the reviews greatly strengthen the case that R/S exerts a causative influence on health. The case for causal influence may now be compelling, and in most cases, R/S involvement is associated with better health, although negative associations also exist'* (Oman and Syme, 2018, p. 280).

The role of nurses in particular in providing spiritual care has also been a subject of extensive research (Ross, 2006; Timmins and McSherry, 2012; Brémault-Phillips, et al., 2015; van Leeuwen and Schep-Akkerman, 2015; Mthembu, Wegner and Roman, 2016; Minton, et al., 2018), with the importance of preregistration education highlighted (Stern and James, 2006; Baldacchino, 2015; Lewinson, McSherry and Kevern, 2015; Timmins, et al., 2016). However, Paley (2009) claims to be appalled by the suggestion that spiritual care should be incorporated into nurse education. He asserts that it is nothing more than speculative metaphysics without a robust evidence base. He also points out that spiritual care is not the same as holistic care and the expectation that nurses should be able to deliver spiritual care cannot be justified ethically due to this lack of evidence.

Since 2009 when that paper was written, the world and how it is viewed has altered dramatically. The explosion in on line resources and technological advances have altered healthcare as well as society in general. In 2013 the Francis Report made 290 recommendations following poor care at the Mid Staffordshire NHS Hospital Trust. These failings and the implications for practice are explored further on page 18.

The education of the nurse in a clinical environment relies heavily on more experienced staff acting as a mentor and role model (Felstead, 2013; Vinales, 2015). In their analysis of the importance of role models in the development of ethical leadership, Brown and Treviño (2014) stress that it is by observation and mimicking behaviour that skills and competence are developed, echoing the assertion by Bandura (1977) that there are two important aspects to learning new behaviours. The first is by modelling based on observation and then using that learning as a guide for action. This development of skills through observation is key in any form of vocational training involving any type of apprenticeship. Despite the move of nurse education into higher education, this development of skills through observation remains fundamental in the training of nurses as well as other healthcare professionals.

As a critical care nurse with over 30 years of experience, I have always had an interest in spirituality. It has been my privilege to be with many patients at the end of their life both in a critical care environment and in less acute settings. The physical end of life occurs when breathing stops. Often in a critical care setting, this was when mechanical ventilation was discontinued, I have always felt that something more than just the physical cessation of breathing occurred.

Paley (2008a) asserts that spirituality is an essential part of all aspects of health, a view that is supported by Pesut (2008) who argued that spiritual care is an intrinsic part of nursing which is given a particular urgency towards the end of life – a view that I subscribe to fully.

Norton, et al. (2017) have shown that some brain activity recorded using electroencephalogical recordings occurs until at least 30 minutes following the declaration of death. This electrical activity offers ethical dilemmas in the diagnosis of brain stem death, which is vital in transplant surgery and the harvesting of donor organs. It could, however, explain apparent metaphysical changes in newly deceased patients. This was a study of four patients, so results should be treated with extreme caution.

Since I have a strong faith, I believe it is a person’s soul which leaves the body at the point of death. Whatever it is called, I feel there is something over and above the physical that changes. Personally, it is this transcendental aspect of attachment to a higher being that provides close links to spirituality and was a strong motivational factor in my choice of topic.

As a Senior Lecturer in Management and Leadership, I was course leader for an MSc in Healthcare Management. A module on this course explored Global Leadership and was developed in conjunction with another Senior Lecturer. An aspect of this module introduced spirituality to participants which was my first exposure to teaching about spirituality in a leadership context.

These lenses – critical care nurse, hospital manager and university lecturer have all influenced and framed the development of this research. My worldview, values and subsequent behaviour have been guided by these experiences. With an acknowledgement that I have a strong personal faith, this research has a personal relevance as well as a professional one.

It was because of this collaboration that my interest in spirituality was awakened and the possibilities for further study highlighted.

As well as an interest in spirituality, most of my teaching career has been in teaching leadership and management to health and social care staff. Because of this, I have developed a definition of leadership, which involves the creation of a culture where excellence can flourish and is appropriately rewarded. There are several elements to this definition. Over the years I have wrestled with whether it is culture, climate or environment that is important. Organisational culture has been investigated widely by several authors including Schein (1990; 2016), Handy (1993), Kotter (2008), Hofstede, Hofstede and Minkov (2010), Cameron and Quinn (2011) as well as Bremer (2018).

Organisational Culture has been described as '*the way things are done around here*' (Handy, 1993; Martin, 2006) and has the elements of an organisation's shared values, symbols, behaviours, and assumptions (Goffee and Jones, 2003). The importance of shared values and practices that these promote are highlighted by their relationship with spiritual intelligence. The significance of the interaction of individuals with the organisation is underlined by this relationship between organisational culture and workplace spirituality (Jurkiewicz and Giacalone, 2004; Lips-Wiersma and Morris, 2011).

There is a difference between culture and climate in an organisation. The climate of an organisation is dependent on temporary changes in the environment whereas culture is more deep-seated and rooted in permanence (Martin, 2006). The difference between the two is important in leadership as climate is easier to create daily rather than influencing culture which has a more permanent effect on behaviour. The changes that a leader may make can either be temporary or permanent. For example, giving a member of staff time off to attend their child's school play affects climate, not culture but can increase their feeling of being valued (Denison, 1996; Bachmann, 2017).

The aim, research question and objectives provide the underpinning justification for the methodological approaches that inform the structure, function and purpose of the research. They also guide in the choice of methodology and the underlying methods made.

1.3 The Aim.

This study aims to explore the awareness of spirituality among healthcare managers using spiritual intelligence as a framework.

1.3.1 Research Question.

The primary research question for the study was:
'What are the elements underpinning the awareness of spirituality among healthcare managers in practice using the lens of spiritual intelligence?'
Spiritual Intelligence will be assessed using a questionnaire developed by Wigglesworth (2012) as a tool primarily for coaches to start a conversation with clients regarding their awareness of both their spirituality and spiritual intelligence. The questionnaire is faith-neutral and can be used by those both with faith and without. It was developed over several years with the intention of answering the question posed by Jesus – How do you love your neighbour as you love yourself? The questionnaire was started to be developed in 2000, just before the September 11th 2001 terror attacks in the USA. Wigglesworth identified that a common language was needed to discuss spirituality to try to reduce interreligious tension and increase tolerance of the worldview of others.
The acceptance of other worldviews is important for healthcare practitioners as it promotes tolerance and understanding of different belief systems which impact on the acceptability and adherence to healthcare treatments
Secondary questions were derived from the aim and primary question and linked to the two phases of the study:

1.3.1.1 Phase One: Quantitative Survey of Healthcare Managers.

What are the dominant and less dominant skills of spiritual intelligence, as measured using Wigglesworth's (2012) SQ21 inventory?

1.3.1.2 Phase Two: Qualitative Interviews with Healthcare Managers.

How do managers articulate their beliefs and understanding of spirituality and spiritual intelligence?
What are managers' perceptions and understanding of spirituality and spiritual intelligence in their role as a healthcare leader?

1.3.2 Objectives.

The first phase of this study involved a survey assessing 21 different skills as measured by the Wigglesworth (2012) SQ 21 Inventory. Informed by the results of the first phase, the second phase involved semi-structured interviews with nine participants who had completed the inventory in Phase One. This data was also used to examine the results from Phase One in an iterative process that helped make sense of the findings.

To summarise, the objectives of this study were to:

- Identify which aspects of spiritual intelligence are more important to healthcare leaders.
- Identify the factors that influence the awareness of spiritual intelligence in healthcare managers.
- Highlight any skills identified in the SQ 21 Inventory that support or hinder the development of awareness of spirituality and spiritual intelligence.

Following the identification of the factors that are important in supporting the development of spirituality and spiritual intelligence, a framework encompassing these skills is proposed that can be used with healthcare professionals at all levels to raise awareness of their spirituality and spiritual intelligence. The transferability and application with practitioners across the professions and in different healthcare settings will be assessed.

1.4 Dissertation Structure.

The dissertation is presented as a series of linked chapters.

Chapter One introduces the dissertation and explores the rationale and context of the study along with providing a conceptual framework and proposed structure.

Chapter Two defines spirituality, spiritual intelligence and intelligence. Different types of intelligence and their assessment will be explored. Other constructs including values, meaningfulness, life purpose and the development of worldviews are presented. The academic literature supporting these constructs will be examined, and their role in healthcare explored.

Chapter Three examines the research process with justification provided for the methods and methodology. The research paradigm chosen is one of pragmatism with a sequential mixed methods study employing a questionnaire followed by semi-structured interviews. The choice of instrument used for data collection and the validity and reliability will be presented with justification for the questions asked in the semi-structured interviews. The methods of data collection will be examined, and explanation for the use of Interpretative Phenomenological Analysis (IPA) (Smith, Larkin and Flowers, 2009) of the interviews will be given.

Chapters Four will provide the findings and analysis of the quantitative phase of the study. It will explore in detail the results from the SQ21 inventory.

Chapter Five will use IPA (Smith, Larkin and Flowers, 2009) to examine the findings from the nine interviews undertaken with healthcare managers.
Chapter Six will synthesise and integrate the results from the two phases of the study to provide some conclusions that allow the research questions to be answered. A framework to raise awareness of spirituality and spiritual intelligence among healthcare staff in practice will be proposed which is based on the design based research process (Easterday, Lewis and Gerber, 2014).
Chapter Seven concludes the study, drawing the themes from the study together, justifying the proposed framework, demonstrate how the research is of a doctoral standard, contributes to original knowledge and identify potential areas for further research.

1.5 Rationale.

In any doctoral study, many choices are made. There is an increasing literature on organisational spirituality (Poole, 2009; Reimer-Kirkham, et al., 2012; Belwalkar and Vohra, 2016) and spirituality in the workplace (Giacalone and Jurkiewicz, 2010; Kinjerski, 2013; Lips-Wiersma and Mills, 2014; Pirkola, Rantakokko and Suhonen, 2016) While this literature has been used, a conscious decision to explore its impact on individuals rather than the organisation has been made. In the same way, there are many different spiritual traditions, but the primary one chosen is the Judaeo-Christian tradition. This choice was made because my background and the background of most of the respondents is in the Judeo-Christian tradition. The literature, in general, is also written in the Judaeo-Christian tradition with a first world US/European viewpoint. Other traditions, for example Buddhism, have also been identified as influencing leadership practice (Rinzler, 2014), but for clarity, the Judeo/Christian tradition is the focus.
The study was restricted to raising awareness of spirituality and spiritual intelligence among staff rather than staff/patient interactions. There is again a body of literature regarding these discussions, with their impact on quality of life indices and projected improvements in health outcomes as their focus (Kass, et al., 1991; Sawatzky, Ratner and Chiu, 2005; Koenig, 2009; Jones, et al., 2016). This study aimed to look at the factors that raise awareness of spirituality rather than the impact that spirituality has in a clinical setting.

Another aspect of this study is the nature of dualism and the context of research. Dualism contends that there are two kinds of categories in any area of study (Robinson, 2016). The fundamental duality was the differentiation between mind and body, which has dominated healthcare for centuries. This differentiation is also known as Cartesian Dualism, which is credited to Rene Descartes in the 17th-century (Mehta, 2011). Bhugra and Ventriglio (2017) suggest that there is a fundamental difference between physical and mental health which has been the underpinning construct of healthcare commissioning and delivery since before the advent of the NHS. This reliance on the Bio-Medical model is limited and does not take account of prevention, cure or the promotion of wellbeing and longevity (Singh, 2010). The differentiation between physical and mental health is important in the context of this study as it provides the backdrop and environment in which the study occurred. The focus was intentionally on staff, and their area of practice was less important than their leadership role. Other dualisms that are an essential part of this study are those of spirituality and religion and the qualitative and quantitative research paradigms. These will be discussed in chapters two and three respectively.

1.5.1 A Conceptual Framework.

The structure of the dissertation outlined above has been developed from the conceptual framework which has underpinned the direction of travel throughout the thesis. The initial, core starting point was the lens of spiritual intelligence in healthcare and the development of a mind map, a technique suggested by Buzan (2006) to identify and make sense of information as it is gathered.

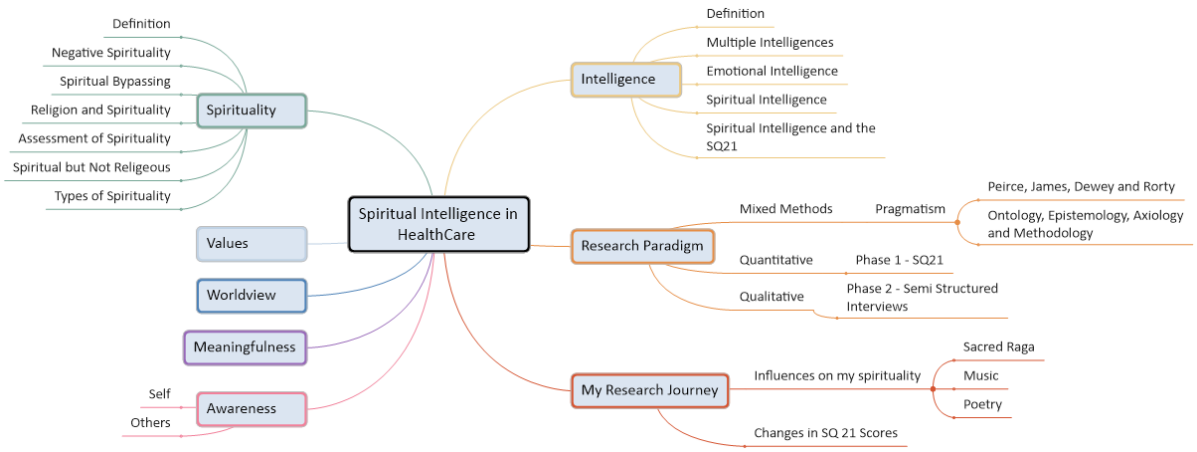


Figure 1-1: Conceptual Framework.

The conceptual framework is useful as it links together the various themes of the dissertation. The relevance and interconnectedness of values, worldview and meaningfulness provide the structure for both the methodological approach as well as the literature surveyed. This conceptual framework helps to contextualise the study in the literature surrounding spirituality, its definition and assessment. An allied theme is the place of multiple intelligences in developing self-awareness and awareness of others in healthcare practitioners and the importance in developing their intelligences to enhance communication with colleagues and patients.

1.6 Chapter Summary.

This chapter has introduced the dissertation, providing a rationale for the choice of topic, research aims and objectives and an overview of the structure to be employed. The next chapter will explore the concepts of spirituality and intelligence, examining the definitions, measurement and background literature that contextualises the study.

CHAPTER TWO.

2.1 Literature Review.

This chapter will explore critical components underpinning this dissertation: spirituality and intelligence. These will be defined, with some of the difficulties in doing so identified. Concepts linked to spirituality including values, worldview and meaningfulness are discussed in greater detail. Potential issues when differentiating between spirituality and religion are examined, supported by the literature. The possible negative aspects of spirituality will be considered. The construct of intelligence and the literature on multiple intelligences will be addressed, with the place of spiritual intelligence in the broader context of intelligence highlighted. The role of love in the manifestation of spiritual intelligence will be probed with four different aspects of love covered.

Many different definitions of spirituality have been proposed. These will now be examined in more detail.

2.2 Spirituality.

'Studying spirituality appears akin to shovelling fog.'

Bender (2010, p. 182) sums up the inherent difficulties in the study of spirituality. The etymology of spirituality can be traced back to the early 15 Century., from Middle French *spiritualite*, from Late Latin *spiritualitatem* (nominative *spiritualitas*), from Latin *spiritualis*. An earlier form was *spiritualty* (late 14 century) (Etymology Dictionary., 2010). Closely linked to this is the word spiritual, which derives from similar sources but incorporates the idea of breathing… *'of or concerning the spirit'* (especially in religious aspects), c.1300, from Old French *spirituel* (12c.), from Latin *spiritualis*, from *spiritus* '*of breathing, of the spirit'* (Etymology Dictionary., 2010). This derivation highlights the longevity of this concept – Theologians, philosophers and other academics have been exploring how an individual's spirituality impacts on their day-to-day existence and how they lead their lives for many generations (Nolan and Holloway, 2014).

This approach to defining concepts from its original entomology is not without its critics. Carrette and King (2005, p. 33) ask why the historical origin is helpful?:

> *Why privilege original meanings? Language and culture evolve throughout history, and terms take on a variety of semantic registers in accordance with the changing social, cultural and political contexts in which they operate. It would be a mistake then to appeal to some 'authentic' meaning for the term 'spirituality', as if such concepts were not embedded in a rich and contested history of usage that shifts according to changing conditions and social agendas.*

The context within which a term is used alters its meaning over time and means the development of definitions should be ongoing rather than a static process.
Clarke (2009) suggested that an individual's spirituality is an important aspect of healthcare, both for the client and practitioner. Achieving optimal health outcomes is depended in part on robust spiritual wellbeing, and this is true for both the client and for those that care for them (Zehtab and Adib-Hajbaghery, 2014). The way that different professional groups deliver spiritual care is dependent on their spirituality, as well as the professional 'lens' through which they view the world. Clarke also goes on to point out that spiritual care has always been provided by healthcare professionals but under the guise of psychosocial care. It is this differentiation between spiritual and psychosocial care that is important for healthcare staff to identify and ensure that both occur. This duality of care is subjective and reliant on the individual practitioner as well as their profession. If there is limited awareness of spirituality, then aspects of care can be missed over and above the more visible elements of spiritual care.

2.2.1 Definitions of Spirituality.

Spirituality has been defined in many ways since the turn of the century. There have been several studies, particularly in nursing, that explore the field and its development (Wu, 2011; Ramezani, et al., 2014; Veloza-Gómez, et al., 2016).
At the start of this study in 2013, three reviews of the literature were selected to provide a theoretical perspective of the definition of spirituality in healthcare. Tanyi (2002) reviewed 76 articles and 19 books to suggest the following definition:

> *Spirituality is a personal search for meaning and purpose in life, which may or may not be related to religion. It entails connection to self-chosen and or religious beliefs, values, and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being.*

Ross (2006) analysed 45 papers on spiritual research between 1983 and 2005. Of those 45 articles, meaning and purpose were identified in ten as being significant. Other areas included faith and belief (17 studies), and harmony and connectedness with others, nature and God (7 studies).
Cockell and McSherry (2012) identified 163 papers published between 2006 and 2010. The review explored several different aspects of spirituality, including spiritual care, assessment tools and the role of education. These are all essential elements as they influence both individuals' personal growth and the role of the leader in promoting this development.
In her analysis of different definitions of spirituality, Gardner (2011a) identified eight different definitions, including Haynes, et al., (2007, p. 2):

> *'Spirituality means something different for everybody, and consequently, there can be no single all-encompassing definition. It relates to how we find meaning and connection, and the resources we use to replenish ourselves and cope with*

> *adversity. Spirituality may be part of religious beliefs or another shared belief system or something entirely personal and self-developed'.*

Gardner (2011a, p. 24) went on to define spirituality as '*that which gives life meaning that includes a sense of something beyond or greater than the self.'*

Weathers, McCarthy and Coffey (2015) performed a concept analysis of predominantly nursing texts (57%), reviewing 47 peer-reviewed papers between 2002 – 2013. There was inevitably some overlap with the Ross and McSherry papers discussed earlier, but their conclusions were broadly congruent. While there was considerable variation in the definitions, all referred to the multidimensional uniqueness of spirituality and that spirituality is broader than religious beliefs or affiliation. They also suggested the same elements of transcendence, connectedness and the need to find meaning were all present in the definitions.

A definition of spirituality emerged based on the findings of their concept analysis which suggests that:

> *'Spirituality is a way of being in the world in which a person feels a sense of connectedness to self, others, and/or a higher power or nature; a sense of meaning in life; and transcendence beyond self, everyday living, and suffering'(P 83).*

Another definition of spirituality is given by Wigglesworth (2012, p. 8) as '*an innate human need to be in relationship with the something larger than ourselves – something we consider to be divine, sacred or of great nobility.'*

A significant area for the study of spirituality has been in end of life and palliative care. Two consensus conferences have been held to develop an operational definition (Puchalski, et al., 2009; Puchalski, et al., p. 646). These conferences developed a definition that described spirituality as:

> *… a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.*

This definition, despite being developed for a palliative care or end of life setting, is equally valid in any care setting, and for those healthcare staff caring for others as well as outside the workplace.

2.2.2 Spirituality and Contemporary Philosophy

The relevance of spirituality to contemporary philosophers has also been identified. Foucault (2005, p. 15) suggested that spirituality is

> *. . . the search, practice, and experience through which the subject carries out the necessary transformations on himself in order to have access to the truth.*

Rabinow (2009) asserts that Foucault felt that spirituality was the dimension missing from modern philosophy. A strong influence on Foucault's views on spirituality was Hadot (1995) who explored a history of spiritual exercises and their influence on the development of the notion that philosophy is above all else a way of seeing and being in the world.
The recommendations in this report were strongly influenced by Foucault and exposed the need for truth (Rabinow, 2009).
Nietzsche (2008) addresses the problem of how to live a fulfilling life in a world without meaning, in the aftermath of 'the death of God', This phrase has been used to identify secular humanism and the role of society where religion is less important than it was historically (Krystal, 2001; Cranney, 2013; Harris, 2014; Osborn, 2017).
The definition of spirituality in academic literature has been criticised by Clarke (2009) as lacking criticality. In her view, this portmanteau approach has led to a blurring of spirituality (particularly spiritual care) into psychosocial care. While the two are linked, clear differentiation between the two remains relevant. She also asserts that *'the number of definitions, very few of which are subjected to criticism and the pressure on scholars to provide them in plenty, have led to an overemphasis on defining the concept to the neglect of developing practical ways of making it real in practice'*.
Claims made for spirituality have also been critisised by Paley (2008b) when he asserts that the claims made have little or no support of argument or evidence and are accepted without challenge.
Biney (2018, p. 142) summed up the position when he pointed out that:

> *Spirituality is a notoriously difficult concept to define. No one definition is concise and broad enough to capture all the various nuances of meaning and practices the term connotes.*

This idea of application rather than definition has been a strong motivational factor for this study. The need for awareness of spirituality and its practical application are at the cornerstone of this research.
As early as 1993 Diaz suggested the lack of consensus concerning the definition of spirituality was to be expected in a new area of academic study, rather than a fatal flaw (Diaz, 1993). Almost 25 years later, this lack of agreement remains problematic rather than fatal.

Dent, Higgins and Wharff (2005, p. 647) council that '*researchers must use the utmost care in defining (spirituality) and showing how it is different from other concepts that can be utilised without the controversy of spirituality associated with them'.* This differentiation is vital in ensuring the barriers in discussing spirituality, and the acknowledgement of the relevance of spirituality in healthcare practice is researched systematically and validly. Both have been characterised as being difficult to define since the definitions are either too broad to be of use or too narrow so that most characteristics missed. Robinson, Smith and Kovacs (2014, p. 39) suggested that definitions of spirituality are:

> *Either explorations proceed by using narrow interpretations of spirituality, which we argue are exclusionary and discriminatory, or commentators fail to define spirituality at all or edge towards an intellectual haziness where the terms are never clarified.*

Rayment and Smith (2007, p. 220) made the same point, emphasising that it is the limitation of language that hinders definition:

> *In searching for an appropriate definition, the leader will be confronted by the limitations of language. Spirituality is a complex, multidimensional phenomenon and no definition will convey the complete essence of spirituality.*

The difficulty in getting a precise definition has also been levelled against intelligence (Gardner, 2003), but in both areas it has not stopped academics from trying to define commonalities and areas where broad agreement can be made.

This lack of clarity was also suggested by Pattison (1990, p. 7), when he suggested that definitions were either too simple leading to the exclusion of important aspects or so broad that they added little to the subject.

This is a view echoed by Paley (2008c, pp. 178–179) when he suggests that

> *Successive attempts to clarify the meaning' of spirituality merely add to the smorgasbord of attributes it is said to possess, and this only serves to increase the scope for disagreement.*

Despite the inherent difficulties in defining spirituality, the common elements that appear in most of the definitions are meaning, value and transcendence (Swinton, 2001; Gardner, 2011a). These elements will now be analysed in more depth.

2.2.3 Meaning.

Meaning is a vital component in spirituality and has been defined as having two aspects. The first is personal life – meaning which is concerned with goals in life and the second is cosmic meaning which is involved with the spiritual dimension of our lives (Yalom, 1980).

What defines what is important is described as meaning, a concept that is related to values but greater. Meaning refers to significance and involves meaning-making (Wrzesniewski, Dutton and Debebe, 2003).

Meaning seeks to explore the rationale for behaviours. There is seldom a single purpose in life, and the interconnectedness of multiple purposes is underpinned by spirituality. Another aspect of this connectedness is the ability to articulate these values to others as misunderstandings can lead to poor communication and conflict.

Meaning is highlighted in the SQ 21 in Skill 2: Awareness of Life Purpose Mission – Why am I here? and Skill 15: Sustaining Faith. To sustain faith when times are difficult requires a purpose in life that can be articulated and striven towards. Without that meaning, life events can be more difficult to accept with equanimity which is an essential part of growing in spiritual intelligence.

Both meaning and purpose in life have been explored for many years. Victor Frankl's book on finding meaning in the most appalling of circumstances is an example of how good and learning can come from the most horrifying environment (Vivyan, 2015).

Frankl (1959) explores what is meant by meaning and how this impacts on the way that lives are lived. One of the sources of meaning is creating a work or doing a deed which is a definition of 'life purpose', as discussed in the literature on self-help (Biali, 2013; Leider, 2015; Vivyan, 2015).

What provides meaning to individuals is different depending on professional background, personal beliefs and the culture in which they reside (Allan, 2017). These elements are all equally important and have a different impact at different stages of life.

Law (2016, p. 443) asserts that workers, many of whom spend more time in the workplace than at home, question their life purpose. They demand meaning in the workplace where they feel fulfilled and that they are contributing to society. This need for a clear life purpose appears universal – It was a key attribute in a Korean concept analysis of spirituality (Ko, Choi and Kim, 2017). This is echoed in the finding for this study – Life purpose is a theme that emerged in the second phase of this study and is explored more fully on page 76

2.2.4 Values.

> *Your beliefs become your thoughts. Your thoughts become your words. Your words become your actions. Your actions become your habits. Your habits become your values. Your values become your destiny. (Gandhi, n.d)*

The crucial second attribute in the definitions of spirituality is the ability to articulate a values system, acknowledging the importance of what these values are and how they developed over time. Over 40 years ago, Rokeach (1973, p. 3) proposed that '*the value concept…[is] able to unify the apparently diverse interests of all the sciences concerned with human behaviour*'. He developed a value survey which explored what he described as terminal and instrumental values. Terminal values are the desired end states of existence or personal goals while instrumental values are the behaviours that support the achievement of these aims.

The identification of these values and differentiating between terminal and instrumental values is a skill that is required to develop awareness of spiritual intelligence. Wigglesworth (2012) when looking at Skill 2: Awareness of Values Hierarchy, suggests that this awareness of values is fundamental in influencing behaviours and actions. She contends that if the values do not lead to action, then they are not true values.

Values define what is important to us in our lives. Schwartz (2012, pp. 3–4) proposed that there are five main features of values which consist of:

- Values are beliefs which are tied to emotion and are not objective ideas.
- Values are motivational goals that individuals strive to achieve.
- Values transcend specific actions and situations. They are abstract, which distinguishes them from norms and attitudes.
- Values tend to guide the selection and evaluation of actions, people and events and therefore serve as standards or criteria.
- Values are ordered by importance relative to one another. This ranking feature also distinguishes them from norms and attitudes.

These 5 values echo much earlier work by Scheler, a German philosopher who proposed that values had an important base in ethics and correlated with three types of feelings: feelings in the body, feelings in life and personal feelings. These feelings show that each person has a unique self-value which has a profound influence on decision making in variable moral situations that frequently occur in healthcare (Frings, 1998; Mircica, 2011).

Schwartz (2012, pp. 5–7) then went on to define what he termed ten basic values, which resonate with the skills of spiritual intelligence. This congruity between espoused values and spiritual intelligence applies especially to universalism and benevolence, both of which in cross-cultural studies were necessary to many individuals. They were also two areas that were highlighted in the results from the interviews in Phase Two of this study.

Value	Descriptor
Self-Direction	Independent thought and action; choosing, creating, exploring.
Stimulation	Excitement, novelty, and challenge in life.
Hedonism	Pleasure and sensuous gratification for oneself.
Achievement	Personal success through demonstrating competence according to social standards.
Power	Social status and prestige, control or dominance over people and resources.
Security	Safety, harmony, and stability of society, of relationships, and of self.
Conformity	Restraint of actions, inclinations, and impulses likely to upset or harm others and violate social expectations or norms.
Tradition	Respect, commitment, and acceptance of the customs and ideas that traditional culture or religion provide the self.
Benevolence	Preserving and enhancing the welfare of those with whom one is in frequent personal contact (the 'in-group').
Universalism	Understanding, appreciation, tolerance, and protection for the welfare of all people and for nature.

Table 2-1: Ten Fundamental Values (Schwartz, 2012, pp. 5-7).

Schwartz (2012, p. 19) then proposed the values be linked in a circular fashion, where adjacent values impact more on each other than those in opposite quadrants.

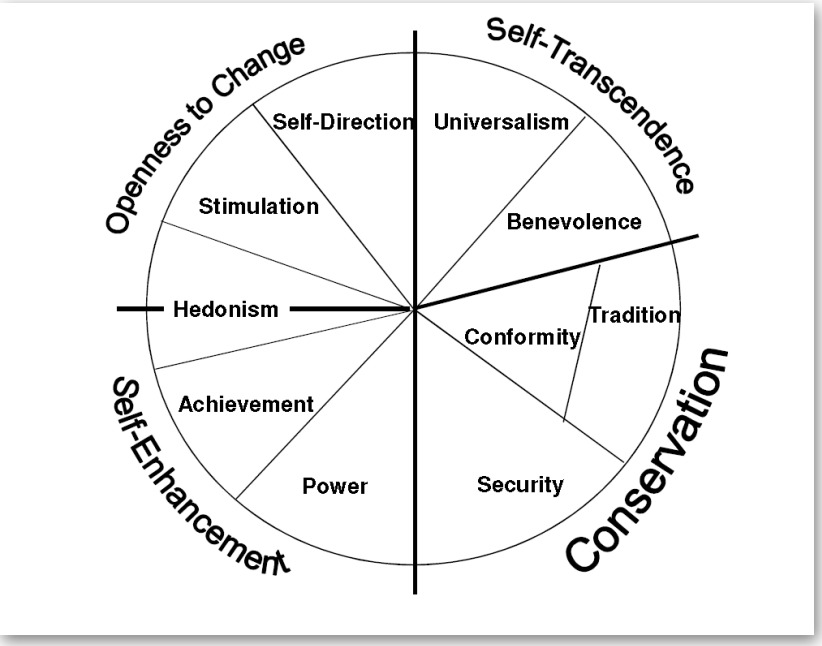


Figure 2-1: Theoretical Model of Relations Among Ten Motivational Types of Value (Schwartz, 2012, p. 19).

There is a tension between conservation and openness to change and self-enhancement and self-transcendence. These different values are influenced by upbringing, culture and opportunity, and while not fixed are difficult to change in any substantial way.

Schwartz (2012), when developing this set of values, considered adding spirituality as a universal aspirational value. On reflection, he decided that because of the cross-cultural differences that influence spirituality it was not universal enough to be included but was still significant to many.

Culliford (2018, p. 44) asserts that mature spiritual values embody wisdom and compassion – two pillars supporting SQ. He suggests that spiritual values include:

- Honesty
- Patience
- Humility
- Devotion
- Compassion
- Hope
- Trust
- Joy
- Gratitude
- Forgiveness
- Wisdom
- Tolerance
- Humour
- Dignity
- Courage
- Beauty

Appelo (2014) suggested that there are two types of values – core and aspirational values. Core values are the ones that come naturally. They are what makes a person who they are. They are frequently developed unconsciously, moulded by culture and upbringing. If core values define who a person is, aspirational values define who that person could be. They complement the core values and over time can become core values.

As well as individuals having core and aspirational values, so do organisations. One of the principal causes of workplace stress is when an individual's value system conflicts with the organisational value system, which is often demonstrated in the mission statement. For example, if a value is ethical behaviour and the organisation is dominated by maximising the bottom line, then tensions can exist, and conflict can occur (Appelo, 2011).

Values produce the belief that life is meaningful and serve as a measure of how meaningful one's actions are consistent with that person's value system. (Vyskocilova, et al., 2015)

While values are essential, Wigglesworth (2012) warns that values should be consciously chosen and not merely handed down from those who came before. Values are not fixed and can change and develop over time. They can also be so deeply rooted that they are unconscious, a view echoed by Vyskocilova, et al. (2015).

The ability to be able to articulate and rank a hierarchy of values is the third skill in the SQ21 spiritual intelligence inventory and was a significant component of the semi-structured interviews in Phase Two of the study and discussed on page 102.

2.2.5 Compassion in Healthcare

Compassion has been identified as a core value underpinning healthcare and is an important part of the NHS Constitution (2015). Compassionate care was identified as being important by Nightingale (1860) in her seminal work on nursing. Cummings and Bennett (2012) also highlighted compassion as a core value in healthcare when they produced their framework of the 6-C's - Care, Compassion, Competence, Communication, Courage and Commitment. They emphasised the importance of relationship based on empathy, respect and dignity. It is interesting to note that Youngson (2011) suggested that reference to compassion was absent from Government healthcare strategies or aspirations and that compassion has been included in documents published subsequently. He also goes on to suggest that compassion should be included as a core management and leadership competence and that compassionate care should be rewarded rather than punished.
A lack of compassion has been highlighted as a major contributory factor in several high-profile cases of sub optimal care, including the Mid–– Staffordshire NHS Trust (Francis, 2013), the Winterbourne View Care Home (Department of Health, 2012), and reports from the Parliamentary and Health Service Ombudsman, (2011).
The report into Mid-Staffordshire NHS Trust listed a catalogue of failures in care including:

- *patients were left in excrement in soiled bed clothes for lengthy periods;*
- *assistance was not provided with feeding for patients who could not eat without help;*
  water was left out of reach; despite persistent requests for help,
  patients were not assisted in their toileting;
- *wards and toilet facilities were left in a filthy condition;*
- *privacy and dignity, even in death, were denied;*
- *staff treated patients and those close to them with what appeared to be callous indifference (Francis, 2013)*

Chochinov (2007, p. 186) suggests that compassion refers to a deep awareness of the suffering of another coupled with the wish to relieve it. This is not without its challenges, since it is to be hoped that few practitioners would wish to make their patients suffer.
Taylor, et al. (2017, p. 355) list 5 defining attributes of compassion in Table 2-2:

Attribute	Description
Recognition	Cognitive recognition of another's adverse circumstances, physical, psychological or emotional well-being
Connection	Personal connection with another based on automatic, authentic and genuine thought
Altruistic desire	Altruistic desire to aid another
Humanistic response	Humanistic, person-to-person, understanding of what it is to be human
Action	Undertaking of an act or responsive behaviour

Table 2-2: 5 Defining Attributes of Compassion (Taylor, et al. 2017, p. 355)

The links to spirituality are close. Recognition of another's adverse circumstances should include spiritual distress and the need for care both in practitioners and patients. Connectedness is also a key element of spirituality and spiritual intelligence. Unfortunately, it is frequently in the last stage of action where problems can occur. Whether this is due to time constraints, compassion fatigue or a lack of knowledge of how to intervene appropriately, the outcome is the same with an environment that is not conducive to care of either group.

2.2.6 Transcendence.

The third element drawn from the definitions is transcendence. Transcendence has been defined as '*a state of being or existence above and beyond the limits of material experience'* (Vocabulary.com, n.d). The link between spirituality and transcendence is highlighted by Barber (2012, p. 379) when he states '*spirituality often involves a search for the transcendent*'. This quest for connection to a higher being is also described by Swinton (2001, p. 2).

> *Spirituality is the outward expression of the inner workings of the human spirit..intrapersonal in that it refers to the quest for inner connectivity.. interpersonal in that it refers to the relationships between people and within communities... transpersonal in so far as it reaches beyond self and others into the transcendent realms of experience.*

It has been suggested by Streib and Hood (2013) that transcendence has a horizontal and vertical dimension which allows those who are not religiously affiliated and identify with non-theism, agnosticism or humanism to self-identify as spiritual without the need for God. The vertical dimension identifies those with faith whereas the horizontal dimension is more in tune with what is now known as secular society. This dualism is reinforced by Mercadante (2014) who also uses the two dimensions of transcendence in her analysis of SBNR. Robinson, Smith and Kovacs (2014, p. 74) sum up spirituality as being:

> *'…a continuing, and often messy, dialogue between belief (culture), concepts (cognitive thinking), value (tied to emotion), virtue (character, and thus identity), and practice (meaning mediated in the created, and thus physical events). Each of*

> *these informs our consciousness (awareness and appreciation) of the social and physical environment.'*

Hungelmann, et al. (1985, p. 152) suggested that spirituality is '*a sense of harmonious interconnectedness between self, others, nature and ultimate which exists throughout and beyond time and space'.* What the nature of the ultimate Is underpins a continuum of different types or aspects of spirituality that will be explored later on page 26.

All the definitions of spirituality have been positive in the main. However, there is some evidence that spirituality can be harmful and this will be explored further.

2.2.7 Spirituality and Reductionism

This approach to exploring spirituality by looking at the individual elements of meaning, values and transcendence was termed a reductionist approach by Paley (2008b). He suggested that this reductionist approach lacked empirical or argumentative justification or support. He also contended that spirituality and spiritual care was subsumed into subdisciplines of psychology. This was a contentious view which was challenged by several authors including Leget (2008). He suggested that the reason that the literature on spirituality was confusing was because of the lack of access to appropriate language which was a barrier to clear and succinct analysis. Leget concluded that whilst Paley offered a strong argument for a critical questioning of the spirituality literature, he failed to offer a solution that is acceptable to many people for whom their own personal spirituality and faith is what provides meaning in life.

Betts and Smith-Betts (2009) also published a response which accused Paley of medicalising existential distress and therefore providing a clinical solution to what, in their opinion is not a medical condition.

Another response was written by Nolan (2009) who sympathised with what he saw as Paley's attempt to differentiate spirituality from religion but disagreed that reductionism was the best mechanism to achieve this. Instead he proposes a more humanistic definition, as proposed by Elkins, et al. (1988, p. 10).

> *[Spirituality is]… a way of being and experiencing that comes through awareness of a transcendent dimension and that is characterized by certain identifiable values in regard to self, others, nature, life, and whatever one considers to be the Ultimate.*

Nolan suggests that this way of being and experiencing moves away from meaning-making and grounds spirituality in experience. This personal experience is important as it frames an individual's worldview and places it in context.

In a long defence of his original paper, Paley (2010, p. 187) robustly defends this reductionist approach, asserting that 'all theories should be tested against evidence, discarded or amended if they turn out to be wrong'.

In a special, 20th anniversary issue of Nursing Philosophy. Kirk (2019) revisited reductionism in spiritual care and observed that concepts were still contentious and open for debate. He suggests that there are four major issues that are still outstanding despite the passage of time. According to Kirk, spiritual care as an important nursing competence has not been clearly defined nor why it should be delivered by nurses. I would contend that unique role the nurse is that they are the only healthcare professional that is with the patient continuously and this allows for holistic and spiritual care to be provided when and as the client needs it. Kirk then goes on to questionIf spiritual care itself can be isolated and identified as something different to holistic care, and if it can why this then becomes important. He asks if spirituality can help explain what makes nursing valuable. He also asks if the links between spirituality and the search for meaning can be used to illuminate the search for meaning in nursing care itself.

Kirk then goes on to echo Paley's fear that nursing literature's assertion that nurses should provide spiritual care is not supported by the evidence available,

This dialogue about whether the discourse surrounding spirituality can be explored using a reductionist approach is important in the wider context of the study of spirituality. The discussion about the evidence-based for spiritual care and about its robust validity can be echoed throughout the literature and only leads to a lack of clarity that is evident throughout.

2.2.8 Negative Spirituality and Spiritual Bypassing.

The concept of negative spirituality is challenging. Rayment and Smith (2011) suggested that negative spirituality includes the deliberate exclusion of other faiths, being selfish, excessively competitive, prejudiced, corrupt or hypocritical. Others have suggested that the correct term might be spiritual bypassing (Zampella, 2017).

Spiritual bypassing was first identified by Welwood (1984) to describe avoidance (or bypassing) of psychological work by focussing solely on the spiritual. It is a negative aspect to spirituality, which according to Sheridan (2017, pp. 360–362) has eight different dimensions:

- The quest for perfection or compulsive goodness,
- Avoidance or repression of undesirable or painful thoughts or emotions,
- Fear of individuation and avoidance of responsibility or accountability,
- Fear of intimacy, closeness, vulnerability,
- Spiritual obsession or addiction,
- Blind faith in charismatic leaders and teachers,
- Spiritual narcissism or ego inflation,
- Flight into humanitarian causes.

Not all these need to be present for spiritual bypassing to occur, and just because one or more elements are present, it does not necessarily indicate spiritual bypassing. For example, an avoidance or repression of undesirable thoughts or emotions could be linked to a lack of emotional intelligence.

There are several different aspects to spiritual bypassing that are relevant for this study. Individuation is the process of becoming a differentiated human being with one's own beliefs and ideals separate from those of parents and society (Welwood, 2000). The development of a personal sense of identity is relevant in the development of an individual's worldview and their value system. It is also an essential process in agate love – a love that lets be (MacQuarrie, 1983) as discussed on page 37.

Spiritual obsession or addiction can be manifested in many ways but is contrasted with spiritually based behaviours to advance understanding and spiritual growth with activities which are used to avoid uncomfortable realities or to engage in difficult change (Sheridan, 2017).

Blind faith in charismatic leaders and teachers has tragically been shown in multiple suicides of cult members including Jonestown and Jim Jones (Storr, 1996; Guinn, 2017) and Waco and David Koresh (Wright, 1995; Storr, 1996).

Using spiritual practices or beliefs to elevate oneself, especially in comparison to others, is a type of spiritual bypassing known as spiritual narcissism or ego inflation. It can be described as kind of 'I'm spiritual, and you're not' (Welwood, 2000; Cashwell, Glosoff and Hammond, 2010; Sheridan, 2017). This elevation of self as being more important than those around you is pertinent in the domain of self-awareness as this type of spiritual bypassing would indicate a potential deficit that could cause a breakdown in communication and disrupt the maintenance of a positive practice environment.

Identification of if spiritual bypassing occurs and how to deal with it are important skills in management that requires both awareness and action. Without these, there is the potential for disruption and detrimental care.

2.2.9 Religion and Spirituality.

One of the dualisms identified on page 6 was religion and spirituality. Pruzan (2013, p. 38) claimed that:

> *…religion is characterised by its more formalised and institutionalised aspects – sacred texts, dogma, belief systems, traditions, priesthoods, rituals and houses of worship – spirituality, … is more personal, introspective and at the same time more inclusive.*

Spirituality is distinguished from religion but can incorporate religious beliefs for some people. It can also be a religious or non-religious system of beliefs and values.

Koenig, McCulloch and Larson (2001, p. 18) identified the following differences between religion and spirituality:

Religion	Spirituality
Community focused	Individualistic
Observable, measurable, objective	Less visible and measurable, more subjective
Formal, Orthodox, organised	Less formal, less orthodox, less systematic
Behaviour oriented, outward practices	Emotionally oriented, inward directed
Authoritarian in terms of behaviours	Not authoritarian, little accountability
Doctrine separating good from evil	Unifying, not doctrine oriented

Table 2-3: Differences Between Religion and Spirituality (Koenig, McCulloch and Larson, 2001, p. 18).

The differences expressed are the community focused basis for religion, rather than individualistic nature of spirituality, the more formal view of worship, and the differentiation placed on separating good from evil in religion which is absent in a more spiritual orientation. Good and evil is another dualism that has been a central part of all religions, not just the Judeo/Christian tradition (Taliaferro, 2018).

Paley (2008c) suggests that the increasing secularization of the United Kingdom has coincided with what he terms an exponential growth in the study of spirituality and that this growth has been fuelled by a search for meaning that is no longer satisfied by more formal religions.

In 2006, the 'Spiritual Based Leadership Research Programme' at the Global Dharma Centre in the US interviewed 36 international leaders about their views on how spirituality might be distinct from and related to religion.

Three clear themes emerged from these interviews. First, religion is organised and tends to occur in groups. Spirituality is more personal and can occur individually. Second, religions tend to worship a deity whereas spirituality is more about connectedness. Finally, religion is more formalised with ritual and dogma while spirituality is more about the essence of life and the day-to-day behaviours that go with it. It is possible to be Spiritual but Not Religious: It is not possible to be religious without being spiritual since religion requires a belief in a deity that is transcendent (Pruzan and Miller, 2003).

Kapuscinski and Masters (2010, p. 193) assert that '*religion is often narrowly defined as associated with institutions whereas spirituality is not. Religion is also considered external, whereas spirituality is associated with personal experience'*. This differentiation between spirituality and religion was highlighted by participants in the second phase of this study and is explored further on page 97.

Some authors argue that the divide between religion and spirituality is artificial with the differences being so marginal that the two concepts are identical. (Pargament, 1999; Hill, et al., 2000; Streib and Hood, 2015) Despite offering his analysis of the differences between spirituality and religion in Table 2-3, Koenig (2012, p. 5), in his review article on religion, spirituality and health makes the following declaration:

> *For the research review presented here, given the similarity in my definition of these terms and the fact that spirituality in the research has either been measured using questions assessing religion or by items assessing mental health (thereby contaminating the construct and causing tautological results), I will be using religion and spirituality interchangeably (i.e., R/S).*

Paley (2017, p. 90) was even more succinct when he suggested *'You simply cannot use the word (Spirituality) without triggering religious associations and connotations'*. This trigger and the use of language is a vital component of this study and is explored further in chapter 6.
In conclusion, the difference between spirituality and religion was summed up by the Dalai Lama XIV (Bstan-'dzin-rgya-mtsho) (1999, p. 22) when he said:

> *…I believe there is an important distinction to be made between religion and spirituality. Religion I take to be concerned with faith in the claims to salvation of one faith tradition or another, an aspect of which is acceptance of some form of metaphysical or supernatural reality, including perhaps an idea of heaven or nirvana. Connected with this are religious teachings or dogma, rituals, prayer and so on. Spirituality I take to be concerned with those qualities of the human spirit – such as love and compassion, patience, tolerance, forgiveness, contentment, a sense of responsibility, a sense of harmony –which bring happiness to both self and others.*

The difference is important in this thesis because it highlights the use of language and how individuals with differing worldviews perceive their reality and what is truth. For those with faith, the transcendent is allied closely to a deity and more formal religion; for those without a faith, the transcendent concerns interconnectedness with something beyond the physical and is often perceived with a more personal experience (Holmes, 2018).
Paley (2009) contends that spirituality provides a link between the mundane and the transcendent, and makes it possible to slide between psychosocial problems and religious vocabulary.

2.2.10 Spiritual but Not Religious (SBNR).

An emerging concept within society has been the development of a designation of Spiritual but Not Religious (SBNR). These are often self-reported individuals who find it difficult to articulate what they mean when they say that they are SBNR (Chaves, 2011). He goes on to say that, along with many others, there is an expressed generalised dissatisfaction with organised religion (Chaves, 2011; Daniel, 2013) and the majority (who are spiritual *and* religious) also cannot define spirituality in any detail (Ammerman, 2013).

Data collected by the Ipsos MORI Global Trends Survey between September and October 2016 suggest that SBNR is gaining in popularity in Great Britain, although still under half that of the US.

SBNR is a point along a continuum that has spiritual and religious at one end and neither spiritual nor religious at the other. This continuum is important when identifying different groups for analysis and was used in Phase Two of this study.

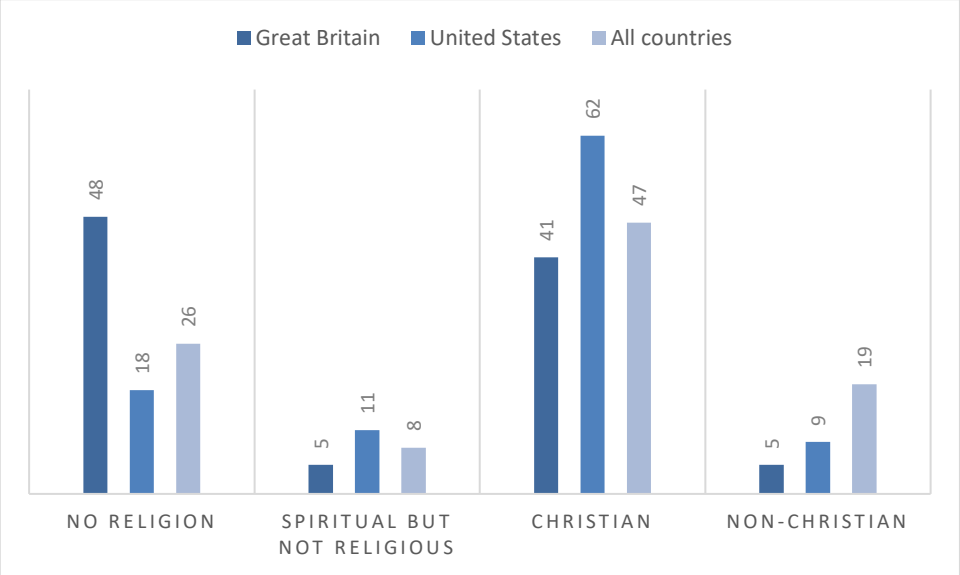


Figure 2-2: Religious Affiliation for GBR, US and Total (Ipsos MORI, 2017).

Mercadante (2014, p. 52) in her analysis of people self-reporting as SBNR suggested five different categories that identify their reasons, formative experiences and goals. These are:

- *Dissenters* - critical of religion,
- *Casuals* – who consider spiritual practices of value because they lead towards better health, stress relief and emotional support and are accessed on an 'as needed' basis and dropped when the crisis has passed,
- *Explorers* – seeking novelty and new experiences without settling,
- *Seekers* – decidedly looking for a fresh spiritual home,
- *Immigrants* – in the pre-commitment process of adjusting to a new spiritual home or community.

People can shift between the categories, but Mercadante (2014) maintains that there are also some factors that are common to all SBNR. These include suffering a life crisis which causes a focus on spirituality and their spiritual practice. Second, there is often significant experimentation and seeking of a spiritual home that feels right. This home is frequently temporary, and the quest for it can be frustrating and arduous. This spiritual home is often rejected because they found the beliefs unbelievable or that fellow members did not live up to them – a criticism frequently levelled at organised, formal religion. It is common for SBNR's to believe – just not in an all-powerful deity. This belief in a higher power links into

the idea of interconnectedness, which has been highlighted as a component of spirituality and which was discussed on page 18.

2.2.11 Types of Spirituality.

Boyce-Tillman (2016, pp. 74–77) identified a continuum of spiritualities which can be ascertained by the questions which underpin the values, meaning-making and the transcendent nature of the worldview. In summary, these can be designated as a classification system:

Spirituality Type	Description	Domain
Metaphysical.	Who or what can I serve? How can I know and serve God? What is the source of my strength? (Kaldor and Miner, 2012, p. 183) There is a mystery and sense of connection with the transcendent.	Spiritual and Religious.
Tradition	Attendance at and gaining strength from established rituals	Spiritual and Religious
Narrative	This 'refers to the fund of 'story' in which an individual 'dwells' and that constitutes the primary reference for religious identity' (Pratt, 2012, p. 4) This is often demonstrated by relating the person to a religious tradition in terms of Islam, Buddhism, Christianity for example.	Spiritual but not always religious
Intrapersonal	'Who am I? Where do I belong? How do I deal with suffering?' (Kaldor and Miner, 2012, p. 187) A sense of coming home to be at peace and one with ourselves (Jorgensen, 2008, p. 208)	Spiritual but not always religious
Interpersonal	The underlying question of the search here concerns how I relate to others (Kaldor and Miner, 2012, p. 187). Empathy arises. A sense of belonging and being at ease in the world replaces competition with caring and attempts to bless.	SBNR
Intergaian	The main question empowering the search is my relationship with the natural world (Kaldor and Miner, 2012, p. 187). There is an experience of a sense of oneness and deep relationship with the other-than-human world (Boyce-Tillman, 2010).	SBNR.
Extrapersonal / Ethical	Communitas arises – a feeling of unity with other beings, people and the wider cosmos (Boyce-Tillman, 2014, p. 24). A sense of wholeness, healing, and the interconnectedness of all things resulting in the finding of ultimate meaning. This results in ethical choices (Tisdell, 2007).	SBNR

Table 2-4: A Continuum of Spiritualities (Boyce-Tillman, 2016, pp. 74–77).

Identifying different types of spirituality domains from spiritual and religious, spiritual but not always religious and Spiritual but Not Religious highlights that there is a continuum across the dualities. There is an additional domain of neither spiritual nor religious which therefore does not include a type of spirituality. These different types were used to help differentiate the participants in Phase Two of the study.

2.2.12 Assessment of Spirituality.

The assessment of spirituality is as contentious as its definition. Many attempts have been made to measure spirituality (Kapuscinski and Masters, 2010). When a search of the literature was performed, assessment tools were identified with different foci. To narrow down the range of tools available three papers were chosen that explored various aspects of assessment. These are Balboni, et al. (2017), who examined papers with a particular end of life focus, Monod, et al. (2011) who examined more general papers related to health and health outcomes, and Smith (2013) who examined spiritual assessment tools from a broader perspective without a particular health focus.

None of these papers focused on healthcare staff, but when used sensitively, some of the potential tools could be used as an indication of spirituality in this population.

Balboni, et al. (2017) pointed out the tools explicitly linked to health have two major foci – research or to support clinical practice, particularly in end of life care. They subdivided the spiritual screening tools into three categories of inquiry: spiritual screening, spiritual history taking and spiritual assessment. The objective of spiritual screening is to assess those who require further intervention through the taking of history and assessment. The spiritual screening tools fit into more general psychosocial screening tools but can also be linked to health outcomes.

Monod, et al. (2011) explored different assessment tools with a health focus. Their classification examined general spirituality measures, spiritual needs measures, spiritual coping measures and spiritual wellbeing measures.

Smith (2013) explored spiritual assessment tools from a broader perspective without a health focus. His classification covered web-based self-help tools, with little more than entertainment value, faith-based assessment tools, spiritual sensitivity assessment tools and spiritual intelligence assessment tools.

It is important to note that most of these assessment tools focus on the assessment of spirituality in client groups and not with staff.

To investigate the research questions correctly, it is vital that the most appropriate instrument is chosen. Since the aim of this study was the development of a framework to raise awareness of spiritual intelligence in healthcare staff, the survey tool should reflect the population studied. For this reason, instruments with a primarily care focus were excluded from consideration. All the papers listed above were assessed for validity and reliability by their authors and so further exclusions could be made. In total, five instruments were selected for more detailed examination. These were Ellison (1983), Fetzer Institute (1999), (Puchalski and Romer, 2000), (Amram and Dryer, 2008), King (2008) and Wigglesworth (2012).

2.2.12.1 Ellison (1983).

The Spiritual Wellbeing Scale (SWBS) measures spiritual wellbeing with two interrelated but distinct aspects of religious and existential wellbeing. The religious element focusses on the respondents relationship to God, while the existential domain looks at the sense of life purpose and life satisfaction (Ellison, 1983). There are 20 items in the assessment, half of which refer to God. While there is an acknowledgement that 'a higher power could replace God', it is not faith-neutral. The SWBS is a self-report inventory with the answers given on a modified Likert scale from Strongly Disagree (one) to Strongly Agree (six). The tool is not sensitive to those with a strong faith, a fact that is acknowledged by its authors (Paloutzian and Ellison, 2017).

2.2.12.2 Fetzer Institute (1999).

This was an assessment tool developed by a working group to explore multidimensional measurement of religiousness and spirituality for use in health research. Table 2-5 shows the 246 elements spread across the following domains:

Domain		
Daily Spiritual Experiences (16 Items)	Meaning (20 Items)	Values (56 Items for ranking)
Beliefs (7 Items)	Forgiveness (10 Items)	Private Religious Practices (4 Items)
Religious/Spiritual Coping (32 Items)	Religious Support (12 Items)	Religious/Spiritual History (6 Items)
Commitment (3 Items)	Organisational Religiousness (8 items)	Religious Preference (72 Items)

Table 2-5: Domains of Spirituality for Assessment (Fetzer Institute, 1999).

A shortened, brief tool with 38 items was also proposed. The authors indicated that researchers should chose items from domains that matched their research questions to explore concepts in more depth. The Religious Preference is a list of 72 possible religious groups that respondents could choose to identify with, ranging from no religion, through Protestant and Roman Catholic, Islamic and Buddhist to Wiccan, which was identified as other ritual magic (Fetzer Institute, 1999, p. 83).

2.2.12.3 Puchalski and Romer (2000).

This assessment tool suggests the following four questions should be asked:

F—Do you belong to a faith tradition?
I—How important is your faith to you?
C—Do you belong to a faith community?
A—How does your faith affect how you would like me to care for you?

This model has been in use for almost two decades with different client groups including those hospitalised older adults (Borneman, 2011), mental health patients (Singh, Ram and Goyal, 2017) and in end of life and palliative care settings (Puchalski, 2014).

Since only a portion of personal values are based on a person's faith, Orr (2015) suggests supplementing this spiritual history with a fifth question: 'What personal values do you have that might also affect how you would like me to care for you?'
These issues also apply to care staff in their relationship with their manager. They have been incorporated into the semi-structured interviews in the second phase of this study to help inform individual respondents own personal spirituality and any potential links to their faith and value system, although the question regarding care was omitted.

2.2.12.4 Amram and Dryer (2008).

The Integrated Spiritual Intelligence Scale (ISIS) was developed as part of a doctoral thesis with the intention of exploring spiritual intelligence. This again has a long and a short form of either 83 items across seven domains or the shortened version which has 45 items across five domains covering consciousness, grace, meaning, transcendence and truth.
The sample populations to develop the test were split into two different groups: Spiritual Teachers and business leaders who either self-reported or who were recommended to the researchers as having vocational success which they attributed to their spirituality. They also nominated a group of MBA students who they considered to be business savvy but without a spiritual focus.

2.2.12.5 King (2008).

The Spiritual Intelligence Self-Report Inventory (SISRI) is a 24-item instrument that covers four domains – Critical Existential Thinking. Personal Meaning Production, Transcendental Awareness and Conscious State Expansion. The scale most closely mirrors Gardner's (2003) assessment of multiple intelligences. Originally an 84 item questionnaire, this was reduced to 24 items using confirmatory factor analysis and has been validated against other psychometric tests (King, 2008, p. 163)

2.2.12.6 Wigglesworth (2012).

The SQ 21 as an instrument to measure spiritual intelligence was first developed in 2004 by a team led by Wigglesworth in United States of America.
The model was based on the four-quadrant model used by Goleman, Boyatzis and McKee (2004) and which is presented on page 34.
A consulting company was hired to help with instrument construction and programming, following which the descriptors were explored informally with 'knowledgeable others' via a web class in 2003.
The terminology was reviewed and tested again with a group of staff from the Methodist Hospital in Texas which included nurses, chaplains and administration staff to establish validity. This pilot resulted in the first official iteration of the survey and report in 2003. There is potential for inbuilt bias for this group of staff, given the working environment the participants came from as it was a Methodist-based foundation.
Initially the pilot study examined one quadrant at a time with improvements based on feedback. A beta pilot was conducted in 2003/4 which assessed all four quadrants at once and was completed by 549 individuals. Following the beta testing, the survey instrument has remained unaltered with only minor amendments to clarify language (Wigglesworth, 2012).
The survey tool is available online through the Deep Change portal at https://www.deepchange.com/assessments and consists of 170 statements, the majority of which are measures of frequency of action. There is a complex algorithm that converts the answers to the statements with a score between zero and five for each of the 21 domains. This algorithm is commercially sensitive and cannot be published under intellectual property rights.

The SQ 21 Inventory was chosen as the instrument for this study. The fact that it was created as a coaching tool rather than a research tool is both its strength and limitation. It was developed as a starting point for coaches to open a dialogue to explore an individual's spiritual intelligence. It was always seen as the window to examine spiritual intelligence more comprehensibly than just a report to be read in isolation. This makes it ideal for use in a sequential, exploratory mixed methods study and allows for in-depth analysis of the research question.

The use of the SQ21 as a research tool is not without its difficulties. It has never been formally evaluated in an academic, peer-reviewed article although Kheswa (2016) used it in a descriptive form although he did not use it with any participants.

Another difficulty is in the use of language. The SQ 21 uses language in a very specific way. To ensure consistency, a glossary of terms was developed which were highlighted in the questions when undertaking the questionnaire. These were clickable and provided a clear definition for their precise use in the SQ 21. There are 36 items identified, including values, worldview, spirituality and religion.

The SQ 21 was originally piloted at the Methodist Hospital in Houston, Texas in 2003 using three focus groups. This might have led to a faith-based healthcare bias, but subsequent testing used a wider group without this potential bias.

The description of the SQ 21 being both faith neutral and faith friendly could also lead to problems. In trying to be inclusive there is a danger that neither group ends up satisfied. As more people undertake the questionnaire and the debrief that accompanies it, then the robustness and validity should increase.

Wigglesworth (2012, p. 194) sums the SQ 21 up when she says

> *[The SQ 21] …is an assessment designed to begin a conversation and a learning journey. It is not perfect. But it's really good as a starting place for one of the richest conversations you might ever have with a coach, or with yourself.*

This starting place makes the SQ21 an ideal tool for use in exploring the research question: *'What are the elements underpinning the awareness of spirituality among healthcare managers in practice using the lens of spiritual intelligence?'*

To explore this in more detail, the construct of intelligence will now be reviewed, with the place of spiritual intelligence within the theory of multiple intelligences examined with support from the literature.

2.3 Intelligence.

The second strand of theory underpinning this dissertation is that of intelligence. This is again a difficult concept to define as it is multifaceted and has been argued about by academics over the centuries. As with spirituality, '*…there seem to be almost as many definitions of intelligence as there were experts asked to define it*.' (Sternberg, 1987, p. 2)

2.3.1 Definition of Intelligence.

Legg and Hutter (2007) wrote a paper with 70 informal definitions of intelligence that they had collected over several years. While they acknowledge that objectively there is not a single definitive definition, they concluded that there were three elements that commonly occurred. These were that intelligence:

- Is a property that an individual agent has as it interacts with its environment or environments,
- Is related to the agent's ability to succeed or profit with respect to some goal or objective,
- Depends on how able the agent is to adapt to different objectives and environments.

From this, they developed their definition of intelligence which asserted that '*intelligence measures an agent's ability to achieve goals in a wide range of environments'* (Legg and Hutter, 2007, p. 17)'. While their use of language is perhaps a little artificial, they conclude the ability to learn, adapt and to understand are implicit within the definition and therefore do not need stating directly.

2.3.2 Multiple Intelligences.

One of the most influential authors on intelligence is Gardner (2011b, p. XXIX) who proposed that multiple conditions fitted his definition of intelligence.

> *'An intelligence is the ability to solve problems, or to create products, that are valued within one or more cultural settings.'*

To qualify as an intelligence, Gardner (2011b, pp. 63–71) suggested eight criteria to assess what he described as 'candidate intelligences' These criteria were:

- the potential for brain isolation by brain damage,
- its place in evolutionary history,
- the presence of core operations,
- susceptibility to encoding,
- a distinct developmental progression,
- the existence of idiot-savants, prodigies and other exceptional people,
- support from experimental psychology, and
- support from psychometric findings.

Based on these criteria, Gardner proposed the following types of intelligence:

Type of Intelligence	Definition or Ability	Suggested Example of a High Achiever
Linguistic	The ability to think in words and use language to express and understand complex meaning.	T. S. Elliot, Author.
Logical-mathematical	The ability to detect and understand cause- and-effect connections and the relationships among actions, objects, events or ideas,	Albert Einstein, Scientist.
Musical	The ability to recognise and appreciate musical patterns, pitches, tones and rhythms, and to compose and perform music.	Arthur Rubinstein, Pianist.
Visual-spatial	The ability to think in pictures, use imagination and perceive the visual world accurately in three dimensions.	Sir Norman Foster, Architect.
Intrapersonal	The ability to understand and manage oneself, one's thoughts and feelings, strengths and weaknesses (part of what is now known as emotional intelligence), and to plan effectively to achieve personal goals.	Howard Schultz of Starbucks.
Interpersonal	The ability to understand other people, display empathy, recognise individual differences, and interact effectively (also related to social intelligence, cultural intelligence and emotional intelligence).	Mahatma Gandhi, Statesman.
Bodily-kinesthetic	The ability to use the body in skilful and complicated ways, involving a sense of timing, coordination of movement and the use of the hands.	Martha Graham, Dancer.
Naturalist	The ability to recognise, categorise and draw upon features of the natural world,	Charles Darwin, Scientist.

Table 2-6: Types of Multiple Intelligences (Gardner, 2011b, pp. 63–71).

All the definitions start with an ability and are to do with thinking or cognition. This, it is argued by Davis, et al. (2011), is what differentiates intelligence from skills. Skills can be grouped into domains which are developed by society and exist outside the individual. Intelligences are a biopsychological potential that all people possess by being human. Gardner himself differentiates intelligences from domains which he describes as a culturally relevant, organised set of activities demonstrated by a symbol system and a set of operations. An example of this is the domain of dance which uses bodily-kinesthetic and musical intelligence (Gardner, 1995).

Other criticisms of multiple intelligence theory include a lack of empirical research to support its development and application (Calik and Birgili, 2013), that it is subjective (White, 1998) and it expands the concept of intelligence so widely as to render it meaningless (Gilman, 2014).

There have been many suggestions for additional intelligences since the initial research was published. Gardner himself has suggested an existential intelligence but resisted all other attempts to increase the number of intelligences covered (Gardner, 2011b, p. XXXVII). He goes on to say that it is *'Important to have a viable model of oneself and of being able to draw effectively upon that model in making decisions about one's life'*. This is another way of defining self-awareness, a key skill in both spiritual and emotional intelligence which will be discussed in more detail.

2.3.3 Emotional Intelligence.

Two of the intelligences proposed by Gardner, intrapersonal and interpersonal, have been combined into a single intelligence of emotional intelligence (Goleman, 1995; Mayer, Caruso and Salovey, 1999). Emotional Intelligence is defined as '*the ability to manage ourselves and our relationships effectively*'.
Boyatzis, Goleman and Rhee (2000, p. 349) developed a four-quadrant model which identified 18 different skills and competencies that underpin their understanding of the components of emotional intelligence:

Self-Awareness		Other Awareness	
Emotional Accurate Self-confidence	self-awareness self-assessment	Empathy Organisational Service Orientation	Awareness
Self-Management		**Relationship Skills**	
Emotional Transparency Adaptability Achievement Initiative Optimism	Self-Control (honest/trustworthy) Orientation	Developing Inspirational Influence Change Conflict Teamwork and Collaboration	Others Leadership Catalyst Management

Table 2-7: Four Quadrants and 18 Skills of Emotional Intelligence (Boyatzis, Goleman and Rhee, 2000, p. 349).

Great claims have been made for emotional intelligence over the years. '*IQ will get you in the door, but emotional intelligence is what makes you successful' (Fry and Wigglesworth, 2013, p. 52)* is a mantra that has been used for 20 years. However, the claims that emotional intelligence can solve all the problems in the world have been disputed (Zeidner, Matthews and Roberts, 2001; Harms and Credé, 2010; Walter, Cole and Humphrey, 2011; Antonakis, 2017)

Some criticisms and doubters dispute the claims made. In the same way that multiple intelligences have been criticised for being too all-inclusive, emotional intelligence has also been accused of being unintelligible and invalid (Locke, 2005). Other criticisms include that the few validity studies performed show that emotional intelligence has little predictive value. Most of the tools to measure EQ are not freely available for confirmatory analysis, replication or verification, a major requirement for research (Landy, 2005).

The importance of emotional intelligence and its relationship to leadership is summed up by Walter, Cole and Humphrey (2011, pp. 51–52) who suggested that:

> *'… In spite of conflicting perspectives on the definition and measurement of emotional intelligence, and in the midst of a continued debate on emotional intelligence construct validity, empirical research on emotional intelligence and leadership has produced notable findings. Even though the scholarly literature does not support the hyperbolic claims regarding emotional intelligence relevance for leadership processes, evidence does suggest that emotional intelligence has potential to help scholars better understand leadership emergence, specific leadership behaviours, and leader effectiveness. That said, we also believe a lot remains to be accomplished'.*

This scepticism and intellectual debate about the validity and usefulness of emotional intelligence continues. The raising of awareness of the importance of emotional intelligence, and the place for emotion in the workplace has been a journey that has taken 20 years and is still evolving. Emotional Intelligence is now in the mainstream of management theory, despite the doubters and suggested lack of validity. The concept of spiritual intelligence, in my view, is at the same point that emotional intelligence was 20 years ago. Raising consciousness of spiritual intelligence to the same level as emotional intelligence is part of the rationale for this study.

The relationship of spiritual intelligence to other intelligences is dependent on self-awareness and awareness of others. The next section will examine spiritual intelligence, its definition and assessment.

2.3.4 Spiritual Intelligence.

The term spiritual intelligence was first used by Zohar (1997) and developed further in collaboration with Marshall (Zohar and Marshall, 2000; 2001; 2004). They argued that IQ and EQ were insufficient to explain the motivation and needs of individuals in organisations and that something was missing. They suggested that computers have a high IQ as defined by the ability to know and follow sets of rules without mistakes. One of the questions asked in both phases of this study asks if it is ever acceptable to break rules? Without much more advanced artificial intelligence, a computer would not understand the question, let alone be able to answer it. Animals have an intuitive sense of their surroundings and respond appropriately. '*Humans use SQ to wrestle with issues of good and evil and to see unrealised*

possibilities, to dream, to aspire, to raise ourselves out of the mud' (Zohar and Marshall, 2001, p. 5). Zohar and Marshall (2004, p. 7) go on to define spiritual intelligence as '*an ability to access higher meanings, values, abiding purposes, and unconscious aspects of the self and to embed these meanings, values and purposes in living a richer and more creative life*'. SQ is uniquely human and is used to develop our capacity for meaning, vision and value. Zohar and Marshall (2001, p. 36) contrast SQ with EQ by saying that:

> *'… My emotional intelligence allows me to judge what situation I am in and then to behave appropriately within it… But my spiritual intelligence allows me to ask if I want to be in the particular situation the first place. Would I rather change the situation, creating a better one?'*

Spiritual intelligence and spiritual leader development are supported by 12 principles as described by Zohar (1997, p. 78):

SQ Principle	Descriptor
Self-Awareness	Knowing what I believe in and value, and what deeply motivates me.
Spontaneity	Living in and being responsive to the moment.
Being Vision- and Value-Led	Acting from principles and deep beliefs, and living accordingly.
Holism	Seeing larger patterns, relationships, and connections; having a sense of belonging.
Compassion	Having the quality of 'feeling-with' and deep empathy.
Celebration of Diversity	Valuing other people for their differences, not despite them.
Field Independence	Standing against the crowd and having one's own convictions.
Humility	Having the sense of being a player in a larger drama, of one's true place in the world.
Tendency to Ask Fundamental 'Why?' Questions	Needing to understand things and get to the bottom of them.
Ability to Reframe	Standing back from a situation or problem and seeing the bigger picture; seeing problems in a wider context.
Positive Use of Adversity	Learning and growing from mistakes, setbacks, and suffering.
Sense of Vocation	Feeling called upon to serve, to give something back.

Table 2-8: The 12 Principles of Spiritual Intelligence (Zohar, 1997, p. 78).

This list echoes the proposition of Emmons (2000) that SQ could transcend the physical and material, the capacity to experience heighten states of consciousness, the ability to sanctify everyday experience and capacity to utilise spiritual resource to solve problems. He also suggested that these abilities fulfilled Gardner's (2011b) criteria for acceptance as the ninth intelligence – A suggestion refuted by Gardner himself (Gardner, 2000).
Wigglesworth (2012, p. 8) defined SQ as '*the ability to behave with wisdom and compassion, while maintaining inner and outer peace (equanimity), regardless of the situation*'. There is an inherent assumption here that spiritual intelligence can be both learnt and developed.

Wigglesworth (2010, p. 6) asserts that SQ is vital in business for the following reasons:

- The reduction in egoic or “small self” perspectives creates a huge increase in innovation for the manager and the team—and new ideas flourish.
- The reduced need to defend the old way of doing things makes change much easier.
- The magnetic attraction of visions generated from this higher perspective of SQ mobilises people into action. It is energising and taps into people’s desire for meaning and purpose in their work lives.
- The vantage point of the Higher Self provides a less “noisy,” less fearful, less drama-prone way of working. This amplifies IQ.
- The calm of a high SQ perspective on problems gives the energy needed to work on complex problems which the business may face. Adrenaline is not wasted on the situation—energy is focused appropriately and can therefore accomplish more.

While Wigglesworth has concentrated on the positive effects in the business environment, these benefits are also applicable in the provision of healthcare. Change is ever present, and anything that might make change easier needs to be explored and embraced. Focussing energy appropriately on complex problems leads to a more nuanced solution that often involves other members of the team. Excellent communication is paramount and an awareness of the skills of spiritual intelligence when used alongside emotional and cognitive intelligence. Skill 18: Being a Wise and Effective Change Agent is a skill in the SQ 21 inventory and is examined in more detail on page 77.

2.3.5 Love.

When developing this definition of SQ, Wigglesworth wanted to use the phrase ‘*Behaving with Love’* (Wigglesworth, 2012, p. 8), She felt, however, that love was too imprecise a term to encapsulate the range of concepts that she wanted to explore. A quote from the East that read: ‘*Love is a bird with two wings. One wing is compassion; the other wing is wisdom. If either wing is broken, the bird cannot fly’* provided the answer that she was looking for.
The concept of love and the imprecise nature of its definition in English has been explored by Pittman McGehee (2011) He suggests using the Greek definitions for love as a model. These are:

- Eros (Passionate Love)
- Philia (Friendship)
- Agape (True or Unconditional Love)
- Storge (Affection or Familial Love)

2.3.5.1 Eros (Passionate Love).

Eros is a non-rational desire to connect, to relate to or to create; it is both a common human experience and part of the human experience. It provides energy or power to create new

consciousness and can be seen in communication, painting, writing or music as well as in the relationship between human beings (Pittman McGehee, 2011, p. 25).

2.3.5.2 Philia (Friendship).

Philia, the friendship kind of love or brotherly love of people who are together in community. It is close to companionship which is a relationship which shares all – All feelings, fears, frustrations fantasies and hopes. It is platonic and the basis of communitas (Zavada, 2018). Movelis (2017, p. 255) commented that philia was related to '*a deep and rich connection with another – to be understood, accepted, embraced for who you are – and to reciprocate those aspects within a relationship is the true reward'*.

2.3.5.3 Agape (True or Unconditional Love).

Nygren (1982) defined agape love as unmotivated as it does not depend on any value or worth in the object of love. It is spontaneous and heedless and does not determine beforehand whether love will be effective or appropriate. Agape love is the love that Christians claim God has for his people and is a central tenement of their faith. Agape love extends beyond emotions. It is much more than a feeling or sentiment. Agape love is active. It demonstrates love through actions.

MacQuarrie (1983, p. 179) claims that agape love can be described as the act of Letting Be – Allowing others to make their own mistakes and not being overly domineering in tell people what they should do. This is an important factor in Skill 17: Being a Wise and Effective Teacher/Mentor of Spiritual Principles which is discussed further on page 81 (Wigglesworth, 2012, p. 104).

Pittman McGehee (2011, pp. 42–43) explained that *'letting be is a love that empowers and helps a person fully realise their potential for being, even if it runs counter to what we need or want them to be – a love that is self-sacrificing*'

2.3.5.4 Storge (Affection or Familial Love).

The fourth type of love defined by the Greeks is Storge Love, which describes the love for one's family – Father, Mother, Brother, Sister and Children. The relevance of storge love can be seen in the development of community with the identification of family values underpinning much of societies moral guidance (Rykkje, Eriksson and Råholm, 2015).

2.3.5.5 Biblical Love.

One of the most famous passages in the bible concerns the nature of love:

> *'Love is patient, love is kind. It does not envy, it does not boast, it is not proud. It does not dishonour others, it is not self-seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight in evil but rejoices with the truth. It always*

> *protects, always trusts, always hopes, always perseveres (The Bible, 1 Corinthians 13:4-7)'*

The moral compass that this type of love exemplifies has an impact on the value system that is identified and has a strong resonance with the values identified by participants in Phase Two of this thesis and is analysed in more depth on page 102.

2.3.6 Spiritual Intelligence and the SQ21.

A major part of Wigglesworth's work has been in the development of an assessment tool that measures spiritual intelligence.

This assessment tool explores four different domains or quadrants which mirrors the four quadrants as outlined by Goleman, Boyatzis and McKee (2004) in their analysis of emotional intelligence described earlier on page 34.

The four quadrants and 21 skills of spiritual intelligence developed by Wigglesworth (2012, p. 46) are given in Table 2-9:

Quadrant One	Quadrant Two
Self/self-Awareness Awareness of Own Worldview Awareness of Life Purpose Awareness of Values Hierarchy Complexity of Inner Thought Awareness of Ego self/ Higher Self	Universal Awareness Awareness of Interconnectedness of Life Awareness of Worldviews of Others Breadth of Time Perception Awareness of Limitations / Power of Human Perception Awareness of Spiritual Laws Experience of Transcendent Oneness
Quadrant Three	**Quadrant Four**
Self/self Mastery Commitment to Spiritual Growth Keeping Higher Self in Charge Living Your Purpose and Values Sustaining Faith Seeking Guidance from Higher Self	Social Mastery/ Spiritual Presence Being a Wise and Effective Teacher / Mentor of Spiritual Principles Being a Wise and Effective Leader / Change Agent Making Compassionate and Wise Decisions Being a Calming, Healing Presence Being Aligned with the Ebb and Flow of Life

Table 2-9: The Four Quadrants and 21 Skills of SQ21. (Wigglesworth, 2012, p. 46)

Wigglesworth differentiates between Self and self and suggests that SQ asks an essential question: Who is driving your life? Is the calmer, wiser 'Higher Self' in charge, or are you being driven by an immature, short-sighted Ego and the beliefs and ideals of others? It is the development of Higher Self that is the fundamental aspect of the SQ21 inventory. It is meant as a developmental tool and the starting point of a meaningful and profound conversation exploring areas of self-development that might not otherwise be identified. It is for this primary reason that it is the preferred assessment tool as the whole justification for the development is the conversations that are had post completion. It therefore fits in seamlessly with a research method which employs a sequential mixed method design. (Wigglesworth, 2012)

2.4 Worldview.

The construct of worldview is an important element of spiritual intelligence. It has been defined by Sire (2015, p. 141) as:

> *A worldview is a commitment, a fundamental orientation of the heart, that can be expressed as a story or in a set of presuppositions (assumptions which may be true, partially true or entirely false) which we hold (consciously or subconsciously, consistently or inconsistently) about the basic constitution of reality, and that provides the foundations on which we live and more and have our being.*

Wolters (2005, p. 2) puts it more succinctly when he says a worldview is '*a comprehensive framework of one's basic beliefs about things'.*

The first skill in SQ21 is an awareness of one's own worldview. At its simplest, worldview is your view of the world. Wigglesworth (2012, p. 49) asserts that it is the framework of beliefs and ideas through which we interpret the world around us. Wright (2013) explores the concept in much more detail. He contends that worldviews are the narrative in our lives that provide our perception of reality. It is this reality that allows us to answer the deeper philosophical questions: who are we, where are we, what is wrong, and what is the solution? Worldviews are like a building's foundations: essential but hidden. They form the template by which humans organise reality. If an individual is unaware of their worldview, then there may be inconsistencies in their beliefs.

A current example of this is the migration crisis in the UK. There is a perception that 'foreigners' are coming to this country to 'steal our jobs'. The reality is that most of the jobs that have been 'stolen' are hard physical labour (for example celery picking in the Cambridgeshire Fens). It is possible that political advantage can be gained by this manipulation of worldview.

The seventh skill in the SQ21 is an awareness of worldview of others. As with all the skills, there are five levels of development which can be attained (Wigglesworth, 2012, p. 73).

Skill Level	Level of Development Descriptor
1	I listen to differing points of view, even when they oppose mine.
2	I seek opportunities to learn about and understand other points of view.
3	I understand other people's points of view and 'tune in' to their feelings even during a conflict. I want to understand their thoughts AND their feelings.
4	I have compassion for the hopes and fears that we all share, regardless of our worldviews. I can demonstrate to people that I understand their feelings. I have considered the many possible worldviews and have chosen a worldview from which to operate.
5	When I learn a better way of looking at things I revise my own worldview. Through compassionate understanding I can put myself inside the worldview of anyone – including murderers and terrorists. Other people feel I really do understand their point of view.

Table 2-10: The Five Skills of a Developing Worldview (Wigglesworth, 2012, p. 73).

The level of spiritual development that a leader has achieved within this skill can have a profound effect on their leadership ability. The development of these skills in their knowledge of worldview can be mirrored in the stages of competency development. Benner (1984) proposed five stages of development: novice, advanced beginner, competent, proficient and expert. These suggest a degree of questioning and engagement with self-development. The model can be represented pictorially, with the five levels represented by stages in a pyramid:

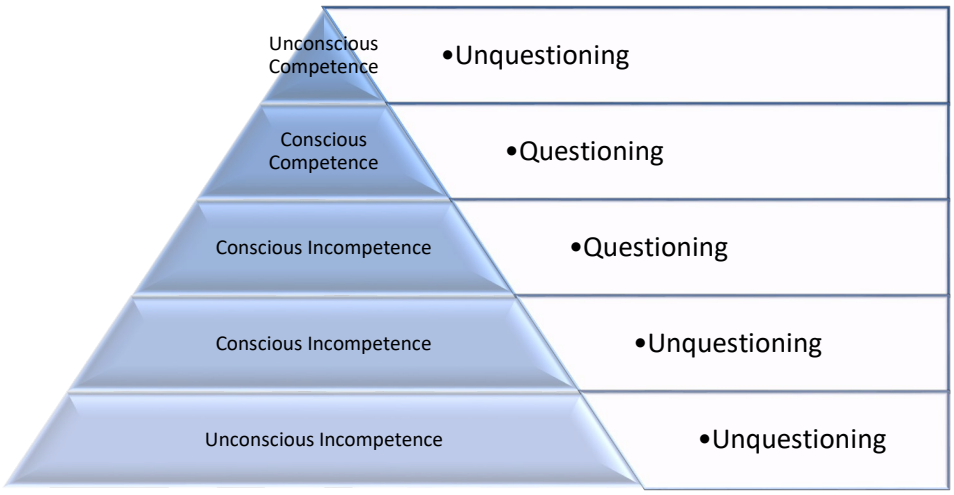


Figure 2-3: Theoretical Representation of Skills Acquisition (Adapted from Benner (1984)).

The conceptual elements of this model are in the awareness (consciousness) and the ability and desire to question. If there is no awareness of a gap in knowledge, an individual will not question this lack of knowledge. It is also argued the expert stops questioning as behaviours and the skills are so ingrained that they have moved on from needing to question.
In terms of the development of a worldview, the elements of development are as follows:

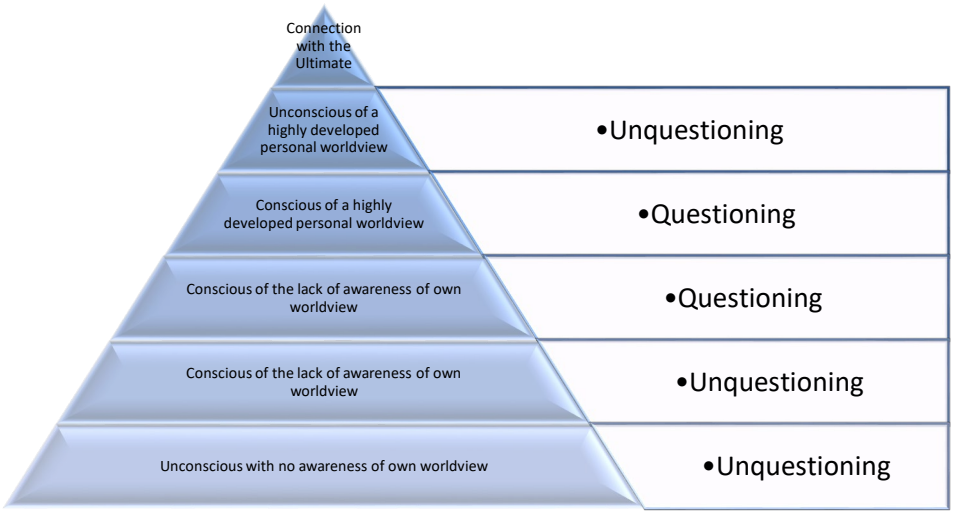


Figure 2-4: Stages of Development of a Worldview.

The lowest level of the pyramid reflects skill one in the SQ21 inventory. Having no awareness of your worldview or its importance is level zero in the domain, and a good starting point for discussion. The skills outlined in table 3 above demonstrate this idea of an increasing skill set and awareness of the importance of both a robust personal worldview and tolerance of others. This, on a much wider scale, is the basis for all diversity training and fundamental to the knowledge required.

For me, the importance of a developed and accepting worldview is summed up by the priest and poet Lucy Berry (2014). In a poem about the Syrian refugee crisis, she sums up the vibrant and accepting need for a coherent worldview.

> *Looking up at my sky, I am watching yours;*
> *gazing into your heaven, you are seeing mine*
> *even between different leaves,*
> *steeples, minarets… domes…*

2.5 Chapter Summary.

This chapter has explored the fundamental properties of spirituality, intelligence and spiritual intelligence. All are difficult to define and the complex nature of them individually is compounded when they are integrated together. The importance of a robust value system along with meaning and worldview was explored to add to the literature studied.

This literature review has identified links between spiritual intelligence, meaning, values and expression of a coherent worldview. These themes are generic and do not focus on healthcare in general or on the influence that they have on the development of staff as mediated by the managers that work in the sector. The uniqueness of this study is that it explores these elements to ascertain how they are important to those who are practitioners that deal with staff on a day-to-day basis.

The next chapter will explore the underpinning methodology of the dissertation and outline the rationale for the selection of a sequential, mixed methods study to answer the research question.

CHAPTER THREE.

3.1 Introduction to the Research Paradigm.

This chapter will describe and justify the methodological approach taken for this research. Previously, spirituality, intelligence and spiritual intelligence have been defined and the relationships between them explored. A mixed method approach was used as this allows complex questions to be viewed from a qualitative and quantitative standpoint, supported by other research and theoretical constructs. Using a single methodological approach would not be enough to study the issues in enough depth to allow the research question to be answered.

It might be argued that this is not a mixed methods study since the response rate for Phase One precluded any advanced statistical analysis. However, the use of the mean scores for each skill ranking along with the range of scores informed the development of the questions for Phase Two and the findings from both phases were integrated into the themes for the framework proposed on on page 128.

Mixed methods studies take the strengths from both qualitative and quantitative approaches and in combination provides depth and greater understanding of the research findings (Wisdom and Creswell, 2013). It is a synthesis that includes ideas from both qualitative and quantitative research (Burke Johnson, Onwuegbuzie and Turner, 2007).

The research question is important as it is this that drives the need for a comprehensive approach to the study. The pragmatism that underpins the choices made builds upon the combination and interpretation of the results in tandem rather than in isolation. This is achieved by analysis of the findings of both phases separately and then integration of the findings to develop a framework that builds on the results.

The underlying philosophy of mixed methods – pragmatism - is described on page 48. An analysis of the pragmatic approach and how it is situated within the wider philosophical arena is explored. The relationship between the mixed methods approach is discussed in relation to a positivist or constructivist paradigm. Denscombe (2008, p. 273) described pragmatism as a ‘philosophical partner’ for mixed methods research where choice for a single paradigm is rejected in favour of consideration of the perceived strengths of both.

The mixed methods design employed was a sequential exploratory mixed method design (Creswell, et al., 2010, p. 180) with two phases. The first phase consisted of a quantitative survey of healthcare managers and used Wigglesworth’s (2012) SQ 21 survey tool. Analysis of findings from the first phase informed the second phase which involved qualitative interviews with a participant selection model as described by Creswell (2013) of those healthcare managers.

Although stated in the introduction, the aim, research questions and objectives are restated here since it helps explore the underlying philosophical standpoint which underpins the study. The philosophical standpoint is one of pragmatism.

3.2 The Aim.

The aim of this study is to explore the awareness of spirituality among healthcare managers using spiritual intelligence as a framework.

3.2.1 Research Question.

The primary research question for the study was:
'What are the elements underpinning the awareness of spirituality among healthcare managers in practice using the lens of spiritual intelligence?'
Secondary questions were derived from the aim and primary question and linked to the two phases of the study:

3.4.1.1 Phase One: Quantitative Survey of Healthcare Managers.

What are the dominant and less dominant skills of spiritual intelligence, as measured using Wigglesworth's (2012) SQ21 inventory?

3.4.1.2 Phase Two: Qualitative Interviews with Healthcare Managers.

How do managers articulate their beliefs and understanding of spirituality and spiritual intelligence?
What are managers' perceptions and understanding of spirituality and spiritual intelligence in their role as a healthcare leader?

3.4.2 Objectives.

The first phase of this study involved a survey assessing 21 different skills as measured by the Wigglesworth (2012) SQ 21 Inventory. Informed by the results of the first phase, the second phase involved semi-structured interviews with nine participants who had completed the inventory in Phase One. This data was also used to examine the results from Phase One in an iterative process that helped make sense of the findings.
To summarise, the objectives of this study were to:

- Identify which aspects of spiritual intelligence are more important to healthcare leaders.
- Identify the factors that influence the awareness of spiritual intelligence in healthcare managers.

- Highlight any skills identified in the SQ 21 Inventory that support or hinder the development of awareness of spirituality and spiritual intelligence.

Following the identification of the factors that are important in supporting the development of spirituality and spiritual intelligence, a framework encompassing these skills will be proposed that can be used with healthcare professionals at all levels to raise awareness of their own spirituality and spiritual intelligence.

3.5 Methodology and Research Paradigms.

Research is defined as a systematic inquiry to understand, explain, predict or control phenomena using data collection, analysis and interpretation (Mackenzie and Knipe, 2006, p. 195). This systematic inquiry consists of justification for the approaches taken from a philosophical standpoint and development of the research methodology. Rajasekar, Philominathan and Chinnathambi (2013, p. 5) suggest that research methodology is a systematic way that provides the principles to guide how to study a problem. It is a science of studying how research is to be carried out. This contrasts with the research methods which are the tools used to collect the relevant information to inform the study. If the appropriate methods are selected, data collected should answer the research question. A clear understanding of paradigms and their role in the research process is articulated and used to justify choices made.

Paradigms have been described as a school of thought (Parahoo, 2014) or a worldview (Guba and Lincoln, 1994) and they govern the theoretical perspective underpinning research including the ontology, epistemology and choice of methods and techniques used in research.

Ontology is defined as the nature of reality, epistemology as the nature of knowledge and methodology as how to perform research relative to the question and context (Denzin and Lincoln, 1994, p. 108; Houghton, Hunter and Meskell, 2012, p. 34).

Ontology is what exists and is a view on the nature of reality. My personal ontological stance is one of relativism. Knowledge is a social reality, impacted on by values (Hammersley, 2017, p. 2) and is based on individual interpretation and is one of the drivers underpinning this study. I am less comfortable with the pluralist view that led to the paradigms war that raged at the turn of the 21st century (Bryman, 2008). The continuum with qualitative at one end and quantitative at the other does not lead to easy interpretation of research.

While several paradigms have been described in the literature, I describe three that are relevant to this study: positivism, interpretivism and pragmatism.

The positivist paradigm is viewed as one that seeks an objective truth by using hypothesis to test questions and principally involves analysis of numerical data using quantitative methods (Antwi and Hamza, 2015). The constructivist paradigm seeks understanding of a research phenomenon and uses qualitative methods such as observation and narrative of a person's lived experience to explore the world from an individual perspective.

The mixed methods approach underpinned by pragmatism was my chosen approach for this study.

The decision to use mixed methods was born of an investigation of these different paradigms and the advantages that the combined strengths of a qualitative and quantitative project that gives more depth and validity to the results than the findings of either strand alone. The raw scores obtained from the SQ 21 survey would be insufficient to explain why and how the scores had been attained, and the questions asked in Phase Two were grounded in the results and theoretical underpinnings from the quantitative survey. The choice of population for Phase Two was also influenced by the results from Phase One.

Creswell (2013, p. 6) explored different worldviews as an underpinning justification of the research methodology used, particularly in mixed methods. These worldviews are presented in Table 3-1

Postpositivist Worldview	Constructivist Worldview	Participatory Worldview	Pragmatist Worldview
Determination	Understanding	Political	Consequences of actions
Reductionism	Multiple participant meanings	Empowerment and issue oriented	Problem centred
Empirical observation and measurement	Social and historical construction	Collaboration	Pluralistic
Theory verification	Theory generation	Change oriented	Real-world practice oriented

Table 3-1: Basic Characteristics of Four Worldviews used in Research (Creswell, 2013, p. 6).

These four worldviews or paradigms support the development of a research methodology which underpins a chosen topic area. For this study, the pragmatist worldview with its focus on real-world practice was the most appropriate one to be used. The participatory worldview was also considered since there is a focus on change management in healthcare leadership and there was a clear focus on this in both phases of the research, It is argued that the distinction between the two is blurred and mixed methods is appropriate for both worldviews.

Pragmatism was selected as the chosen research worldview as the nature of spiritual intelligence lends itself to this worldview. SQ examines the reasons behind certain behaviours and is underpinned by 'what works' which is the underlying worldview of pragmatism. Many healthcare managers have a practical focus to their role which is underpinned by experience and a reliance on what works. There is not one single reality as it is the lived experience that is important to the provision of high quality healthcare (Goodrich and Cornwell, 2008).

3.6 Pragmatism and Mixed Methods.

Creswell and Plano Clark (2011) suggest the complexity of research problems calls for answers beyond simple numbers in a quantitative sense or words in a qualitative sense. It is this synthesis that adds value to both elements that is the rationale and justification for mixed method studies and is the reason for its selection here. Since the questions in Phase Two were guided in part by the responses to Phase One, the answers to the research question were more detailed than would have been possible by using the two phases independently. Mixed methods research methodology is an attempt to utilise the best elements of qualitative and quantitative research, combining different approaches to analyse the responses, understanding and thought processes that informed the answers to the questions in Phase One. This research achieves this in the development of a framework that supports practice and is underpinned by the implicit knowledge and experience of practitioners. It is a synthesis that includes ideas from qualitative and quantitative research (Burke Johnson, Onwuegbuzie and Turner, 2007, p. 113).

3.6.1 Pragmatism.

Pragmatism as a philosophy was developed at the end of the 19th century in America, particularly by James (1907). Dewey challenged the dualism that is inherent in the quantitative / qualitative debate that has occurred for most the last century. Dewey rejected this dualism in favour of addressing 'the problems of men' (Dewey, 1946, p. 4)
Pragmatism fell out of favour in the 1940s, possibly because there was no natural successor to Dewey (McDermid, 2013). Interest was revived in the 1980s with the writings of Rorty (Rorty, Williams and Bromwich, 1980; Rorty, 1982; 1990). Rorty discussed the nature of truth and the practical considerations of the consequences of what truth meant.
McDermid, (2013, p. 2) sums this up when he asks the question '*What concrete practical difference would it make if my theory were true and its rival(s) false?'* The assertion as to the nature of truth is dependent on the worldview espoused and the nature of experience.
James and Dewey both espoused the notion that truth is what works.

Pragmatism is not committed to a specific research philosophy or paradigm (Bloomberg and Volpe, 2008) but explores the practical application of workable solutions to research problems. The underlying principle of pragmatism is that it is based on experience at the intersection of the conscious self with the world (Kloppenberg, 1996).

It is in the combination and integration of the results from two contrasting paradigms the added value of mixed methods approach comes to prominence (Burke Johnson and Onwuegbuzie, 2004; Andrew and Halcomb, 2007, Morgan, 2014). All paradigms have their weaknesses. The accusation against pragmatism is the idea that it is a default position that is used because the researcher does not like the alternatives (Burke Johnson and Onwuegbuzie, 2004).

Pragmatism focuses on the 'what' and 'how' of the research problem (Creswell, 2013, p. 11) and therefore was considered as a suitable paradigm for this study. Spiritual intelligence is a developmental model which is skills-based and can be developed by increasing awareness and practical application of the skills identified. How a manager demonstrates their spiritual intelligence can be seen by their knowledge of themselves and their role. This is particularly applicable for this study which had a sequential, exploratory approach. Phase One and the SQ 21 survey concentrates on self-awareness and self-knowledge, with Phase Two exploring how these impact on day-to-day actions and approaches to management as well as exploring their awareness of spirituality and spiritual intelligence which manifested itself in their Phase One responses. This dovetails with the pragmatic approach which focuses on real-world problems.

Morgan (2014, p. 43) suggested:

> *The most common alternative to pragmatism concentrates on realism and constructivism as two alternate ways to understand the world and what it would mean to have knowledge of that world. From a pragmatic point of view, however, questions about the nature of reality are less important than questions about what it means to act and experience the consequences of those actions.*

To address the issues of the appropriateness of the research methods, the research design as well as the research question and philosophical underpinnings need to be considered. This explores the practical implications of the methodological approaches used with justification for the choices made.

3.7 Research Design.

Burke Johnson, Onwuegbuzie and Turner (2007) assert that there are three stages to any research project – stating the research objective, collecting the data, and analysis and interpreting the data. This is an interesting breakdown of the stages of a research project as it misses out completely the research design which is essential in the whole process. Analysis of the timings and methods used in these processes has been developed into a typology which indicates typical designs in mixed method studies (Teddlie and Tashakkori, 2012).

A fundamental aspect of mixed methods research is when the integration of the different approaches throughout the study occurs. Tashakkori and Teddlie (2010) propose that there are four areas that need to be answered when identifying the approach to be undertaken and their sequence and timing. These are:

- Number of methodological approaches
- Number of strands or phases
- The type of implementation process
- The stage of integration of the phases.

The answers to these questions inform the mixed methods study design. Creswell and Plano Clark (2011, p. 155) identified at least four different models which could be used depending on these choices.

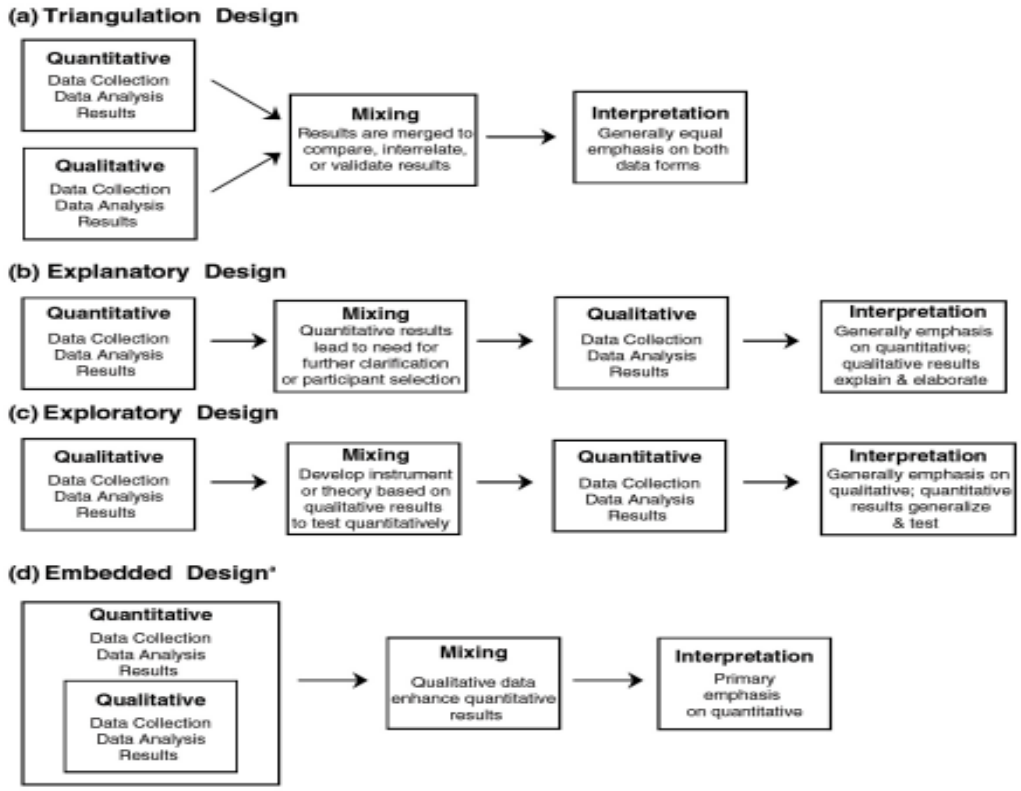


Figure 3-1: 4 Mixed Methods Designs (Creswell and Plano Clark, 2011, p. 155).

This study therefore uses the exploratory design since it commences with the collection of quantitative data from the SQ21 inventory which informed the questions used in the qualitative semi-structured interviews in Phase Two with the findings integrated into the framework that has been developed to support answering the research question.
Using these theoretical models as a guide, the four questions as outlined earlier by Tashakkori and Teddlie (2010) on page 50 will now be used to inform the choice of the study design.

3.7.1 Number of Methodological Approaches.

This study used two methods – a quantitative prospective cross-sectional survey using a self-administered questionnaire in Phase One and a semi-structured qualitative interview in Phase Two. The questionnaire measured the spiritual intelligence skills of the respondent while the interviews were explanatory and applied in that the questions explored the responses given in Phase One. This allowed more detailed exploration of their responses, particularly those which scored a zero. These are relevant as these scores can indicate unconscious values and behaviours but have an impact when explored and made conscious. Scores of five will also be analysed, as that is the highest level attainable in the SQ21 and is indicative of a highly developed skill. Detailed analysis of Phase Two will be undertaken using interpretive phenomenological analysis (Smith, Larkin and Flowers, 2009).

3.7.2 Number of Strands or Phases in the Research Design.

There were two phases – the survey which was exploratory and the interviews which were explanatory, investigating in more depth the responses to the survey in Phase One.

3.7.3 Type of Implementation Process.

The type of implementation was sequential since Phase Two built on the results from Phase One. This allowed for an exploration of the results of the Phase One data and greater critical appraisal of the results. It was also important as the population for the Phase Two interviews had all completed Phase One and agreed to take part in Phase Two.

3.7.4 Stage of Integration of the Phases.

The results from Phase One informed the questions for Phase Two. The analysis of Phase Two was integrated with the results from Phase One during analysis of the results. There was further integration between Phase One and Phase Two using purposeful sampling with the participants for the semi-structured interviews being drawn from those who had completed the questionnaire in Phase One.

It could be argued that because of the small sample size, the analysis of Phase One is rather descriptive. However, the results from the semi -structured interviews in Phase Two also built on the results from Phase One in an iterative process that culminated in the development of a framework that supports raising of awareness of SQ in healthcare practitioners. For this reason, the integration of the two phases complement each other and provide a richness that would be missing if either phase had been excluded.

It is important to differentiate between exploratory and explanatory mixed method designs. While the approach is similar in both, an exploratory design is used when qualitative data helps explain or builds upon the initial quantitative results (Creswell, et al., 2010). The researcher identifies specific quantitative findings that need additional explanation and uses these as the basis for the second phase. The participant selection model is used when a researcher needs quantitative information to identify and purposely select participants for follow-up in-depth qualitative study. Initially, it was planned the participants for Phase Two would be sampled from a range of participants from Phase One but because of the limited response to Phase One, all those that volunteered were subsequently interviewed. Participation was invited by entering an email address for a follow – up contact and subsequent interviews. Three participants from Phase One offered to be interviewed but two declined due to external work pressures and the third had left his role and I did not have any contact details for him subsequently.

The explanatory mixed method design is used when the results of the first (qualitative) method helps to develop or inform the second (quantitative) method. This design is particularly useful when a researcher needs to develop and test an instrument because one is not available or to identify important variables to study quantitatively when variables are now unknown (Creswell, et al., 2010). This was not the case in this study since there was a validated tool available.

This study used a sequential exploratory mixed method. The process for the study is outlined in Figure 3-2 which is a process flow diagram of the procedures undertaken.

Phase One				Phase Two		
Quantitative Data Collection	Quantitative Data Analysis	Quantitative Data Results	Develop questions for Qualitative Data Collection	Qualitative Data Collection	Qualitative Data Analysis	Overall Findings and Interpretation
Tools				Tools		
SQ21 Survey Tool	Frequency Identification of significant results	Interpretation of Survey results		Semi-Structured Interviews	Interpretive Phenomenological Analysis	Explain Quantitative results with Qualitative Findings

Figure 3-2: Sequential Explanatory Mixed Method.

The results at the end of Phase One indicated a list of four key skills that were more developed in the managers than the other skills. Initially, it was intended that purposive sample of participants with the five highest and five lowest mean scores for these skills would be invited to participate in Phase Two. After Phase One was completed those who had expressed a willingness to be interviewed were approached. Due to various procedural problems, including changes in contact details and change in role, nine participants were interviewed.

The findings for Phase Two were structured using the questions used in the interviews and then integrated as themes with the findings from Phase One.

3.8 Methods.

The method of collecting data from a sample population is key in supporting the objectives and answering the research question. In this study, a mixed methods approach was adopted to allow both a broad understanding of spiritual intelligence awareness and its influence on healthcare management combined with a more in-depth exploration of the survey results using interviews to probe the issues raised from the survey.

This mixed methods study had two phases. The justification of this has already been given, since it provided a greater level of critical appraisal than would be possible with a single methodological approach.

The next section will explore the research questions for Phase One, examine the development of the SQ 21 survey tool, explain how the population for Phase One was obtained and describe the tools used for analysing the results.

3.9 Phase One Quantitative Survey.

Phase One of the study involved the administration of a quantitative non-experimental prospective cross-sectional survey of healthcare managers using a validated self-administered e-questionnaire. This questionnaire has been developed to measure spiritual intelligence as defined by Wigglesworth called the SQ 21 Inventory (Wigglesworth, 2012). The focus for Phase One was to answer the following research questions:

> What are the dominant and less dominant skills among the 21 skills of spiritual intelligence, as measured using the SQ21 tool?
>
> Is there a relationship between healthcare managers' experience and skill development in any of the 21 skills identified by the SQ21 tool?

The SQ 21 survey tool has been explored on page 30, with a comprehensive justification given for its choice as the instrument for use in this study.
In the justification for any research methodology, there are issues behind validity, reliability and ethics that are important areas that underpin the relevance and robustness of the research. These will now be examined in more detail for the two phases of the study

3.9.1 Validity and Reliability in Phase One.

Validity of a measure refers to the extent to which the measurement process is free from both systematic and random error. Reliability of a measure refers to the extent to which the measurement process is free from random errors. Validity is concerned with the question: Are we measuring what we think we are measuring? Reliability, on the other hand, is concerned with the consistency, accuracy, and predictability of the research findings (Bryman, 2016, p. 156).
Research has been undertaken to assess both the validity and reliability of SQ21. One assessment of validity used is the Cronbach Alpha (Tavakol and Dennick, 2011) which was measured with a positive alpha of 0.97 (Wigglesworth, 2012, p. 193). This compared with a Cronbach Alpha of 0.84 from the sample population in this study.
Two other studies have explored the SQ21. In 2006 a criterion validity study showed that the SQ 21 results, when compared to essays and/or interviews of research subjects, yielded results that aligned positively and the SQ 21 seemed to measure what it claims to measure. A second, construct validity study compared the SQ 21 with stages of adult development. (Wigglesworth, 2012, p. 194).
There now follows a description of the process for collecting the results and the means of selecting the participants.

3.9.2 Data Collection for Phase One.

For a quantitative study, it is important to have a representative sample to enable generalisation of the results. As the research question identified healthcare managers as the target, it was important to identify only those people who were working in health care in a managerial position. With the advent of social media, the availability and access to potential research populations has increased dramatically (Bright, et al., 2014). There are two types of populations that exist. The first is membership organisations whose criteria for membership fulfil certain gateways without which membership is denied. These are either dictated by statute or by the rules for that organisation.

Examples of membership by statute are medicine, nursing and allied health professionals but there is no legal status for healthcare managers. It must be remembered, however, that a significant proportion of healthcare managers also have a professional qualification which is protected by statute.

The second group are self-selecting in that they apply for membership and are linked by a common interest. Examples of these include LinkedIn and CHAIN.

3.9.3 Population and Data Collection.

Initially, the proposed target population for Phase One were members and fellows of the Institute of Healthcare Management (IHM). Due to changes at the IHM and resulting difficulties with recruitment the final sample was widened to include members drawn from the organisation CHAIN.

The membership of the IHM is split between fellows (N=210) and members (N=1457).

A request for participation appeared in the IHM September 2015 newsletter. Initially ten individuals expressed an interest of whom four completed the questionnaire. This gives a response rate of less than 0.2% (4/1667). Part of the reason for this was that a proportion of membership were Armed Forces personnel who had undertaken training with the IHM it is difficult to ascertain what proportion of the membership were in this category. The senior officer with responsibility for coordinating the Armed Forces membership placed a blanket ban on any personnel completing the questionnaire because it had not been through the army ethical committee processes. A request to the Institute for an individualised email was unsuccessful and could not be granted due to data protection laws. Since this was an insufficient number for any meaningful analysis the invitation to was widened to managers and senior members of the CHAIN network.

3.9.3.1 CHAIN Network,

CHAIN is a successful online mutual support network of people working in health and social care. The network originated 15 years ago in the NHS Research & Development programme in England. It is multi professional and cross organisational and is designed to connect like-minded health and social care practitioners, educators, researchers and managers.
CHAIN is open to anyone working in health and social care. Involvement in the family of organisations involved in health and social care; being willing to share experience and aspirations and being prepared to respond to other members' questions are the only criteria for joining CHAIN. Due to the diversity of members it was necessary to develop criteria to focus the recruitment of suitable participants from CHAIN. This was applied to filters (Table 3-2) which indicated that 1,565 individuals matched the criteria. An e-invitation to participate in the study was sent to these individuals who met the criteria.

Inclusion Criteria	Exclusion Criteria
Member of CHAIN UK	Overseas CHAIN Members
Working in Primary, secondary or Tertiary Healthcare	Non-Healthcare workers – Specifically academics in educational fields or social care
Self-reported job title includes 'Manager', 'Director', 'Head of', 'Senior' or 'Chief'	Self-reported job title does not include 'Manager', 'Director', 'Head of', 'Senior' or 'Chief'
Organisation type contains NHS, Foundation Trust, CGC or Clinical Commissioning Group, Hospital and Practice	Organisation type contains Academic or Education

Table 3-2: CHAIN UK Inclusion and Exclusion Criteria for Participation in the Study.

The inclusion and exclusion criteria were discussed and applied in conjunction with the Director of CHAIN, which utilised his knowledge of previous requests for participation. A blanket request to all 11,888 members was not considered good practice so the inclusion and exclusion criteria were applied to give a more focused sample. A breakdown of the numbers of potential participants by inclusion group is given on page 175. This led to an inclusion group that were top-heavy in experience – the participants were managers but there was a spread of participants with varying lengths of time in management positions.
An invitation to participate in the study was sent to the 1565 potential participants. This gives an overall response rate of 1% (31/3231). However, these figures need to be treated with caution. All contact was via email or a mailing list before the change in the general data protection regulations (2018) came into force. There are now much more stringent regulations regarding the use of such databases which might have assured more active engagement with the potential participants. If the number of completed questionnaires is

viewed as a proportion of those who expressed an interest, then the percentage increases to 61% (31/51).

Following this invitation to participate, those interested who clicked the link were transferred to a Googles Doc page that had the Participant Information Sheet (PIS) as required for meeting ethical approval. After the required information was given, participants were asked for demographic and work-related information: experience of healthcare management; role in healthcare management; age; job title and grade.

The demographic information and email addresses were sent to an administrator at Deep Change, the company which administers the SQ21 inventory, who removed any data that could be used to identify the respondents (Email addresses, role and timestamp). The administrator then sent a unique code to each participant which allowed access to the SQ21 inventory for completion. 46 expressions of interest were received, with 21 completed questionnaires received after 3 weeks. A follow-up reminder was sent to those who had not completed the survey which resulted in a further ten completed responses, resulting in 31 completed questionnaires at the end of Phase One.Results from completed questionnaires were sent as an Excel spreadsheet after all the responses had been received. This was to avoid potential identification of participants who expressed an interest late. If interim results had been provided, it could be possible to identify any late submissions.

The four participants from the IHM were contacted by the administrator for the revised demographic information which was incorporated into a final spreadsheet for analysis.

3.10 Data Analysis for Phase One.

The data was examined with two particular aims identified to answer the research question for Phase One. The first was to identify if any of the skills on the SQ21 were particularly dominant or reduced in significance and the second was to inform the Phase Two of the study, both in identifying population and informing the structure of the questions to be used in the interview process.

The results produced by the questionnaire gave 21 ordinal numbers for each participant. Data for each question was collated and then two approaches to describe and summarise the data were completed (Parahoo, 2014).

The frequency or the number of times the same score was found for each question was calculated. From this, percentage breakdowns were calculated to enable easier comparisons and diagrammatic presentation for dissemination and understanding of the study findings (Maltby, et al., 2010).

The second tool utilised was the mean and standard deviation of the responses.

This analysis allowed the identification of the dominant and lesser skills of the respondents along with an indication of relative levels of spiritual intelligence. These were used to inform the second, quantitative element of this mixed methods study in the selection of questions used.

Two different criteria were used to differentiate between the levels of experience of participants. The first was age, and the second experience in healthcare management. The age bands chosen were 20 - 49 (n15) and 50 - 60+ (n18). The experience bands chosen were 0-8 years (n10) and over 16 years (n13). These two ranges were chosen as they were at each end of the possible responses and would provide an indication if age or experience were factors in measuring SQ.

3.11 Qualitative Interviews for Phase Two.

Phase Two was the qualitative strand of the mixed method study. The aim of Phase Two was to develop the understanding from the results from Phase One and explore in more detail the responses given.

In Phase Two, nine in-depth qualitative interviews were conducted with a sample of the managers who completed the questionnaire from Phase One. The sample was purposive sample in that the participants were selected from those who volunteered and gave consent and were identified after initial analysis of Phase One results. This used the participant selection model as outlined earlier on page 44.

A more detailed description of the participants is provided on page 85.

The interview schedule was informed by Phase One and the interviews were conducted using Skype. The option of face to face or telephone interviews was given, depending on the preference of the participant, the geographical location and the time available for the interviews but all chose Skype interviews.

3.11.1 Interviews.

Interviews were selected as the data collection tool for Phase Two. Historically, in-depth qualitative interviews are performed face to face to allow maximum in-depth coverage of the selected research area with acknowledgement of body language and non-verbal communication as well as the spoken word. Classically, the interview would be recorded with field notes taken to support the analysis of what was said (Onwuegbuzie, et al., 2009).

With the advent of modern communications and robust VoIP tools such as Skype, the need for face to face interviews has lessened. The advantages of face to face interviews are that a great deal of data can be collected in a relatively short period of time, the responses to questions can be developed further with intelligent probing, a range of viewpoints from different participants can be gained and participants are encouraged to 'speak for themselves' and increase the validity of the data collected (Fox, 2009, p. 7).
Disadvantages include the physical time required, normally between 30 and 60 minutes plus any travelling. This again can be overcome by using VoIP technologies. A second potential disadvantage, more applicable in a larger study, is when more than one interviewer is used. The skill of the interviewer is paramount and despite training, consistency when multiple interviews are used can influence the data collected. This was not a problem in this study as all the interviews were conducted by the researcher. This could also lead to subjective bias both in the collection and interpretation of the interview data. Another potential disadvantage is that there is a possibility that participants may not stick to the research areas of interest (Fox, 2009, p. 12).
The interview is an example of social interaction (Paley, 2017). This means that the context within which the interview is conducted is important as it can influence the responses given. There is an unconscious and conscious wish on the part of the interviewee to please the researcher to avoid embarrassment. It is vital to establish clear parameters to set the context at the beginning of any interview. Because the researcher had been a senior manager within the health service, there was common ground already established. Care therefore needed to be taken that unconscious assumptions about the context and background were acknowledged and accounted for in the interpretation and integration of the data. Paley (2017) points out that there is a difference between description and interpretation and that just describing what was said in interview is not sufficient if true integration is going to occur.
Interviews can be placed along a continuum between structured and unstructured. Structured interviews using closed questions are analogous to questionnaires whilst unstructured interviews have more similarity with observation. Somewhere in the middle are semi-structured interviews, which were used in this study. No matter which approach is used, what is important is the extent to which interviews can be compared. Using a semi-structured approach allows for consistency in analysis and ensures that important areas are not missed (Newton, 2010).

Other types of interviews that are used as research tools include email conversations, instant messaging and chat rooms and professional networking groups such as LinkedIn. These were considered as alternatives but given the richness that in-depth interviews can provide these were chosen as the tool of choice.

Morse (1994, p. 231) identified five different question types to provide a framework for consistency in semi-structured interviews:

- Meaning questions: eliciting the essence of experiences
- Descriptive questions: of values, beliefs, practices of cultural group
- 'Process' questions: experience over time or change, may have stages and phases
- Questions regarding verbal interaction and dialogue
- Behavioural questions: macro, micro.

Each of these question types were used to develop both an interview schedule and a sense of journey in the individual respondent's growth in spiritual intelligence. The interview schedule was derived from the findings in Phase One, in line with the research design.

3.11.2 Interview Schedule for Phase Two.

An interview schedule was developed from analysis of the literature and from the results of Phase One and is given in appendix 7 on page 177.
The questions with an asterisk were demographic and provided information that helped categorise the answers given. The other questions had a more descriptive and exploratory focus and have been analysed individually with themes identified.

3.11.3 Sampling for Phase Two.

The process for identifying participants to interview for a more in-depth analysis and a qualitative narrative approach was based on the results from Phase One. Since the results for Phase One were coded to provide anonymity to the participants, the codes of those identified from the analysis of Phase One were sent to the administrator at DeepChange. The organisation then provided the email addresses for those who have indicated a willingness to participate and these were used to contact the potential participants. These potential participants were identified as follows:
The mean average for the 21 domains was calculated and top five and bottom five who expressed a willingness to be interviewed were contacted and invited to participate in Phase Two. This gave data across the respondents which provided a variety of experience and level of spiritual intelligence. Further analysis of the demographic information was used to support the discussion and findings.

While the respondent with the lowest average was interviewed, the next participant who was interviewed ranked tenth in the list of respondents because the previous nine either did not express a willingness to be interviewed or were not contactable or available at a convenient time or place. This was a weakness of the study but unavoidable. The rankings of the interviewees were as follows:

Participant	Average	SD	Rank	Score of 0	Score of 5
1	1.29	1.19	1	7	0
2	1.76	1.48	10	6	0
3	2.10	1.30	15	4	0
4	2.81	1.21	22	2	1
5	2.81	1.36	23	2	2
6	2.90	1.97	24	4	7
7	3.00	1.55	27	4	7
8	3.62	1.43	30	1	8
9	3.67	1.49	31	1	8

Table 3-3: Participant SQ 21 Mean Scores, Ranking and Scores of 0 and 5.

3.11.4 Data Collection for Phase Two.

All interviews were conducted using Skype. The interviews were recorded using a third-party add-on which allowed for a complete record to be kept. These are stored on a password protected computer. The interviews were edited using Audacity software and then transcribed verbatim. The transcripts were uploaded to NViVo 11 where coding and identification of themes was undertaken. All the data will be destroyed at the end of the project in line with ethical committee requirements.

3.12 Data Analysis for Phase Two.

Following the coding from the data collection, it was intended that thematic analysis would be used to analyse the data (Braun and Clarke, 2006, p. 79). They describe thematic analysis as '*a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail.*' There are various levels of analysis, including exploring the whole dataset or specific aspects, inductive or theoretical thematic analysis and semantic or latent themes. Semantic themes record what was said; latent themes examine the meaning behind what was said (Ryan and Bernard, 2003, p. 88).

Thematic analysis can be an essentialist or realist method, which reports experiences, meanings and the reality of participants (Braun and Clarke, 2006, p. 81). However, Braun and Clark also point out that thematic analysis differs from other analytical methods such as thematic decomposition analysis and Interpretative Phenomenological Analysis.

This study had intended to use thematic analysis as the underpinning approach to data analysis but IPA was adopted as the method of choice since the small number of interviews lends itself more to IPA rather than thematic analysis (Braun and Clarke, 2006).

IPA has been developed as an analytical tool, particularly in semi-structured interviews in psychology (Smith, 1995; 1996). According to Smith and Eatough (2007, p. 37), '*The aim of IPA is to explore in detail individual personal and lived experience and to examine how participants are making sense of their personal and social world'*. Given the importance of meaning making in spirituality, it seems entirely appropriate that IPA is used in this context.

Paley (2017) wrote extensively on the use of IPA in social science research with his analysis of three different studies including Smith, Larkin and Flowers (2009). He contends that the idea of 'self' and 'identity' are key to the interpretation of results and are open to different interpretations by the researcher and therefore could be subject to bias. Paley says that any coding or classification adds to and potentially modifies the data and the only source for this modification is the researcher. Although this could be seen as a disadvantage, the benefits of a robust framework for analysis of interviews outweighs the potential negativity.

IPA offers a valid and repeatable framework which will enable cross study analysis as well as high quality internal analysis and appraisal for individual studies. The importance of integration has been highlighted and this is only possible with a clear framework and logical system for analysis which can be provided by IPA.

Creswell (2013, p. 185) identified four stages of data analysis that need to be undertaken to provide a systematic scrutiny of the interviews.

The initial stage was verbatim transcription of the interviews which was undertaken by the researcher. While rather time consuming, this allowed an in-depth immersion in the narratives and engendered a familiarity with the responses that would not have occurred without personal transcription.

Once the interviews had been transcribed, the transcripts were uploaded into NViVo™ Ver 11. Prior to uploading, all the questions were converted to headings and then auto coded using these questions. This helped to sort the responses both by participants and by each question. Each transcript was read at least twice to identify themes that were not immediately apparent from the questions and these themes were recorded. Each question was then analysed using the lens of the skills of spiritual intelligence as outlined in Phase One. This ensured that the results from the two phases were integrated and analysed together to ensure that the two phases were not simply two stand-alone projects.

The development of themes occurred on two levels – Initial themes were identified from the interview questions and findings presented under each question, but the experiences of the participants taken from the interviews also provided an extension of these themes as an iterative process. Findings from Phase One interviews were also incorporated into the themes, both at the question level and in the subsequent discussion of the emergent themes.

The underlying philosophies behind IPA are phenomenology, hermeneutics and idiography. Phenomenology is a description of events while hermeneutics is the interpretation of those events (Moran, 2000, p. 6). The key aspect of this description is in meaning making and a clear focus on experience and its perception (Smith, Larkin and Flowers, 2009, p. 12). In an earlier work, (Smith and Eatough, 2007, p. 38) describe a double hermeneutic approach to the interpretation of these experiences which goes beyond the simple description. The participant is trying to make sense of their world and the researcher is trying to make sense of how the participant is trying to make sense of this world. It also emphasises the dual role of the researcher who must interpret someone else's worldview while adjusting and refining their own worldview in light of the experience.

The third strand in IPA is idiography. This is contrasted with a nomothetic study which looks at the study of populations and groups and ascribes probabilities that an individual will respond in the same way rather than an individual case study. With an ideographical approach. detailed analysis of a single case or interview is undertaken before analysis of subsequent interviews occurs. In this way, it is possible to learn something about both the individual lived experience as well as generating more generic themes across the detailed interviews (Smith, Larkin and Flowers, 2009, p. 29).

To summarise, Smith, Larkin and Flowers (2009, p. 4) suggest that

> *…Data collection is usually (but not necessarily) in the form of semi-structured interviews where an interview schedule is used flexibly and the participant has an important stake in what is covered. Transcripts of interviews are analysed case by case through a systematic, qualitative analysis. This is then turned into a narrative account where the researcher's analytic interpretation is presented in detail and is supported with verbatim extracts from participants.*

The interview schedule was used to ensure consistency between participants and was adhered to in the main. The main exceptions to this was in the interviews with two participants, (P1 and P6). Participant One suggested her values when discussing the spiritual leaders' traits and Participant Six when asked about either/or and both/and wanted time to consider his answer and so was followed up at the end of his interview.

3.12.1 Rigour and Validity.

It is just as important in the qualitative phase that issues of rigour and validity are addressed. It is easier in quantitative studies to ensure this since statistical analysis can provide reassurance. It is more difficult to measure in quantitative studies. Guba and Lincoln (1994) suggest the major objective in assessing the quality of quantitative research is trustworthiness. Five factors were identified as contributing to trustworthiness. These are credibility, dependability, confirmability, transferability and authenticity.

Credibility is the confidence in the truth of the data and its interpretation; Dependability refers to the stability of data over time and over different conditions; confirmability examines the concept of neutrality – the potential for congruence between two or more people about data accuracy, relevance and meaning; transferability, or the extent to which findings can be transferred to other settings or groups.

Noble and Smith (2015, pp. 34–35) have suggested the following strategies to ensure the trustworthiness of quantitative findings:

- Accounting for personal biases which may have influenced findings;
- Acknowledging biases in sampling and ongoing critical reflection of methods to ensure sufficient depth and relevance of data collection and analysis;
- Meticulous record keeping, demonstrating a clear decision trail and ensuring interpretations of data are consistent and transparent;
- Establishing a comparison case/ seeking out similarities and differences across accounts to ensure different perspectives are represented;
- Including rich and thick verbatim descriptions of participants' accounts to support findings;
- Demonstrating clarity in terms of thought processes during data analysis and subsequent interpretations;
- Engaging with other researchers to reduce research bias;
- Respondent validation: includes inviting participants to comment on the interview transcript and whether the final themes and concepts created adequately reflect the phenomena being investigated;
- Data triangulation, whereby different methods and perspectives help produce a more comprehensive set of findings.

Consideration of all these aspects was made in the collection of data from the interviews. Transcription of the interviews was performed by the researcher. Coding was undertaken with use made of NViVo 11 software to ensure that themes from across interviews were captured and analysed. The results were verified in discussion with the supervisory team to ensure that research bias was minimised.

Smith and Eatough (2017, p. 200) suggest using the criteria developed by Yardley (2000) to ensure the results of any qualitative study are valid. Using Yardley's criteria, the analysis of the results from Phase Two will now be examined to highlight the validity of the results attained.

3.12.2 Sensitivity to Context.

Sensitivity to context is demonstrated in several ways. The use of purposive sampling of healthcare managers ensures a homogenous group with similar lived experiences which fits into the idiographic approach of IPA. The development of an interview schedule is also dependent on the context since it was developed both from the results of Phase One and a survey of the literature. Sensitivity to context is also demonstrated by sensitive analysis of the data collected. The interviewer needs to show respect to the interviewee, putting them at ease and facilitating a fruitful and worthwhile dialogue. While this is interactive to a certain extent, the importance of the contribution made by the participant cannot be emphasised enough. This is also shown using verbatim quotes in the analysis of the semi-structured interviews. It is important the participant's voices are heard clearly.

3.12.3 Commitment and Rigour.

This is demonstrated again by the dedication demonstrated by the researcher in the attentiveness and sensitivity shown during interview process. There is a skill in interviewing which needs to be developed. My own development came about as part of the interview process. Initially, the first interviews were more of a conversation and dialogue rather than an interview. In later interviews, there is much less of my own personal input. This was difficult, as I have always had an open and engaged style, but necessary to ensure the participants voice was heard clearly without too much prompting and guidance. Smith, Larkin and Flowers (2009, p. 180) indicated that there is degree of overlap between sensitivity to context and commitment and rigour and in some respects are synonymous.
Rigour explores the thoroughness of the study. The sample population must be appropriate for the research question with the analysis of the data being interpretative rather than just descriptive. There should be a mixture of thematic analysis and support from the lived experience and meaning making of the participants.

3.12.4 Transparency and Coherence.

Transparency is important and shown by a clear description of the stages undertaken in the research process. If the process is transparent, other researchers should be able to replicate the steps undertaken and repeat the study (Campbell, Loving and Lebel, 2014). This means the write-up must be sufficiently detailed for this to occur. Coherence refers to the consistency of analysis of the data. The analysis should be logical in its structure and sequenced appropriately. Grand claims for the data should be avoided as the idiographic nature of the study means that transference to wider populations should only be made with caution. That is not to say that these claims cannot be made, only that they should be viewed within the context of the study (Braun and Clarke, 2013).

3.12.5 Impact and Importance.

Yardley's final criterion is one of impact and importance. Any study must add to the academic body of knowledge and IPA studies are no different.

3.12.6 Stages in Data Analysis for Phase Two.

To maintain consistency, the following steps were undertaken to aid the analysis of each of the semi structured interviews:

- Each interview was transcribed by the researcher. This gave greater knowledge of the detail behind each interview.
- The questions were included in the transcripts as headings which were used for auto coding in Nvivo 11 software.
- Each auto code was then read in context for each interview with differences and similarities recorded.
- Enabling factors, limiting factors and those that were both were identified for the development of spiritual intelligence and recorded
- Each interview was then re-read to ensure that all factors had been addressed.

Once these steps had been completed, further analysis was undertaken to support the integration of the data

3.13 Integration of Data.

One of the methodological considerations in a sequential exploratory mixed methods study is when to integrate the results from the data collection. Creswell (2013) suggests that integration can occur at the beginning of the study, when choosing the research design; at the intermediate stage between data collection for Phase One and Phase Two; and at the writing up stage after data collection has been concluded.

Ivankova, Creswell and Stick (2006, p. 11) suggest that '*another connecting point might be the development of the qualitative data collection protocols, grounded in the results from the first, quantitative, phase, to investigate those results in more depth through collecting and analysing the qualitative data in the second phase of the study'*. This is a fundamental part of this study, with both the participants and interview schedule questions grounded firmly in the results from Phase One.

While the analysis of the data from Phase One and Phase Two will be reported in Chapters Four and Five of this dissertation, the integration of the two phases will be highlighted in Chapter Six.

In any research study, the ethical implications for the study are an important and fundamental area for exploration. These will now be investigated in more detail.

3.14 Ethical Considerations.

Research is governed by a code with principles that guide the conduct of research. History is littered with unethical research trials, such as the Nazi Holocaust experimentation in concentration camps (Weindling, et al., 2016), the Tuskegee Syphilis Study (1932 -72) (Reverby, 2009) and examples of un-consented trials on prisoners in US jails (Hornblum, 1999) which led to first the Nuremberg Code (1947), the Helsinki Declaration, originally published in 1964 and revised seven times until the current version published in 2013 (World Medical Association, 2013). This lays out the standard of protection for any research involving humans in studies.

The overarching objective of the Helsinki Declaration is that medical research is subject to ethical standards that promote and ensure respect for all human subjects and protect their health and rights. Elements that contribute to this are identification of risks, informed consent, privacy and confidentiality, independent external scrutiny and guidelines on the use of human materials and data (World Medical Association, 2013, pp. 2191–2194). While this is not medical research per se, these elements are still important to ensure that any study is ethically sound and will now be discussed in more detail.

3.14.1 Identification of Risk.

The Helsinki Declaration was primarily aimed at therapeutic trials where the risk to individuals (particularly patients) is potentially greater. Well-designed research should demonstrate benefit to the participants and society (beneficence) while also minimising risks (non-malfeasance), including wellbeing (Owonikoko, 2013, p. 243). While the survey questions were not thought to be particularly upsetting, some explored deeply held beliefs and value systems. The survey tool is careful to challenge the understanding of these assumptions, but not challenge the assumptions themselves. The delivery format of the questionnaire enabled participants to decline to answer any questions they found upsetting, and they could withdraw at any time up to the point of submission. The Participant Information Sheet (PIS) on page 165 contained links to organisations concerned with wellbeing that could be accessed if required.

3.14.2 Informed Consent.

According to del Carmen and Joffe (2005, p. 637) there are five elements that make up informed consent – volunteerism, capacity, disclosure, understanding and decision.
As the population for this research were practising healthcare professionals, capacity was unlikely to be a barrier to completion.
Volunteerism implies that there is no coercion or pressure brought to bear to ensure participation. Since none of the participants were known to the researcher in person, and there was no power relationship, coercion was not an issue. All participants were volunteers who chose to participate of their own free will.
Disclosure was ensured using a Participant Information Sheet (PIS). This was the front page of the Google Docs link that those participants who expressed an interest clicked a link to get further details – http://goo.gl/forms/p9MwvHXarf. This is reproduced on page 165.
This PIS included information to ensure that potential participants were aware of what study involvement would entail. The PIS also had contact information both for myself, as primary researcher, and the study supervisor. This was important as it added an extra level of transparency required for the ethical approval of the study. Two potential participants contacted me using the email address provided. These were both questions about submitting the form since on some workplace computers, firewalls prevented submission. The suggestion was made that participants waited until they were on their home computer, and reassurance given that their response was still valid and welcome.

There is little to suggest that provision of a PIS implies understanding. del Carmen and Joffe (2005, p. 638) indicate the courts have not generally held that failure of understanding invalidates informed consent. Instead, they have relied on evidence of disclosure when determining if a participant was adequately informed. This again indicates the importance of the PIS and information provided.

The final element of informed consent is the decision made by the participant. Since the questionnaire was administered electronically, consent is normally deemed to have been given by the submission of the answers to the survey. For the face to face interviews, participants provided written consent at the end of Phase One and reinforced this with verbal consent prior to the interview taking place.

3.14.3 Privacy and Confidentiality.

To protect the privacy of all participants, the email addresses of the CHAIN UK network were not provided to the researcher. This was also in compliance with the Data Protection Act (1998) which does not allow for the sharing of such information. The volunteers chose to submit their email addresses which were then forwarded to the office manager at DeepChange. This administrator removed all identifiable information and allocated a code for each participant. Each participant was sent a unique URL and password to access the survey. The results for this survey are stored on a secure database in United States of America. The security of this data is guaranteed by the website provider and is only accessible by staff at DeepChange.

The results of the questionnaire were uploaded to a password protected spreadsheet which was emailed to me as the researcher.

3.14.4 Independent External Scrutiny.

Independent external scrutiny was provided by an application for ethical approval from Anglia Ruskin University Ethics Research Committee. This was granted in November 2014 following completion of appropriate paperwork (See appendix 2). Following the change in population to be surveyed, an amendment was put before the committee in January 2016 with approval in March 2016 (See appendix 3). This considerable delay was due to administrative errors and had a serious negative impact on the progression of the study.

In summary, paragraph 26 of the Helsinki Declaration states:

> *In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information*. (World Medical Association, 2013, Paragraph 26)

The information provided to participants and external reviewers ensured that robust guidelines and ethical probity are maintained.

3.15 Ethical Considerations for Phase Two.

Consideration of the ethics in Skype interviews is similar to those for face to face. Allmark, et al. (2009, pp. 51–52), in a review of the literature surrounding 80 research articles that used face to face interviews suggested several themes for analysis. These were privacy and confidentiality, informed consent, harm, dual role and over involvement, and politics and power. These will now be discussed in more detail.

3.15.1 Privacy and Confidentiality.

All potential interviewees were contacted by email after they had expressed an interest following Phase One. A time for the interview was arranged and technical checks were made for access to Skype. Advice was given as to how to access and use the software where needed. Each participant was advised that the interviews were being recorded, would be transcribed and verified after the interview. The physical environment was such that it was not possible to be overheard or disturbed during the interview. Mobile phones and landlines were switched off during the interview. The audio files created during the interviews were stored on a password protected computer and backed up to a secure server on the cloud. This ensured the information gained was both secure and safe from computer malfunction and potential cyber-attack. Consideration was made for using the video facility so that body language and non-verbal cues could be seen, but bandwidth constraints and resultant increase in file size precluded their use.

3.15.2 Informed Consent.

Consent was gained both from the agreement to participate after Phase One and verbally prior to the start of the interview. This can make the interview feel more formal than necessary and could influence the tone of the interview (Deakin and Wakefield, 2013, p. 607). It was felt to be necessary to protect the participants that this consent was gained, and that the interview could be suspended or concluded at any time without any negative consequences. None of the participants expressed any concerns during the interviews – indeed, several commented on how much they had enjoyed the process.

3.15.3 Harm.

The potential for harm in interviewing managers regarding their personal spirituality is present for both face to face and Skype interviews. In some respects, Skype interviews are easier to terminate because the interview can be ended with the simple click of a button. If the interview is face to face, then the participant may feel a degree of coercion to continue despite misgivings (Janghorban, Latifnejad Roudsari and Taghipour, 2014, p. 2). Again, no harm was expressed by participants in the interviews.

3.15.4 Dual Role and Over Involvement.

Having a dual role with subsequent over involvement was identified as potential barrier in these interviews as the researcher had a clinical background as well as a research role. In this case the researcher had also been a hospital manager so understood the context of the research but had no other contact with the participants other than as part of the research process. There was also the potential for over involvement as the researcher identified with the participants and the possibility of the interviews being used for discussion of the issues identified. The initial interviews were rather discursive, but this was less apparent in subsequent interviews

3.15.5 Politics and Power.

Again, politics and power were not an issue in this case since the researcher had no power over the participants who were all experienced and independent healthcare managers.

3.16 Chapter Summary.

Schoonenboom and Burke Johnson (2017, p. 2) have suggested seven different stages in the development of a mixed method study. These are:

1 Purpose
2 Theoretical drive
3 Timing (simultaneity and dependence)
4 Point of integration
5 Typological versus interactive design approach
6 Planned versus emergent design
7 Complexity

In this chapter I have defined the purpose of the study and explored the rationale for the design. The integration has occurred at the developmental as well as the analysis stages with an emergent framework linking the two phases.

The underlying philosophical underpinnings for the study have been explored and the reason for choices made in the development of the methods that were utilised for data collection and analysis. Consideration of the sample for both phases has been made along with discussion of ethical considerations which are important to protect all those involved in the research process.

The next chapter will present the results from the Phase One quantitative survey, describing the demographic breakdown of the sample and the results obtained.

CHAPTER FOUR.

4.1 Phase One Quantitative Analysis.

This chapter presents the findings from the first stage of data collection, the quantitative analysis phase of the study. The quantitative phase used the SQ21 inventory (Wigglesworth, 2012) as a way of collecting data about spiritual intelligence and how that might be applied in the context of healthcare provision among healthcare managers.

The results of 31 completed SQ 21 inventories are presented in this chapter. It is recognised that this is a small sample of leaders from whom data was collected, and consequently any conclusions drawn must take cognizance of it being a small sample. The research question for Phase One asked what the dominant and less dominant skills of spiritual intelligence were, as measured using the SQ21 inventory. The second question asked if there were any demographics that influenced the development of spiritual intelligence.

4.2 Participant Demographics.

All the respondents were healthcare managers of varying age and experience. These were as follows:

Age	N	%	Experience of Healthcare Management	N	%	Grade	N	%
20 - 29	1	3.2%	0 - 2 Years	3	9.7%	Band 5 and 6	3	9.7%
30 - 39	3	9.7%	3 - 8 Years	4	12.9%	Band 7 and 8	18	58.1%
40 - 49	8	25.8%	9 - 15 Years	7	22.6%	Consultant	4	12.9%
50 - 59	14	45.2%	Over 16 Years	17	54.8%	Senior Manager	6	19.4%
60 +	5	16.1%						

Table 4-1: Participant Profile by Age, Experience and Grade.

To analyse the data collected, these participants responses were grouped by age (20-49 or Over 50) and experience of healthcare management (15 years or less or more than 16 years) and designated role by grade (band 5-8) or other designation (senior manager and medical consultant) as well as the total:

Age	N	%	Experience of Healthcare Management	N	%	Grade	N	%
20 -49	12	38.7%	15 years or less	14	45.2%	Band 5-8	21	67.7%
Over 50	19	61.3%	More than 16 years	17	54.8%	Consultant and Senior Manager	10	33.3%

Table 4-2: Participant Profile by Age - 20 - 49 and Over 50.

These boundaries were identified to examine if age, experience or professional grouping were significant factors. The results will now be given, first as the total respondents and then by the different demographic groupings. These results will be structured using the four quadrants model described on page 30.

4.3 Quadrant One – Know Thyself.

The first quadrant examines self-awareness from the perspective of spiritual intelligence. If you are aware of who you are now, growth and self-development are possible. Without that self-knowledge, even the need for this self-development might not be identified and opportunities missed for shaping who you want to be in the future. This increase in self-awareness is not always positive (Silvia and Phillips, 2004). If you are not comfortable with the characteristics of the developed personality, then the effects can be harmful. It is for this reason that the SQ21 inventory is supplemented by support from a trained facilitator or coach who provides guidance and explores the implications for participants to ensure that their growth is positive.

4.4 Dominant Skills of Spiritual Intelligence.

The analysis was aimed at determining the importance of skills development assessed by means and ranks. The results show that the most important skill development in this sample is Skill 2: Awareness of Life Purpose, since it has the highest mean of 3.68 and a standard deviation of 1.11 followed by Skill 18: Being a Wise and Effective Change Agent with a mean of 3.10 and standard deviation of 1.42. In addition, Skill 21: Being Aligned with the Ebb and Flow of Life with a mean of 3.03 and a standard deviation of 1.35 was considered important followed by Skill 7: Awareness of Other Worldviews which had a mean of 2.97 and a standard deviation of 0.95.

Skill	Mean	N	S.D.	Rank
Skill 2: Awareness of Life Purpose	3.68	31	1.11	1
Skill 18: Being a Wise and Effective Change Agent	3.10	31	1.42	2
Skill 21: Being Aligned with the Ebb and Flow of Life	3.03	31	1.35	3
Skill 7: Awareness of Other Worldviews	2.97	31	0.95	4

Table 4-3: Dominant Skills of Spiritual Intelligence.

4.5 Less Developed Skills of Spiritual Intelligence.

The results also showed that the least developed skills were Skill 19: Making Compassionate and Wise Decisions and Skill 12: Demonstrating Commitment to Personal Spiritual Growth with a mean of 1.10 and standard deviation of 1.19 and 1.58 respectively, since these skills had the lowest mean. This was followed by Skill 16: Seeking Guidance from Higher Power/ Higher Self and Skill 17: Being a Wise and Effective Teacher of Spiritual or Universal Principles with a mean of 1.42 and standard deviation of 1.80 and 2.13 respectively.

Skill	Mean	N	S.D.	Rank
Skill 19: Making Compassionate and Wise Decisions	1.10	31	1.19	21
Skill 12: Demonstrating Commitment to Personal Spiritual Growth	1.10	31	1.58	20
Skill 16: Seeking Guidance from Higher Power/ Higher Self	1.42	31	1.80	19
Skill 17: Being a Wise and Effective Teacher of Spiritual or Universal Principles	1.42	31	2.13	18

Table 4-4: Less developed Skills of Spiritual Intelligence.

4.6 Variations in Skill Level by Population Subsets.

The mean and standard deviation for each skill level was then ranked using the demographic breakdown as outlined above. The rank for each category was inspected, and when a standard deviation of greater than four occurred the results noted. More complex statistical analysis was not undertaken due to the small sample size and the role of Phase One as a recruitment tool as outlined on page 55.

The greatest variation in age occurred in Skill 4: Complexity of Thought and Perspective Taking which had an overall rank of eight but a rank of 16th in the 20 - 49 age group and a rank of fifth in the over 50's. Similarly, Skill 21: Being Aligned with the Ebb and Flow of Life and overall rank of third but ranked 13th in the 20 – 49 age group and ranked second in the over 50's.

When the skill sets were ranked by experience, the greatest variation occurred with Skill 1: Awareness of Own Worldview which ranked 10th overall but for those with less than 15 years of experience it ranked at fourth while those with more than 15 years of experience ranked this skill at 15th. This was the only skill where more experience reduced the ranking score. In line with the demographic for age, Skill 21: Being Aligned with the Ebb and Flow of Life demonstrated a similar increase in skill level with more experience.

Skill	All Rank	20 - 49 Rank	Over 50 Rank	Mean	S.D.
Skill 4: Complexity of Thought & Perspective Taking	8	16	5	9.67	5.69
Skill 21: Being Aligned with the Ebb and Flow of Life	3	13	2	6.00	6.08
Experience Skill	All Rank	Less than 15 Years Rank	More than 15 Years Rank	Mean	S.D.
Skill 1: Awareness of Own Worldview	10	4	15	9.67	5.51
Skill 21: Being Aligned with the Ebb and Flow of Life	3	11	2	5.33	4.93

Table 4-5: Variations in Skill Level by Population Subset.

4.7 Discussion.

Each of these skills will now be analysed and suggestions given as to their position in the rank and any demographic variations explored.

4.8 Dominant Skills.

4.8.1 Skill 2: Awareness of Life Purpose.

Why am I here? This skill focuses on an awareness of life's purpose, mission, vocation or calling. Clarifying the mission is central to self-knowledge – knowing not just who you are but why you are here. In the SQ 21, this skill is broken down into levels that begin with the simple aspiration to live in alignment with one's purpose, and develop through the ability to identify one's own gifts and talents, describe one's life mission, examine one's choices and actions in light of that mission, and finally, the highest level, to be stable in that mission in the face of great challenges (Wigglesworth, 2012, p. 54).

Awareness of Life Purpose was the skill that had the highest mean across all categories, with the exception of those with less than 15 years' experience where it ranked second, behind Being a Wise and Effective Change Agent. Healthcare as a vocation is well supported in the literature e.g. (González, 2012; Rotman, 2017; Laurel, 2018), and is closely linked to the expression of spirituality (Weiss, et al., 2004). González (2012, p. 52) suggests that a vocation is a sense of being called to serve… *'with skills of empathy, compassion, engagement and a wish to be of use'*. This fits in with the philosophy of meaning on page 13 and are skills echoed by Wilkes, Cassel and Klau (2018) in their review of medical education. This supports the view of Puchalski and Guenther (2012, p. 255) who declared that *'Physicians must be compassionate and empathetic in caring for patients, and must be trustworthy and truthful in all of their professional dealings'.*

At the lowest level, there is a possible lack of commitment to discovering and living by a higher purpose (Mission). Recognising that each person has a reason for existence and identifying that reason might mean making major changes to the way that life is lived. This might not be comfortable for an individual or for those around them. As the skill develops, being able to articulate life purpose and mission becomes possible. At the higher levels, this articulation of life purpose gets mirrored in behaviours that support the achievement of that purpose – Instead of dreaming about the future, it might be being lived.

For practitioners, it is essential that they identify early what their life purpose is, and that it is congruent with their value system and worldview. If there is a dissonance, it leads to dissatisfaction at least, and potential mental health issues if the conflict is not addressed.

4.8.2 Skill 18: Being a Wise and Effective Change Agent.

Skill 18 focuses on being a wise and effective leader or change agent. They help navigate through changes in a way that result in good solutions, fast implementation of change, and less stress and grieving. As a starting point, there are four requirements to be a change agent: understanding all the participants viewpoints; seeking win-win solutions; honouring the natural process; and ego -less (or Higher Self) participation.

The first three are common to any change agent. Understanding participants viewpoints is an essential management technique that is broader than just managing change. It is dependent on recognising that other people have different worldviews which have to be acknowledged. Seeking win-win situations tries to avoid an unhappy compromise as this leads to discontent and in extreme cases sabotage. Honouring the natural process recognises that it takes individuals time to adjust to change that occurs around them and mirrors the grieving process outlined by Kübler-Ross (2009). Trying to force change through too quickly tends to lead to resentment and difficulties in every aspect of managing the change (Kanter, 2012).

Ego – less (or Higher Self) participation is the requirement that lends itself particularly to a highly developed spiritual intelligence. The immature ego which tends to be contracted, self-righteous and fear-based should not interfere with the change process. Reacting badly when others do not 'get it' and appear to be obstructive the change process is not helpful in facilitating change. A more mature approach that tries to identify why resistance is occurring is seen as a high-level skill (Wigglesworth, 2012, p. 108).

It is reassuring that, although self-reported, participants in this study appear to have a well developed strategy for leading change. Healthcare management by definition requires good facilitation skills in an environment that is one of constant change and development.

Another aspect of being a wise and effective change agent is the response when a change initiative fails. A person with a less developed spiritual intelligence in this area might blame others or the organisation for the failure. Those with a more developed spiritual intelligence would reflect on the process and try to learn from the failure so that mistakes made might not be replicated in future.

4.8.3 Skill 21: Being Aligned with the Ebb and Flow of Life.

Skill 21: Being Aligned with the Ebb and Flow of Life is the final skill identified in the SQ 21 Inventory. It is seen as a cumulative skill that is based on the development of other skills of spiritual intelligence. Life is seldom straightforward and predictable with many unexpected twists and turns that provides both threats and opportunities. Someone who is aligned with the ebb and flow of life recognises this and adjusts behaviour accordingly. It is also seen as a point of intersection between physical intelligence and spiritual intelligence. If you ignore your body's signals, then it is harder to function appropriately. At the highest level, it appears the universe is working through you rather than you working through the universe (Wigglesworth, 2012, p. 117).

It is suggested that this mirrors Maslow's (1965) level of self-actualisation, which Maslow defined as realising personal potential, self-fulfilment, seeking personal growth and peak experiences. A desire *'to become everything one is capable of becoming (Maslow, 1987, p. 64)'.*

It is interesting to note that Maslow's five-stage model has been expanded to include cognitive and aesthetic needs and later transcendence needs (McLeod, 2007). Transcendence needs were defined as being motivated by values which transcend beyond the personal self (e.g., mystical experiences and certain experiences with nature, aesthetic experiences, sexual experiences, service to others, the pursuit of science, religious faith, etc.). This is at the heart of spiritual intelligence and is another lens through which behaviour is observed.

4.8.4 Skill 7: Awareness of Other Worldviews.

The definition of a worldview, as given earlier on page 41, is a framework of beliefs and ideas through which the world is interpreted. These are shaped by cultural background, including religion, ethnicity and education.

This skill is closely aligned to and builds upon Skill 1: Awareness of Own Worldview. Skill 1 moves from the most basic level, which involves being able to effectively describe your own belief system, through the more advanced levels at which you start to recognise that your worldview is not the only legitimate one, to appreciate its importance and its limitations, to develop humility about your own beliefs and, finally, to hold a non-judgemental space in which you are not imposing your beliefs on others (Wigglesworth, 2012, pp. 49–52). The importance of recognising and appreciating the worldview of others is vital in all aspects of leadership and is fundamental both in self-awareness and awareness of others.

4.9 Less Developed Skills.

Those skills with the lowest mean averages will be examined and possible rationale for their relatively low averages explored.

4.9.1 Skill 19: Making Compassionate and Wise Decisions.

On first inspection, Skill 19: Making Compassionate and Wise Decisions being the skill which scored the lowest mean average is surprising. Wigglesworth (2012, p. 110) suggests that decisions should be made with the Higher Self rather than the ego self as dominant. She proposes the five developmental levels for this skill are:

1 I am able to make decisions that are compassionate towards myself. I am able to maintain a clear intention to develop and grow in SQ, while simultaneously not berating myself for not yet being ‘perfectly enlightened.’
2 I am able to be compassionate towards children, spouses, relatives, and friends who are not working on their own growth in a manner or speed I might wish they were. I am able to let these significant people in my life grow as they will, knowing that I don’t really know what is highest and best for every person.
3 I am able to be compassionate towards those who feel they are my enemy or who act to harm me. I set healthy boundaries around behaviours but don’t hate the person who is acting out. I use power wisely, carefully—and with loving intent.
4 Universal and Higher Self-awareness is so strong that my decision making process always factors in the pain and suffering of other beings. Yet I am not paralysed by this awareness. I take balanced actions that honour all beings.
5 Universal awareness and strong connection with Higher Self means that my inner guidance is strongly and clearly felt. With steady self mastery, my inner guidance is translated into wise and compassionate action, which seems to flow through me from Source or Life or my Higher Power as I understand it.

She suggests that well-intentioned and spiritually intelligence people can score zero on this skill because they are their own harshest critic and find it difficult or impossible to forgive themselves when they make mistakes or unwise decisions. This skill was highlighted in four of the participants in Phase Two and is discussed further on page 108. It is the nature of healthcare practice that reflection on care and the decisions made is promoted and expected. With more experience, this reflection becomes second nature. Care needs to be taken that compassion towards oneself is not overlooked in the search for optimum care for the patient. It is suggested that sometimes a healthcare professional can subjugate their own needs to support the needs of others – both clients and other members of staff. Wigglesworth (2012, p. 111) sums this up perfectly – '*If we cannot forgive our own imperfections and have compassion towards our own mistakes we will not be fully capable of forgiving others. So, the first step in developing this skill is to have compassion for yourself*'.

4.9.2 Skill 12: Demonstrating Commitment to Personal Spiritual Growth.

Skill 12 focuses on ways in which commitment to spiritual growth is demonstrated in action. Recognising one's belief system of birth or early childhood and entering into a more conscious analysis of it reflects a commitment to spiritual growth.
This is another skill which can cause an unintended zero. One of the questions asked is whether you 'seek to learn about spiritual topics from people, articles, books or sacred teachings from within the belief system in which were raised.' If the answer is not at least 'sometimes', a score of zero is recorded. People commonly score zero for one of two reasons. The first is that they don't recognise they were brought up in a belief system and so think that the question is irrelevant to them. The second reason is frequently they have rejected their faith of origin and so it is the last place that they would look for spiritual wisdom. It is also important to note that personal spiritual growth and not knowledge of religion or faith is the underpinning skill demonstrated here (Wigglesworth, 2012, pp. 88–91).

4.9.3 Skill 16: Seeking Guidance from Higher Power/ Higher Self.

Seeking guidance from the Higher Self is about developing easier access to the wisdom of the best part of human beings. They actively seek guidance from sources beyond their own logic or ego. This includes seeking the wisdom of people they respect, of great teachers and writers, and from their Higher Self or Higher Power. In the spiritual intelligence context, leaders seek to develop their openness to intuition and their sensitivity to its messages.

If access to a Higher Power is not identified because of the nature of being SBNR, then it is axiomatic that seeking guidance in this way will not occur. As with many skills, awareness is vital and it is important to acknowledge the higher power does not have to be a religious or faith-based deity. The idea of interconnectedness is key to developing a broad spiritual intelligence. Intuition occurs in both religious and non-religious people and this skill looks at increasing the accuracy of these 'gut' feelings.

4.9.4 Skill 17: Being a Wise and Effective Teacher of Spiritual or Universal Principles.

Skill 17 explores becoming a wise and effective teacher of spiritual principles or spiritual laws through leading by example and awakening the learner in other people as a movement from lower motives to higher motives. The lower motives might be that persons teach others out of a need to control how they think and behave. At the highest level of skill attainment persons can teach by demonstrating-being-the change they want to experience in themselves and in the world around them. What they teach others by words and how they behave (deeds) are the same (Wigglesworth, 2012, p. 105).

When analysing this sample, it is possible the participants understanding of the role of teaching within healthcare management was identified as formal, classroom-based delivery. Within the realm of spiritual intelligence, the idea of role modelling and leading by example is defined as teaching in a wider format than might have been felt by participants.

The perceived reluctance of participants to teach spiritual or universal principles reflects the culture of organisations within healthcare. The concept of forcing religious beliefs on patients who could be viewed as being vulnerable leads to discussions regarding spirituality being left to chaplaincy services. This reticence was identified further in the in-depth interviews and will be discussed further on page 118.

It is interesting to note that Skill 18 is high on the list of developed skills in this sample but sandwiched between Skills 16, 17 and 19 which are less developed. This might be that this is due to the nature of healthcare leadership and the importance attached to change management skills in general.

4.9.5 Skill 4: Complexity of Thought and Perspective Taking.

The first skill that showed significant differences when ranked according to age was Skill 4: Complexity of Thought and Perspective Taking. This skill ranked at 16 for the 20 to 49-year-old age group and at five for the over 50 age group. This would indicate that as individuals get older, this skill is more developed.

Skill 4 has two significant aspects. The first is whether it is ever acceptable to break rules. The first level of this skill is the recognition that '*rules are guidelines and sometimes a higher principle requires that I break the rules'* (Wigglesworth, 2010, p. 56). A classic example of this was Mahatma Gandhi with his nonviolent protest against British rule in India before independence in 1947 (Gandhi, 2001).

The second is whether two viewpoints can be held and honoured at the same time. This can be seen by looking at whether the mindset is one of either/or or both/and thinking. According to Collins and Porras (2005), this can seem as the genius of the AND which contrasts with the tyranny of the OR. They suggest the genius of the AND embraces both extremes across a number of dimensions at the same time. An example of this is having purpose AND profit or continuity AND change.

In the context of healthcare leadership, a common and prevalent either or as opposed to both and comes in the provision of quality care in a tight financial situation. Currently, health systems are working on a very constrained budget while providing high quality care possible. An example of this was at Addenbrooke's Hospital which was placed in special measures by the Care Quality Commission in 2015 as a result of perceived financial mismanagement. This was against a backdrop of world-class care in a tertiary referral centre, where care was classified as 'outstanding' (Pym, 2015).

One of the reasons for a high-ranking in the over 50s is that age gives wisdom as to which rules it is possible or acceptable to break. This supported by the results for this skill where the rank for less than 15 years experience was 12th while the rank for more than 16 years experience was seventh. Experience allows individuals to choose when to break the rules and know the consequences of their actions.

4.9.6 Skill 21: Being Aligned with the Ebb and Flow of Life.

The second skill that demonstrated a difference in rank between age and experience was Skill 21: Being Aligned with the Ebb and Flow of Life. As was highlighted earlier, this was a dominant skill overall, but it appears from the results of the small sample that being older and more experienced tends to increase the reported level of skill attainment. While life is seldom straightforward and predictable with many unexpected twists and turns that provides both threats and opportunities, this becomes increasingly evident with age. The resilience provided by age could be a reason that this skill ranks higher in more experienced practitioners.

4.10 Chapter Summary.

This chapter has analysed the results from a small sample (N = 31) of responses by healthcare leaders and has identified some indication of dominant and less dominant skills of spiritual intelligence. The most dominant skill was Skill 2: Awareness of Life Purpose. An Awareness of Life Purpose corresponds strongly to the idea that work needs to be meaningful and demonstrates the vocational nature of healthcare. The less dominant skills included those with a strong link to a connection with a higher power and the teaching of spiritual principles. The next chapter will explore some of these themes with the analysis of nine semi-structured interviews with healthcare managers who had a range of scores identified from the SQ 21 Inventory.

CHAPTER FIVE.

5.1 Phase Two Qualitative Analysis.

The previous chapter analysed the findings from Phase One. This chapter will analyse Phase Two of the research. This consisted of individual, semi-structured interviews with nine participants who had previously completed the SQ 21 Inventory. They had indicated a willingness to be interviewed and had been selected because of the variety of roles held in healthcare management and the range of scores achieved across the questionnaire.
The first objective of the Phase Two interviews was to explore how managers articulate their beliefs and understanding of spirituality and spiritual intelligence. The second objective was to investigate the managers' perceptions and knowledge of spirituality and spiritual intelligence in their role as a healthcare leader.
The data will be presented using the interview schedule given in appendix on page yy. The responses given to the individual questions will be reported, themes identified and discussed using a modified IPA structure. The items with an asterisk (Questions 1, 2, 12, 17 and 18) have been combined to give demographic and participant information. Once the themes from the interview questions have been identified, the interviews will be discussed with overarching or superordinate themes highlighting the perceptions and understanding of the participants.

5.2 Demographic Breakdown.

Nine participants took part in the second phase of the study. An overview of the demographic data is given in appendix 8
Of the nine participants, six were female and three male. All were at least 40, with three in the age band 40 – 49, five in the age band 50 – 59 and one was 60+. Seven of the participants had a clinical qualification, with three adult nurses, one learning disability nurse, one midwife and an occupational therapist. There was one medical doctor and one of the nonclinical participants had a counselling qualification. There was an even split between those with a predominantly clinical focus (P1, P3 and P7) or a policy focus (P4, P5, P6 and P8) in the perception of their role. Two participants (P2 and P9) had a position that was equally split between a clinical and policy focus. All bar one had current line management responsibility (P1) but she had managed over 500 staff in a previous role.

Participants' spiritual identity varied. When asked to identify whether they considered themselves spiritual or religious, four participants self-reported as spiritual and religious (P2, P7, P8 and P9). Three of the respondents reported as being SBNR (P3, P4 and P5), although a fourth suggested that he was a spiritual atheist (P6). Only one reported being neither spiritual nor religious (P1).
A more detailed description of the participants now follows, based on the demographic information provided prior to Phase One and the responses to questions 1, 2, 12, 17 and 18.

Participant One (P1) was in the 50 to 59 age band with over 16 years of experience in healthcare management. She was a Senior Manager and Programme Director leading on a variety of programmes, most notably her Trust's savings programme. Originally a nurse, this was the first role that she had not had direct line management responsibility although as a clinical services leader she had had line management responsibility for up to 500 staff. Her preferred leadership style was *"to be engaging, inclusive, be open to, um, change and people's su … you know, the team and wor … and I'm very, very team focused, I much prefer to work in tea … in a team than … and work together to find solutions, that's my preferred option*." She also went on to say that unfortunately, under pressure, she sometimes resorted to being somewhat dictatorial.
She self-reported as neither spiritual nor religious, although she had had a strong faith, particularly in her early 20s which she had now lost. Because of this she questioned her legitimacy in taking part in the study:

> *I feel a bit of a charlatan being involved in this, because I don't think I have a spiritual element to what, you know, my approach to life. So I do feel a bit like I might be a bit of an odd one out in terms of who you might be interviewing (P1).*

She was the only participant who self-identified as having no spiritual element to her life. Her SQ 21 mean value was the lowest of all the participants, at 1.29 with seven scores of zero and none of 5.
Participant Two (P2) was in the 50 to 59 age band with over 16 years of experience in healthcare management. She was the Assistant Director of Nursing at a large NHS hospital Trust with responsibility for commissioning all non-medical education. Another major part of her role was as a clinical and strategic policy overview across nursing and other related health professions. She had line management responsibility for 11 band seven nurses and one band 8A nurse. This gave her an overview of the impact that her managerial decisions had on affecting patient care. Her preferred leadership style was one of empowerment with a clear mixture of *'a cross between being facilitative and sort of visionary in some respect..''*
Participant Two self-reported as spiritual and religious. She was very clear about the role that her faith played in both her personal and professional life:

> *Well, I believe in God. I go to church. All be it not as regularly as perhaps as others but I do go. I have faith. And in my heart, I'm a Christian. And I feel that I have spiritual support if you like through that (P2).*

This is a metaphysical spirituality type with some echoes of traditional although she did acknowledge that she did not attend formal church services as often as she would like. Despite this strong faith, Participant Two had a mean average SQ 21 average of 1.76, scored six scores of zero and one score of five.

Participant Three (P3) was in the 40 – 49 age band, also with over 16 years of healthcare management experience. She was the only participant that still carried out clinical care as the manager of a cardiac unit with 50 beds. She had direct line management responsibility for 45 staff across two different areas. Her preferred leadership style was transformational and believed in engaging with staff with a bottom-up approach. She self-reported as SBNR, commenting that:

> *I grew up in an Anglican church environment but my parents were not particularly religious. I went to church occasionally on Sundays as a child in Brownies, so up to the age of 11. Outside of that, I've visited many different kind of churches, temples and whatever in various travels, and I've always found them to be places that are very restful, very calming to the soul, the kind of environment that they generate, but I have no religion that I follow (P3).*

This spirituality type is identified as interpersonal spirituality with a high degree of empathy and acknowledgement of the role of religion despite a lack of identification with a formal religious tradition.

Her SQ 21 mean average was 2.10 with four scores of zero, and none of 5.

Participant Four (P4) was in the 40 – 49 age band with 9 to 15 years of healthcare management experience. With a clinical background in occupational therapy, she had worked in a variety of settings including children, elderly people, in a hospice and in a mental health setting. Her current role was in a research and development unit investigating clinical care settings. She had line management responsibility for two staff. She had very clear views on her own personal leadership style:

> *You know I think my leadership style shifts according to the environment that I am in and I think that you have to shift. Generally speaking, I'm quite a democratic leader but there are times when I'm not and certainly in a hospice situation where there is death and dying involved it wasn't democratic – you didn't have a big discussion about things, you just did it (P4).*

Participant Four self-reported as SBNR, particularly because she did not like to be identified with any formal religious practices:

> *Because I don't adhere to any particular denomination. I don't, at this point in time, attend any formal church on a regular basis – I do go, but not a regular basis. I I don't like the… I use this word very cautiously… I don't like some of the bigotry that is involved in some of our formal religion (P4).*

Her spirituality type was recorded as interpersonal since her relationship with others was very important to her and had an impact on her positive worldview.

Her SQ 21 average score was 2.81 with two scores of zero and one score of five.

Participant Five (P5) was in the 40 – 49 age band with 9 to 15 years of healthcare management experience. His role was as a serving officer in the Royal Air Force and was a part of the team responsible for developing deployed hospitals for the military which involved:

> *… if you wanted to have the function of your theatre, your ED, labs, pharmacy, wards, ITU, et cetera, et cetera, and you wanted all those facilities to be deployed into a random field anywhere, fully powered, fully supported with IT systems, with all the beds and everything else that you would require for a functioning hospital, that is kind of what we develop. Say for instance, if we went to an austere environment say, well, say Sierra Leone for instance, where there was maybe no power of opportunity, things like that, you may have to set up a facility with nothing apart from a landing strip for your aircraft and then from that, you would then build a deployed hospital (P5).*

Participant Five did not have a clinical qualification but had an operational and strategic role in ensuring optimum care for personnel serving in combat situations. As a flight lieutenant, he had line management responsibility for a flight which consists of between 20 and 30 staff. His preferred leadership style was one of approachability and openness. Respect was also important but had to be earned. He also made the point that if the leadership style was too autocratic then it could have an adverse effect on performance:

> *Because when they do you can then just educate them on that, rather than be so autocratic and in their face all the time that they're too scared to step out of line because then they're too scared to perform at their peak, I believe (P5).*

Prior to completing the questionnaire, Participant Five had not considered his own spirituality. When self-reporting as SBNR, he suggested that:

> *See, after I had completed the questionnaire, I actually thought about this. Because I would then actually say, because I kept relating, I think, spiritual to religion too much until probably that kind of question came up a little bit. I would say probably I am a little bit spiritual, but I am definitely not religious in any way, shape or form (P5).*

His descriptive spiritual type was again interpersonal with a strong connection to others.

His SQ 21 average score was 2.81 with two scores of zero and two scores of five.

Participant Six (P6) was in the 50 to 59 age band with over 16 years of experience in healthcare management. He was medically qualified in anaesthesiology. After eight years of clinical practice, he undertook an MBA after which he ran a small healthcare organisation which grew into one which managed 13 hospitals with 2500 beds. He was CEO of that organisation for 20 years. Following semi-retirement, he was headhunted to a management consultancy specialising in healthcare. In this role, he had line management responsibility for other consultancy staff. When asked about his preferred leadership style, he considered himself to be participative and consultative.

Participant Six self-reported as a spiritual atheist. He had been brought up in the Greek Orthodox Tradition. He was very passionate about his beliefs as an atheist but just as convinced that there was a higher power which was not sentient:

> *In terms of do I believe in a God? One would need to once again qualify what you mean by God. If you're saying to me, do you believe in the God of the bible? My answer would be categorically no. The God of the bible is man-made. And the bible is man-made. And there is absolutely no evidence that there is, the God of the bible exist. If one, if you want to become an atheist, the easiest way to become an atheist is just to read the bible with its genocide, with its misogyny, it's paedophilia. And most new and old testament so the answer is no. If you ask me, is there a higher power that I don't understand, my answer would be yes, there is a higher power. But I need to qualify it. It is not a higher power that can suspend the laws of nature. So the higher power would not be intelligent as it was in the question that was supposed to mean, your questionnaire, is their intelligence. And the answer would be no. I don't believe for one second there is a higher power with intelligence (P6).*

This was an example of Intergaian spirituality with a connection to the natural world that does not rely on an intelligent higher being.

Participant Six had a mean SQ 21 score of 2.90 with four scores of zero and seven scores of five.

Participant Seven (P7) was in the 50 to 59 age band with over 16 years of experience in healthcare management. As a supervisor of midwives and modern matron, she had direct line management responsibility for 60 clinical and ancillary staff. Her preferred leadership style was one of inclusiveness, although she felt autocracy was appropriate in emergency situations, saying that:

> *I like to do an inclusive leadership, that everybody has their point of view so I can put it all in the melting pot, so to speak, and we can all work out together a plan (P7).*

Participant Seven self – reported as spiritual and religious, although she expressed concern that categorising people by religion was putting them into boxes:

> *… some people are quoting the religion as putting somebody in a box and what I certainly have, and I've always felt that ecumenical Christian faith, and we can share so much together, and not one particular religion or denomination is correct.*

> *But then you have the… the same thing when people talk about religion, I'm talking about the Christian faith, but there are other religions in the world too (P9).*

She felt that her spirituality was a mixture of traditional with ritual playing an important role and extrapersonal with a strong sense of purpose

She had a mean SQ 21 score of 3.0 with four scores of zero and seven of five.

Participant Eight (P8) was in the 60 + age band with over 16 years of experience in healthcare management. He did not have a clinical qualification but had a history of pastoral care, counselling and teaching. His role when interviewed was the head of the bereavement support team for an NHS Trust. This consisted of approximately 30 volunteers who he line-managed and supported in their role. His leadership style was again one of inclusiveness, commenting that:

> *My leadership style would tend to be as inclusive as possible with as much consensus as possible but once decisions are made and agreed, I take responsibility. And if others disagree, even though I may not have been 100% in favour of absolutely everything that's been decided together, at the end of the day, I'm manager, I get on with it and I take the wrap, so that's my style (P8).*

He self-reported as spiritual and religious, reflecting that his upbringing had been Christian, but he had explored other religions, particularly those who had influenced him musically:

> *I guess a lot of the folks that I was interested in musically and particularly were exploring different approaches to social engagement, political action and also philosophies and religions and so forth, so I got into all that sort of stuff and actually got involved with a little bit of westernised Zen, Buddhist type of stuff in terms of meditation and the sort of anattā all the sort of, you know, no-self so you try to… and I don't believe that now, I believe that there is a self but it was for a while very much part of my development. My parents seem to just… as long as I was doing the right sort of things that boys are supposed to do, I think they allowed me to get on with it, so that's fine. (Chuckles) And I had a conversion experience in my later teens and since then I have been very much involved in church life and Christian life (P8).*

Participant Eight demonstrated traditional spirituality.

He had a mean SQ 21 score of 3.62 with one score of zero and eight of five.

Participant Nine (P9) was in the 50 – 59 age group with over 16 years of healthcare management experience. Originally trained as a general nurse, she spent 12 years as community midwife before a career change which involved retraining as a learning disabilities nurse. Her current role was as the research manager for a secure behaviour therapy unit with a line management responsibility for three permanent staff and two volunteers.

Her preferred leadership style was quoted as fair but firm. She differentiated between emergency and non-urgent situations:

> *I will be fair and I will judge things and I will allow people to do things that really the rules might not say they ought to do. But if something needs to be done and something needs to happen then yes, I'm firm (P9).*

While self-reporting as spiritual and religious, her religious journey had been very varied but always in the Christian tradition:

> *I was brought up a Catholic, I have been a member of a Baptist church, I have been a member of the United Reformed Church, and to me it doesn't really matter what denomination I currently worship in. It's the fact that's it's a Christian denomination and it follows a very biblical teaching. So Christianity is the main thing to me. The building is not essential, it's the people (P9).*

This strong emphasis on ritual and focus on individuals would indicate that her spirituality type was traditional and extrapersonal.

Her mean SQ21 score was the highest of all participants, at 3.67 with one score of zero and 8 of 5.

5.3 Responses to Interview Questions.

The responses to the interview questions will now be explored in the order that they were asked, with verbatim quotes given as reflected in the IPA methodology and to highlight the lived experience. It is important that the voice of the participant is heard, with some brief commentary and reference back to the literature.

5.3.1 Awareness of Spiritual Intelligence

The first question after the opening demographical questions was if participants had enjoyed completing the SQ21 inventory. While this was asked as an introductory icebreaker, the responses sum up the importance of spiritual intelligence awareness. All the participants found satisfaction in completing the survey tool with a very strong emphasis on the reflective nature of the tool and the need for careful thought and self - analysis. This was highlighted by several participants, saying:

> *I quite like looking into my own head and thinking what I think about things. And I think questionnaires like that make you think and question yourself (P2).*

> *It was just a very different type of question that I've not done before and it actually does get you thinking in a different way (…) I'm quite glad for the opportunity to actually do that, the questionnaire to be honest, it was… yeah. Great (P5)*

> *So it brought me down to earth in terms of thinking and reflecting on myself, of myself and what is around me when I went through that questionnaire (P6).*

> *I found some of the questions quite interesting and thought provoking. (P7)*

> *It struck me as being questions that are dear to my heart (P9).*

One of the challenges identified was the importance of honesty in the completion of the questionnaire.

> *I actually found it quite challenging. It was good to be in a situation where I had to really think hard and make sure that I was trying to be as honest as possible with my responses as the questionnaire wanted me to do. So it was stimulating I think is the best word. (P3)*

> *It does require a fair bit of thought and also not to try and contradict myself (laughter) as I get to be as honest as I can, but not contradict myself throughout (P5).*

Both these participants listed honesty as one of their key values.

Finally, although Participant One said that she had enjoyed completing the questionnaire, spirituality was not something that she had ever considered and because of this she felt that:

> *I feel a bit of a charlatan being involved in this, because I don't think I have a spiritual element to what, you know, my approach to life. So I do feel a bit like I might be a bit of an odd one out in terms of who you might be interviewing (P1).*

She apologised that her results would not be consistent with others with greater reported personal spirituality. Although her SQ21 Inventory scores were the lowest of those analysed, her responses to the questions in the interview were consistent with others interviewed. Her use of language was different, but the importance of a clearly defined life purpose, having a strong personal value system and a knowledge of her personal worldview were similar to others. The biggest difference was that her values did not develop from a faith which was the case with those with a more faith-based worldview.

5.3.2 Spiritual Leaders.

Participants were invited to identify spiritual leaders who had a relevance to them. These leaders could be living or dead, famous or relatively unknown or had had an individual influence on the participants. The leaders mentioned were:

Spiritual Leader	Dates	Religious or Secular	Political or Social Activist Who Had Conflict with Authority	Participant
God	N/A	Religious	N/A	1, 2, 6, 7, 8 and 9
Individual Influence	N/A	Both	N/A	1, 2 and 3
Mother Theresa	1910 - 1997	Religious	N	1 and 9
Jesus Christ	4 BC – c. 30 / 33 AD	Religious	Y	4, 8 and 9
Dalai Lama	1935	Religious	Y	4 and 9
Buddha	circa 563 BCE - 483 BCE	Religious	N	4
Winston Churchill	1874 - 1965	Secular	Y	5
Daniel Dennett	1942	Secular	N	6
Sam Harris	1967	Secular	N	6
Martin Luther King	1929 - 1968	Religious	Y	7 and 8
Nelson Mandela	1918 – 2013	Secular	Y	8
Menno Simons	1496 – 1561	Religious	Y	8
Deepak Chopra	1947	Secular	N	9
Jean Vanier	1928	Both	N	9
Henri J Nouwen	1932 – 1996	Religious	N	9

Table 5-1: Spiritual Leaders Identified by Participants in Phase Two.

There was a distinction made in the individuals identified between religious and secular spiritual leadership. There was an even split in the responses between religious and secular leaders, with seven leaders identified in each category. Given the predominantly Christian nature of those who professed to be spiritual and religious, God and Jesus Christ were identified by all those who were self-categorised in this way. Those who are both spiritual and religious also identified the more humanist modern-day philosophers (Daniel Dennett and Sam Harris) who have been linked to distrust and question the role of religion in modern society (Dennett, 2007; Harris, 2014).

Participant Six differentiated between religious and secular spiritual leaders.

> *I see spiritualism in two compartments. The religious, spiritual leaders, whether they are fictitious or real. And then spiritual leaders in a secular sense that have wisdom, have empathy, have compassion. So I don't have much, if it's worded correctly...I don't have much admiration for religious spiritual leaders (P6).*

This distinction is relevant as broadly those who reported as SBNR tended to identify secular spiritual leaders in contrast with the spiritual and religious category who suggested more religious leaders.

The most frequent spiritual leader identified was God, who was mentioned by six of the participants with one (P4) suggesting Jesus without mentioning God. According to Christian faith, Jesus is the physical manifestation of God on earth and is therefore synonymous. Those participants who declared themselves to be spiritual and religious all cited God as a spiritual leader that they admired.

All of those who expressed they were spiritual and religious highlighted the importance of their faith as a reflection of the spiritual leaders they admired. For example, Participant Four suggested that:

> *Oh, well I'm a Christian so my… My….I'm a number one fan of Jesus… But we've got a yeah.. So I'm a Christian obviously, so I follow Jesus (P4).*

This was echoed by Participant Nine, who also differentiated between Jesus Christ and God despite expressing a very strong Christian faith:

> *Jesus Christ first of all, I am a Christian by background. But there are many other inspiring human leaders shall we say, other than God himself (P9).*

The participants who said that individual influences were important spiritual leaders that they admired were the three who had the lowest SQ 21 score following Phase One.

Participant One found suggesting a spiritual leader that she admired challenging because of her professed lack of faith:

> *So … so I guess this is a little difficult for me because, um, I don't have a faith, um, I don't believe in a higher being and so, um, my, um, if I admire someone about being a … being a spiritual leader it is probably more about their, um, um, value system and their ability to lead (P1).*

Participant Two, despite self-declaring as spiritual and religious did not identify any spiritual leaders other than a female vicar who had had a profound influence on both her spiritual and religious development and that of her family:

> *And I guess there was a female vicar some years ago now who actually got my two elder children involved in the becoming Christians (P2).*

She went on to describe the influence that this vicar had had on her husband who is an atheist, although he is supportive of his wife's faith. The vicar had said that she was completely certain that, given enough time, she could persuade this man to change his mind:

> *I admired her ability to have conversations with, for example, my husband and be absolutely sure that she was going to change his mind. She didn't. But she had no doubt that she would eventually if she's had long enough with him she tells me (P2).*

The other individual influence echoes the importance of connectedness to the spiritual experience. Participant Three suggested a tour guide in Australia as being a particularly significant person in her spiritual journey:

> *A person who gave me a fairly spiritual encounter was when I was backpacking in Australia. The leader that we had on a trip that I did out there, was somebody who took me to these places where I definitely had, to me, spiritual interactions with nature. So I'm not sure you'd call him a spiritual leader but he enabled me to experience spiritual encounters. (P3)*

In this sample, there was an even split between secular and religious spiritual leaders. One potentially surprising omission was Mahatma Gandhi who in other literature is often quoted as an example of a spiritual leader (Klenke, 2007; Fry and Wigglesworth, 2013; Copeland, 2014).

This list of spiritual leaders is consistent with the list offered by Wigglesworth (2012, p. 5) who has asked this question of many hundreds of people, both before, during and after the development of the SQ21 Inventory. The spiritual leaders listed is also consistent with those offered by Black (2014).

After identification of significant spiritual leaders to them, participants were invited to reflect on what characteristics or traits these spiritual leaders possessed. The commonest characteristic identified was that they understood and valued people (P2, P4, P5, P7 and P9).

Participant Two suggested that Mother Theresa was a spiritual leader who:

> *… was charismatic. She had confidence, energy, passion and understanding of probably what people wanted (P2).*

This idea of understanding people was picked up on by Participant Seven who identified Martin Luther King Jr as a profoundly influential spiritual leader for her, and suggested that:

> *He tried to be fair and tried to try to understand where people were coming from, like they do it in the southern states of America from the white against the black Americans. (…) And I think, some of his traits were trying to say, you know, trying to bring all people from all of different backgrounds together (P7).*

This was echoed by Participant Five when he advocated that a trait of spiritual leadership was that *"…it's understanding the everyman" (P5).*

Participant Four, despite professing a strong faith, reported as SBNR as she did not wish to participate in formal religious observance. She identified the main trait of strong spiritual leadership as being:

> *It's about values. It's a values-based thing that we often have to see the commonality (P4).*

Compassion and empathy were highlighted by two as being important traits in spiritual leaders. Fry and Nisiewicz (2013, p. 107) point out that while compassion and empathy do not get respected in most organisations, compassion aids in making and implementing tough decisions. Other traits that were expressed by only a single participant included charisma, confidence, energy, fairness and commitment to a cause.

These traits are seen in spirited leaders and also identified by Hyson (2013, p. 110) who suggested the traits of being:

> *loving; kind; forgiving; peaceful; courageous; honest; generous; persistent; faithful; wise; inspirational; humble; calm; passionate; visionary; and who see the gifts in others and seek to develop them. (Hyson, 2013, p. 110).*

This idea of developing others is a consistent overarching theme tat encapsulates may of the other traits that were suggested.

Participants were then asked how these traits could be developed in both themselves and in others.

Three participants (P1. P2 and P3) identified that developing spiritual leadership traits was difficult. Since Participant One did not have an expressed spirituality or faith tradition, she suggested that environment, particularly when young, and the development of a strong value system was a defining factor:

> *… there is something about, I believe, in terms of how your value system, how your brought up in … how you develop your value system from, um, from being young and the environment that you're in, that enables you to develop that value system (P1).*

This idea of the importance of a strong value system was echoed by Participant Four when she said:

> *Well in the team, we actually have our six values […] We want people with shared values to join us… We don't want people who don't have those values on the team really (P4).*

The six values that she referred to were not the 6 C's as proposed by Cummings and Bennett (2012) but internally formulated ones from the Trust that she worked for.

While using different language, Participant Three suggested that it was important to know the individual:

> *I usually try and get things back to an individual, what's important for that individual, because in the team I work with currently, it's very different for all of them depending on their background origin, their culture, their country and what religion, if they subscribe to one it is that they practise. (P3).*

What is important to an individual is very strongly linked to their value system.

The influence of environment, particularly in the early years was also felt to be a significant contributory factor by Participant Two when she suggested that:

> *… you can develop a lot of characteristics through nurturing and how you bring people up (P2).*

This was endorsed by Participant Six, saying:

> *How are you brought up in your home and what influences you have directly from your parents and indirectly from other relatives? Sadly, education probably pays one of the most important aspects of learning these things (P6).*

The use of the word "sadly" in this context indicated that he felt that education had failed and that the traits of leadership that he had identified (desire for world peace, and respect for all life forms) were not values that were highly enough regarded by society in their education of young people.

Participant Five had received 30 weeks of leadership training in the RAF and was comfortable with both the content and need for this development, although perhaps a slightly lacklustre form:

> *I have to really say that yes, you can teach leadership, you can teach these qualities, because that's what they give us 30 weeks' training all about, pretty much. So, I have to kind of take the party line on that one, really (P5).*

He did not identify if there was a spiritual component to this leadership development.

Participant Eight suggested that the development of spiritual leadership traits went beyond clinical competence:

> *I think the common thing that I would say is vital is for them to move beyond mere clinical competence through to a desire for compassion, for love, for perhaps being prepared to make oneself vulnerable and recognise that in that vulnerability there is something that happens in a way that doesn't happen in a straightforward clinical engagement. What one needs then is to ensure that the individuals who are making themselves vulnerable and compassionate, et cetera, in that way are themselves sustained (P8).*

This need for creating a supportive environment is a key leadership skill, and one which should be developed (Vardiman, Houghton and Jinkerson, 2006).

5.3.3 Religion and Spirituality.

The participants were asked what they considered to be the major differences between religion and spirituality. The first major difference identified by several participants was the individualistic nature of spirituality compared with the more ritualistic and community based perception that participants associated with more formal religion. Participant One suggested:

> *… that religion is about, um, having, a … a … a … an organised, um, approach to a belief system. And, spirituality is linked to a belief system, doesn't have to be linked to anything that's organised so it can be purely individual. Um, but is about a kind of a … a belief system or a view of the world or what you get from the world, if you see what I mean (P1).*

The idea of ritual in religion was also mentioned by Participant Six, particularly in the context of the interconnectedness of individuals.

> *Technically, I would say religion is a whole set of beliefs, (pause) a degree of ritual engagement and expression. (…) Because what happens in religion is in a religious context, people's connectedness is done through rituals. And that's specifically done and every religion has its rituals. And those rituals make the person feel that they are connected and they are part of it (P6).*

This idea of interconnectedness was echoed by Participant Nine, stating:

> *To me, spirituality is what we mentioned earlier; it's not a label, it's not a religion, it's a personal connection with God. And for me God is the God of the Christians. But that's not important in terms of other people if they connect with a different perception of God. To me, as long as people connect with something somewhere and feel that sense of peace, that's huge and that's really important (P9).*

While not stated explicitly, both comments indicate the importance of the gathering together of like-minded individuals, often with a common belief and value system, which contrasts with the more individualistic nature of spirituality.

Participant Nine went on to comment further on the individual nature of spirituality:

> *Spirituality is something very, very personal. It's deep within yourself. I think we all have the capacity for spirituality and spiritual awakening. Religion is the manmade rules that go up around how we're going to do that basically (P9)*

That religion was a set of manmade rules as outlined by Participant Nine was also mentioned by Participant Four. She suggested that these rules were set down in religious texts and were similar across religions.

> *For me, religion is a structured environment often with a guidebook whether it'd be the Torah, the Qur'an, the bible or whatever it is that people use to give them a footpath through their life, to try and help them aspire to be the best person they can be. The difference I think with spirituality is in not necessarily having a rulebook for that (P4).*

The idea of the personal nature of spirituality compared with the concept that religion was larger and involved more people was also commented on by Participant Five:

> *I'd go with Christianity because that's what I grew up with, but I would say that spirituality is more personal to me, religion is just this big kind of thing that I don't live daily (P5).*

He contrasted this with his perception of Muslims, whom he suggested a blurring of spirituality and religion in their communities:

> *When I went to the mosque and realising how a Muslim lives their life, they live daily, it is… everything they do is pretty much spiritual and religion is pretty much hand in hand (P5).*

This he contrasted with Christianity, which he had practised as a child but no longer had any formal religious observance:

> *Christianity and the way that I see it when I grew up, Christianity was one thing I was brought up with as a child but the spiritual side of thing was always there with me, religion not so much (P5).*

Participant Two also commented on the importance of a belief system, particularly in regard to spirituality:

> *In my head, how I would define the two is if somebody said to me, "Are you religious?" I would say, "Well, I believe in God. I go to church. Or be it not as regularly as perhaps as others but I do go. I have faith. And in my heart, I'm a Christian. And I feel that I have spiritual support if you like through that." I think some people believe a religion is just, it's something that's there but they don't necessarily enact it or you know to me a religion if you say what religion are you, you almost imply what race are you, what colour are your eyes. I think it's more of a statement rather than a belief. And I feel that belief is where spirituality comes in (P2).*

She differentiated between faith and belief with religion being linked to faith and belief linked to spirituality. This was echoed by Participant One as pointed out earlier.

One difficulty in differentiating between spirituality and religion suggested by two participants was the sheer range and number of religions. Participant Six suggested that:

> *There are maybe anything between 2 and 4,000 different religions each believing having their own doctrines, each believing in their own God. And most people are born into a religion. They do not choose a religion so they don't have a choice (P6).*

This was echoed by Participant Eight:

> *I'm trying to not focus on one particular religion here and it is difficult because there are so many religions (P8).*

Another perspective of the difference between spirituality and religion was suggested by Participant Two. She described a minister who she had encountered who had told her that:

> *… there's no way that I could be a Christian because I didn't go to church every Sunday because I didn't put church above everything on a Sunday morning and that I didn't you know and therefore I wasn't a true Christian (P2).*

She went on to say:

> *I don't think necessarily going to church makes you Christian. And I guess that's where I'm coming from. I mean he went and he preached every single Sunday. He took services every single Sunday. He led the life of a minister but he was horrible to his wife. He was vicious. He was unpleasant. And he did some terrible things (P2).*

This idea of conflict was also raised by Participant Six, who suggested that confrontation because of differing opinions might be an issue:

> *I would not like to find myself in a confrontation with religious people that would see that my spiritual views would conflict with their spiritual views (P6).*

The difference highlighted by this small sample is that religion is frequently seen as ritualistic and involves many people whereas spirituality is more individualistic and personal. Religion tends to be a formal set of manmade rules and rituals that help some individuals to lead a more spiritual life. These rules and rituals are what defines each religion and provides many opportunities for individuals to express their own spirituality as well as more collective expressions. It is possible to be neither spiritual nor religious, SBNR, or spiritual and religious. It is also possible to be religious without being spiritual.

The findings from the interviews mirrored the findings in the literature, particularly Koenig, McCulloch and Larson (2001, p. 18) as highlighted on page 23. However, Bester and Muller (2017) assert that while there is growing support for a spirituality that is not embedded in religion, it cannot be overlooked that *'the overwhelming spiritual experience in the world is aligned with religion'* (Roof, 2015, p. 588).

The major point in the problem of raising awarness of spirituality and religion is one of use of language. Both religion and spirituality use a vocabulary that is unique to them and if not understood, can be offputting (Barber, 2012; Bloom, 2018).

5.3.4 Meaningfulness.

Participants were asked if meaningfulness was a term that was familiar to them, and if it was, whether it was significant in their day-to-day managerial practice. Three participants (P1, P6 and P9) were unfamiliar with meaningfulness as a term, but all the other participants were familiar with it as a concept.

Meaning has been discussed on pages 13-14, but the meaning that we give to life is often based on our worldview, on what we believe about the purpose of life and afterlife. However, meaningfulness is not a belief. It describes the bridge that we create between what we believe and how we live our daily lives (Lips-Wiersma and Morris, 2011).

Despite being unfamiliar with the concept, Participant One suggested that there were links to meaningfulness and different value systems.

> *That … that … that it feels like your … your layer … overlaying values, a … into the word meaningfulness. So for a banker, I'm sure they would see their efforts to move money around the world meaningful. Um, the fact that other people don't see that as being meaningful, (laughter). Do you see what I mean, it's different … different value system? (P1)*

Those who were familiar with meaningfulness all defined it in a similar fashion. Participant Two, for example, suggested that meaningfulness is:

> *Something that is like why you're doing something, what it's impacted on yourself, the people you're doing it to the world around you (P2).*

This idea of purpose and function was also echoed by Participant Nine. She said that:

> *Meaningfulness is to me, means that there has to be meaning in what you do. There has to be meaning in everything in your life. And if you've got a meaning to what you do, well that makes the things in life seem okay. Because basically, life is full good things and bad things and ups and downs, but if you've got a meaning as to why you're here and what you think your meaning is and what you can contribute to life, well then, it makes life worth living (P9).*

Participant Five recognised that meaningfulness for him involved connection with a higher cause and the ability to make a difference:

> *I think having meaning in what I do and having almost a higher cause in a non-religious sense motivates you and this drives you forward to better yourself. And don't get me wrong, earning a day's… doing a hard day's work for a day's pay to support your family and stuff is fine, but I would say maybe you don't work meaningfully, the work may not be meaningful but what you get out of it as in your pay is very meaningful because it helps you provide for your family. But for me, I need to have meaning at work as in what I do does make a difference somewhere (P5).*

This idea of a higher cause was also explored by Participant Six. He suggested that meaningfulness was linked to the reason for our existence on earth:

> *So in the context I see it, it would be whatever actions or thoughts or behaviours one has is there a meaning to it, and is there a reason for us being on this planet? (P6).*

He went on to say that:

> *I certainly would not try and explain it in terms of we have been put here by a higher power and it is our purpose to serve this higher power. Because once you get into that realm, you start, need to ask the question, who put that higher power here (P6).*

He self-reported as a spiritual atheist so it is perhaps not surprising that he questioned the existence of a higher power but still emphasised the need for meaning as related to the purpose of human existence.

The relationship between meaningfulness and the interaction with other people in the context of the health care was a key finding in this small sample. Participant Seven suggested that meaningfulness had played an important part in her role as a matron and midwife:

> *Yes, I think certainly in my role as a matron, as a midwife over the years, doing things, there had to be a meaning for it and a reason why we were doing things. And also our relationship with other people had to be meaningful because actually I think they can see through people who are forced. So there must be a meaning in the things that we do and our response to other people. (P7)*

Participant Eight also suggested that meaningfulness had a sense of fulfilling a purpose and that this purpose involved human interaction:

> *I'm not so sure that it's that exact word but people talk in terms of purpose, fulfilled purpose, vocation, you know, those types of things. I think all of those have got a degree of meaningfulness about what's going on, without that, I think, most jobs involving human interaction could not be sustained over a long period (P8).*

Meaningfulness is linked to life purpose in the literature (Baumeister and Vohs, 2002; Halama and Strizenec, 2004; Lips-Wiersma and Morris, 2011) and has been explored more fully on page 13.

5.3.5 Values.

The next question asked participants to list their top three values and why they were important to them.

These values were not suggested or pre-prepared. There are many authors that have suggested values lists, including The Janki Foundation For Global Health (2011, p. 119), Wigglesworth (2012, p. 204) and Appelo (2014, p. 100) but participants were not given any of these lists as it was felt that this might introduce bias. Honesty was the most frequent value (P2, P3, P5 and P8). Truthfulness was also included (P4). Integrity was the second most common value (P4, P5 and P8). The third value, and the only other one that was duplicated was love (P1 and P8).

Participant One was very sure in her belief in the importance of values, despite her professed lack of spirituality. When asked, she had difficulty in identifying her personal values as they were aspirational rather than lived:

> *Leaving the world a better place than when you came into it […] so that's number one. Um, gosh, um, so (sigh) I can't … it might be an important value but I really don't live this, um, (laughter). So … so it is something about respecting and valuing other people and … and, um, valuing difference so not … so not being … but again, so I don't live it but I should, I want to, about not being judgemental and not being discriminatory and not … not, um, err, and … and, yeah, value … valuing difference and … and … and … and not being intolerant (P1).*

Participant Three had no such difficulty in identifying her top three values, but made the additional point that they had been with her since childhood:

> *I think honesty, trust and fairness. Why are they important to me? I believe I grew up in an environment where those values were perceived as being very important. So as a child, it was very important to learn very early on that you didn't lie or else you got into trouble if you were found out. And even if you weren't found out, you felt it internally and you had to confess anyway (P3).*

The early influences on the development of values also included the childhood environment in which these were developed, as identified on page 97.

Participant Five was particularly interesting in his analysis of personal value systems, and their integration into his work environment and the context in which this value system operated. He is a serving officer in the RAF and suggested that while honesty and integrity were similar they were both important to him:

> *Top three values, yeah. I looked at this question before, but for me, I always think that loyalty, honesty… I think loyalty is one of the key things. Honesty and some… I*

> *know it ties in, honesty and integrity are very similar, but integrity, I don't see the point in… I don't see any… many wins in lying. Sometimes I guess it is a necessity, but I luckily don't have to lie in what I do. Integrity, again it comes with the role and also, we run in the air force, we have the core ethos of the air force anyway; respect, integrity, service, and excellence. So, integrity is one of our main core values and it has been for last 17 years of my career. And if I don't… if my lads or troops or anything like that don't think that I have their back because I'm not being honest with them, then they're not going to follow me and they won't have my back when I need them. Yeah. So, they would be my three (P5).*

The other participant who felt that the context was important was Participant Eight. He said:

> *I use love as a word deliberately from time to time with other members of staff, whether it's the nursing staff, physiotherapists, occupational therapist, you know, it doesn't matter and I do it quite deliberately because I think it's an important part of our work environment to recognise that that element belongs in healthcare and you can't have health without love and you can't have care without love (P8).*

Other important values that can be grouped were respect, equality and understanding of people, particularly for colleagues. Reliability, friendship and trust were also felt to be key values. Other important values included the idea of facilitation, particularly in helping others to be successful, joyful and peaceful.

Potentially surprising values not mentioned by participants were humility, compassion and empathy. Given that compassion particularly is key to the development of spiritual intelligence according to Wigglesworth (2012, p. 112), this omission was unexpected.

5.3.6 Breaking the Rules.

The next question explored a specific skill from the SQ 21 Inventory and was chosen because of the hierarchical nature of healthcare. The organisational culture of many large workplaces is described as a role culture (Handy, 1993, p. 186). This has been likened to a Greek temple, with strong departmental structures analogous to the pillars of the temple. The interaction between departments is regularly controlled by rules and procedures, which are the major methods of influence (Handy, 1993, p. 185).

There was a very strong feeling that, given certain situations, it was necessary to break rules. Only one participant (P2) said that she wouldn't break rules and another, (P7) was unsure.

Participant Two suggested that:

> *I don't break rules. I've never broken rules. I've always been well known for not breaking rules (P2).*

Despite being adamant about this, she then immediately qualified this when she asserted:

> *Having said that, would I break a rule if it was to save someone's life? Possibly. If it was to save my own life, probably. If it, if the benefit of breaking that rule completely outweighed the cost of what it would be if I broke the rule. So you know there's a saying rules are made to be broken. For me, rules are there for a reason. And*

> *they're there usually to be fair to protect the general public and I guess I don't have, I don't say that you can't break rules (P2).*

It was perhaps significant that she could not think of any consequences of breaking rules when asked.

Participant Seven was unsure. She felt that it was unacceptable to break rules if it were purely for personal gain. She also made a differentiation between rules and guidelines:

> *I think (Pause) in health, you have what you call the strict rules and regulations that you must abide and then you have your guidelines, and they're supposed to guide you to keep to those rules (P7).*

The potential consequences of breaking rules was important to those that said that they would do so, with broad agreement that rule breaking for personal gain was unacceptable. Two participants (P1 and P3) linked rule breaking with their value system.

> *… um, that's probably a more difficult question to answer, um, so … so it's going to be more about my personal values and whether, um, it's okay for those to be broken. And that may not be that helpful because of course we break our own values all the time don't we? So … (P1).*

> *Well, (Pause) part of me has a rebellious strip which always feels that rules are made to be broken. (Chuckles) But actually most of the time, most of the rules that we have, that have maybe been lay down in law, et cetera, are there to protect the greatest number and preserve the greatest good for the greatest number which is a value, again, which I think is important (P3).*

When giving examples of when rules were broken, behaviour in a car was an area where adherence to the rules was less strict.

> *I break the law by speeding regularly, all the time. So I obviously make a choice that my need to get to work faster is more important than the laws of the land and the law … and absolutely speeding increases the risk of significant harm to people, doesn't it? And I live in a large rural county and there's a … probably got the highest road accident rate going. So … so I'm making a cal … I'm taking a calculated risk around whether it's okay for that law to be broken and I'll speed in certain places, I won't speed in others, but it's wrong. I shouldn't be doing it. So I break that one, um, and it's all about … so … so … but that one it's about whether, A I'm gonna get personally hurt, B whether I'm gonna hurt anybody else, C whether I'm going to get caught (P1).*

> *I have travelled on numerous times to Africa. And certain hotspots in Africa are quite dangerous. So for example if I'm driving a vehicle in certain cities in Africa which I know are dangerous, I would for example not stop at a red light. I would break that rule knowingly because I also know that if I stopped at there to red street light for long enough, I might get attacked or my family would get attacked. So there is a typical example of where I would break the rule (P6).*

Where rule breaking and the complexity of inner thought is concerned, it is important that practitioners are aware of the impact that their decisions have both on themselves, their colleagues and patients. Participant Three gave an example that exemplifies the importance of context and the environment in which decisions are made:

> *A very standard example in my line of work would be for example, visiting times and visiting times are 2:00 until 8:00. But you have got a family member who is dying, who's undergoing palliative care, and you may choose to have open visiting for those families to enable them to achieve what they need to at that person's end of life (P3).*

In her view, the end of life context was more important than the rules. Guidelines are useful for less experienced practitioners but for this group of managers two aspects were considered. The first was the ability to override guidelines when the situation demanded and second, the ability to amend locally implemented guidelines in line with local policies and procedures. This evolution of guidelines requires a higher level of thinking and experience which is supported by an increased awareness of spiritual intelligence, particularly with regards to worldview and value systems (Kavar, 2015; Jones, et al., 2016; Kheswa, 2016).

5.3.7 Decision Making.

Skill 19: Making Compassionate and Wise Decisions was not a skill that was well developed in the population of managers in Phase One, as discussed on page 79. For this reason, a question was asked regarding the decision-making process which tried to identify why this skill was not particularly well developed. Rather than asking directly about their decision-making process a polarity approach was used. Polarity Management theory suggests that "Either/Or" thinking must be supplemented with "Both/And" thinking to effectively manage dilemmas (Johnson, 1996).

Participant One identified that there was a polarity that involved compromise:

> *When I'm working with other people, it might be that I need to work with them to reach the compromise position to help people move between polarised positions (P1).*

Narrowing down options was identified by Participant Two as a consequence of the either/or option:

> *Well, I guess with either/or thinking, you possibly might lose out on something because you're making a decision you either do it or you do something else. Whereas if you, well I could do it this way. I could it that way. Let's try it both and see what happens. You've got that so you still leave your doors open. So I suppose the consequence of doing either/or as opposed to the other is that you narrow your options (P2).*

Participant Three linked either/or thinking to her perception of a worldview, and how that influenced the decision-making process:

> *'Either/or' is much easier thinking, it's much more black and white and it's what makes most people feel more comfortable, myself included. But if you're looking at both sides of the situation or trying to understand somebody else's thought processes to why they think the way that they do, then you tend to end up with the 'and' thinking. I don't always manage to achieve that but I always try to understand what is the motivator for somebody else thinking in a different way from myself*

> *because if you have that degree of insight, it can then help you to form potentially a different solution, they may well see something much more clearly than you do as a longer term horizon scanning outcome which you haven't even begun to consider (P3).*

Participant Four echoed the importance of worldviews, and gaining different perspectives:

> *Often I can see both, which is always a bit of a challenge, because… I try to listen to lots of points of views and most peoples' points of view are valid so that can make a decision making a bit difficult.*
>
> *In what way?*
>
> *If it's all aligned with your values and your thinking and it's just different, it doesn't make it wrong (P4).*

In terms of spiritual intelligence, having a rounded view which took account of evidence was discussed by Participant Nine, who said:

> *So yes, I do tend to sort of look at both sides and see either/and/or, but and try and make decision around all the evidence. I don't tend to be black and white, I tend to sort of look at everything (P9).*

5.3.8 Staff Involvement.

A question was then asked about how staff were involved in the decision-making process and whether involvement of staff in the process was important. This was not a good question since it was too complicated and had too many themes.

The responses were mixed, but the essence was given by Participant Six who linked connectedness to a positive leadership style:

> *So I'm not sure if I could be labelled as a spiritual leader because that's quite a vague term. But I think that as a person who think about spirituality and who has this feeling of connectedness with other humans and other loving entities that by gathering people together and understanding that we as a humanity are connected making the decisions and enforcing decisions and requiring input from individuals whether they are subordinates or peers and having that understanding of that we are all connected in some form or other. And if you want to use the word spirituality, use it. It gives you a leadership style that doesn't antagonise people. It doesn't offend people. It doesn't put people down. And I think that is the secret of, if you want to call it spiritual leadership as opposed to a dogmatic, arrogant, capricious leadership style (P6).*

Participant Two also linked the performance of her role to her leadership style:

> *Well, I think that probably sums up quite well the way I like to lead to be honest which is give them the information so assume that they can make an intelligent decision and encourage them to do that independently of me if you like. And my role is merely as a conductor of the orchestra and not as an instrumentalist you know. It's about actually the, facilitating those and then providing them with the information to make the right decisions (P2).*

The context in which decisions were made was felt to be important to Participant Three:

> *I think the premise of that is that there's an expectation in there that people, in the right circumstances, actually want to take ownership and want to be involved in decision making and therefore, wanted to accept accountability and responsibility for the actions that they take (P3).*

Participant Eight felt that a barrier to getting intelligent decisions was an autocratic leadership style which was not conducive to developing staff. There was also the possibility of some staff not wanting the responsibility.

> *Encouraging, enabling and working with people so that they can make decisions, make contributions and develop, it seems to me… well, it's never going to happen in the sort of very strong, "do what I say" type of leadership, you are allowing it if you are more approachable and open and nurturing. Do I believe that everybody is going to make intelligent decisions? (pause). Most of the time, most of the people, nearly all the time, nearly all the people, everyone? Maybe not (P8).*

5.3.9 Teaching.

Participants were then asked if teaching was a part of their role. This caused a degree of confusion as to what constituted teaching as discussed on page 81.

It was interesting that the three participants (P2, P3 and P4) who said that they had no teaching role were the three who self-reported as SBNR.

Participant Two felt that she did not have a teaching role in her current position as an Associate Director of Nursing but that if the opportunity had arisen in her previous job as a Specialist Nurse, then she could have taught about spiritual principles:

> *I suppose if I think about spiritual principles within my role, if I think about my role as a specialist nurse, yes, I think probably. In my current role, I don't think so (P2).*

Participant Three differentiated between a formal and informal teaching role, saying:

> *So I have more of a coaching, counselling kind of a role rather than more than a formal traditional kind of teaching in a classroom or lecture theatre environment (P3).*

Participant Four did not have a teaching role, but still identified a supportive role:

> *No not really… Not teaching in the sense that we stand up and spout we do a little bit of that around supporting people to access NHR fellowships and things but I wouldn't say it was teaching in a big way (P4).*

Of those with a more formal teaching role, only one felt comfortable with teaching about spiritual principles:

> *So it seems to me that I can't do any teaching unless there's some overlap with spirituality. And then in the training courses that we run for own volunteers as potential members of our team, those principles come out quite clearly. We also have a very short section specifically on spiritual needs, a spiritual understanding of our clients and I ask them to reflect on their own spirituality and unresolved issues (P8).*

Despite having a passion for coaching. mentoring and teaching Participant Six did not feel that he could teach about spiritual principles. He identified two barriers, that went further than a teaching role, that prevented him from discussing spirituality:

> *I think the biggest barrier is that it's not something that I have spent a lot of time thinking about. And I would not like to find myself in a confrontation with religious people that would see that my spiritual views would conflict with their spiritual views. So I would probably try and avoid it. It's not a topic that I even get into a discussion with (P6).*

This differentiation alluded to between religion and spirituality reflects his views on the differences between the two as discussed on page 99.

While the question asked specifically about teaching about spiritual principles, more general barriers to discussing spirituality emerged which is analysed further

5.4 Skills of the SQ21.

Since the SQ21 was developed as a starting point for discussion, a focus was made on those scores that were particularly high or low. For this reason, participants were asked about skills where they had a score of zero, and a score of five.

Participant	Low skill question asked	High skill question asked
One	Skill 9: Awareness of Limitations / Power of Human Perceptions	Skill 2: Awareness of Life Purpose
Two	Skill 19: Making Compassionate and Wise Decisions	Skill 18: Being a Wise and Effective Change Agent
Three	Skill 16: Seeking Guidance from a Higher Power / Higher Self	Skill 2: Awareness of Life Purpose
Four	Skill 19: Making Compassionate and Wise Decisions	Skill 18: Being a Wise and Effective Change Agent
Five	Skill 19: Making Compassionate and Wise Decisions	Skill 18: Being a Wise and Effective Change Agent
Six	Skill 15: Sustaining Faith During Difficult Times	No Data
Seven	Skill 9: Awareness of Limitations / Power of Human Perceptions	No Data
Eight	Skill 8: Breadth of Time Perception	Skill 2: Awareness of Life Purpose
Nine	Skill 9: Awareness of Limitations / Power of Human Perceptions	Skill 2: Awareness of Life Purpose

Table 5-2: Low and High Questions Asked for Scores in SQ21.

5.4.1 Low Scores in Response to Questions in the SQ21 Inventory.

Skill 19: Making Compassionate and Wise Decisions was the joint most frequent low skill (P2, P4 and P5). The potential reasons for this low score has been discussed on page 79 and identifies skills in self-compassion and the ability to be compassionate when they fail.

Participant Two did not see this as a weakness but felt that it made her more empathetic and a better leader as a result:

> *I think it makes me a compassionate leader. I think it makes me understand some of the dilemmas and it makes me more forgiving of other's mistakes and, or not mistakes but errors if you like. I think it gives me insight into how others might be feeling although actually to some extent I give, perhaps give them too much credit to this that they overanalyse like I do. I do think it makes me more a compassionate and empathetic leader, yeah (P2).*

The importance of compassion in forgiveness was echoed by Participant Four:

> *(Researcher) Do you think that this [lack of self-compassion affects the way that you lead?*
> *(Long pause)*
> *(P4) I do. I think that sometimes, because I'm so hard on myself I think sometimes I can be hard on other people.*
> *(Researcher) Right. Yes.*
> *(P4) I try to be conscious of it, but I… On reflection I think that the lack of compassion I have for myself when I make mistakes can be transferred to other people.*
> *(Researcher) Do you think that compassion is important?*
> *(P4) Yes*
> *(Researcher) In what way?*
> *(P4) I think… I think compassion is… Enables you to be more of yourself, enables you to make mistakes and it's a long way away from the blame culture that creates a safe environment, a compassionate environment (P4).*

This creation of a safe and compassionate environment resonates with my personal leadership definition given on page 3.

Participant Five disagreed that his lack of self-compassion made him a better leader:

> *It puts more pressure in me, definitely. I will kick myself even if I make the biggest…. No one's ever had a problem or come to me with a problem with my leadership or leadership style, apart from one boss actually, but he was bully so I didn't really listen. But yeah, I think that you should be able to reflect on it. It's easier knowing what to do than actually doing it because I know that I should be less harsh on myself when a decision's wrong or that kind of thing. But yeah, I believe it does make it more difficult to lead or… yeah, you shouldn't be so harsh on yourself when you do make the wrong decisions. But unfortunately, that's just who I am (P5).*

The joint most frequent low score (P1, P7 and P9) was Skill 9: Awareness of Limitations / Power of Human Perceptions. This skill suggests that the five conventional physical senses (taste, touch, smell, sight and hearing) are augmented by a sixth sense – Intuition or gut feelings. At higher levels of this skill, intuition is seen as a source of knowledge to help balance flawed sensory processes. This intuitive sense — which could be identified as spiritual insight — enhances the five physical senses (Wigglesworth, 2012, p. 79).

This is an example of the importance of the conversation that follows completion of the inventory. All three respondents identified the role of intuition, particularly in healthcare:

> *Um, so as a manager of people, as clinician, so I've worked with patients obviously in the past, um, gut feel is, um, something that I know I use and know influences me, hel … but, whether you'd call it gut feel, intuition, um, whether it's an, err, um, using your senses in a much more broad way, if you see what I mean. So your … you'll … you might … you might perceive it as a gut feel, so this is the flipping, um, err, you know, ex-nurse in me, you might perceive it as … as a gut feel, but actually it's being triggered by visual, um, clues that other, you know, other member of staff or that the patient is putting, you know, putting out there, that you don't, err, err, you don't, you know, consciously, um, note, but unconsciously you do and it forms a gut feel (P1).*
>
> *I think there's something more. Because to me, God is the more, Jesus Christ is more, you know, through my spiritual… And so, I think the sense in touching, all of the other senses is part of it, so there is an inert spirituality that I feel quite strong. And I know I have felt it whether at work or in other areas which is more conducive to spiritual environment. I'd say I have felt it (P7).*
>
> *You get a gut feeling around something that's either right or wrong. You get a gut feeling about things…. I suppose gut feelings to some people are just gut feelings. Some people have a spiritual barometer telling you whether something is morally right or wrong. So you get a kind of feeling for that definitely. And you got a gut feeling as to whether people are being honest with you and things like that. And sometimes you can learn that through sort of body behaviour and language and stuff, but sometimes it comes down to gut feeling as whether you're in a comfortable place or not (P9).*

It is suggested that intuition is a valued contributor to high quality healthcare, but one that is not necessarily conscious. All three participants recognised the importance of intuition but still scored zero when completing the inventory. It can be seen from their responses to the question in Phase Two, that intuition was important to them, but this was not reflected in their response in Phase One.

5.4.2 High Scores Identified in Respondents to the SQ21.

Skill 2: Awareness of Life Purpose was scored as a 5 by 4 participants (P1, P3, P8 and P9). This skill has been discussed at some length on page 76 but it is interesting to examine how it was articulated by those interviewed.

Participant One linked her value system to her life purpose:

> *So I guess that first value that I described about coming into this world to … and leaving it in a better place, would be the life purpose (P1).*

Participant Three also referred to her vision of being the best that she could be:

> *I think it's basically very, very simple and just try and be the best person that I can be to my family, to my friends, to my work colleagues, to patients and relatives that I interact with, whoever you come into contact with in the course of your life, whether*

> *it's your work life, your outside life, whatever it is. So, I've kept my vision and mission in life very, very basic and simple and just to be the best person I can be (P3).*

Participant Eight maintained that his life purpose was closely aligned to his strong Christian faith:

> *My life purpose? Wow. (chuckles) I believe and it is very much a Christian understanding but I believe in a developing relationship with God and a God who does love, who does want to produce the best that has made us different and given us different capabilities and et cetera, in order for us to have interactive, creative diversity to bring about something which is beautiful within the world (P 8).*

The sense of vocation outlined earlier was discussed explicitly by Participant Nine, who also related it back to her strong faith:

> *So my life purpose is very much around helping others which is why I'm a nurse and started off as a nurse and had continued in some shape or form as a nurse. And it's around…yeah, it's about being here and trying to do what little I can to bring others the spiritual awareness of God and to support others in their time of need, which is where the whole nursey bit comes in. To me, my job and my life is a vocation and I'm not in it for the money - Well definitely not in the NHS, am I? But I'm in it for what I can do in it, if you like.*

Skill 18: Being a Wise and Effective Change Agent was again a key skill identified from Phase One of this study, and is analysed on page 77. Three participants (P2, P4 and P 5) all scored 5 on this skill, and were clear on the impact that this skill had on their practice:

> *I'm passionate and I'm enthusiastic. And if I believe in the change, I absolutely believe in it. And I think my belief and passion and excitement and energy is what encourages other people. And I think by having that energy and engagement and the way that I am in my personality, well I'm very happy to listen to what other people have said. I'm very to mix firmness with humour and encourage others along the way to make suggestions. So I guess, and I'm not fixed or I'm not always fixed in my own ideas (P2).*

> *I've done postgraduate training in change management so I've done a lot of stuff on change... I've experienced change. I've had services closed, I've been made redundant and also changes in personal circumstances so I've done a lot of work around Kubler Ross and death and dying and that sort of thing. So I've got a lot of understanding of change and I've been through it personally and I… It's a forever changing environment in the NHS and if you can't negotiate that then you wouldn't last very long, certainly not as a manager (P4).*

> *I'm taking change agent as in being able to, well, as what it says, being able to change things that you see are not either right or changing things up. I just think people respond well to me, or react well to me. So, when I want something done or need something changed or whatever, they believe that there's a reason behind it and they… and people… I always find people follow well when I… I don't know what they say behind my back, but I believe it's just that being approachable, people… not my way or the highway, being quite adaptable to other ways of thinking as well I think helps me in that kind of respect (P5).*

The role of change agent influences how decisions are made which is also linked to whether it is acceptable to break rules and polarity thinking as discussed on pages 103 and 105.

5.5 Conclusion.

The objectives of the study were to identify which aspects of spiritual intelligence are important to healthcare leaders, identify the factors that influence the awareness of spiritual intelligence in healthcare managers and highlight any skills identified in the SQ 21 Inventory that support or hinder the development of awareness of spirituality and spiritual intelligence.
The most important aspects of spirituality and spiritual intelligence highlighted in both phases of the study were the awareness of life purpose, how this purpose fitted in with a personal values system and the influence that worldview had on the perception and development of spirituality and spiritual intelligence.
The importance of role models in the development of both spirituality and spiritual intelligence was highlighted by participants and is reflected in the literature. (Lerner, et al., 2006)

5.6 Chapter Summary.

This chapter has reported on the interviews undertaken as the second phase of this mixed methods study supporting the development of themes using verbatim quotes from participants.
Themes identified include the traits of spiritual leadership, the difference between religion and spirituality, values, meaningfulness and rule breaking, particularly in the context of decision making.
The next chapter will look at the possible enablers and barriers for raising awareness of spirituality and spiritual intelligence from a broader perspective and will develop the themes identified further.
The relevance and application of these findings to practice and professional development will then be explored in the next chapter. They will be integrated with the results from Phase One. This will be structured around the development of a framework that will provide a roadmap for raising awareness of spiritual intelligence using the emergent themes suggested by the integration of the two phases of the study.

CHAPTER SIX.

6.1 Discussion of Enabling and Limiting Factors.

The previous two chapters have analysed the results from the two phases of the study to help answer the primary research question which is *What are the elements underpinning the awareness of spirituality among healthcare managers in practice using the skills of spiritual intelligence?* These elements can be divided into enabling and limiting factors, although it should be noted that several items can be present in both domains depending if they are viewed positively or negatively. These will be addressed as a third category.
Following the discussion of the enabling and limiting factors, a framework will be proposed that suggests mechanisms for raising awareness of the factors with healthcare practitioners.

6.2 Enabling Factors.

The main enabling factors in recognition of spirituality and spiritual intelligence in this research were the ability to articulate a clear personal value system, identify influences on the development of both personal value systems and spirituality and having a defined life purpose. The importance of love and compassion were also highlighted
An awareness of a particular worldview with a tolerance of the worldview of others was identified Phase One of the study and in the literature but was not reflected in Phase Two.

6.2.1 A Personal Value System.

The importance of value systems was identified by several participants (P2, P4, P5, P7 and P9), particularly when identifying the traits of their nominated spiritual leaders. Valuing and understanding people was seen as key in the development of a positive working relationship, mainly as a response to question 5: What traits or characteristics do you think that they [spiritual leaders] have? The ability to know what motivated fellow workers and treating them with compassion and respect was a constant theme in these five interviews. The most important individual values suggested were honesty and integrity. Both of these values have been highlighted in the literature as being important – Green, et al. (2017, p. 490) surveyed 518 paediatric critical care staff to rate 59 leadership skills, behaviours and attitudes: honesty and integrity was the only item deemed an essential leadership skill by all respondents. The relevance of a personal awareness of one's own values and beliefs was identified as a competency in the domain of self-awareness and use of self in a review of the literature undertaken by Attard, Ross and Weeks (2019).

Linked to value systems is behaviour. The difference between values and goals is that goals are achievable, values are not (Harris, 2012, p. 187). Values serve as motivators for behaviour and are often aligned with goals so the things that are aimed for (goals) are the things that are intrinsically important and provide a greater sense of meaning. Value congruence is the extent to which an individual's behaviour is consistent with the stated value. Where this is not the case, value incongruence occurs and procrastination can often be the result (Pennock, 2015).

Another aspect of value system is where the values come from. They are either conscious or unconscious, owned by the individual or inherited from others and can be viewed as core or aspirational. All these influence behaviour and that behaviour is linked to spiritual intelligence, although this behaviour may not be conscious.

The outward manifestation of values is seen in behaviours. If someone has an espoused value of honesty and then commits fraud, then they are not true to their values. This is particularly important when assessed against attitudes to rule breaking and the impact that this has on how values are demonstrated in practice.

6.2.2 Rule Breaking.

The attitude to breaking rules has already been touched on in Skill 4: Complexity of Thought and Perspective Taking on page 81. This suggests that 'rules are guidelines and sometimes a higher principle requires that I break the rules' (Wigglesworth, 2012, p. 56).

Wallace Stegner (2012) in his book All the Little Live Things suggested that '*It is the beginning of wisdom when you recognise that the best you can do is choose which rules you want to live by'.* Osborn and Morris (2017) went further when they asserted that you should *'Follow the rules that help you and play along just like the rules guy. And, when the rules don't serve your higher purpose, break them*'

In this research, all bar one of the participants (P2) in Phase Two agreed that it was permissible to break rules, but that there were strict boundaries around doing so. These were that the rule breaking had to be conscious and deliberate, and that the consequences of doing so were clearly understood and accepted. This also was linked to values, particularly moral and ethical ones. After all, a burglar when setting out to rob a property does so as a result of a conscious decision and is well aware of the consequences of being caught. The important distinction as far as spiritual intelligence is concerned, is that the values system that allows this behaviour is not one that most members of society subscribe to – It is another example of different worldviews and the impact that these have on behaviour.

There is an important distinction that needs to be made about the difference between treating everybody equally and treating people equitably. Treating everybody the same is not always fair but is dependent on context and circumstance. The perception of fairness and how staff are treated is an important skill in people management which is influenced by spiritual intelligence. Developing an environment which allows for self expression, creativity and individuism are key elements in those demonstaiting higher levels of spiritual intelligence.

6.3 Love and Compassion.

The final emergent theme that the findings from the two phases highlighted was the importance of love and compassion as concepts that underpinned participants' relationships and how they communicated. The two aspects of love that were demonstrated were philia and agate love (See page 38).

6.3.1 Philia.

Participant Two was eloquent when describing her personal experience of end of life care when it involved a personal relationship that exemplifies the philia love of friendship:

> *My friend, my best friend died three, four years ago now. And she said to me when she was dying, "I've got three sets of friends. I've got fair weather friends, bad weather friends and all weather friends." And she said, "You're my only all weather friend." She said, "You are here whatever happens to me." She said, "I've got bad weather friends who will come the minute things are bad. 'Oh my word, I saw the ambulance. Are you okay?'" I've got good weather friends who only come because they want to see when I'm happy but not when she's not because they can't deal with it. And she said I was one of the few people that was there whatever. It didn't matter if I arrived and she said go away, I feel rubbish I'd go away (P2).*

The idea that there are three types of friend – Fair weather, bad weather and all weather friends can be extrapolated into the workplace where all three can be identified in members of staff. As a team leader the knowledge of the relationships that individuals have with each other can use these types as a lens through which their interactions can be viewed and interpreted accordingly.

Participant Eight talked extensively about love both in a client and staff context as one of his core values:

> *For me, it's about being prepared to allow myself to love the staff I work with and I'm not talking about any sort of sexual expression of that or any sort of, oh I don't know, sort of lovey-dovey huggy type, it's about because they matter then if somebody is visibly upset about something, the fact that I work with them and they do matter as people means that overrides within reason (P8).*

He made a clear distinction between eros and agate love and it was agate love that was essential to him in a work context:

> *I use love as a word deliberately from time to time with other members of staff, whether it's the nursing staff, physiotherapists, occupational therapist, you know, it doesn't matter and I do it quite deliberately because I think it's an important part of our work environment to recognise that that element belongs in healthcare and you can't have health without love and you can't have care without love (P8).*

6.3.2 Agate.

The relevance of agate love to Participant Nine was a core dimension to her faith as a Christian:

> *It's about valuing people. It's about seeing the good in people and sharing love with people.` It's very, very easy to criticise and it's not so easy to look for the good and the value in all people. And that's really in terms of the sort of main commandments if you like, of being a Christian is to love the Lord your God with all your heart, with all your mind, with all your soul, and to love each other as yourself (P9).*

This echoes the first commandment:

> *Love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength' (The Bible: Mark 12:30).*

6.3.2.1 Compassion.

Compassion was an overarching theme that was seen as a trait of spiritual leaders and as a value in the literature although not specifically mentioned as one by participants. It is seen as a higher level skill in the SQ 21 Inventory where it comes in the fourth quadrant
In December 2012, the Chief Nurse for England, Cummings and Bennett (2012, p. 13), produced a vision paper on compassion in practice. This emphasised a 6C framework and elements of which are care, communication, compassion, courage, competence and commitment.

> *The values and behaviours covered by the 6Cs are not, in themselves, a new concept. However, putting them together in this way to define a vision is an opportunity to reinforce the enduring values and beliefs that underpin care wherever it takes place. It gives us an easily understood and consistent way to explain our values as professionals and care staff and to hold ourselves to account for the care and services that we provide. Each of these values and behaviours carry equal weight. Not one of the 6Cs is more important than the other five. The 6Cs naturally focus on putting the person being cared for at the heart of the care they are given.*

While there is a clear emphasis on person-centred care, there was a resonance with caring and valuing staff that was evident from the interviews with four of the participants in Phase Two (P4, P6, P8 and P9) who mentioned compassion:

> *But these spiritual leaders that is the consistent message is to have compassion to have empathy, to have a love for your fellow creatures, for your fellow human beings to be concerned about the environment (P6).*
>
> *I think the common thing that I would say is vital is for them to move beyond mere clinical competence through to a desire for compassion, for love, for perhaps being prepared to make oneself vulnerable and recognise that in that vulnerability there is*

> *something that happens in a way that doesn't happen in a straightforward clinical engagement (P8).*
>
> *All these people that I've talked about in terms of spiritual leadership, they all have this same love of humanity and this compassion for humanity, and this want to do the very best for other people that you can possibly do (P9).*

4.1.1.1 Self-Compassion.

Being compassionate to oneself is an essential skill in SQ. If you do not have self-compassion, then it is difficult to have compassion for others. Wigglesworth (2012, p. 111) sums this up perfectly – '*If we cannot forgive our own imperfections and have compassion towards our own mistakes we will not be fully capable of forgiving others. So, the first step in developing this skill is to have compassion for yourself*'.

6.3.3 Meaningfulness.

The concept of meaningfulness is very important in the study of spiritual intelligence. It has been identified as the reason for existence (van Tilburg and Igou, 2011; van Hattem, et al., 2013), the importance of making a difference both personally and in society (Hemingway and Maclagan, 2004; Huguelet, et al., 2016) and in contributing to life purpose as discussed on page 13.

Participant Two, at the end of her interview, asked what my personal definition of meaningfulness was. I responded:

> *Meaningfulness for me is almost a back-door entry into spirituality. Because if you talk about meaningfulness in terms of what people value and how they feel valued and what adds meaning to their life then that then reflects back on spirituality which is for me about the interconnectedness of life and having some higher purpose than just the day-to-day delivery of care or just your day-to-day existence (Researcher).*

Similarly, Participant One asked for an example of meaningfulness. The one I used was:

> *Moving money round the world […] as a banker, doesn't have particularly meaningfulness, whereas the … providing Healthcare, there is an inherent meaning to the work and a purpose in the work, that is implicit in what we do and therefore has an impact on how, um, care is provided I suppose (Researcher).*

She then made a link between meaningfulness and value systems and the impact that they have on meaningfulness and life purpose.

> *A banker, I'm sure they would see their efforts to move money around the world meaningful. Um, the fact that other people don't see that as being meaningful, (laughter). Do you see what I mean, it's different … different value system (P1)?*

This identification of meaningfulness is closely linked to having a purpose in life that is clear and supported by the manager and the environment that the practitioner works in. The necessity for the manager to know their staff is paramount.

6.4 Limiting Factors.

Another significant theme which crossed over several of the questions asked regarded barriers to discussing spirituality. These included lack of knowledge, fear, assumptions and the environment.

6.4.1 Lack of Knowledge.

One barrier to discussing spirituality identified by some participants was a perceived lack of knowledge regarding spirituality, particularly in identifying the difference between spirituality and religion. The SBNR respondents particularly identified that they were uncomfortable discussing spirituality because they felt that they lacked the knowledge required to open a meaningful conversation on the subject. Participant Three identified that:

> *Teaching somebody about spiritualism. I could certainly go away, learn more about the different religions that I've read about and put something together on it, but I suspect that I would learn more from the audience participants and what that then brought up for them (P3).*

When asked about spirituality, she picked up on religion and while she differentiated between the two earlier in the interview this was not reflected when discussing potential barriers.

This barrier to discussing spirituality due to a lack of knowledge is reflected in the literature, although it is more clearly identified in staff/patient and care interventions than in communication between staff (Meredith, et al., 2012; Best, Butow and Olver, 2016; Jones, 2018)

Participant Six, despite self-reporting as spiritual and religious did not tend to discuss spirituality because he had not thought in any depth about doing so. He also felt that confrontation could be a problem if there were conflicting worldviews:

> *I think the biggest barrier is that it's not something that I have spent a lot of time thinking about. And I would not like to find myself in a confrontation with religious people that would see that my spiritual views would conflict with their spiritual views. So I would probably try and avoid it. It's not a topic that I even get into a discussion with (P6).*

Participant Nine was also reticent about exploring spirituality with colleagues. In her case, it was because of a strong Christian background and not wishing to upset others of a different religion. She again highlighted the importance of sharing spirituality rather than religion:

> *But if I'm trying to talk about Christian principles in terms of sharing God's love from a Christian standpoint, I have to be very mindful of the fact that there are other people from other religions in this trust, Muslim, Jewish, et cetera, et cetera. So it's the sensitivity to other people's backgrounds and where they might perceive I'm coming from. So I tend to talk about spiritual things rather than religious things, but I personally am coming from a Christian background (P9).*

A solution to the lack of knowledge is linked to the development and use of appropriate language that allows healthcare staff to be comfortable in discussing spirituality and the impact that it has on their attitudes and behaviour. This research suggests that the language surrounding meaningfulness and life purpose might be a more acceptable starting point for discussions, rather than spirituality.

6.4.2 Environment.

Since all the respondents were reflecting in the main about their workplace, the setting in which discussions occur regarding spirituality reflected the degree of openness and transparency that was appropriate.

Participant One was conscious of the environment and organisational culture which in her opinion precluded the discussion of spirituality. She made clear links between spirituality and the articulation of a value system as outlined above, commenting: For the other participants, there were barriers to discussing spirituality which was broader than just in a teaching context.

> *In the process of that (decision-making) their values around what is important to them and to their services and their staff and their patients, um, play out don't they. And those values may be generated by a … a spiritual kind of belief system for individuals, but it in the culture in the organisation that is not going to be overt (P1).*

She was also very adamant about the negative effects of that type of discussion in her organisation:

> *Giving them, um, an opportunity to discuss how their own spiritual, um, err, experiences or feelings influence their approach to leadership, no. I think I would get slaughtered if I tried to do that (P1).*

She also felt that the environment of the NHS was not conducive to openness and that challenged all employees, but particularly those with a strong faith:

> *Um, no I guess your questions have really made me think about the fact that though, people who do have strong … so I've observed in my years in the NHS, people who do have a strong faith or, you know, a … a … a strong faith or a spiritual element and I've worked with somebody recently who would describe herself as extremely spiritual but not, um … not in any kind of organised religion as such. It's those … I think those people are discriminated against, it is not … it is not … it is that I think that they find it very hard to … to talk about their faith. I think, um, that from whatever … whatever religious background or whether you … whether you have a particular spiritual bent. It is frowned upon about being open about that. Um, and I think that must be incredibly hard for people who have a strong faith, um, err, to work in that kind of environment (P1).*

End of life and palliative care settings tended to be a more conducive environment for discussion of spirituality, particularly with clients. This openness was reflected in the literature, particularly in the definition of spirituality (Puchalski, et al., 2009; Balboni, et al., 2017; Steinhauser, et al., 2017).

It was interesting that despite the research in spirituality in end of life care, which is evident from the literature (Ronaldson, et al., 2012; Gilbert, 2013; Paiva, et al., 2015), none of the interview participants worked specifically in this field, although one (p8) was the manager of bereavement services which has close links with end of life care. Given the open nature of the invitation to participate it was surprising that none of the participants were from that environment.

6.5 Both Enabling and Limiting Factors.

There were two factors that could be viewed positively or negatively depending on the context that they were seen. These were early influences, particularly with regard to upbringing and the influence of role models.

6.5.1 Early Influences.

In the same way that where values come from, spirituality and spiritual intelligence are influenced by upbringing as identified on page 15. Of relevance to participants in this study was the contribution made by their early environment and whether they had had exposure to religion in childhood. All the participants who self-reported as SBNR (P1, P3, P4 and P5) had had a faith-based upbringing that had not lasted past their teenage years. The influence of education and the environment in which participants were brought up was also felt to be important.

> *And also … so I was brought up in that [the Christian tradition], I then, um, in my early 20's, um, became … and so … so I had a break if you like and then … and then, you know I left home and it wasn't an issue. And then I became extremely religious, err, extre … you know, regular attender at church and, yeah whatever. Um, and then lost my faith … So I kind of had two … two, you know, two goes at it, if you like (P1).*
>
> *I grew up in an Anglican church environment but my parents were not particularly religious. I went to church occasionally on Sundays as a child in Brownies, so up to the age of 11 (P3).*
>
> *I was brought up in it as a child within a very religious structure and walked away from it as a young adult and then came back to it (P4).*
>
> *I was brought up Church of England, and then my mum then made the switch to Roman Catholic. And I was an altar boy and all that went with it. Yeah, so I was brought up religious, but I am no longer religious, no (P5).*

This changing attitude to faith on the journey into adulthood was an important factor, particularly in the articulation of values. The value system developed in childhood tended to be influenced by the home environment, parental and peer pressure and more recently social media.

6.5.2 Role Models.

Another strong influence in the development of spirituality and SQ were role models and spiritual leaders that participants had been exposed to, as discussed on page 92. While most role models were felt to be positive, not all were viewed in a positive light. This was particularly true for Participant Two who had had a very negative experience with a vicar whose church she had attended. It is argued that this could be viewed as an example of a person who is religious but not spiritual. It is perhaps all too common for people who attend church once a week for an hour to consider themselves religious but then act in a completely different manner for the rest of the week. This minister's value system was not one that was congruent with Participant Two's value system and the conflict challenged her and her faith. In another individual it could be that the negativity might be sufficient to cause a loss of faith and disillusionment.

While the influence of faith leaders was strong for those participants who had a more faith-based perception of spirituality, other influences came from unexpected sources. Participant Three had travelled extensively and while her spirituality was strong, she had had great guidance from a tour guide with whom she had travelled. This relationship had a profound, positive influence on her life and the way that she behaved.

Fry (2003, p. 700) highlights the importance of role models in the development of charismatic leadership; particularly for the beliefs and values leaders want their followers to adopt. He gives the example of Gandhi as a model for non-violent civil disobedience and another is the behaviour of Mother Theresa in Calcutta (Now Kolkata).

Not all role models are positive. History is littered with dictatorial leaders who are not a positive example of spiritual leadership. While they often had some of the skills associated with spiritual leadership, there was always a flaw that negated their positive attributes. An example of this was Adolf Hitler – A charismatic leader who got things done. He was lacking in personal integrity and was completely intolerant of other worldviews – The Jewish worldview. This led to the Holocaust and murder of over 6 million Jews during the Second World War.

Four research questions were asked during this research. To summarise, the answers to these questions are given in Table 6-1

What are the elements underpinning the awareness of spirituality among healthcare managers in practice using the lens of spiritual intelligence?	Awareness of own worldview and tolerant of the worldview of others. A robust value system that is the basis for behaviour A clear life purpose.
What are the dominant and less dominant skills of spiritual intelligence, as measured using Wigglesworth's (2012) SQ21 inventory?	Dominant – Skill 2: Awareness of Life Purpose. Skill 7: Awareness of Other Worldviews. Skill 18: Being a Wise and Effective Change Agent. Skill 21: Being Aligned with the Ebb and Flow of Life. Less Dominant – Skill 4: Complexity of Thought and Perspective Taking. Skill 12: Demonstrating Commitment to Personal Spiritual Growth. Skill 16: Seeking Guidance from Higher Power/ Higher Self. Skill 17: Being a Wise and Effective Teacher of Spiritual or Universal Principles. Skill 19: Making Compassionate and Wise Decisions. Skill 21: Being Aligned with the Ebb and Flow of Life.
How do managers articulate their beliefs and understanding of spirituality and spiritual intelligence?	Understanding of spirituality and spiritual intelligence was increased as a result of undertaking this study. Awareness of own worldview, the articulation of a clear value system and identification of a clear life purpose were all important factors in the development of understanding.
What are managers' perceptions and understanding of spirituality and spiritual intelligence in their role as a healthcare leader?	The importance of spirituality and spiritual intelligence was highlighted with particular reference to healthcare leadership. It was also identified that these concepts are generic and applicable with both clients, fellow professionals and in other leadership contexts.

Table 6-1: Summary of Responses to the Research Questions

6.6 Chapter Summary.

This chapter has summarised the enablers and barriers to the expression of spirituality and spiritual intelligence. These have been supported by the findings from the two phases of the study and compared with the academic literature.

The next chapter will summarise the findings from the research, highlighting some of the limitations and offer suggestions for future research. The doctoral journey undertaken, along with a comparison of my SQ21 scores will be examined before some concluding thoughts and summation of the thesis.

CHAPTER SEVEN.

7.1 Crystallisation and Reflexivity.

When studying a complex area such as spirituality, the acknowledgement of personal influences on the researcher are important. Ellingson (2009) proposed that using a methodology of crystallisation enhanced the overall view of a piece of writing. This built on Richardson (2000) work looking at feminist perspectives on writing. While Ellingson suggests that it is personally created items such as poetry or music that are important, I contend that it is those personal spiritual influences which add breadth and depth to a subject. It also increases the reflexivity of any research.

The development of a worldview is an essential component of this research, and this development has been strongly influenced by my own personal journey both as a researcher and more generally. The influences on my own spiritual development have positively enhanced my awareness of my maturing worldview, and tolerance of the worldview of others.

Due to my professional background as a nurse and then university lecturer, I have always had an interest in people and their motivation and ‘what makes them tick’.

This has positively contributed to the lens through which the data has been analysed. Throughout I have been aware of my strong personal faith and the potential bias that this might have had on the interpretation of results. This awareness has helped to mitigate against such bias with a faith – neutral stance taken where possible.

To illuminate this journey, several reflections on important areas in my life are offered that have had a personal influence on my spirituality.

7.1.1 Personal Reflection One: My Faith.

As part of my teaching of management and leadership, I have frequently invited students to take part in an 'I am' exercise. This consists of writing down the phrase 'I am' 10 times and then completing each statement. The first five or six are relatively easy to complete, statements seven and eight get harder, and nine and ten begin to identify some fundamental beliefs.

When doing this exercise with a group of students, I asked if they wish to share and one lady volunteered. Her first 'I am' was 'I am a Christian'.

This gave me a real pause for thought because despite having done the exercise many times myself 'I am a Christian' had never been on my list despite having a strong faith and attending church most weeks.

Some of our deepest beliefs are unconscious and need to be uncovered.

7.1.2 Personal Reflection Two: Choral Music.

Music is a vital part of my life. I am a member of two choirs and sing regularly in both church and concert halls. I have sung many times in leading venues, particularly in London, including the Royal Albert Hall, Festival Hall and the Wigmore Hall.

As well as singing classical music, I have also appeared in several musicals, including playing a brothel keeper in Steven Sondheim's A Funny Thing Happened on the Way to the Forum.

Music allows me to lose myself in another world. It requires concentration, commitment and practice.

Some of the times when I have felt most connected with a higher being have been in music.

7.1.3 Personal Reflection Three: Stillness and Calm.

In my music, hymns and religious music are vital. I have chosen two hymns that sum up the calming nature of music and the sense of peace that my faith gives me.

Dear Lord and Father of Mankind

Dear Lord and Father of Mankind,
Forgive our foolish ways;
Reclothe us in our rightful mind;
In purer lives Thy service find,
In deeper reverence, praise,
In deeper reverence, praise.

With that deep hush subduing all
Our words and works that drown
The tender whisper of Thy call,
As noiseless let Thy blessing fall
As fell Thy manna down,
As fell Thy manna down.

Breathe through the heats of our desire
Thy coolness and Thy balm;
Let sense be dumb, let flesh retire;
Speak through the earthquake, wind and fire,
O still small voice of calm,
O still small voice of calm!
Whittier (1872)

O Sabbath rest by Galilee!
O calm of hills above,
Where Jesus knelt to share with Thee
The silence of eternity,
Interpreted by love,
Interpreted by love.

Drop Thy still dews of quietness,
Till all our strivings cease;
Take from our souls the strain and stress,
And let our ordered lives confess
The beauty of Thy peace,
The beauty of Thy peace.

Lord, Make me an Instrument of your Peace

Lord, make me an instrument of your peace;
where there is hatred, let me sow love;
where there is injury, pardon;
where there is doubt, faith;
where there is despair, hope;
where there is darkness, light;
and where there is sadness, joy.

O Divine Master,
grant that I may not so much seek to be consoled as to console;
to be understood, as to understand;
to be loved, as to love;
for it is in giving that we receive,
it is in pardoning that we are pardoned,
and it is in dying that we are born to Eternal Life.
Amen.
(Banks and St Francis of Assisi, 1953)

This prayer has been attributed to St Francis of Assisi but no record of it exists in his collected works or prior to 1912 when it first appeared in Paris France (Renoux, 2014). *A still small voice of calm* in my own life is essential. In this busy world, a sense of inner peace and time for reflection and meditation is often missing and needs to take a more prominent place to allow learning and growth to occur.

7.1.4 Personal Reflection Four: Orchestral Music

As well as choral music, orchestral music is another place where I find peace and tranquillity. The oboe and clarinet have an important role in my spiritual journey, with Albinoni and Mozart being favourites. Indeed, most of this dissertation has been written to a background of Albinoni's oboe concertos.

7.1.5 Personal Reflection Five: Prayer

The role of prayer and meditation is essential to me. The universal Christian pray is the Lord's Prayer which has been translated into hundreds of different languages from the original, which was probably in Aramaic

Abwoon d'bashmaya
Netqaddash shmak
Teete malkutah
Nehvwey tzevyannach aykanna d'bashmaya aph b'arha
Havlan lahma d'sunqananan yaomana
Washbwoqlan haubvayn aykana daph hnan shbvoqan l'hayyabayn

Wela tahlan le'ynesyuna. Ela patzan min bisha
Metul dilakhe malkuta wahayla wateshbuhta l'ahlam almin
Amen

(The Nazarene Way of Essenic Studies, 2012)

The original translated version is taken from the King James Bible, first published in 1611:

Our Father which art in heaven, Hallowed be thy name.
Thy kingdom come, Thy will be done in earth, as it is in heaven.
Give us this day our daily bread.
And forgive us our debts, as we forgive our debtors.
And lead us not into temptation, but deliver us from evil:
For thine is the kingdom, and the power, and the glory, for ever. Amen.

(The KJV Bible, Matthew 6:9-13)

A more modern version was published in 2011 in the New International Version:

Our Father in heaven, hallowed be your name.
Your Kingdom come, your will be done, on earth as in heaven.
Give us today our daily bread.
Forgive us our sins, as we forgive those who sin against us.
Lead us not into temptation, but deliver us from evil.
For the kingdom, the power and the glory are yours.
Now and for ever.Amen.

(The NIV Bible, Matthew 6:9-13)

While using this as a guide for daily living, the Aramaic version is used by me as a musical meditation composed by Indiajiva (2005). This is a recording that I listen to regularly when in need of renewal.

7.1.6 Personal Reflection Six: Photography.

The final influence on my personal spiritual journey is a passion for photography. I was told as a child that I was not creative, because I had no talent for drawing or painting. Many years later, I have come to understand that the ability to draw is a very narrow criteria for defining creativity. In both my music and photography, I have found an expression of my creativity that has enriched my spiritual journey.

7.2 General Conclusions.

This final chapter will describe and justify the research design and methods used in this study, present the research outcomes, propose that the study is at doctoral level and advances knowledge, and opportunities for further research (Trafford, Leshem and Bitzer, 2014). The limitations and challenges of the study will be highlighted, and the chapter ends with a short reflection on the doctoral journey that has been undertaken.

The overarching research question was *What are the elements underpinning the awareness of spirituality among healthcare managers in practice using the skills of spiritual intelligence?* To address this question, a mixed method sequential exploratory study was undertaken. The first phase explored the skills of spiritual intelligence as defined by Wigglesworth (2012). The results of 31 questionnaires suggested that the most developed skills of spiritual intelligence among the respondents were having an awareness of life purpose, being a wise and effective change agent, being aligned with the ebb and flow of life and having an awareness of other worldviews which was discussed on pages 110 - 112.

There was little differentiation between experience levels or age, with the most significant difference being in Skill 4: Complexity of Thought and Perspective Taking. This skill explores attitudes to rule breaking and was more developed in the over 50 age band. A possible reason for this is that with age comes experience and more certainty of which rules can safely be ignored if the situation and the consequences demand it.

The SQ 21 Inventory was developed primarily for use by coaches in a leadership context. It was designed to promote discussion and growth around the areas of spirituality and spiritual intelligence. While it is possible to use the tool in isolation, it is recommended that a comprehensive debrief occurs with a coach who is trained in its administration and assessment. Although I am qualified to administer the SQ 21, no personal or financial gain has been accrued as a result of the tool being used in this research. The use of the tool for research differs from its use as a coaching tool. When used for research, the questions that were used for the interviews were generated and driven by the researcher. When used as a coaching tool, the role of the coach is more as a facilitator with a more interactive dialogue occurring. In both settings, however the key result should be a dialogue that promotes reflection and raises awareness.

The second phase of the study built upon the results of the first stage both in the development of the semi-structured interview questions and in exploring the answers given.

While spiritual intelligence is an important construct, it is not the only 'lens' through which a manager can support and develop their staff. For some, the concept will be alien and unhelpful way to view the world. For others, it will be a breath of fresh air and contextualise their existence and add meaning to life. In the same way, emotional intelligence was viewed with a degree of suspicion 20 years ago but now has moved into the mainstream of management thinking. It has taken these 20 years for emotional intelligence to gain this recognition although as with most constructs, its importance and relevance remains controversial.

This research has demonstrated that some of the principles underpinning spiritual intelligence are essential in good management practice and should be taught from an early stage in any professional development programme, including preregistration education and training. These principles are:

- The exploration of an individual's worldview and their acceptance or otherwise of other people's worldview.
- The articulation of a clear value system that is important and acted upon by the individual.
- A recognition of the importance of meaningfulness and life purpose in the day-to-day activities undertaken, both at home and at work.

While these are important aspects of spiritual intelligence, they are much broader constructs that underpin how society functions and should be explored with everyone in society. The language of spiritual intelligence itself could be perceived as a barrier and inclusivity might be lost in those who are suspicious of any discussion of anything that explores spirituality. Participant One articulated this clearly when she suggested that she was a fraud and felt uncomfortable in even participating in the research.

7.3 Mechanisms to Raise Awareness of Spirituality and Spiritual Intelligence.

It is important to acknowledge the importance of application to practice in a study that was based around the views of practitioners. As an educationalist and practitioner, the identification of a framework that can be used both in a more formal classroom setting as well as in a supervisory capacity was a driving force behind the study. A framework is therefore proposed that takes the main findings of this research and develops some prompts to support their discussion by practitioners:

Stage	Activity	Prompt
One	Articulate the difference between Religion and Spirituality.	*Do you think that there is a difference between Religion and Spirituality? What are the differences?*
Two	Articulate your own Worldview and the impact of another's Worldview on you.	*What is your Worldview and how is it different to those around you?*
Three	Identify significant Spiritual Leaders and their characteristics.	*Who do you admire as a spiritual leader? Why?*
Four	Articulate your own values.	*Rank your top three values in order of importance and say why they are important to you.*
Five	Define what your life purpose is.	*Why do you get up in the mornings? Where do you see yourself in 2- or 5-years' time?*
Six	Develop an action plan.	*What assistance do you need to help you fulfil this action plan? From Whom?*
Seven	Reflect on the process.	*Has your practice been affected by your increased knowledge? How?*

Table 7-1: A Framework to Raise Awareness of Spirituality and Spiritual Intelligence.

During the development of this framework, Ross and McSherry (2018) published a paper that proposed that spiritual care could be enhanced by asking two simple questions.

> *What is most important to you now?*
> *How can I (we) help?*

While this is intended as a tool supports the provision of care, the same two questions can be asked by a manager of their staff or at its most fundamental level, one colleague of another.

The response to these questions will fall into one of the four intelligences that (Wigglesworth, 2012) argues are interconnected and essential for growth – physical, intellectual, emotional and spiritual. The solution and support required will be different depending on the area that needs addressing. Physical health needs might involve a referral to Occupational Health; intellectual needs might be met by the provision of further training and development; emotional needs addressed through discussion of factors including workload, relationships and contact with external stakeholders. I suggest that spiritual needs, if identified at all are often ignored and only dealt with if crisis occurs.

If the spiritual dimension is addressed, it allows compassion and care to be demonstrated, both on a physical as well as an emotional and spiritual level.

Reflection is an important skill that is familiar to most healthcare professionals and is essential in supporting their professional development (NHS Scotland, 2009; Lewinson, McSherry and Kevern, 2015)

It should also be noted that the terms spirituality and spiritual intelligence have been avoided apart from in the identification of the difference between religion and spirituality and in spiritual leadership. This was deliberate as it helps to reduce the barrier that might exist if the concepts are too prominent.

7.4 Contribution to Original Knowledge

This study makes an original contribution to knowledge in three ways. First, the study adds to the academic body of knowledge by using the SQ21 inventory as a primary research tool. The inventory was initially developed and used worldwide by certified leadership coaches as the starting point for a discussion about individuals' spiritual intelligence. This is both its biggest strength and greatest weakness as it was not developed as a research tool. Its development and greatest strength is in the conversations that are had following completion. It is for this reason that it is ideal for use in a mixed method study as the semi-structured interview questions are partly based on the results from the SQ21 inventory. It has not been used in a doctoral study before which makes this study unique. Other studies use the skills identified in the SQ21 e.g. Kheswa (2016) but this is the only study that has had participants completing the questionnaire.

Second, the development of a framework to raise awareness of spirituality and spiritual intelligence within any practice setting among healthcare managers has not been proposed before and this will influence practice development.

Third, the outcomes of the dissertation link firmly back to the development of staff. The focus of the thesis is on individual development, and the results have a bearing on the identification of practitioners' worldview, tolerance of other worldviews and the development of focused core values. Early discussion and development of core values is beneficial to healthcare staff to aid decision making, inspire, focus and assist in clarifying the purpose of the group or individual (Sauter, 2016). Finally, this study makes a modest but significant contribution to academic scholarship by developing a practice framework which explores the nature of spiritual intelligence and its influence on staff development

7.5 Limitations of the Study.

In any research, there are limitations that arise both with the conceptual framework and the research process itself. Murray and Beglar (2009) assert that no study is perfect and intellectual honesty requires pointing out areas where the study could be improved. In this study, the following limitations have been identified:

The response rate to Phase One was disappointingly small and therefore the results need to be treated with caution as the number of respondents makes any firm conclusions indicative rather than certain. Initial plans to use the Institute of Healthcare Management fellows and members did not achieve a satisfactory response rate and ethical approval had to be reapplied for to allow the study to progress.

The SQ 21 Inventory is a commercial product which is not accessible without payment. I was privileged to be given access for this study but the availability for future research would need to be negotiated separately.

The interviewees became self-selected due to the low numbers of participants in Phase One and all those who had expressed an interest and were available for interview were selected. The group of healthcare managers interviewed in Phase Two were quite homogenous and experienced. A greater range of experience would have been beneficial to gain an added breadth of discussion and meaning making in the IPA context.

As a single researcher, with an acknowledged and strong faith, the risk of bias is always present. This has always been at the forefront of my mind when analysing the findings and particularly in coding the interviews. Research bias was avoided by discussion of the findings with the supervisory team and constant awareness of the risks involved.

Although experienced in the interview process, my personal style is interactive and conversational. This was a limitation, particularly in the early interviews in that there was a tendency for discussion during these interviews. This was recognised early, and subsequent interviews were less discursive, and thus the participants voice more clearly heard.

7.6 Recommendations for Future Research.

There are several different avenues for further research, including:

- Administering the SQ 21 Inventory to different professional groups within healthcare, particularly nurses, since they are fundamental in the administration of spiritual care;
- Using the framework with a variety of different professional groups and practitioners with varied experience of healthcare;
- A longitudinal study with pre and post-questionnaires following the use of framework with practitioners;
- Repeated interviews with different professional groups.

There are a range of different approaches that can be used to support future research. They can be identified by replicating the two phases of the study with different professional groups as well as isolating the two phases to explore if there is robust reliability for the research.

7.7 Reflection on the Personal Journey.

Despite my strong personal faith, I had no interest in academic spirituality until co-teaching on a module with another senior lecturer who had developed the Global Fitness Framework with another colleague (Rayment and Smith, 2007). In discussion, Rayment asserted that everything in the world could be assigned to be either physical, mental or spiritual. If an idea or exercise could not be deemed to be physical or mental it must be spiritual. I felt this was a generalisation that needed further exploration and introduced me to the academic study of spirituality.

During this introduction to the academic study of spirituality, I discovered a sub – section of spiritual intelligence. Given my background in academic development, the idea that spirituality and spiritual intelligence could be measured and potentially enhanced through education was significant.

My interest was further strengthened when I joined the British Association for the Study of Spirituality (BASS). I have attended three conferences, the first in 2012 and then in 2016 and 2018. Following a breakfast conversation with Peter Gilbert at the 2012 conference, he invited me to contribute a chapter on spirituality in leadership in palliative care settings for a book that he was editing (Hayward, 2013). This process of writing the chapter consolidated my desire to explore spirituality and spiritual intelligence in greater detail and was another motivating factor in the choice of topic for this PhD.

Exposure to a group of like-minded individuals was also a factor in the development of this thesis. I was fortunate enough to present interim results at both the conferences in 2016 and 2018. This gave me feedback and encouragement to continue to research and develop my ideas further.

This investigation of spiritual intelligence led me to the work of Cindy Wigglesworth (2012) who had developed the SQ 21 with the intention of raising awareness of spiritual intelligence in the same way that Goleman, Boyatzis and McKee (2004) had done with emotional intelligence 10 years before.

I first undertook the SQ 21 Inventory in August 2012, the results of which are shown in Table 7-2. Following further discussions and exploration of the literature, Wigglesworth offered me the opportunity to use the SQ 21 Inventory as a part of a PhD study. To use the tool successfully, I needed to be aware of the four quadrants and the 21 skills in more detail.

I attended a certification workshop in November 2012, working alongside three other coaches in order to develop a greater understanding of the tool and its application. I subsequently applied for ethical approval from the University and commenced this study. After administering the SQ 21 Inventory for Phase One, I then retook the inventory in February 2017.

Successful completion of the certification class enabled me to access the SQ 21 Inventory for Phase One of the study, but there was another unintended positive consequence of becoming a certified practitioner. I gained access to a community of practice of fellow coaches all of whom had an interest in spirituality and spiritual development. I have attended coaches conferences in San Francisco, Houston, London and Amsterdam were again I have presented interim results from this study. There was also the opportunity to discuss the development of the research and these conversations were key in the development and the direction of travel.

On a personal level, I have undertaken the Inventory twice as outlined above. The scores were very different and analysis of the changes in the scores will now be undertaken.

7.8 Analysis of my SQ 21 Scores.

My personal SQ 21 scores were as follows:

SQ21 Skill	August 2012	February 2017	Difference
Skill 1: Awareness of Own Worldview	3	5	2
Skill 2: Awareness of Life Purpose	4	5	1
Skill 3: Awareness of Values Hierarchy	3	5	2
Skill 4: Complexity of Thought & Perspective Taking	0	5	5
Skill 5: Awareness of ego self & Higher Self	2	5	3
Skill 6: Aware of the Interconnectedness of All Life	3	5	2
Skill 7: Awareness of Other Worldviews	3	5	2
Skill 8: Breadth of Time Perception	3	4	1
Skill 9: Awareness of Limits & Power of Human Perception	4	5	1
Skill 10: Awareness of Spiritual Laws / Universal Principles	4	4	0
Skill 11: Experience of Transcendent Oneness	4	4	0
Skill 12: Demonstrating Commitment to Personal Spiritual Growth	2	5	3
Skill 13: Keeping Higher Self/Spirit in Charge	3	2	-1

SQ21 Skill	August 2012	February 2017	Difference
Skill 14: Living your Purpose and Values with Compassion and Wisdom	2	4	2
Skill 15: Sustaining Faith During Difficult Times	3	5	2
Skill 16: Seeking Guidance from Higher Power/ Higher Self	4	5	1
Skill 17: Being a Wise and Effective Teacher of Spiritual or Universal Principles	4	5	1
Skill 18: Being a Wise and Effective Change Agent	4	2	-2
Skill 19: Making Compassionate and Wise Decisions	1	0	-1
Skill 20: Being a Calming and Healing Presence	3	4	1
Skill 21: Being Aligned with the Ebb and Flow of Life	4	4	0
Mean SQ21 Score	**3**	**4.14**	

Table 7-2: SQ21 Scores from 2012 and 2017.

When undertaking the SQ 21 Inventory in August 2012, I did not score a single 5, with 7 scores of 4 and 1 score of 0. By February 2017, I scored 12 scores of 5 and 1 score of 0, although that had changed from a 0 on Skill 4: Complexity of Thought & Perspective Taking to a 0 on Skill 19: Making Compassionate and Wise Decisions. The first quadrant skills of self-awareness were all scored at 5.

Of the 21 skills, my scores increased in 15 skills, decreased in 3 skills and remained the same in 3 skills. My mean score increased from 3 in 2012 to 4.14 in 2017. I do not believe that my personal spiritual intelligence had increased that greatly in the intervening five years. The difference in scores can be attributed to increased familiarity with tool rather than any particularly significant increase in spiritual intelligence.

The skills that scored lower on the two assessments were Skill 13: Keeping Higher Self/Spirit in Charge (2012 score 3, 2017 score 3), Skill 18: Being a Wise and Effective Change Agent (2012 score 4, 2017 score 2) and Skill 19: Making Compassionate and Wise Decisions (2012 score 1, 2017 score 0). Of those that increased, the most significant change was in Skill 4: Complexity of Thought & Perspective Taking where the score of 0 increased to 5. These skills will now be explored in more detail to identify what elements had changed to influence the change in score.

Skill 13: Keeping Higher Self/Spirit in Charge concerns the motivation for actions. These motivations can be fear or anger when the Ego self is dominant to love and forgiveness when the Higher Self is in charge. A possible reason for the reduction in score is that self-forgiveness is an important attribute prior to forgiving others. Forgiveness is a gift you give yourself – it is a letting go of clinging to the past and an affirmation that you can move on. Being at peace with oneself is a higher-level skill and fundamental to keeping the Higher Self in charge.

Skill 18: Being a Wise and Effective Change Agent score decreased from 4 to 2. A score of 2 is generated by answering ‘often’ or ‘consistently’ to the statement that the primary focus on addressing a problem is the problem itself and not the underlying causes. This is an example of the care that needs to be taken when undertaking a self-evaluation questionnaire as the score of 4 is possibly more accurate. This highlights the need for careful interpretation of the results and the power of dialogue that is an essential part of the SQ 21 Inventory.

The final skill that showed a decrease, and the only score of 0 was Making Compassionate and Wise Decisions. This highlighted the role that self-compassion has in the development of spiritual intelligence. If you cannot be compassionate towards yourself, it is very difficult to be compassionate towards others. This is an aspect of my life that has been challenging throughout and being more tolerant of my own imperfections is a long and difficult journey. To develop my spiritual intelligence further, I must be more forgiving of myself and tolerant of the mistakes that I have made.

The skill which changed the most was Skill 4: Complexity of Thought & Perspective Taking. This was the skill which increased from 0 to 5 over the period and was one that gave me great pause for thought.

The reason for the initial 0 was that I said that it was never acceptable to break rules. My personal philosophy has always been that rules should never be broken – they should be changed and rewritten rather than broken. There is an assumption that you can rewrite rules which may not be the case. An example of this is the non-violent protest of Mahatma Gandhi in India prior to the end of British rule in 1948.

When reflecting on my own practice in academia, I discovered that whilst I never wittingly broke rules, I used to bend them so that they were meaningless. When writing validation documents, my favourite word when writing regulations was ‘normally’. Students will normally have three A-levels prior to commencing the course. The use of ‘normally’ in this context means that the rule can be ignored without it being broken.

The discussion around rule breaking opened my eyes to my own practice and made me more honest in my motivations.

7.9 Conclusion.

The importance of spirituality and spiritual intelligence is summed up by Participant Nine when she said:

> *I mean, to me, spirituality is what we mentioned earlier; it's not a label, it's not a religion, it's a personal connection with God. And for me God is the God of the Christians. But that's not important in terms of other people if they connect with a different perception of God. To me, as long as people connect with something somewhere and feel that sense of peace, that's huge and that's really important (P9).*

Spiritual intelligence is an important tool in a portfolio of management techniques available to managers. As with any tool, careful consideration as to the effectiveness, appropriateness and usefulness of this tool needs to be assessed on an individual basis. In the same way that a hammer is an inappropriate tool for removing a screw, the discussion of spiritual intelligence and using it as a framework in the practice environment may not be appropriate. This research demonstrates that there are three factors which underpin spiritual intelligence. These are the identification of a personal worldview and tolerance of the worldview of others, the articulation and behaviours consistent with a developed personal value system and identification of a meaning and purpose in life. These are important in the development of spirituality and spiritual intelligence and have an influence that is wider than just the lens of spirituality. These behaviours should be addressed early in any course leading to professional registration and revisited frequently as the participant develops in their chosen career.

When I first started on this doctoral journey, I assumed that my research would examine the relationship of spirituality to leadership. Very quickly I realised that a leadership focus was too narrow. My definition of leadership is the creation of an environment in which excellence can flourish and is appropriately rewarded. Spirituality and spiritual intelligence play a significant part in the creation of this environment, but they are not the only thing that should be considered. Awareness and tolerance of worldview, a strong personal value system that influences behaviour and a clearly articulated life purpose are all precursors to the development of an environment where excellence can flourish.

The evolution of a framework that supports the development of a constructive environment was a natural process that grew from the results of the two phases of the study.

Spirituality and spiritual intelligence, when used in the correct context are useful tools for any manager, but particularly healthcare managers. If the member of staff involved has difficulty with the language surrounding spirituality, similar results can be obtained by the discussion of worldview, values and life purpose without ever mentioning spirituality.

A BLESSING.

Prayer of Blessing	***Gweddi o Fendith***
God's blessing on our community	Bendith Duw ar ein cymuned
God's blessing on our families	Bendith Duw ar ein teuluoedd
God's blessing on our children	Bendith Duw ar ein plant
God's blessing on those who live alone	Bendith Duw ar y rhai hynny sy'n byw wrth eu hunain
God's blessing on the schools	Bendith Duw ar ein hysgolion
God's blessing on the businesses	Bendith Duw ar ein busnesau
God's blessing on the land and those who work it	Bendith Duw ar ein tir a'r rhai hynny sy'n gweithio arni
God's blessing on the weak	Bendith Duw ar y rhai gwan
God's blessing on the strong	Bendith Duw ar y rhai cryf
The blessing of the Father who loves us	Bendith y Tad sy'n ein caru ni
The blessing of the Son who died for us	Bendith y Mab a fu farw drosom ni
The blessing of the Spirit who comforts and leads us	Bendith yr Ysbryd sy'n ein cysuro ac yn ein harwain ni
The blessing of the One God be on our community	Bendith yr Unig Wir Dduw ar ein cymuned
This day and always.	Heddiw ac ar hyd yr amser
Amen	Amen

REFERENCES.

Ai, A. L., Tice, T. N., Peterson, C. and Huang, B., 2005. Prayers, Spiritual Support, and Positive Attitudes in Coping with the September 11 National Crisis. *Journal of Personality,* 73(3), pp. 763–791. http://dx.doi.org/10.1111/j.1467-6494.2005.00328.x.

Allan, B. A., 2017. Task Significance and Meaningful Work. A Longitudinal Study. *Journal of Vocational Behavior,* 102, pp. 174–182. http://dx.doi.org/10.1016/j.jvb.2017.07.011.

Allmark, P., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A. and Tod, A. M., 2009. Ethical Issues in the Use of In-Depth Interviews. Literature Review and Discussion. *Research Ethics,* 5(2), pp. 48–54. http://dx.doi.org/10.1177/174701610900500203.

Ammerman, N. T., 2013. Spiritual but Not Religious? Beyond Binary Choices in the Study of Religion. *Journal for the Scientific Study of Religion,* 52(2).

Amram, Y. and Dryer, C., 2008. The Integrated Spiritual Intelligence Scale (ISIS). Development and Preliminary Validation. In: 116 Annual Conference of the American Psychological Association, ed. 2008. Boston.

Anandarajah, G. and Hight, E., 2001. Spirituality and Medical Practice. Using the HOPE Questions as a Practical Tool for Spiritual Assessment. *American Family Physician,* 63(1), p. 81–81.

Andrew, S. and Halcomb, E. J., 2007. Mixed Methods Research is an Effective Method of Inquiry for Community Health Research. *Contemporary Nurse,* 23(2), pp. 145–153. http://dx.doi.org/10.5172/conu.2006.23.2.145.

Antonakis, J., 2017. Emotional Intelligence. The Hype, the Hope, the Evidence. In: C. Price, and E. Walle, eds. 2017. *Emotion Researcher. ISRE's Sourcebook for Research on Emotion and Affect*.

Antwi, S. K. and Hamza, K., 2015. Qualitative and Quantitative Research Paradigms in Business Research. A Philosophical Reflection. *European Journal of Business and Management,* 7(3), pp. 217–225.

Appelo, J., 2011. *Management 3.0. Leading Agile Developers, Developing Agile Leaders.* Upper Saddle River, NJ: Addison-Wesley.

Appelo, J., 2014. *# Workout. Games, Tools and Practices to Engage People, Improve Work, and Delight Clients.* Rotterdam: Happy Melly Express.

Attard, J., Ross, L. and Weeks, K. W., 2019. Developing a Spiritual Care Competency Framework for Pre-Registration Nurses and Midwives. *Nurse Education in Practice,* 40, p. 102604–102604. http://dx.doi.org/10.1016/j.nepr.2019.07.010.

Bachmann, B., 2017. *Ethical Leadership in Organizations.* Cham: Springer International Publishing.

Balboni, T. A., Fitchett, G., Handzo, G., Johnson, K. S., Koenig, H. G., Pargament, K. I., Puchalski, C. M., Sinclair, S., Taylor, E. J. and Steinhauser, K. E., 2017. State of the Science of Spirituality and Palliative Care Research PART II. Screening, Assessment, and Interventions. *Journal of Pain and Symptom Management.* http://dx.doi.org/10.1016/j.jpainsymman.2017.07.029.

Baldacchino, D., 2015. Spiritual Care Education of Health Care Professionals. *Religions,* 6(2), pp. 594–613. http://dx.doi.org/10.3390/rel6020594.

Balk, D. E., 1999. Bereavement and Spiritual Change. *Death Studies,* 23(6), pp. 485–493. http://dx.doi.org/10.1080/074811899200849.

Bandura, A., 1977. *Social Learning Theory.* New York, NY: General Learning Press.

Banks, H. and St Francis of Assisi, 1953. A Prayer of St. Francis. *The Annals of Iowa,* 31(8), p. 611–611. http://dx.doi.org/10.17077/0003-4827.7297.

Barber, C., 2012. Spirituality and Religion. A Brief Definition. *British Journal of Healthcare Assistants,* 6(8), pp. 378–381. http://dx.doi.org/10.12968/bjha.2012.6.8.378.

Baumeister, R. F. and Vohs, K. D., 2002. The Pursuit of Meaningfulness in Life. In: S. J. Lopez, and C. R. Snyder, eds. 2002. *Handbook of Positive Psychology.* Oxford: Oxford University Press, pp. 608–618.

Belwalkar, S. and Vohra, V., 2016. Workplace Spirituality, Job Satisfaction and Organizational Citizenship Behaviors. A Theoretical Model. *International Journal of Business and Management,* 11(8), p. 256–256. http://dx.doi.org/10.5539/ijbm.v11n8p256.

Bender, C., 2010. *The New Metaphysicals. Spirituality and the American Religious Imagination.* Chicago: University of Chicago Press.

Benito, E., Oliver, A., Galiana, L., Barreto, P., Pascual, A., Gomis, C. and Barbero, J., 2014. Development and Validation of a New Tool for the Assessment and Spiritual Care of Palliative Care Patients. *Journal of Pain and Symptom Management,* 47(6), pp. 1008–1018. http://dx.doi.org/10.1016/j.jpainsymman.2013.06.018.

Benner, P. E., 1984. *From Novice to Expert. Excellence and Power in Clinical Nursing Practice.* Menlo Park, California: Addison-Wesley.

Berg, G. E., 1994. The Use of the Computer as a Tool for Assessment and Research in Pastoral Care. *Journal of Health Care Chaplaincy,* 6(1), pp. 11–25. http://dx.doi.org/10.1300/J080v06n01_03.

Berg, G. E., 1998. A Statement on Clinical Assessment for Pastoral Care. *Chaplaincy Today,* 14(2), pp. 42–50. http://dx.doi.org/10.1080/10999183.1998.10767095.

Berg, G. E., 2011. The Relationship Between Spiritual Distress, PTSD and Depression in Vietnam Combat Veterans. *The Journal of Pastoral Care & Counseling,* 65(1), pp. 1–11. http://dx.doi.org/10.1177/154230501106500106.

Berry, L., 2014. *Everyone's the Same*. [online]. Available at: <https://www.bmsworldmission.org/product/everyones-the-same-by-lucy-berry-syrias-forgotten-families/> [Accessed 9 June 2016].

Best, M., Butow, P. and Olver, I., 2016. Why do We Find It so Hard to Discuss Spirituality? A Qualitative Exploration of Attitudinal Barriers. *Journal of Clinical Medicine,* 5(9). http://dx.doi.org/10.3390/jcm5090077.

Bester, A. and Muller, J. C., 2017. Religion. An Obstacle to Workplace Spirituality and Employee Wellness? *Verbum et Ecclesia,* 38(1). http://dx.doi.org/10.4102/ve.v38i1.1779.

Betts, C. E. and Smith-Betts, A. F. J., 2009. Scientism and the Medicalization of Existential Distress. A Reply to John Paley. *Nursing Philosophy,* 10(2), pp. 137–141. http://dx.doi.org/10.1111/j.1466-769X.2008.00382.x.

Bhugra, D. and Ventriglio, A., 2017. Mind and Body. Physical Health Needs of Individuals with Mental Illness in the 21st Century. *World Psychiatry,* 16(1), pp. 47–48. http://dx.doi.org/10.1002/wps.20381.

Biali, S., 2013. *6 Keys to Finding Your Purpose. Solve the Mystery of What you're Meant to do with Your Life*. [online]. Available at: <https://www.psychologytoday.com/blog/prescriptions-life/201211/6-keys-finding-your-purpose> [Accessed 10 June 2017].

Biney, M., 2018. Spirituality from the Margins. West African Spirituality and Aesthetics. In: H. Salazar, and R. Nicholls, eds. 2018. *The Philosophy of Spirituality. Analytic, Continental, and Multicultural Approaches to a New Field of Philosophy.* Leiden, Boston: Brill-Rodopi, pp. 122–142.

Black, D., 2014. *Characteristics and Qualities of a Great Leader. A Quote Book Filled with Truth and Wisdom. [e-book].* <http://danblackonleadership.com/> [Accessed 15 May 2017].

Bloom, W., 2018. A New Vocational Qualification in Spirituality and Health. *Journal for the Study of Spirituality,* 8(1), pp. 91–96. http://dx.doi.org/10.1080/20440243.2018.1431364.

Bloomberg, L. and Volpe, M., 2008. *Completing Qualitative Research. A Roadmap from Beginning to End.* Thousand Oaks CA: Thousand Oaks: Sage Publications.

Borneman, T., 2011. Assessment of Spirituality in Older Adults. FICA Spiritual History Tool. *The Hartford Institute for Geriatric Nursing,, (*SP5).

Boyatzis, R., Goleman, D. and Rhee, K., 2000. Clustering Competence in Emotional Intelligence. Insights from the Emotional Competence Inventory (ECI). In: R. Bar-On, and J. Parker, eds. 2000. *The Handbook of Emotional Intelligence. Theory, Development, Assessment, and Application at Home, School, and in the Workplace.* San Francisco: Jossey-Bass, pp. 343–362.

Boyce-Tillman, J., 2010. Even the Stones Cry Out. Music, Theology and the Earth. In: L. Isherwood, and E. Bellchambers, eds. 2010. *Through Us, With Us, In Us. Relational Theologies in the Twenty-First Century.* London: SCM Press, pp. 153–178.

Boyce-Tillman, J., 2014. Music and Well-being. *Journal for Transdisciplinary Research in Southern Africa,,* 10(2).

Boyce-Tillman, J., 2016. *Experiencing Music - Restoring the Spiritual. Music as Well-Being.* New York NY: Peter Lang.

Braun, V. and Clarke, V., 2006. Using Thematic Analysis in Psychology. *Qualitative Research in Psychology,* 3(2), pp. 77–101. http://dx.doi.org/10.1191/1478088706qp063oa.

Braun, V. and Clarke, V., 2013. *Successful Qualitative Research. A Practical Guide for Beginners.* Los Angeles: Sage.

Brémault-Phillips, S., Olson, J., Brett-MacLean, P., Oneschuk, D., Sinclair, S., Magnus, R., Weis, J., Abbasi, M., Parmar, J. and Puchalski, C., 2015. Integrating Spirituality as a Key

Component of Patient Care. *Religions,* 6(2), pp. 476–498. http://dx.doi.org/10.3390/rel6020476.

Bremer, M., 2018. *Developing a Positive Culture Where People and Performance Thrive.* New York: Motivational Press, Incorporated.

Bright, J., Margetts, H., Hale, S. and Yasseri, T., 2014. *The Use of Social Media for Research and Analysis. A Feasibility Study.* Leeds. <https://webarchive.nationalarchives.gov.uk/20160117051406/https://www.gov.uk/government/publications/use-of-social-media-for-research-and-analysis> [Accessed 21/06/17].

Brown, M. E. and Treviño, L. K., 2014. Do Role Models Matter? An Investigation of Role Modeling as an Antecedent of Perceived Ethical Leadership. *Journal of Business Ethics,* 122(4), pp. 587–598. http://dx.doi.org/10.1007/s10551-013-1769-0.

Bryman, A., 2008. Of Methods and Methodology. *Qualitative Research in Organizations and Management: An International Journal,* 3(2), pp. 159–168. http://dx.doi.org/10.1108/17465640810900568.

Bryman, A., 2016. *Social Research Methods.* Oxford, UK: Oxford University Press.

Bultz, B. D., Groff, S. L., Fitch, M., Blais, M. C., Howes, J., Levy, K. and Mayer, C., 2011. Implementing Screening for Distress, the 6th Vital Sign. a Canadian Strategy for Changing Practice. *Psycho-oncology,* 20(5), pp. 463–469. http://dx.doi.org/10.1002/pon.1932.

Burke Johnson, R. and Onwuegbuzie, A. J., 2004. Mixed Methods Research. A Research Paradigm Whose Time Has Come. *Educational Researcher,* 33(7), pp. 14–26. http://dx.doi.org/10.3102/0013189X033007014.

Burke Johnson, R., Onwuegbuzie, A. J. and Turner, L. A., 2007. Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research,* 1(2), pp. 112–133. http://dx.doi.org/10.1177/1558689806298224.

Büssing, A., Balzat, H. J. and Heusser, P., 2010. Spiritual Needs of Patients with Chronic Pain Diseases and Cancer. Validation of the Spiritual Needs Questionnaire. *European Journal of Medical Research,* 15(6), p. 266–266. http://dx.doi.org/10.1186/2047-783X-15-6-266.

Buzan, T., 2006. *Mind Mapping:* Pearson Education.

Calik, B. and Birgili, B., 2013. Multiple Intelligence Theory for Gifted Education. Criticisms and Implications. *Journal for the Education of the Young Scientist and Giftedness,* 1(2), pp. 1–12. <http://files.eric.ed.gov/fulltext/ED557779.pdf> [Accessed 22 February 2019].

Cameron, K. S. and Quinn, R. E., 2011. *Diagnosing and Changing Organizational Culture Based on the Competing Values Framework.* San Francisco, CA: Jossey-Bass.

Campbell, L., Loving, T. J. and Lebel, E. P., 2014. Enhancing Transparency of the Research Process to Increase Accuracy of Findings. A Guide for Relationship Researchers. *Personal Relationships,* 21(4), pp. 531–545. http://dx.doi.org/10.1111/pere.12053.

Carrette, J. R. and King, R., 2005. *Selling Spirituality. The Silent Takeover of Religion. [e-book]:* Routledge. <https://books.google.co.uk/books?id=mPd7BI5NvCoC>.

Cashwell, C. S., Glosoff, H. L. and Hammond, C., 2010. Spiritual Bypass. A Preliminary Investigation. *Counseling and Values,* 54(2), pp. 162–174. http://dx.doi.org/10.1002/j.2161-007X.2010.tb00014.x.

Chaves, M., 2011. *American Religion. Contemporary Trends.* Princeton, NJ: Princeton University Press.

Chochinov, H. M., 2007. Dignity and the Essence of Medicine. The A, B, C, and D of Dignity Conserving Care. *BMJ,* 335(7612), pp. 184–187. http://dx.doi.org/10.1136/bmj.39244.650926.47.

Chopra, S., 2002. *Know your Spritual Quotient*. [online]. Available at: <https://www.lifepositive.com/know-your-spritual-quotient/> [Accessed 17 July 2017].

Clarke, J., 2009. A Critical View of how Nursing has Defined Spirituality. *Journal of Clinical Nursing,* 18(12), pp. 1666–1673. http://dx.doi.org/10.1111/j.1365-2702.2008.02707.x.

Cockell, N. and McSherry, W., 2012. Spiritual care in Nursing. An Overview of Published International Research. *Journal of Nursing Management,* 20(8), pp. 958–969. http://dx.doi.org/10.1111/j.1365-2834.2012.01450.x.

Collins, J. and Porras, J. I., 2005. *Built to Last. Successful Habits of Visionary Companies.* London: Random House Business.

Colyer, H. M., 2004. The Construction and Development of Health Professions. Where Will it End? *Journal of Advanced Nursing,* 48(4), pp. 406–412. http://dx.doi.org/10.1111/j.1365-2648.2004.03209.x.

Copeland, M. K., 2014. The Emerging Significance of Values Based Leadership. A Literature Review. *International Journal of Leadership Studies,* 8(2), pp. 105–135.

Coyle, J., 2002. Spirituality and Health. Towards a Framework for Exploring the Relationship Between Spirituality and Health. *Journal of Advanced Nursing,* 37(6), pp. 589–597. http://dx.doi.org/10.1046/j.1365-2648.2002.02133.x.

Cranney, S., 2013. Do People Who Believe in God Report More Meaning in Their Lives? The Existential Effects of Belief. *Journal for the Scientific Study of Religion,* 52(3), pp. 638–646. http://dx.doi.org/10.1111/jssr.12046.

Creswell, J. W. and Plano Clark, V. L., eds., 2011. *Designing and Conducting Mixed Methods Research.* 3rd ed. Los Angeles: SAGE Publications.

Creswell, J. W., 2013. *Research Design. Qualitative, Quantitative, and Mixed Methods Approaches.* 4th ed.: Sage.

Creswell, J. W., Plano Clark, V. L., Gutmann, L. and Hanson, W., 2010. Advanced Mixed Methods Research Designs. In: A. Tashakkori, and C. Teddlie, eds. 2010. *Sage Handbook of Mixed Methods in Social and Behavioral Research.* 2nd ed. Thousand Oaks, CA: Sage.

Culliford, L., 2018. *Seeking Wisdom. A Spiritual Manifesto.* Buckingham: University of Buckingham Press.

Cummings, J. and Bennett, V., 2012. *Compassion in Practice. Nursing, Midwifery and Care Staff: Our Vision and Strategy.* London. <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> [Accessed 23 September 2019].

Daaleman, T. P. and Frey, B. B., 2004. The Spirituality Index of Well-Being. A New Instrument for Health-Related Quality-of-Life Research. *The Annals of Family Medicine,* 2(5), pp. 499–503. http://dx.doi.org/10.1370/afm.89.

Daaleman, T. P., Frey, B. B., Wallace, D. and Studenski, S. A., 2002. Spirituality Index of Well-Being Scale. Development and Testing of a New Measure. *The Journal of Family Practice,* 51(11), p. 952–952.

Dalai Lama XIV (Bstan-'dzin-rgya-mtsho), 1999. *Ethics for the New Millennium.* New York: Riverhead Books.

Daniel, L., 2013. *When "Spiritual but Not Religious" is not Enough. Seeing God in Surprising Places, Even the Church.* London: Jericho Books.

Davis, K., Christodoulou, J., Seider, S. and Gardner, H., 2011. The Theory of Multiple Intelligences. In: R. J. Sternberg, and S. Kaufman, eds. 2011. *Cambridge Handbook of Intelligence.* Cambridge: Cambridge University Press, pp. 485–503.

Deakin, H. and Wakefield, K., 2013. Skype Interviewing. Reflections of Two PhD Researchers. *Qualitative Research,* 14(5), pp. 603–616. http://dx.doi.org/10.1177/1468794113488126.

del Carmen, M. G. and Joffe, S., 2005. Informed Consent for Medical Treatment and Research. A Review. *The Oncologist,* 10(8), pp. 636–641. http://dx.doi.org/10.1634/theoncologist.10-8-636.

Delaney, C., 2005. The Spirituality Scale. Development and Psychometric Testing of a Holistic Instrument to Assess the Human Spiritual Dimension. *Journal of Holistic Nursing,* 23(2), 145-67; discussion 168-71. http://dx.doi.org/10.1177/0898010105276180.

Denison, D. R., 1996. What is the Difference between Organizational Culture and Organizational Climate? A Native's Point of View on a Decade of Paradigm Wars. *The Academy of Management Review,* 21(3), p. 619–619. http://dx.doi.org/10.2307/258997.

Dennett, D. C., 2007. *Breaking the Spell. Religion as a Natural Phenomenon.* London: Penguin Books.

Denscombe, M., 2008. Communities of Practice. *Journal of Mixed Methods Research,* 2(3), pp. 270–283. http://dx.doi.org/10.1177/1558689808316807.

Dent, E. B., Higgins, M. E. and Wharff, D. M., 2005. Spirituality and Leadership. An Empirical Review of Definitions, Distinctions, and Embedded Assumptions. *The Leadership Quarterly,* 16(5), pp. 625–653. http://dx.doi.org/10.1016/j.leaqua.2005.07.002.

Denzin, N. K. and Lincoln, Y. S., eds., 1994. *The Sage Handbook of Qualitative Research.* 2nd ed. Thousand Oaks CA: Sage.

Department of Health, 2012. *Transforming Care. A National Response to Winterbourne View Hospital.* London. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf> [Accessed 24 September 2019].

Department of Health, 2015. *The National Health Service Constitution.* London. <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england> [Accessed 29 September 2019].

Dewey, J., 1946. *Problems of Men. [e-book]:* Philosophical Library/Open Road. <https://books.google.co.uk/books?id=q3iMBAAAQBAJ> [Accessed 22 February 2016].

Diaz, D. P., 1993. Foundations for Spirituality. Establishing the Viability of Spirituality within the Health Disciplines. *Journal of Health Education,* 24(6), pp. 324–326. http://dx.doi.org/10.1080/10556699.1993.10616412.

Easterday, M. W., Lewis, D. R. and Gerber, E. M., eds., 2014. *Design-Based Research Process. Problems, Phases and Applications:* International Conference of the Learning Sciences.

Elkins, D. N., Hedstrom, L. J., Hughes, L. L., Leaf, J. A. and Saunders, C., 1988. Toward a Humanistic-Phenomenological Spirituality. *Journal of Humanistic Psychology,* 28(4), pp. 5–18. http://dx.doi.org/10.1177/0022167888284002.

Ellingson, L. L., 2009. *Engaging Crystallization in Qualitative Research:. An Introduction.* Thousand Oaks, CA: SAGE Publications.

Ellison, C., 1983. Spiritual Well-Being. Conceptualization and Measurement. *Journal of Psychology and Theology,* 11(4), pp. 330–340. http://dx.doi.org/10.1177/009164718301100406.

Emmons, R. A., 2000. Is Spirituality an Intelligence? Motivation, Cognition, and the Psychology of Ultimate Concern. *The International Journal for the Psychology of Religion,* 10(1), pp. 3–26.

Etymology Dictionary., 2010. *Online Etymology Dictionary.* [online]. Available at: <http://www.dictionary.com/browse/spirituality> [Accessed 19 June 2017].

Felstead, I., 2013. Role Modelling and Students' Professional Development. *British Journal of Nursing,* 22(4), pp. 223–227. http://dx.doi.org/10.12968/bjon.2013.22.4.223.

Fetzer Institute, 1999. *Multidimensional Measurement of Religiousness / Spirituality for use in Health Research:* John E. Fetzer Institute.

Fischbeck, S., Maier, B.-O., Reinholz, U., Nehring, C., Schwab, R., Beutel, M. E. and Weber, M., 2013. Assessing Somatic, Psychosocial, and Spiritual Distress of Patients with Advanced Cancer. Development of the Advanced Cancer Patients' Distress Scale. *The American Journal of Hospice & Palliative Care,* 30(4), pp. 339–346. http://dx.doi.org/10.1177/1049909112453640.

Fitchett, G. and Risk, J. L., 2009. Screening for Spiritual Struggle. *The Journal of Pastoral Care & Counseling,* 63(1-2), pp. 1–12. http://dx.doi.org/10.1177/154230500906300104.

Fitchett, G., 2002. *Assessing Spiritual Needs. A Guide for Caregivers.* Lima (Ohio): Academic Renewal Press.

Foucault, M., 2005. *The Hermeneutics of the Subject. Lectures at the Collège de France, 1981-1982. [e-book].* New York: Picador. <http://www.loc.gov/catdir/bios/hol059/2004049020.html> [Accessed 20 October 2019].

Fox, N., 2009. *Using Interviews in a Research Project.* 2nd ed. Sheffield.

Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London.

Frankl, V. E., 1959. *Man's Search for Meaning.* New York: Simon and Schuster.

Frick, E., Riedner, C., Fegg, M., Hauf, S. and Borasio, G., 2006. A Clinical Interview Assessing Cancer Patients' Spiritual Needs and Preferences. *European Journal of Cancer Care,* 15(3), pp. 238–243. http://dx.doi.org/10.1111/j.1365-2354.2005.00646.x.

Frings, M., 1998. Max Scheler. Early Pioneer of Twentieth Century Philosophy. *Modern Age,* 40(3), pp. 271–280.

Fry, L. W. and Nisiewicz, M., 2013. *Maximizing the Triple Bottom Line Through Spiritual Leadership. [e-book].* Palo Alto: Stanford University Press. Available at: Fry, Louis (VerfasserIn). <http://gbv.eblib.com/patron/FullRecord.aspx?p=1056988> [Accessed 24 May 2017].

Fry, L. W. and Wigglesworth, C., 2013. Toward a Theory of Spiritual Intelligence and Spiritual Leadership Development. *International Journal on Spirituality and Organisational Leadership,* 1(1), pp. 47–80.

Fry, L. W., 2003. Toward a Theory of Spiritual Leadership. *The Leadership Quarterly,* 14(6), pp. 693–727. http://dx.doi.org/10.1016/j.leaqua.2003.09.001.

Galanter, M., Dermatis, H., Bunt, G., Williams, C., Trujillo, M. and Steinke, P., 2007. Assessment of spirituality and its relevance to addiction treatment. *Journal of Substance Abuse Treatment,* 33(3), pp. 257–264. http://dx.doi.org/10.1016/j.jsat.2006.06.014.

Gandhi, M., 2001. *Non-Violent Resistance. Satyagraha.* Mineola N.Y.: Dover.

Gardner, F., 2011a. *Critical Spirituality. A Holistic Approach to Contemporary Practice. [e-book].* Oxford, UK: Routledge. <https://play.google.com/books/reader?printsec=frontcover&output=reader&id=LqOh2dg5u6QC&pg=GBS.PP1>.

Gardner, H., 1995. Reflections on Multiple Intelligences. Myths and Messages. *Phi Delta Kappan,* 77(3), pp. 200–209.

Gardner, H., 2000. A Case Against Spiritual Intelligence. *International Journal for the Psychology of Religion,* 10(1), pp. 27–34. http://dx.doi.org/10.1207/S15327582IJPR1001_3.

Gardner, H., 2011b. *Frames of Mind. The Theory of Multiple Intelligences.* New York: Basic Books.

Gardner, H., ed., 2003. *Multiple Intelligences after 20 years*.

Genia, V., 1997. The Spiritual Experience Index. Revision and Reformulation. *Review of Religious Research,* 38(4), p. 344–344. http://dx.doi.org/10.2307/3512195.

Giacalone, R. A. and Jurkiewicz, C. L., 2010. *Handbook of Workplace Spirituality and Organizational Performance.* 2nd ed. Armonk, N.Y.: M.E. Sharpe; London.

Gilbert, P., ed., 2013. *Spirituality and End of Life Care. A Handbook for Service Users, Carers and Staff Wishing to Bring a Spiritual Dimension to Palliative Care:* Pavilion Publishing.

Gilman, L., 2014. *The Theory of Multiple Intelligences*. [online]. Available at: <http://www.intelltheory.com> [Accessed 25 July 2018].

Goffee, R. and Jones, G., 2003. *The Character of a Corporation. How Your Company's Culture Can Make or Break Your Business.* 2nd ed. London: Profile.

Goleman, D., 1995. *Emotional intelligence. Why it can matter more than IQ.* London: Bloomsbury.

Goleman, D., Boyatzis, R. and McKee, A., 2004. *Primal Leadership. Learning to Lead with Emotional Intelligence.* Boston: Harvard Business School.

González, R. A., 2012. The Vocation to Serve. Cornerstone of Healthcare. *MEDICC Review,* 14, p. 52–52. http://dx.doi.org/10.1590/S1555-79602012000300012.

Goodrich, J. and Cornwell, J., 2008. *Seeing the Person in the Patient. The Point of Care Review Paper.* London. <https://www.kingsfund.org.uk/sites/default/files/Seeing-the-person-in-the-patient-The-Point-of-Care-review-paper-Goodrich-Cornwell-Kings-Fund-December-2008.pdf> [Accessed 28 November 2018].

Great Britain., 1998. *Data Protection Act 1998 : Chapter 29. [e-book].* London: Stationery Office. <http://worldcatlibraries.org/wcpa/oclc/39736600>.

Green, M. L., Winkler, M., Mink, R., Brannen, M. L., Bone, M., Maa, T., Arteaga, G. M., McCabe, M. E., Marcdante, K., Schneider, J. and Turner, D. A., 2017. Defining Leadership Competencies for Pediatric Critical Care Fellows. Results of a National Needs Assessment. *Medical Teacher,* 39(5), pp. 486–493. http://dx.doi.org/10.1080/0142159X.2017.1297527.

Guba, E. G. and Lincoln, Y. S., 1994. Competing paradigms in qualitative research. In: N. K. Denzin, and Y. S. Lincoln, eds. 1994. *The Sage Handbook of Qualitative Research.* 2nd ed. Thousand Oaks CA: Sage, pp. 105–117.

Guinn, J., 2017. *The road to Jonestown. Jim Jones and Peoples Temple.* New York: Simon & Schuster.

Hadot, P., 1995. *Philosophy as a Way of Life. Spiritual Exercises from Socrates to Foucault.* Oxford: Blackwell.

Halama, P. and Strizenec, M., 2004. Spiritual, Existential or Both? Theoretical Considerations on the Nature of 'Higher' Intelligences (Discussion). *Studia Psychologica,* 46(3), pp. 239–253.

Hammersley, M., 2017. On the Role of Values in Social Research. Weber Vindicated? *Sociological Research Online,* 22(1), pp. 1–12. http://dx.doi.org/10.5153/sro.4197.

Handy, C., 1993. *Understanding Organizations.* 4th ed. London: Penguin Books Limited.

Harms, P. D. and Credé, M., 2010. Remaining Issues in Emotional Intelligence Research. Construct Overlap, Method Artifacts, and Lack of Incremental Validity. *Industrial and Organizational Psychology,* 3(2), pp. 154–158. http://dx.doi.org/10.1111/j.1754-9434.2010.01217.x.

Harris, R., 2012. *The Happiness Trap. Stop Struggling, Start Living.* London: Robinson.

Harris, S., 2014. *Waking Up. A Guide to Spirituality Without Religion.* New York: Simon & Schuster.

Hatch, R. L., Burg, M. A., Naberhaus, D. S. and Hellmich, L. K., 1998. The Spiritual Involvement and Beliefs Scale. Development and Testing of a New Instrument. *Journal of Family Practice,* 46(6), pp. 476–487. <http://go.galegroup.com/ps/i.do?p=AONE&sw=w&issn=00943509&v=2.1&it=r&id=GALE%7CA20842642&sid=googleScholar&linkaccess=fulltext>.

Haynes, A., Hilbers, J., Kivikko, J. and Ratnavyuha, D., 2007. *Spirituality and Religion in Health Care Practice. a Person-Centred Resource for Staff at the Prince of Wales Hospital.* Sydney. <http://www.rch.org.au/uploadedfiles/main/content/cultural_services/spirituality_staff_resource.pdf> [Accessed 27 June 2017].

Hayward, R., 2013. Spirituality and Leadership in End of Life Care. In: P. Gilbert, ed. 2013. *Spirituality and End of Life Care. A Handbook for Service Users, Carers and Staff Wishing to Bring a Spiritual Dimension to Palliative Care:* Pavilion Publishing.

Helliwell, T., 2010. *Spiritual Intelligence Test Online*. [online]. Available at: <http://www.iitransform.com/sq/> [Accessed 31 August 2017].

Hemingway, C. A. and Maclagan, P. W., 2004. Managers' Personal Values as Drivers of Corporate Social Responsibility. *Journal of Business Ethics,* 50(1), pp. 33–44. http://dx.doi.org/10.1023/B:BUSI.0000020964.80208.c9.

Hermann, C., 2006. Development and Testing of the Spiritual Needs Inventory for Patients Near the End of Life. *Oncology Nursing Forum,* 33(4), pp. 737–744. http://dx.doi.org/10.1188/06.ONF.737-744.

Hill, P. C., Pargament, K. I., Hood, R. W., McCulloch, M., Swyers, J. P., Larson, D. B. and Zinnbauer, B. J., 2000. Conceptualizing Religion and Spirituality. Points of Commonality, Points of Departure. *Journal for the Theory of Social Behaviour,* 30(1), pp. 51–77. http://dx.doi.org/10.1111/1468-5914.00119.

Hodge, D. R., 2003. The Intrinsic Spirituality Scale. *Journal of Social Service Research,* 30(1), pp. 41–61. http://dx.doi.org/10.1300/J079v30n01_03.

Hofstede, G. H., Hofstede, G. J. and Minkov, M., 2010. *Cultures and Organizations. Software of the Mind: Intercultural Cooperation and its Importance for Survival.* 3rd ed. [e-book]. New York, London: McGraw-Hill. <http://www.loc.gov/catdir/enhancements/fy1009/2010010437-d.html>.

Holland, J. C., Kash, K. M., Passik, S., Gronert, M. K., Sison, A., Lederberg, M., Russak, S. M., Baider, L. and Fox, B., 1998. A Brief Spiritual Beliefs Inventory for use in Quality of Life Research in Life-Threatening Illness. *Psycho-oncology,* 7(6), pp. 460–469. http://dx.doi.org/10.1002/(SICI)1099-1611(199811/12)7:6<460::AID-PON328>3.0.CO;2-R.

Holmes, O., 2018. *Spirituality, Naturalism, and Agnosticism. Investigating the Principles and Benefits of Worldviews in Psychology.* PhD. [e-book]. <https://researchbank.swinburne.edu.au/file/7826746f-fb06-49f5-86ae-b3c8b58d5af9/1/oliver_holmes_thesis.pdf>.

Hornblum, A. M., 1999. *Acres of Skin. Human Experiments at Holmesburg Prison. [e-book]:* Taylor & Francis. <https://books.google.co.uk/books?id=NGCLMQF85SkC>.

Houghton, C., Hunter, A. and Meskell, P., 2012. Linking Aims, Paradigm and Method in Nursing Research. *Nurse Researcher,* 20(2), pp. 34–39. http://dx.doi.org/10.7748/nr2012.11.20.2.34.c9439.

Howden, J., 1992. *Development and Psychometric Characteristics of the Spirituality Assessment Scale.* PhD. Texas Women's University.

Huguelet, P., Guillaume, S., Vidal, S., Mohr, S., Courtet, P., Villain, L., Girod, C., Hasler, R., Prada, P., Olié, E. and Perroud, N., 2016. Values as Determinant of Meaning Among Patients with Psychiatric Disorders in the Perspective of Recovery. *Scientific Reports,* 6, p. 27617–27617. http://dx.doi.org/10.1038/srep27617.

Hungelmann, J., Kenkel-Rossi, E., Klassen, L. and Stollenwerk, R. M., 1985. Spiritual Well-Being in Older Adults. Harmonious Interconnectedness. *Journal of Religion and Health,* 24(2), pp. 147–153. http://dx.doi.org/10.1007/BF01532258.

Hungelmann, J., Kenkel-Rossi, E., Klassen, L., & Stollenwerk, R., ed., 1989. *Development of the JAREL spiritual well-being scale*.

Hyson, P., 2013. The Spirited Leader. The Potential of Spiritual Intelligence to Improve Leadership. *International Journal of Leadership in Public Services,* 9(3/4), pp. 109–115. http://dx.doi.org/10.1108/IJLPS-10-2013-0028.

Idler, E. L., Musick, M. A., Ellison, C. G., George, L. K., Krause, N., Ory, M. G., Pargament, K. I., Powell, L. H., Underwood, L. G. and Williams, D. R., 2003. Measuring Multiple Dimensions of Religion and Spirituality for Health Research. *Research on Aging,* 25(4), pp. 327–365. http://dx.doi.org/10.1177/0164027503025004001.

Indiajiva, 2005. Lord's Prayer. Abwoon D'bashmaya. In: . 2005. *Sacred Ragas:* CD Baby.

Ipsos MORI, 2017. *Global Trends Survey*. [online]. Available at: <http://www.ipsos-mori-generations.com/religion> [Accessed 21/10/17].

Ironson, G., Solomon, G. F., Balbin, E. G., O'Cleirigh, C., George, A., Kumar, M., Larson, D. and Woods, T. E., 2002. The Ironson-Woods Spirituality/Religiousness Index is Associated with Long Survival, Health Behaviors, Less Distress, and Low Cortisol in People with HIV/AIDS. *Annals of Behavioral Medicine,* 24(1), pp. 34–48. http://dx.doi.org/10.1207/S15324796ABM2401_05.

Ivankova, N. V., Creswell, J. W. and Stick, S. L., 2006. Using Mixed-Methods Sequential Explanatory Design. From Theory to Practice. *Field Methods,* 18(1), pp. 3–20. http://dx.doi.org/10.1177/1525822X05282260.

James, W., 1907. *Pragmatism. A New Name for Some Old Ways of Thinking.* Auckland: The Floating Press.

Janghorban, R., Latifnejad Roudsari, R. and Taghipour, A., 2014. Skype Interviewing. The New Generation of Online Synchronous Interview in Qualitative Research. *International Journal of Qualitative Studies on Health and Well-being,* 9, pp. 1–3. http://dx.doi.org/10.3402/qhw.v9.24152.

Johnson, B., 1996. *Polarity Management. Identifying and Managing Unsolvable Problems.* Amherst, Mass.: HRD Press.

Jones, J., Topping, A., Wattis, J. and Smith, J., 2016. A Concept Analysis of Spirituality in Occupational Therapy Practice. *Journal for the Study of Spirituality,* 6(1), pp. 38–57. http://dx.doi.org/10.1080/20440243.2016.1158455.

Jones, K. F., 2018. Spirituality. More than Just Religion. *Journal of the Australasian Rehabilitation Nurses Association,* 21(2), pp. 12–14. <https://search.informit.com.au/documentSummary;dn=978149216740268;res=IELHEA> [Accessed 12 February 2018].

Jurkiewicz, C. L. and Giacalone, R. A., 2004. A Values Framework for Measuring the Impact of Workplace Spirituality on Organizational Performance. *Journal of Business Ethics,* 49(2), pp. 129–142. http://dx.doi.org/10.1023/B:BUSI.0000015843.22195.b9.

Kaldor, S. and Miner, M., 2012. Spirituality and Community Flourishing. A Case of Circular Causality. In: M. Miner, M. Dowson, and S. Devenish, eds. 2012. *Beyond Well-Being. Spirituality and Human Flourishing*. Charlotte, N.C.: Information Age Pub, pp. 183–198.

Kanter, R. M., 2012. *Ten Reasons People Resist Change*. [online]. Available at: <https://hbr.org/2012/09/ten-reasons-people-resist-chang#comment-section> [Accessed 16 July 2018].

Kapuscinski, A. N. and Masters, K. S., 2010. The Current Status of Measures of Spirituality. A Critical Review of Scale Development. *Psychology of Religion and Spirituality,* 2(4), pp. 191–205. http://dx.doi.org/10.1037/a0020498.

Kass, J. D., Friedman, R., Leserman, J., Zuttermeister, P. C. and Benson, H., 1991. Health Outcomes and a New Index of Spiritual Experience. *Journal for the Scientific Study of Religion,* 30(2), p. 203–203. http://dx.doi.org/10.2307/1387214.

Kaur, D., Sambasivan, M. and Kumar, N., 2013. Effect of Spiritual Intelligence, Emotional Intelligence, Psychological Ownership and Burnout on Caring Behaviour of Nurses. A Cross-Sectional Study. *Journal of Clinical Nursing,* 22(21-22), pp. 3192–3202. http://dx.doi.org/10.1111/jocn.12386.

Kavar, L., 2015. Spirituality and the Sense of Self. An Inductive Analysis. *The Qualitative Report,* 20(5), pp. 697–711.

Kheswa, G. E., 2016. *Exploring the Contribution of Spiritual Intelligence to Leadership in the Public Sector.* DPhil. [e-book]. University of South Africa. <http://uir.unisa.ac.za/bitstream/10500/20018/1/thesis_kheswa_g_e.pdf>.

King, D., 2008. *Rethinking Claims of Spiritual Intelligence. A Definition, Model, and Measure.* Msc. Ontario, Canada.

King, M., Jones, L., Barnes, K., Low, J., Walker, C., Wilkinson, S., Mason, C., Sutherland, J. and Tookman, A., 2006. Measuring Spiritual Belief. Development and Standardization of a Beliefs and Values Scale. *Psychological Medicine,* 36(3), pp. 417–425. http://dx.doi.org/10.1017/S003329170500629X.

King, M., Speck, P. and Thomas, A., 1995. The Royal Free Interview for Religious and Spiritual Beliefs. Development and Standardization. *Psychological Medicine,* 25(06), pp. 1125–1134. http://dx.doi.org/10.1017/S0033291700033109.

King, M., Speck, P. and Thomas, A., 2001. The Royal Free Interview for Spiritual and Religious Beliefs. Development and Validation of a Self-Report Version. *Psychological Medicine,* 31(06), pp. 1015–1023. http://dx.doi.org/10.1017/S0033291701004160.

Kinjerski, V., 2013. The Spirit at Work Scale. Developing and Validating a Measure of Individual Spirituality at Work. In: J. Neal, ed. 2013. *Handbook of Faith and Spirituality in the Workplace.* New York: Springer, pp. 383–402.

Kirk, T. W., 2019. Nursing, Spirituality, and the Work of Paley and Pesut. *Nursing Philosophy,* 20(3), e12261. http://dx.doi.org/10.1111/nup.12261.

Klenke, K., 2007. Authentic Leadership. A Self, Leader, and Spiritual Identity Perspective. *International Journal of Leadership Studies,* 3(1), pp. 68–97.

Kloppenberg, J. T., 1996. Pragmatism. An Old Name for Some New Ways of Thinking? *The Journal of American History,* 83(1), pp. 100–138. http://dx.doi.org/10.2307/2945476.

Ko, I. S., Choi, S. Y. and Kim, J. S., 2017. Evolutionary Concept Analysis of Spirituality. *Journal of Korean Academic Nursing,* 47(2), pp. 242–256. http://dx.doi.org/10.4040/jkan.2017.47.2.242.

Koenig, H. G., 2009. Research on Religion, Spirituality, and Mental Health. A Review. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie,* 54(5), pp. 283–291. http://dx.doi.org/10.1177/070674370905400502.

Koenig, H. G., 2012. Religion, Spirituality, and Health. The Research and Clinical Implications. *International Scholarly Research Notices Psychiatry,* 2012. http://dx.doi.org/10.5402/2012/278730.

Koenig, H. G., McCulloch, M. and Larson, D., 2001. *Handbook of Religion and Health.* Oxford: Oxford University Press.

Kotter, J. P., 2008. *Corporate Culture and Performance. [e-book]:* Free Press. <https://books.google.co.uk/books?id=pWudzigl0ucC>.

Krystal, A., 2001. Why Smart People Believe in God. *The American Scholar,* 70(4). <https://www.jstor.org/stable/41213217>.

Kübler-Ross, E., 2009. *On Death and Dying. What the Dying have to Teach Doctors, Nurses, Clergy and Their Own Families.* Abingdon: Routledge.

Landy, F. J., 2005. Some Historical and Scientific Issues Related to Research on Emotional Intelligence. *Journal of Organizational Behavior,* 26(4), pp. 411–424. http://dx.doi.org/10.1002/job.317.

Laurel, S. J. D., 2018. Medicine as a Sacred Vocation. *Baylor University Medical Center Proceedings,* 31(1), pp. 126–131. http://dx.doi.org/10.1080/08998280.2017.1400318.

Law, P., 2016. Spiritual Leadership. In: T. H. Veldsman, A. J. Johnson, and T. Madonsela, eds. 2016. *Leadership. Perspectives from the Front Line.* Randburg, South Africa: KR Publishing, pp. 443–455.

Leget, C., 2008. Spirituality and Nursing. Why be Reductionist? A Response to John Paley. *Nursing Philosophy,* 9(4), pp. 277–278. http://dx.doi.org/10.1111/j.1466-769X.2008.00363.x.

Legg, S. and Hutter, M., 2007. A Collection of Definitions of Intelligence. *Frontiers in Artificial Intelligence and Applications,,* 157, pp. 17–24. <http://arxiv.org/pdf/0706.3639> [Accessed 21 March 2017].

Leider, R. J., 2015. *The Power of Purpose. Creating Meaning in Your Life and Work.* 3rd ed.: Berrett-Koehler Publishers.

Lerner, R., Alberts, A., Anderson, P. and Dowling, E., 2006. On Making Humans Human. Spirituality and the Promotion of Positive Youth Development. In: P. E. King, P. L. Benson, and E. C. Roehlkepartain, eds. 2006. *The Handbook of Spiritual Development in Childhood and Adolescence.* Thousand Oaks, Calif.: SAGE Publications.

Lewinson, L., McSherry, W. and Kevern, P., 2015. Spirituality in Pre-Registration Nurse Education and Practice. A Review of the Literature. *Nurse Education Today,* 35(6), pp. 806–814. http://dx.doi.org/10.1016/j.nedt.2015.01.011.

Lips-Wiersma, M. and Mills, A. J., 2014. Understanding the Basic Assumptions About Human Nature in Workplace Spirituality. Beyond the Critical Versus Positive Divide. *Journal of Management Inquiry,* 23(2), pp. 148–161. http://dx.doi.org/10.1177/1056492613501227.

Lips-Wiersma, M. and Morris, L., 2011. *Map of Meaning. How to Sustain Our Humanity in the World of Work.* Sheffield, UK: Greenleaf Publishing Limited.

Locke, E. A., 2005. Why Emotional Intelligence is an Invalid Concept. *Journal of Organizational Behavior,* 26(4), pp. 425–431. http://dx.doi.org/10.1002/job.318.

Loscalzo, M., Clark, K., Dillehunt, J., Rinehart, R., Strowbridge, R. and Smith, D., 2010. SupportScreen. A Model for Improving Patient Outcomes. *Journal of the National Comprehensive Cancer Network,* 8(4), pp. 496–504. http://dx.doi.org/10.6004/jnccn.2010.0036.

Lucas, A. M., 2001. Introduction to the Discipline for Pastoral Care Giving. *Journal of Health Care Chaplaincy,* 10(2), pp. 1–33.

MacDonald, D. A., 2000. Spirituality. Description, Measurement, and Relation to the Five Factor Model of Personality. *Journal of Personality,* 68(1), pp. 153–197. http://dx.doi.org/10.1111/1467-6494.t01-1-00094.

Mackenzie, N. and Knipe, S., 2006. Research Dilemmas. Paradigms, Methods and Methodology. *Issues in Educational Research,* 16(2), pp. 193–205.

MacQuarrie, J., 1983. *In Search of Humanity. A Theological and Philosophical Approach.* New York: Crossroad.

Mako, C., Galek, K. and Poppito, S. R., 2006. Spiritual Pain Among Patients with Advanced Cancer in Palliative Care. *Journal of Palliative Medicine,* 9(5), pp. 1106–1113. http://dx.doi.org/10.1089/jpm.2006.9.1106.

Maltby, J., Williams, G., McGarry, J. and Day, L., 2010. *Research Methods for Nursing and Healthcare.* Harlow, England: Pearson Education Limited.

Martin, M. J., 2006. That's the Way We Do Things Around Here. An Overview of Organizational Culture. *Electronic Journal of Academic and Special Librarianship,* 7(1). <http://southernlibrarianship.icaap.org/content/v07n01/martin_m01.htm> [Accessed 21 January 2016].

Maslow, A. H., 1987. *Motivation and Personality.* 3rd ed. New Delhi: Pearson Education; Dorling Kindersley.

Maslow, A., 1965. *Self-Actulisation and Beyond.* Winchester. MA: New England Board of Higher Education.

Maugans, T. A., 1996. The SPIRITual History. *Archives of Family Medicine,* 5(1), pp. 11–16.

Mayer, J. D., Caruso, D. R. and Salovey, P., 1999. Emotional Intelligence Meets Traditional Standards for an Intelligence. *Intelligence,* 27(4), pp. 267–298. http://dx.doi.org/10.1016/S0160-2896(99)00016-1.

McBride, J. L., Pilkington, L. and Arthur, G., 1998. Development of Brief Pictorial Instruments for Assessing Spirituality in Primary Care. *The Journal of Ambulatory Care Management,* 21(4), pp. 53–61. <http://journals.lww.com/ambulatorycaremanagement/Fulltext/1998/10000/Development_of_Brief_Pictorial_Instruments_for.4.aspx> [Accessed 16 December 2017].

McDermid, D., 2013. Pragmatism. In: J. Fieser, and B. Dowden, eds. 2013. *Internet Encyclopedia of Philosophy*.

McLeod, S., 2007. Maslow's Hierarchy of Needs. *Simply Psychology,* 1.

Mehta, N., 2011. Mind-Body Dualism. A Critique from a Health Perspective. *Mens Sana Monographs,* 9(1), pp. 202–209. http://dx.doi.org/10.4103/0973-1229.77436.

Mercadante, L. A., 2014. *Belief Without Borders. Inside the Minds of the Spiritual but Not Religious.* New York: Oxford University Press.

Meredith, P., Murray, J., Wilson, T., Mitchell, G. and Hutch, R., 2012. Can Spirituality be Taught to Health Care Professionals? *Journal of Religion and Health,* 51(3), pp. 879–889. http://dx.doi.org/10.1007/s10943-010-9399-7.

Minton, M. E., Isaacson, M. J., Varilek, B. M., Stadick, J. L. and O'Connell-Persaud, S., 2018. A Willingness to Go There. Nurses and Spiritual Care. *Journal of Clinical Nursing,* 27(1-2), pp. 173–181. http://dx.doi.org/10.1111/jocn.13867.

Mircica, N., 2011. Scheler's Phenomenology of Values. *Review of Contemporary Philosophy,* 10, pp. 240–245.

Moberg, D. O., 2002. Assessing and Measuring Spirituality. Confronting Dilemmas of Universal and Particular Evaluative Criteria. *Journal of Adult Development,* 9(1), pp. 47–60. http://dx.doi.org/10.1023/A:1013877201375.

Mohr, S., Gillieron, C., Borras, L., Brandt, P.-Y. and Huguelet, P., 2007. The Assessment of Spirituality and Religiousness in Schizophrenia. *The Journal of Nervous and Mental Disease,* 195(3), pp. 247–253. http://dx.doi.org/10.1097/01.nmd.0000258230.94304.6b.

Monod, S., Brennan, M., Rochat, E., Martin, E., Rochat, S. and Büla, C. J., 2011. Instruments Measuring Spirituality in Clinical Research. A Systematic Review. *Journal of General Internal Medicine,* 26(11), pp. 1345–1357. http://dx.doi.org/10.1007/s11606-011-1769-7.

Monod, S., Martin, E., Spencer, B., Rochat, E. and Büla, C. J., 2012. Validation of the Spiritual Distress Assessment Tool in Older Hospitalized Patients. *BMC Geriatrics,* 12(1), p. 13–13. http://dx.doi.org/10.1186/1471-2318-12-13.

Moran, D., 2000. *Introduction to Phenomenology.* New York: Routledge.

Morgan, D. L., 2014. *Integrating Qualitative and Quantitative Methods. A Pragmatic Approach. [e-book].* Los Angeles: SAGE Publications. <https://dx.doi.org/10.4135/9781544304533>.

Morin, A., 2011. Self-Awareness Part 1. Definition, Measures, Effects, Functions, and Antecedents. *Social and Personality Psychology Compass,* 5(10), pp. 807–823. http://dx.doi.org/10.1111/j.1751-9004.2011.00387.x.

Morse, J. M., 1994. Designing Funded Qualitative Research. In: N. K. Denzin, and Y. S. Lincoln, eds. 1994. *The Sage Handbook of Qualitative Research.* 2nd ed. Thousand Oaks CA: Sage, pp. 220–235.

Movelis, A., 2017. Relationships. Sublime or Ridiculous. In: L. Beardon, and D. Worton, eds. 2017. *Love, Partnership, or Singleton on the Autism Spectrum.* London: Jessica Kingsley Publishers, pp. 247–256.

Mthembu, T. G., Wegner, L. and Roman, N. V., 2016. Teaching Spirituality and Spiritual Care in Health Sciences Education. A Systematic Review. *African Journal for Physical Activity and Health Sciences,* 22(41), pp. 1036–1057.

Murray, N. and Beglar, D., 2009. *Writing Dissertations and Theses.* Harlow: Pearson Longman.

My Skills Profile, 2010. *SPQ32*. [online]. Available at: <http://www.myskillsprofile.com/tests/spq32> [Accessed 1 September 2017].

Nasel, D. D. and Haynes, D., 2005. Spiritual and Religious Dimensions Scale. Development and Psychometric Analysis. *Australian Journal of Psychology,* 57(1), pp. 61–71. http://dx.doi.org/10.1080/00049530412331283408.

Nelson, A. E., 2010. *Spiritual Intelligence. Discover Your SQ. Deepen Your Faith.* Grand Rapids: Baker Pub. Group.

Nelson-Becker, H., 2005. Development of a Spiritual Support Scale for Use with Older Adults. *Journal of Human Behavior in the Social Environment,* 11(3-4), pp. 195–212. http://dx.doi.org/10.1300/J137v11n03_10.

Newton, N., 2010. *The Use of Semi-Structured Interviews in Qualitative Research. Strengths and Weaknesses.* PhD. [e-book]. Bristol. <http://www.academia.edu/1561689/The_use_of_semi-structured_interviews_in_qualitative_research_strengths_and_weaknesses> [Accessed 20 October 2019].

NHS Scotland, 2009. . *Spiritual Care Matters.* Edinburgh: NHS Scotland.

Nietzsche, F., 1885. *Thus Spoke Zarathustra. A Book for Everyone and Nobody.* Oxford: Oxford University Press.

Nightingale, F., 1860. *Notes on Nursing. What it is, and What it is Not.* Philadelphia: J.B. Lippincott Company.

Noble, H. and Smith, J., 2015. Issues of Validity and Reliability in Qualitative Research. *Evidence-Based Nursing,* 18(2), pp. 34–35. http://dx.doi.org/10.1136/eb-2015-102054.

Nokelainen, P., Ubani, M. and Tirri, K., 2006. Conceptual Definition and Empirical Validation of the Spiritual Sensitivity Scale. *Journal of Empirical Theology,* 19(1), pp. 37–62. http://dx.doi.org/10.1163/157092506776901870.

Nolan, S. and Holloway, M., 2014. *A-Z of Spirituality.* Basingstoke: Palgrave Macmillan.

Nolan, S., 2009. In Defence of the Indefensible. An Alternative to John Paley's Reductionist, Atheistic, Psychological Alternative to Spirituality. *Nursing Philosophy,* 10. http://dx.doi.org/10.1111/j.1466-769X.2009.00400.x.

Norton, L., Gibson, R. M., Gofton, T., Benson, C., Dhanani, S., Shemie, S. D., Hornby, L., Ward, R. and Young, G. B., 2017. Electroencephalographic Recordings During Withdrawal of Life-Sustaining Therapy Until 30 Minutes After Declaration of Death. *The Canadian Journal of Neurological Sciences,* 44(2), pp. 139–145. http://dx.doi.org/10.1017/cjn.2016.309.

Nygren, A., 1982. *Agape and Eros.* Chicago: University of Chicago Press.

Oman, D. and Syme, S. L., 2018. Weighing the Evidence. What Is Revealed by 100+ Meta-Analyses and Systematic Reviews of Religion/Spirituality and Health? In: D. Oman, ed. 2018. *Why Religion and Spirituality Matter for Public Health. Evidence, Implications, and Resources.* Cham, Switzerland: Springer, pp. 261–281.

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L. and Zoran, A. G., 2009. A Qualitative Framework for Collecting and Analyzing Data in Focus Group Research. *International Journal of Qualitative Methods,* 8(3), pp. 1–21.

Orr, R., 2015. Incorporating Spirituality into Patient Care. *American Medical Association Journal of Ethics,* 17(5), pp. 409–415.

Osborn, D. and Morris, P., 2017. *Wealth Can't Wait. Avoid the 7 Wealth Traps, Implement the 7 Business Pillars, and Complete a Life Audit Today! [e-book]:* Greenleaf Book Group Press. <https://books.google.co.uk/books?id=wO9UDgAAQBAJ>.

Osborn, R. E., 2017. *Humanism and the Death of God. Searching for the Good after Darwin, Marx, and Nietzsche.* Oxford: Oxford University Press.

Owonikoko, T. K., 2013. Upholding the Principles of Autonomy, Beneficence, and Justice in Phase I Clinical Trials. *The Oncologist,* 18(3), pp. 242–244. http://dx.doi.org/10.1634/theoncologist.2013-0014.

Paiva, B. S. R., Carvalho, A. L., Lucchetti, G., Barroso, E. M. and Paiva, C. E., 2015. Oh, yeah, I'm Getting Closer to God. Spirituality and Religiousness of Family Caregivers of Cancer Patients Undergoing Palliative Care. *Supportive Care in Cancer,* 23(8), pp. 2383–2389. http://dx.doi.org/10.1007/s00520-015-2604-1.

Paley, J., 2008a. Philosophy and Palliative Care. *Nursing Philosophy,* 9(2), pp. 75–76. http://dx.doi.org/10.1111/j.1466-769X.2008.00348.x.

Paley, J., 2008b. Spirituality and Nursing. A Reductionist Approach. *Nursing Philosophy,* 9(1), pp. 3–18. http://dx.doi.org/10.1111/j.1466-769X.2007.00330.x.

Paley, J., 2008c. Spirituality and Secularization. Nursing and the Sociology of Religion. *Journal of Clinical Nursing,* 17(2), pp. 175–186. http://dx.doi.org/10.1111/j.1365-2702.2006.01917.x.

Paley, J., 2009. Keep the NHS Secular. *Nursing Standard (Royal College of Nursing (Great Britain) : 1987),* 23(43), pp. 26–27. <https://link.gale.com/apps/doc/A204206105/AONE?u=anglia_itw&sid=AONE&xid=31397ee2>.

Paley, J., 2010. Spirituality and Reductionism. Three Replies. *Nursing Philosophy,* 11(3), pp. 178–190. http://dx.doi.org/10.1111/j.1466-769X.2010.00439.x.

Paley, J., 2017. *Phenomenology as Qualitative Research. A Critical Analysis of Meaning Attribution.* London, New York: Routledge Taylor & Francis Group.

Paloutzian, R. F. and Ellison, C. W., 2017. *The Spiritual Well-Being Scale. FAQ's*. [online]. Available at: <http://www.lifeadvance.com./spiritual-well-being-scale/6-faqs.html> [Accessed 6 September 2017].

Parahoo, K., 2014. *Nursing Research Principles, Process and Issues.* 3rd ed. Basingstoke: Palgrave Macmillan.

Pargament, K. I., 1999. The Psychology of Religion and Spirituality? Yes and No. *International Journal for the Psychology of Religion,* 9(1), pp. 3–16. http://dx.doi.org/10.1207/s15327582ijpr0901_2.

Parliamentary and Health Service Ombudsman, 2011. *Care and Compassion. Report of the Ombudsman on Ten Investigations Into NHS Care of Older People.* London.

Pattison, S., 1990. Healing. A Flight from Definition. *Contact,* 101(1), pp. 7–11. http://dx.doi.org/10.1080/13520806.1990.11758650.

Pennock, S. F., 2015. *A Short Definition of 'Values' and 'Value Congruence'*. [online]. Available at: <https://positivepsychologyprogram.com/values-definition/> [Accessed 11 November 2018].

Pesut, B., 2008. A Conversation on Diverse Perspectives of Spirituality in Nursing Literature. *Nursing Philosophy,* 9(2), pp. 98–109. http://dx.doi.org/10.1111/j.1466-769X.2008.00341.x.

Peterman, A. H., Fitchett, G., Brady, M. J., Hernandez, L. and Cella, D., 2002. Measuring Spiritual Well-Being in People With Cancer. The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being Scale (FACIT-Sp). *Annals of Behavioral Medicine,* 24(1), pp. 49–58. http://dx.doi.org/10.1207/S15324796ABM2401_06.

Piedmont, R. L., 1999. Does Spirituality Represent the Sixth Factor of Personality? Spiritual Transcendence and the Five-Factor Model. *Journal of Personality,* 67(6), pp. 985–1013. http://dx.doi.org/10.1111/1467-6494.00080.

Pirkola, H., Rantakokko, P. and Suhonen, M., 2016. Workplace Spirituality in Healthcare. An Integrated Review of the Literature. *Journal of Nursing Management,* 24(7), pp. 859–868. http://dx.doi.org/10.1111/jonm.12398.

Pittman McGehee, J., 2011. *The Paradox of Love. A Jungian Look at the Dynamics of the Greatest Mystery.* Houston: Bright Sky Press.

Poole, E., 2009. Organisational Spirituality - A Literature Review. *Journal of Business Ethics,* 84(4), pp. 577–588. http://dx.doi.org/10.1007/s10551-008-9726-z.

Pratt, D., ed., 2012. *The Persistence and Problem of Religion. Exclusivist Boundaries and Extremist Transgressions.*

Pruyser, P. W., 1976. *The Minister as Diagnostician. Personal Problems in Pastoral Perspective.* Philadelphia: Westminster Press.

Pruzan, P. and Miller, W. C., 2003. Spiritual-Based Leadership. Initial Observations from a Research Programme. In: J. Rendtorff, ed. 2003. *Værdier, etik og ansvar i virksomheder – Brudflader og konvergens (English translation: Values, Ethics and Responsibility in the Corporate World – Movements and Convergence).* Roskilde, Denmark: Kluwer Academic Publishers, pp. 21–46.

Pruzan, P., 2013. Integrating Rationality and Spirituality in Leadership. *International Journal on Spirituality and Organisational Leadership,* 1(1), pp. 33–47. <https://www.iispiritualleadership.com/wp-content/uploads/SLTISOL_SI.pdf> [Accessed 14 August 2017].

Puchalski, C. M. and Guenther, M., 2012. Restoration and Re-Creation. Spirituality in the Lives of Healthcare Professionals. *Current Opinion in Supportive and Palliative Care,* 6(2), pp. 254–258. http://dx.doi.org/10.1097/SPC.0b013e3283522223.

Puchalski, C. M. and Romer, A. L., 2000. Taking a Spiritual History Allows Clinicians to Understand Patients More Fully. *Journal of Palliative Medicine,* 3(1), pp. 129–137. http://dx.doi.org/10.1089/jpm.2000.3.129.

Puchalski, C. M., 2014. The FICA Spiritual History Tool. *Journal of Palliative Medicine,* 17(1), p. 105–105. http://dx.doi.org/10.1089/jpm.2013.9458.

Puchalski, C. M., Blatt, B., Kogan, M. and Butler, A., 2014a. Spirituality and Health. The Development of a Field. *Academic Medicine : Journal of the Association of American Medical Colleges,* 89(1), pp. 10–16. http://dx.doi.org/10.1097/ACM.0000000000000083.

Puchalski, C. M., Ferrell, B., Virani, R., Otis-Green, S., Baird, P., Bull, J., Chochinov, H., Handzo, G., Nelson-Becker, H. and Prince-Paul, M., 2009. Improving the Quality of Spiritual Care as a Dimension of Palliative Care. The Report of the Consensus Conference. *Journal of Palliative Medicine,* 12(10), pp. 885–904. http://dx.doi.org/10.1089/jpm.2009.0142.

Puchalski, C. M., Vitillo, R., Hull, S. K. and Reller, N., 2014b. Improving the Spiritual Dimension of Whole Person Care. Reaching National and International Consensus. *Journal of Palliative Medicine,* 17(6), pp. 642–656. http://dx.doi.org/10.1089/jpm.2014.9427.

Pym, H., 2015. *Addenbrooke's Hospital in Special Measures. [e-book]:* BBC. <http://www.bbc.co.uk/news/av/health-34322666/cambridge-hospitals-placed-in-special-measures> [Accessed 21 March 2018].

Rabinow, P., 2009. Foucault's Untimely Struggle. *Theory, Culture & Society,* 26(6), pp. 25–44. http://dx.doi.org/10.1177/0263276409347699.

Rajasekar, S., Philominathan, P. and Chinnathambi, V., 2013. Research Methodology. E print https://arxiv.org/pdf/physics/0601009.pdf. *arXiv preprint physics/0601009,* pp. 1–53. Available at: TY RPRT

RefWorksID doc:58fa7456e4b0ed41e27f7ddb. <https://arxiv.org/pdf/physics/0601009.pdf> [Accessed 2 February 2016].

Ramezani, M., Ahmadi, F., Mohammadi, E. and Kazemnejad, A., 2014. Spiritual Care in Nursing. A Concept Analysis. *International Nursing Review,* 61(2), pp. 211–219. http://dx.doi.org/10.1111/inr.12099.

Rayment, J. and Smith, J., 2007. *Global Spirituality and the Global Fitness Framework.* Anglia Ruskin University: Practitioner Paper Series, Ashcroft International Business School.

Rayment, J. and Smith, J., 2011. *MisLeadership - Prevalence, Causes and Consequences.* London: Gower.

Reed, P. G., 1986. Religiousness Among Terminally Ill and Healthy Adults. *Research in Nursing & Health,* 9(1), pp. 35–41. http://dx.doi.org/10.1002/nur.4770090107.

Reimer-Kirkham, S., Pesut, B., Sawatzky, R., Cochrane, M. and Redmond, A., 2012. Discourses of Spirituality and Leadership in Nursing. A Mixed Methods Analysis. *Journal of Nursing Management,* 20(8), pp. 1029–1038. http://dx.doi.org/10.1111/j.1365-2834.2012.01480.x.

Renoux, C., 2014. *The Origin and Original Text of the Peace Prayer of St. Francis*. [online]. Available at: <http://www.franciscan-archive.org/franciscana/peace.html> [Accessed 12 March 2019].

Reverby, S. M., 2009. *Examining Tuskegee. The Infamous Syphilis Study and its Legacy.* Chapel Hill: University of North Carolina Press.

Richardson, L., 2000. Writing. A Method of Inquiry. In: N. K. Denzin, and Y. S. Lincoln, eds. 2000. *Handbook of Qualitative Research.* 2nd ed. Thousand Oaks, CA: Sage Publications, Inc, pp. 923–948.

Rinzler, L., 2014. *The Buddha Walks into the Office. A Guide to Livelihood for a New Generation.* Boston: Shambhala.

Robinson, H., 2016. Dualism. In: E. N. Zalta, ed. 2016. *The Stanford Encyclopedia of Philosophy:* Metaphysics Research Lab, Stanford University.

Robinson, S., Smith, J. and Kovacs, J., 2014. *Co-Charismatic Leadership. Critical Perspectives on Spirituality, Ethics and Leadership.* Bern, Switzerland: Peter Lang AG.

Rokeach, M., 1973. *The Nature of Human Values.* New York: Free Press.

Ronaldson, S., Hayes, L., Aggar, C., Green, J. and Carey, M., 2012. Spirituality and Spiritual Caring. Nurses' Perspectives and Practice in Palliative and Acute Care Environments. *Journal of Clinical Nursing,* 21(15-16), pp. 2126–2135. http://dx.doi.org/10.1111/j.1365-2702.2012.04180.x.

Roof, R. A., 2015. The Association of Individual Spirituality on Employee Engagement. The Spirit at Work. *Journal of Business Ethics,* 130(3), pp. 585–599. http://dx.doi.org/10.1007/s10551-014-2246-0.

Rorty, R., 1982. *Consequences of Pragmatism. Essays, 1972-1980. [e-book]:* University of Minnesota Press. <https://books.google.co.uk/books?id=6L2Wkls7UnwC>.

Rorty, R., 1990. *Objectivity, Relativism, and Truth. Philosophical Papers. [e-book]:* Cambridge University Press. <https://books.google.co.uk/books?id=fvLoAwAAQBAJ>.

Rorty, R., Williams, M. and Bromwich, D., 1980. *Philosophy and the Mirror of Nature:* Cambridge University Press.

Ross, L. and McSherry, W., 2018. The Power of Two Simple Questions. *Nursing Standard (Royal College of Nursing (Great Britain) : 1987),* 33(9), pp. 78–80. http://dx.doi.org/10.7748/ns.33.9.78.s22.

Ross, L., 2006. Spiritual Care in Nursing. An Overview of the Research to Date. *Journal of Clinical Nursing,* 15(7), pp. 852–862. http://dx.doi.org/10.1111/j.1365-2702.2006.01617.x.

Rotman, M., 2017. Vocation in Theology and Psychology. Conflicting Approaches? *Christian Higher Education,* 16(1-2), pp. 23–32. http://dx.doi.org/10.1080/15363759.2017.1249763.

Rowan, N. L., Faul, A. C., Cloud, R. N. and Huber, R., 2006. The Higher Power Relationship Scale. A Validation. *Journal of Social Work Practice in the Addictions,* 6(3), pp. 81–95. http://dx.doi.org/10.1300/J160v06n03_07.

Ryan, G. W. and Bernard, H. R., 2003. Techniques to Identify Themes. *Field Methods,* 15(1), pp. 85–109. http://dx.doi.org/10.1177/1525822X02239569.

Rykkje, L., Eriksson, K. and Råholm, M.-B., 2015. Love in Connectedness. *SAGE Open,* 5(1). http://dx.doi.org/10.1177/2158244015571186.

Sauter, F., 2016. *Why Should We Care About Our Company Core Values?* [online]. Available at: <https://www.happymelly.com/company-core-values-2/> [Accessed 29 August 2018].

Sawatzky, R., Ratner, P. A. and Chiu, L., 2005. A Meta-Analysis of the Relationship Between Spirituality and Quality of Life. *Social Indicators Research,* 72(2), pp. 153–188. http://dx.doi.org/10.1007/s11205-004-5577-x.

Schein, E. H. and Schein, P., 2016. *Organizational Culture and Leadership.* 5th ed. Hoboken, New Jersey: John Wiley and Sons.

Schein, E. H., 1990. Organizational Culture. What it is and How to Change it. In: P. Evans, Y. Doz, and A. Laurent, eds. 1990. *Human Resource Management in International Firms. Change, Globalization, Innovation.* London: Palgrave Macmillan UK, pp. 56–82.

Schoonenboom, J. and Burke Johnson, R., 2017. How to Construct a Mixed Methods Research Design. *KZfSS Kölner Zeitschrift für Soziologie und Sozialpsychologie,* 6(7), p. 55–55. http://dx.doi.org/10.1007/s11577-017-0454-1.

Schwartz, S. H., 2012. An Overview of the Schwartz Theory of Basic Values. *Online Readings in Psychology and Culture,* 2(1). http://dx.doi.org/10.9707/2307-0919.1116.

Seidlitz, L., Abernethy, A. D., Duberstein, P. R., Evinger, J. S., Chang, T. H. and Lewis, B.'b. L., 2002. Development of the Spiritual Transcendence Index. *Journal for the Scientific Study of Religion,* 41(3), pp. 439–453. http://dx.doi.org/10.1111/1468-5906.00129.

Sheridan, M., 2017. Addressing Spiritual Bypassing. Issues and Guidelines for Spiritually Sensitive Practice. In: B. R. Crisp, ed. 2017. *The Routledge Handbook of Religion, Spirituality and Social Work:* Taylor & Francis.

Shields, M., Kestenbaum, A. and Dunn, L. B., 2015. Spiritual AIM and the Work of the Chaplain. A Model for Assessing Spiritual Needs and Outcomes in Relationship. *Palliative and Supportive Care,* 13(1), pp. 75–89. http://dx.doi.org/10.1017/S1478951513001120.

Silvia, P. J. and Phillips, A. G., 2004. Self-Awareness, Self-Evaluation, and Creativity. *Personality & Social Psychology Bulletin,* 30(8), pp. 1009–1017. http://dx.doi.org/10.1177/0146167204264073.

Singh, A. R., 2010. Modern Medicine. Towards Prevention, Cure, Well-being and Longevity. *Mens Sana Monographs,* 8(1), pp. 17–29. http://dx.doi.org/10.4103/0973-1229.58817.

Singh, N. K., Ram, D. and Goyal, N., 2017. Role of Spirituality in Mental Health Practice. *Indian Journal of Psychiatric Social Work,* 8(1), pp. 44–49.

Sire, J. W., 2015. *Naming the Elephant. Worldview as a Concept. [e-book]:* InterVarsity Press. <https://books.google.co.uk/books?id=ZdIHBgAAQBAJ>.

Smith, B., 2013. Spiritual Intelligence. Definitions and Measurements. *Fielding Graduate University: unpublished paper for integral theory certificate*.

Smith, J. A. and Eatough, V., 2007. Interpretative Phenomenological Analysis. In: E. Lyons, and A. Coyle, eds. 2007. *Analysing Qualitative Data in Psychology.* London: SAGE Publications, Ltd, pp. 35–50.

Smith, J. A. and Eatough, V., 2017. Interpretative Phenomenological Analysis. In: C. Willig, and W. S. Rogers, eds. 2017. *The SAGE Handbook of Qualitative Research in Psychology:* SAGE Publications, pp. 193–212.

Smith, J. A., 1995. Semi-Structured Interviewing and Qualitative Analysis. In: J. A. Smith, R. Harré, and L. van Langenhove, eds. 1995. *Rethinking Methods in Psychology.* London: Sage, pp. 9–26.

Smith, J. A., 1996. Beyond the divide between cognition and discourse. Using interpretative phenomenological analysis in health psychology. *Psychology & Health,* 11(2), pp. 261–271. http://dx.doi.org/10.1080/08870449608400256.

Smith, J., Larkin, M. and Flowers, P., 2009. *Interpretative Phenomenological Analysis. Theory, Method and Research.* Los Angeles: Sage.

Stegner, W., 2012. *All the Little Live Things.* London: Penguin Classics.

Steinhauser, K. E., Fitchett, G., Handzo, G., Johnson, K. S., Koenig, H. G., Pargament, K. I., Puchalski, C. M., Sinclair, S., Taylor, E. J. and Balboni, T. A., 2017. State of the Science of Spirituality and Palliative Care Research Part I. Definitions and Taxonomy, Measurement, and Outcomes. *Journal of Pain and Symptom Management.* http://dx.doi.org/10.1016/j.jpainsymman.2017.07.028.

Steinhauser, K. E., Voils, C. I., Clipp, E. C., Bosworth, H. B., Christakis, N. A. and Tulsky, J. A., 2006. "Are you at Peace?". One Item to Probe Spiritual Concerns at the End of Life. *Archives of Internal Medicine,* 166(1), pp. 101–105. http://dx.doi.org/10.1001/archinte.166.1.101.

Stern, J. and James, S., 2006. Every Person Matters. Enabling Spirituality Education for Nurses. *Journal of Clinical Nursing,* 15(7), pp. 897–904. http://dx.doi.org/10.1111/j.1365-2702.2006.01663.x.

Sternberg, R. J., 1987. Intelligence. In: R. Gregory, ed. 1987. *The Oxford Companion to the Mind.* Oxford, UK: Oxford University Press, p. 2–2.

Stewart, C. and Koeske, G. F., 2006. A Preliminary Construct Validation of the Multidimensional Measurement of Religiousness/Spirituality Instrument. A Study of Southern USA Samples. *International Journal for the Psychology of Religion,* 16(3), pp. 181–196. http://dx.doi.org/10.1207/s15327582ijpr1603_3.

Storr, A., 1996. *Feet of Clay. A Study of Gurus.* London: Harper Collins.

Streib, H. and Hood, R. W., 2013. Modeling the Religious Field. Religion, Spirituality, Mysticism, and Related World Views. *Implicit Religion,* 16(2), pp. 137–155. http://dx.doi.org/10.1558/imre.v16i2.133.

Streib, H. and Hood, R. W., 2015. Understanding Spirituality. Conceptual Considerations. In: H. Streib, and R. W. Hood, eds. 2015. *Semantics and Psychology of Spirituality. A Cross-Cultural Analysis:* Springer International Publishing, pp. 3–17.

Sunaryo, H., Nirwanto, N. and Manan, A., 2017. The Effect of Emotional and Spiritual Intelligence on Nurses' Burnout and Caring Behavior. *International Journal of Academic Research in Business and Social Sciences,* 7(12). http://dx.doi.org/10.6007/IJARBSS/v7-i12/3753.

Swinton, J., 2001. *Spirituality and Mental Healthcare. Rediscovering a 'Forgotten' Dimension.* London: Kingsley.

Taliaferro, C., 2018. Philosophy of Religion. In: E. N. Zalta, ed. 2018. *The Stanford Encyclopedia of Philosophy:* Metaphysics Research Lab, Stanford University.

Tanyi, R. A., 2002. Towards Clarification of the Meaning of Spirituality. *Journal of Advanced Nursing,* 39(5), pp. 500–509. http://dx.doi.org/10.1046/j.1365-2648.2002.02315.x.

Tashakkori, A. and Teddlie, C., eds., 2010. *Sage Handbook of Mixed Methods in Social and Behavioral Research.* 2nd ed. Thousand Oaks, CA: Sage.

Tavakol, M. and Dennick, R., 2011. Making Sense of Cronbach's Alpha. *International Journal of Medical Education,* 2, pp. 53–55. http://dx.doi.org/10.5116/ijme.4dfb.8dfd.

Taylor, A., Hodgson, D., Gee, M. and Collins, K., 2017. Compassion in Healthcare. A Concept Analysis. *Journal of Radiotherapy in Practice,* 16(4), pp. 350–360. http://dx.doi.org/10.1017/S1460396917000322.

Taylor, E. J., 2006. Prevalence and Associated Factors of Spiritual Needs Among Patients With Cancer and Family Caregivers. *Oncology Nursing Forum,* 33(4), pp. 729–735. http://dx.doi.org/10.1188/06.ONF.729-735.

Teddlie, C. and Tashakkori, A., 2012. Common “Core” Characteristics of Mixed Methods Research. A Review of Critical Issues and Call for Greater Convergence. *American Behavioral Scientist,* 56(6), pp. 774–788. http://dx.doi.org/10.1177/0002764211433795.

The Bible: New International Version, 2011. London: Hodder and Stoughton.

The Janki Foundation for Global Health, 2011. *Values in Healthcare. A Spiritual Approach.* Southampton.

The Nazarene Way of Essenic Studies, 2012. *The Lord's Prayer*. [online]. Available at: <http://thenazareneway.com/lords_prayer.htm> [Accessed 13 March 2019].

Thomas, B. C., Thomas, I., Nandamohan, V., Nair, M. K. and Pandey, M., 2009. Screening for Distress can Predict Loss of Follow-Up and Treatment in Cancer Patients. Results of development and validation of the Distress Inventory for Cancer Version 2. *Psycho-oncology,* 18(5), pp. 524–533. http://dx.doi.org/10.1002/pon.1422.

Timmins, F. and McSherry, W., 2012. Spirituality. The Holy Grail of Contemporary Nursing Practice. *Journal of Nursing Management,* 20(8), pp. 951–957. http://dx.doi.org/10.1111/jonm.12038.

Timmins, F., Murphy, M., Begley, T., Neill, F. and Sheaf, G., 2016. The Extent to Which Core Nursing Textbooks Inform Holistic Spiritual Care. *Nursing Management,* 23(5), pp. 31–37. http://dx.doi.org/10.7748/nm.2016.e1455.

Tisdell, E. J., 2007. In the New Millennium. The Role of Spirituality and the Cultural Imagination in Dealing with Diversity and Equity in the Higher Education Classroom. *Teachers College Record,* 109(3), pp. 531–560.

Trafford, V., Leshem, S. and Bitzer, E., 2014. Conclusion Chapters in Doctoral Theses. Some International Findings. *Higher Education Review,* 46(3), pp. 52–81.

Tuinman, M. A., Gazendam-Donofrio, S. M. and Hoekstra-Weebers, J. E., 2008. Screening and Referral for Psychosocial Distress in Oncologic Practice. Use of the Distress Thermometer. *Cancer,* 113(4), pp. 870–878. http://dx.doi.org/10.1002/cncr.23622.

Underwood, L. G. and Teresi, J. A., 2002. The Daily Spiritual Experience Scale. Development, Theoretical Description, Reliability, Exploratory Factor Analysis, and Preliminary Construct Validity Using Health-Related Data. *Annals of Behavioral Medicine,* 24(1), pp. 22–33. http://dx.doi.org/10.1207/S15324796ABM2401_04.

van Hattem, A. Y., Ossenkop, C., S.E. Dikkers, J. and J. Vinkenburg, C., 2013. Life Role Salience and Values. *Cross Cultural Management: An International Journal,* 20(4), pp. 607–624. http://dx.doi.org/10.1108/CCM-09-2012-0082.

van Leeuwen, R. and Schep-Akkerman, A., 2015. Nurses' Perceptions of Spirituality and Spiritual Care in Different Health Care Settings in the Netherlands. *Religions,* 6(4), pp. 1346–1357. <https://www.mdpi.com/2077-1444/6/4/1346/pdf>.

van Tilburg, W. and Igou, E. R., 2011. On the Meaningfulness of Existence. When Life Salience Boosts Adherence to Worldviews. *European Journal of Social Psychology,* 41(6), pp. 740–750. http://dx.doi.org/10.1002/ejsp.819.

Vardiman, P., Houghton, J. and Jinkerson, D., 2006. Environmental Leadership Development. Toward a Contextual Model of Leader Selection and Effectiveness. *Leadership & Organization Development Journal,* 27(2), pp. 93–105. http://dx.doi.org/10.1108/01437730610646606.

Veloza-Gómez, M., Muñoz de Rodríguez, L., Guevara-Armenta, C. and Mesa-Rodríguez, S., 2016. The Importance of Spiritual Care in Nursing Practice. *Journal of Holistic Nursing.* http://dx.doi.org/10.1177/0898010115626777.

Vinales, J. J., 2015. The Mentor as a Role Model and the Importance of Belongingness. *British Journal of Nursing,* 24(10), pp. 532–535. http://dx.doi.org/10.12968/bjon.2015.24.10.532.

Vivyan, C., 2015. *Finding Meaning and the Pursuit of Happiness*. [online]. Available at: <https://www.getselfhelp.co.uk//meaning.htm> [Accessed 10 June 2017].

Vocabulary.com, n.d. *Transcendence. Dictionary Definition*. [online]. Available at: <https://www.vocabulary.com/dictionary/transcendence> [Accessed 4 July 2018].

Vyskocilova, J., Prasko, J., Ociskova, M., Sedlackova, Z. and Mozny, P., 2015. Values and Values Work in Cognitive Behavioral Therapy. *Activitas Nervosa Superior Rediviva,* 57(1-2), pp. 40–48.

Walter, F., Cole, M. S. and Humphrey, R. H., 2011. Emotional Intelligence. Sine Qua Non of Leadership or Folderol? *Academy of Management Perspectives,* 25(1), pp. 45–59. http://dx.doi.org/10.5465/amp.25.1.45.

Wattis, J., Curran, S. and Rogers, M., 2017. What Does Spirituality Mean for Patients, Practitioners and Healthcare Organisations? In: J. Wattis, S. Curran, and M. Rogers, eds. 2017. *Spiritually Competent Practice in Healthcare.* Boca Raton: CRC Press, pp. 1–17.

Weathers, E., McCarthy, G. and Coffey, A., 2015. Concept Analysis of Spirituality. An Evolutionary Approach. *Nursing Forum,* 51(2), pp. 79–96. http://dx.doi.org/10.1111/nuf.12128.

Weindling, P., Villiez, A. von, Loewenau, A. and Farron, N., 2016. The Victims of Unethical Human Experiments and Coerced Research Under National Socialism. *Endeavour,* 40(1), pp. 1–6. http://dx.doi.org/10.1016/j.endeavour.2015.10.005.

Weiss, J. W., Skelley, M. F., Haughey, J. C. and Hall, D. T., 2004. Calling, New Careers and Spirituality. A Reflective Perspective for Organizational Leaders and Professionals. In: M. L. Pava, and P. Primeaux, eds. 2004. *Spiritual Intelligence at Work. Meaning, Metaphor, and Morals.* Amsterdam, London: JAI, pp. 175–201.

Wells-Di Gregorio, S., Porensky, E. K., Minotti, M., Brown, S., Snapp, J., Taylor, R. M., Adolph, M. D., Everett, S., Lowther, K., Callahan, K., Streva, D., Heinke, V., Leno, D., Flower, C., McVey, A. and Andersen, B. L., 2013. The James Supportive Care Screening. Integrating Science and Practice to Meet the NCCN Guidelines for Distress Management at a Comprehensive Cancer Center. *Psycho-oncology,* 22(9), pp. 2001–2008. http://dx.doi.org/10.1002/pon.3256.

Welwood, J., 1984. Principles of Inner Work. Psychological and Spiritual. *The Journal of Transpersonal Psychology,* 16(1), pp. 63–74.

Welwood, J., 2000. *Toward a Psychology of Awakening.* Boston: Shambhala.

White, J., 1998. *Do Howard Gardner's Multiple Intelligences Add Up?* London: University of London.

Whittier, J. G., 1872. Dear Lord and Father of Mankind. [Lyrics]. <https://hymnary.org/hymn/CMP2000/111> [Accessed 11 March 2019].

WHOQOL SRPB Group, 2006. A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life. *Social Science & Medicine,* 62(6), pp. 1486–1497. http://dx.doi.org/10.1016/j.socscimed.2005.08.001.

Wigglesworth, C., 2010. *Deep Intelligence. The Critical Intelligences for Leadership Success in the 21st Century.* Houston.

Wigglesworth, C., 2012. *The Twenty One Skills of Spiritual Intelligence.* New York: Select Books.

Wilkes, M., Cassel, C. and Klau, M., 2018. If We Keep Doing What We're Doing We'll Keep Getting What We're Getting. A Need to Rethink "Academic" Medicine. *Medical Teacher,* 40(4), pp. 364–371. http://dx.doi.org/10.1080/0142159X.2017.1417580.

Wisdom, J. P. and Creswell, J. W., 2013. *Mixed Methods. Integrating Quantitative and Qualitative Data Collection and Analysis While Studying Patient-Centered Medical Home Models.* Rockville MD.

Wolman, R., 2001. *Thinking With Your Soul. Spiritual Intelligence and Why It Matters. [e-book]:* Harmony Books. Available at: PsychoMatrix Spirituality Inventory (PSI). <https://books.google.co.uk/books?id=utaODV8R6U4C>.

Wolpin, S., Berry, D., Austin-Seymour, M., Bush, N., Fann, J. R., Halpenny, B., Lober, W. B. and McCorkle, R., 2008. Acceptability of an Electronic Self-Report Assessment Program for patients with cancer. *Computers, Informatics, Nursing : CIN,* 26(6), pp. 332–338. http://dx.doi.org/10.1097/01.NCN.0000336464.79692.6a.

Wolters, A. M., 2005. *Creation Regained. Biblical Basics for a Reformational Worldview. [e-book]:* Eerdmans Publishing Company. <https://books.google.co.uk/books?id=tNSR1_f02PYC>.

World Medical Association, 2013. Declaration of Helsinki. Ethical Principles for Medical Research Involving Human Subjects. *Jama,* 310(20), pp. 2191–2194. http://dx.doi.org/10.1001/jama.2013.281053.

Wright, N. T., 2013. *Christian Origins and the Question of God.* London: SPCK.

Wright, S. A., 1995. *Armageddon in Waco. Critical Perspectives on the Branch Davidian Conflict.* Chicago, IL, London: University of Chicago Press.

Wrzesniewski, A., Dutton, J. E. and Debebe, G., 2003. Interpersonal Sensemaking and the Meaning of Work. In: R. M. Kramer, and B. M. Staw, eds. 2003. *Research in Organizational Behavior. An Annual Series of Analytical Essays and Critical Reviews.* Oxford, UK: Elsevier Ltd, pp. 93–135.

Wu, L.-F., 2011. Exploration of Clinical Nurses' Perceptions of Spirituality and Spiritual Care. *The Journal of Nursing Research,* 19(4), pp. 250–256. http://dx.doi.org/10.1097/JNR.0b013e318236cf78.

Yalom, I. D., 1980. *Existential Psychotherapy.* New York: Basic Books.

Yardley, L., 2000. Dilemmas in Qualitative Health Research. *Psychology,* 15(2), pp. 215–228.

Yong, J., Kim, J., Han, S. S. and Puchalski, C. M., 2008. Development and Validation of a Scale Assessing Spiritual Needs for Korean Patients with Cancer. *Journal of Palliative Care,* 24(4), p. 240–240.

Youngson, R., 2011. Compassion in Healthcare. The Missing Dimension of Healthcare Reform? In: I. Renzenbrink, ed. 2011. *Caregiver Stress and Staff Support in Illness, Dying, and Bereavement*. Oxford: Oxford University Press.

Zamanzadeh, V., Jasemi, M., Valizadeh, L., Keogh, B. and Taleghani, F., 2015. Effective Factors in Providing Holistic Care. A Qualitative Study. *Indian Journal of Palliative Care,* 21(2), pp. 214–224. http://dx.doi.org/10.4103/0973-1075.156506.

Zampella, T., 2017. *Research Help Needed*. [online]. Available at: <http://deepchange.groupsite.com/discussion/topics/722929/messages?page=1#message-1236015> [Accessed 28 August 2017].

Zavada, J., 2018. *What Is Philia Love?* [online]. Available at: <https://www.thoughtco.com/what-is-philia-700691> [Accessed 24 October 2018].

Zehtab, S. and Adib-Hajbaghery, M., 2014. The Importance of Spiritual Care in Nursing. *Nursing and Midwifery Studies,* 3(3), e22261. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25699285> [Accessed 21 January 2019].

Zeidner, M., Matthews, G. and Roberts, R. D., 2001. Slow Down, You Move Too Fast. Emotional Intelligence Remains an "Elusive" Intelligence. *Emotion,* 1(3), pp. 265–275. http://dx.doi.org/10.1037/1528-3542.1.3.265.

Zimmer, Z., Jagger, C., Chiu, C.-T., Ofstedal, M. B., Rojo, F. and Saito, Y., 2016. Spirituality, Religiosity, Aging and Health in Global Perspective. A Review. *SSM - Population Health,* 2, pp. 373–381. http://dx.doi.org/10.1016/j.ssmph.2016.04.009.

Zohar, D. and Marshall, I. N., 2000. *SQ. Connecting With our Spiritual Intelligence.* New York: Bloomsbury.

Zohar, D. and Marshall, I. N., 2001. *SQ - Spiritual Intelligence. The Ultimate Intelligence.* London: Bloomsbury.

Zohar, D. and Marshall, I. N., 2004. *Spiritual Capital. Wealth We Can Live By.* London: Bloomsbury.

Zohar, D., 1997. *Rewiring the Corporate Brain. Using the New Science to Rethink how We Structure and Lead Organizations. [e-book]:* Berrett-Koehler Publishers. <https://books.google.co.uk/books?id=ogYNWheBLZYC>.

APPENDICES

Appendix 1: A Survey of Spiritual Assessment Tools.

Balboni, et al., 2017	Monod, et al., 2011	Smith, 2013
Dedicated Spiritual Screening Tools	General Spirituality Measures	Self-Help; Entertainment Tools
Berg, 1994; 1998; Balk, 1999; Mako, Galek and Poppito, 2006; Steinhauser, et al., 2006; Fitchett and Risk, 2009; Berg, 2011	Reed, 1986; Kass, et al., 1991; Howden, 1992; King, Speck and Thomas, 1995; Genia, 1997; Hatch, et al., 1998; McBride, Pilkington and Arthur, 1998; Fetzer Institute, 1999; Piedmont, 1999; MacDonald, 2000; King, Speck and Thomas, 2001; Ironson, et al., 2002; Seidlitz, et al., 2002; Underwood and Teresi, 2002; Hodge, 2003; Idler, et al., 2003; Delaney, 2005; King, et al., 2006; Rowan, et al., 2006; Stewart and Koeske, 2006	Chopra, 2002; Helliwell, 2010
Spiritual Screening Embedded in Psychosocial Screening Tools	Spiritual Needs Measures	Faith-Based Spiritual Assessment Tools
Tuinman, Gazendam-Donofrio and Hoekstra-Weebers, 2008; Wolpin, et al., 2008; Thomas, et al., 2009; Loscalzo, et al., 2010; Bultz, et al., 2011; Fischbeck, et al., 2013; Wells-Di Gregorio, et al., 2013	Hermann, 2006; Taylor, 2006; Galanter, et al., 2007; Yong, et al., 2008; Büssing, Balzat and Heusser, 2010	Nasel and Haynes, 2005; Nelson, 2010
Spiritual History Taking Tools	Spiritual Coping Measures	Spiritual Sensitivity Assessment Tools
Maugans, 1996; Puchalski and Romer, 2000; Anandarajah and Hight, 2001; Frick, et al., 2006	Holland, et al., 1998; Ai, et al., 2005; Nelson-Becker, 2005; Mohr, et al., 2007	Wolman, 2001; Nokelainen, Ubani and Tirri, 2006; My Skills Profile, 2010; Kinjerski, 2013
Spiritual Assessment Tools	Spiritual wellbeing measures	Spiritual Intelligence Assessment Tools
Pruyser, 1976; Lucas, 2001; Fitchett, 2002; Monod, et al., 2012; Benito, et al., 2014; Shields, Kestenbaum and Dunn, 2015	Ellison, 1983; Hungelmann, J., Kenkel-Rossi, E., Klassen, L., & Stollenwerk, R., 1989; Daaleman, et al., 2002; Moberg, 2002; Peterman, et al., 2002; Daaleman and Frey, 2004; WHOQOL SRPB Group, 2006	Amram and Dryer, 2008; King, 2008; Wigglesworth, 2012

Table 10-1: A Survey of Spiritual Assessment Tools.

SID Number 1124520

Appendix 2: DREP Ethical Approval.

Anglia Ruskin University
Cambridge & Chelmsford

Cambridge Campus
East Road
Cambridge
CB1 1PT

T: 0845 271 3333
Int: +44 (0)1223 363271
www.anglia.ac.uk

1st December 2014
Richard Hayward
Dear Richard
Principal Investigator: *Richard Hayward*

DREP number: *SNM/DREP/14-001*

Project Title: Is there a relationship between spirituality and leadership in adult healthcare?

I am pleased to inform you that your ethics application has been approved by the Faculty Research Ethics Panel (FREP) under the terms of Anglia Ruskin University's Research Ethics Policy (Dated 23/6/14, Version 1).
Ethical approval is given for a period of 3 years from 1st December 2014.
It is your responsibility to ensure that you comply with Anglia Ruskin University's Research Ethics Policy and the Code of Practice for Applying for Ethical Approval at Anglia Ruskin University, including the following.

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these amendments until you have received approval from DREP for them.
- The procedure for reporting adverse events and incidents.
- The Data Protection Act (1998) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the DREP copies of this documentation if required, prior to starting your research.
- Any laws of the country where you are carrying the research and obtaining any other approvals or permissions that are required.
- Any professional codes of conduct relating to research or requirements from your funding body (please note that for externally funded research, a Project Risk Assessment must have been carried out prior to starting the research).
- Completing a Risk Assessment (Health and Safety) if required and updating this annually or if any aspects of your study change which affect this.
- Notifying the DREP Secretary when your study has ended.

Please also note that your research may be subject to random monitoring.

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely,

Sarah Redsell

Date 26.11.14

V1.0

Cc Eddie Wallis-Redworth/Marie Smith-Owens/Dave Hawkes (DREP Reviewers)
Sharon Andrew (Supervisor) Beverley Pascoe (RESC Secretary)

SID Number 1124520

Appendix 3:Amended DREP Ethical Approval.

Anglia Ruskin University

Cambridge & Chelmsford

Cambridge Campus
East Road
Cambridge
CB1 1PT

T: 0845 271 3333
Int: +44 (0)1223 363271
www.anglia.ac.uk

23rd February 2016
Richard Hayward
Dear Richard

Principal Investigator	Richard Hayward
DREP Number	SNM/DREP/14/001 - Amendments
Project Title	Is there a relationship between spirituality and leadership in adult healthcare?

I am pleased to inform you that your ethics application (amendments) has been approved by the Faculty Research Ethics Panel (FREP) under the terms of Anglia Ruskin University's Research Ethics Policy (Dated 23/6/14, Version 1).
Ethical approval is given for a period of 3 years from 23rd February 2016.
It is your responsibility to ensure that you comply with Anglia Ruskin University's Research Ethics Policy and the Code of Practice for Applying for Ethical Approval at Anglia Ruskin University, including the following.

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these amendments until you have received approval from DREP for them.
- The procedure for reporting adverse events and incidents.
- The Data Protection Act (1998) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the DREP copies of this documentation if required, prior to starting your research.
- Any laws of the country where you are carrying the research and obtaining any other approvals or permissions that are required.
- Any professional codes of conduct relating to research or requirements from your funding body (please note that for externally funded research, a Project Risk Assessment must have been carried out prior to starting the research).
- Completing a Risk Assessment (Health and Safety) if required and updating this annually or if any aspects of your study change which affect this.
- Notifying the DREP Secretary when your study has ended.

Please also note that your research may be subject to random monitoring.
Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely,

SID Number 1124520

Emmanuel Idowu

Dr Emmanuel Idowu (Chair)
For the Nursing & Midwifery Department Research Ethics Panel (DREP)
T:

E:

cc: Andy McVicar/Amanda Drye (DREP Reviewers)
Sharon Andrew (Supervisor) Beverley Pascoe (RESC Secretary)

SID Number 1124520

Appendix 4: Participant Information Sheet – Phase One.

What is the relationship between spiritual intelligence and leadership effectiveness among health care managers?

Purpose and value of the study
You are invited to participate in a doctoral study undertaken by Richard Hayward, a PhD. Student and formerly a Senior Lecturer in Management and Leadership at Anglia Ruskin University.
Little is known about the interaction between spiritual intelligence and health care manager's leadership. Therefore, the aim of this study is to examine the relationship between spiritual intelligence and leadership effectiveness among healthcare managers.

Invitation to participate
As a member of the CHAIN Network you are invited to be a part of this survey. Your opinion is very useful whether it is positive, negative or neutral.

What does the study involve?
Your participation in the study is voluntary and you may choose not to participate. If you choose to participate you are asked to complete an on - line questionnaire that will take approximately 35 minutes of your time. The study will be administered by a US based company called Deep Change. Deep Change is an organisation that provides leadership development and coaching using a spiritual intelligence inventory. Over 2500 questionnaires have been administered using the SQ 21 Inventory worldwide, including the UK, US, Australia and the Middle East. If you choose to participate in this study, then you will be taken to a unique URL that has been provided specifically for the purposes of the study. This will assess your level of spiritual intelligence and consists of 170 statements and should take no more than 30 minutes.
Please answer the questions honestly. There are no right or wrong, good or bad answers.
As a thank you for your time, you can choose to be entered into a prize draw for a copy of SQ21: The Twenty-One Skills of Spiritual Intelligence. There will be 20 copies available. The draw will be made from those who submit their email address at the end of the questionnaire. This will not be linked in any way to your responses which will remain anonymous.
All responses will be stored by Deep Change on their secure databases and the anonymous results of your questionnaire will be stored securely by the organisation.
There will be a follow – up phase to the study. A small number of participants will be invited to explore the role of spiritual intelligence in their leadership practice. If you would be interested in taking part then you will be invited to submit your email address at the end of this invitation.

Do I have to take part?
Your participation in the study is voluntary.

What are the risks?
There are no physical risks for participating in the study. Agreement to participate in the study should not compromise your legal rights should something go wrong. There are no special precautions that you need to take before, during or after taking part in the study. While unusual, if you feel any psychological distress from your participation then you should stop completing the questionnaire. There are several support networks that you can access, including the Samaritans, ReThink and Mind.

SID Number 1124520

Confidentiality, Data Storage & Withdrawing from the Study
Your participation is confidential. Your questionnaire will be given a randomised code. The data will be collected by who will also administer the on – line questionnaire. Data entered onto computer file will use this random code only. Data is aggregated anonymously for data analysis and you can withdraw from the study at any time up until this step occurs. By agreeing to participate in this study, you are providing informed consent.

What will happen to the results of the study?
The results of the study will be used as a part of a doctoral thesis undertaken at Anglia Ruskin University as well as published in scholarly journals and may be presented at conferences. All information will be anonymous.

Who has reviewed the study?
The study has been reviewed by the Anglia Ruskin University Faculty Research Ethics Committee.

If you want further information please contact:
Richard Hayward[1]
Senior Lecturer
Tel:
email:

Dr Sharon Andrew[2]
Professor of Nursing,
Doctoral Supervisor
Tel:
Email:
Consent will be assumed by completing the questionnaire.

[1] Faculty of Health & Social Care, Anglia Ruskin University East Road Campus Young Street Site Cambridge CB1 1PT UK

[2] Faculty of Health & Social Care, Anglia Ruskin University 4th Floor William Harvey Building, Bishops Hall Lane, Chelmsford CM I 1 SQ UK

Appendix 5: Numbers of Potential Participants by Inclusion Group.

CHAIN Category	Number
CHAIN UK	11880
Primary	2511
Secondary	2528
Tertiary	997
Working in Primary, Secondary or Tertiary Healthcare	4292
Manager	2080
Director	959
Head of	566
Senior	1310
Chief	116
Self-reported job title includes Manager or Director or Head of or Senior or Chief	4802
NHS	4296
Foundation Trust	1310
CGC	2
Clinical Commissioning Group	136
Hospital	1900
Practice	44
Organisation type contains NHS or Foundation Trust or CGC or Clinical Commissioning Group or Hospital or Practice	5255
UK, [job title] manager, Director, head of, chief; [org] NHS, foundation Trust, ccg, clinical commissioning group, hospital, practice;	1565

Table 10-2: Numbers of Potential Participants from the CHAIN Membership.

Appendix 6: Text of E mail to the CHAIN Membership.

Dear CHAIN member,
Richard Hayward, a member and student at Anglia Ruskin University would like to ask for your help in his PhD research. Your input would be completing an online survey, which should not take long, but will give him the data which will be key to his study. Your help would therefore be greatly appreciated.
Richard writes:
"Dear CHAIN member, your help is requested.
Is there a relationship between spiritual intelligence and leadership in adult healthcare?
Spiritual intelligence is the ability to behave with wisdom and compassion, while maintaining inner and outer peace regardless of the situation.
I am a PhD student exploring the impact of spiritual intelligence on healthcare management.
As a member of the CHAIN network your help is requested in completing a questionnaire that assesses spiritual intelligence. This will then be used to inform the study
As a thank you for participating, you will have the option to be entered into a draw for a copy of SQ21 - The 21 Skills of Spiritual Intelligence.
The survey will take approximately 20 - 30 minutes to complete. Survey responses are strictly confidential and data from this research will be summarised in the aggregate.
All participants will be sent a copy of the findings and recommendations on completion.
For more information, click on the following link
http://goo.gl/forms/p9MwvHXarf
Thank you in advance for your help
Richard Hayward
Doctoral Student
Anglia Ruskin University
richard.hayward@student.anglia.ac.uk.

Appendix 7: Interview Questions for Phase Two.

Question Number for Coding	Question	Question Type According to Morse (1994)
1	Tell me a little bit about yourself. Do you have a clinical qualification, and what is your area of practice?*	Behavioural and process
2	Do you have line management responsibilities for staff? If Yes, how many and at what level?*	Behavioural and process
3	Did you enjoy completing the questionnaire? Why?	Verbal Interaction
4	Who do you admire as a spiritual leader?	Descriptive
5	What traits or characteristics do you think that they have?	Descriptive
6	How would you think it is possible to develop these characteristics in yourself and others?	Process
7	What do you think is the difference between religion and spirituality?	Meaning
8	A lot of my research has indicated that meaningfulness in the work environment is important. Is it a concept that you are familiar with? Does it have an impact on your role?	Process
9	Can you tell me what your top three values are? Why are they important to you?	Descriptive and verbal interaction
10	One of the skills identified and is of particular interest to me is about the complexity of inner thought. Rules are guidelines and sometimes a higher principle requires breaking the rules. Is it ever acceptable to break rules, and if so, when? Can you give me an example of when sticking or not to the rules caused unintended consequences?	Meaning
11	When faced with alternatives, do you tend to see either or or both /and thinking. Can you give me an example of the consequences of either sorts of thinking?	Meaning
12	Do you have a preferred leadership style?*	Behavioural
13	Spiritual leaders lead people through intellectual discourse and dialogue and believe that people, when they are involved and properly informed, can make intelligent decisions and that, with appropriate information, can assume responsibility for decisions that affect their lives (Powers, 1979). How is this demonstrated in your own leadership style? How is this shown in your organisation?	Behavioural
14	Is teaching a part of your role? If yes, could you teach about spiritual principles in your role? What are the possible barriers? How does a spiritual approach alter the way that you teach?	Process
15	Individual question about a score they scored 0 in on the SQ21 questionnaire.	Meaning
16	Individual question about a skill they scored 5 in on the SQ21 questionnaire.	Meaning
17	Do you have a particularly strong faith / religious tradition which you practice frequently?* Were you brought up in a faith tradition?*	Meaning
18	Would you call yourself Spiritual but Not Religious, or spiritual and religious?*	Meaning
19	Is there anything that you would like to tell me?	Process
20	Is there anything else that you would like to ask?	Process

Table 10-3: Interview Questions for Phase Two.

Appendix 8: Summary of Demographic Information for Phase Two Participants.

Participant	Gender	Age Range	Experience	Grade[3]	Line Management Responsibility	Clinical Qualification	Professional Qualification	Preferred Leadership Style	SQ 21 Mean Average
One (P1)	Female	50 - 59	Over 16 Years	Senior Manager	More than 50	Yes	Nurse	Engaging, inclusive and team focused	1.29
Two (P2)	Female	50 - 59	Over 16 Years	Band 7 and 8	0-20	Yes	Nurse	Empowering, facilitative and visionary	1.76
Three (P3)	Female	40 - 49	Over 16 Years	Band 7 and 8	21-49	Yes	Nurse	Transformational	2.10
Four (P4)	Female	40 - 49	9 - 15 Years	Band 7 and 8	0-20	Yes	Occupational Therapist	Democratic when time allowed	2.81
Five (P5)	Male	40 - 49	9 - 15 Years	Band 5 or 6	21-49	No	None	Approachable and open	2.81
Six (P6)	Male	50 - 59	Over 16 Years	Medical Consultant	More than 50	Yes	Medical Doctor	Participative and consultative	2.90
Seven (P7)	Female	50 - 59	Over 16 Years	Band 7 and 8	More than 50	Yes	Midwife	Inclusive	3.00
Eight (P8)	Male	60 +	Over 16 Years	Band 7 and 8	21-49	No	None	Inclusive, gaining consensus but ultimately accountable	3.62
Nine (P9)	Female	50 - 59	Over 16 Years	Band 7 and 8	0-20	Yes	Nurse, Midwife and Learning Disability Nurse	Fair but firm	3.67

Table 10-4: Summary of Demographic Information for Phase Two.

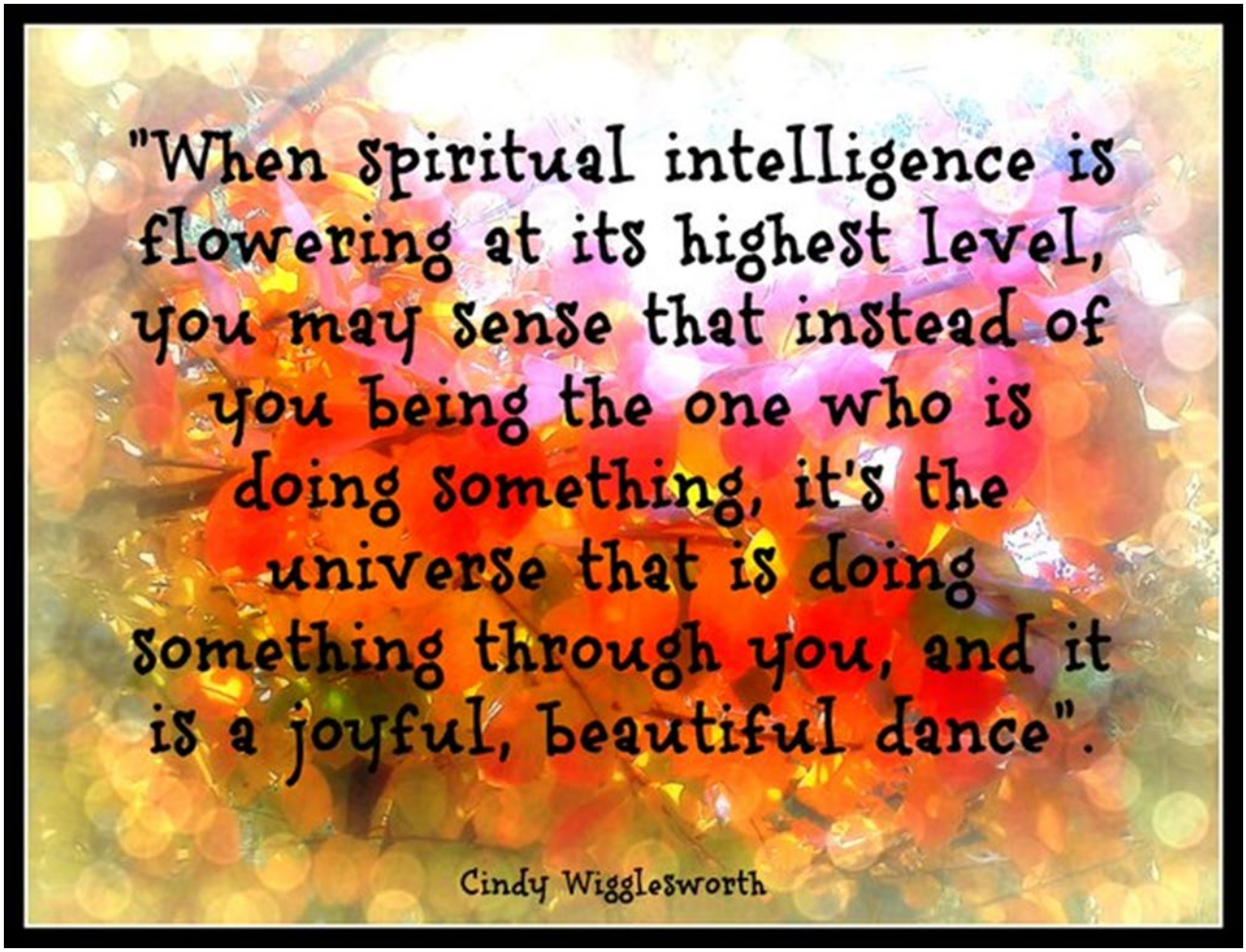
[3] A breakdown in managerial responsibilities for each NHS grade band is given in Table 14-5

Appendix 9: Managerial Responsibility by Grade.

Band	5	6	7	8	9
Job Statement	Assess and treat own caseload of patients/clients and maintained associated records. May supervise support workers/students working with post-holder	Assesses and treats own specialist caseload of patients/clients and maintains associated records Supervises, trains, assesses less experienced staff, assistants and students working with post-holder. May participate in research activities	Provides leadership and management for specialist and other staff Assesses patients/clients, plans, implements care, provides specialist advice; maintains associated records May liaise with other agencies in planning programmes of care and/or health and education programmes May hold budget	Manages staff, including recruitment, appraisal, CPD, performance Responsible for policy & service development Clinically accountable for clinical service delivery: liaises with other agencies as appropriate Responsible for budget & physical resources	Manages staff, including recruitment, appraisal, CPD, performance Responsible for policy & service development Clinically accountable for clinical service delivery: liaises with other agencies as appropriate Responsible for budget & physical resources
Knowledge, Training & Experience	Expertise within specialism, underpinned by theory Professional, clinical knowledge acquired through training to degree/diploma level	Specialist knowledge across range of procedures underpinned by theory Professional knowledge acquired through degree or equivalent, plus short specialist courses, experience to postgraduate equivalent diploma level	Highly developed specialist knowledge, underpinned by theory and experience. Degree plus specialist training to Masters level or equivalent plus practical experience	Highly developed specialist knowledge, underpinned by theory and experience Professional knowledge acquired through degree, supplemented by further training, short specialist courses Masters equivalent level	Advanced theoretical & practical knowledge Professional knowledge acquired through degree, supplemented by specialist training to doctorate or equivalent level, management qualification or equivalent, experience
Responsibility for Patient/Client Care	Develop programmes of care/care packages; Provide specialised advice in relation to care Assesses, plans, implements and evaluates clinical care of patients/clients; gives specialist advice to clients/carers	Develop programmes of care/care packages; Provide specialised advice in relation to care/ Develop specialised programmes of care/ care packages; provide highly specialised advice Assesses, plans, implements and evaluates clinical care of patients/clients; gives specialist advice to patients/clients/carers/ Develops and implements specialist programmes of care	Develop specialist programme of care/care packages. Assesses and implements specialist treatments, care packages and programmes	Provide highly specialised advice concerning care; Accountable for direct delivery of subdivision of a clinical, clinical technical or social care service Delivers highly specialised case management advice to the multi disciplinary team across sectors; accountable for service delivery	Accountable for direct delivery of clinical, clinical technical, social care service(s) Clinically accountable to trust for delivery of a clinical or clinical technical service

Band	5	6	7	8	9
Responsibility for Policy/Service Development	Follow policies in own role, may be required to comment Follows departmental policies, comments on proposals	Implement policies and propose changes to practices, procedures for own area Proposes and implements policy in own area	Propose policy or service changes, impact beyond own area Contributes to policies & procedures which impact on own and other professions	Proposes policy or service changes, impact beyond own area Participates in reviews of work practices which impact on service delivery to patients/clients and other specialities	Responsible for policy implementation & development for a service/ Responsible for policy implementation & development for directorate or equivalent Responsible for proposing & implementing service/departmental policies/ responsible for policy implementation and service development for a directorate or equivalent
Responsibility for Financial & Physical Resources	Personal duty of care in relation to equipment, resources/handle cash, valuables; maintain stock control. Personal duty of care/security of Valuables; responsible for ordering supplies	Personal duty of care in relation to equipment, resources/safe use of equipment other than equipment used personally; maintain stock control. Responsible for equipment used in course of treatment/responsible for equipment used by patients and others; orders supplies	Authorised signatory; purchase of some supplies; hold delegated budget/budget holder for department, service. Authorises payment; makes purchases/holds budget	Authorised signatory; Purchase of some assets; monitoring budgets. Responsible for training budget Signs off expenses; orders supplies; oversees management of budget	Budget holder for department/service; procurement of physical assets or supplies for department/service/ responsible for budget for several services Holds budget; procures capital equipment, supplies/ holds budgets for several services
Responsibility for Human Resources	Demonstrates own work/ clinical supervision Demonstrates work/ may supervise work of support workers, assistant(s), students	Day-to-day supervision; clinical supervision; provides training in own discipline Supervises work of recently qualified staff, support worker(s), assistants, students; trains staff in own subject	Day-to-day management; Allocate, place and supervise staff or students/ Line manager for single function or department Manages staff; organises student placements or allocates placement and supervision of staff, students/ Line management	Day-to-day management; allocate, place and supervise staff or students; responsible for specialist training Manages less experienced staff, students; provides training to less experienced staff or other healthcare professionals or carers within the specialist area	Line manager for single function or department/ several/ multiple departments Manages staff of department/ directorate or equivalent including recruitment career development, performance, work evaluation
Responsibility for Research & Development	Undertake surveys or audits, as necessary to own work/ Regularly undertake R & D activity; clinical trials Occasional participation in R&D activity/ clinical trials	Occasionally participates in/ regularly undertakes R&D activity Occasionally/ regularly participates in research and development activities	Undertake surveys or audits as necessary to own work/regularly undertake R&D activity Complete surveys as required/undertakes complex audits	Regularly undertakes R&D activity/major job requirement Undertakes complex clinical audits, undertakes research in one or more formal research programmes; undertakes research activity as major job requirement	Regularly undertakes R&D activity; R&D as major job requirement; co-ordinate, implement R&D activity as job requirement Undertakes research; carries out research as major job requirement/ co-ordinates and implements R & D programmes

Table 10-5: Managerial Responsibilities by Grade.


"When spiritual intelligence is flowering at its highest level, you may sense that instead of you being the one who is doing something, it's the universe that is doing something through you, and it is a joyful, beautiful dance".
Cindy Wigglesworth