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REVIEW

Meaning given to spirituality, religiousness and personal beliefs: explored by a sample of a Norwegian population

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Aims and objectives. The aim of this article is to explore the meanings given to the words 'spirituality', 'religiousness' and 'personal beliefs' by a Norwegian sample of healthy and sick individuals.

Background. Studies show that a high proportion of nurses do not identify the spiritual needs of their patients, even if the nurses are educated to give care for the whole person, including the spiritual dimension.

Design. This study used an exploratory qualitative design.

Methods. Qualitative data generated from six focus groups were collected in southeast Norway. The focus groups were comprised of three groups of health professionals ($n = 18$) and three groups of patients from different institutions ($n = 15$).

Results. The group discussions revealed that the meanings of spirituality, religiousness and personal beliefs were interwoven, and the participants had difficulty in finding a common terminology when expressing their meanings. Many of the participants described the spiritual dimension with feelings of awe and respect. They were dependent on spirituality in order to experience balance in life and cope with life crises.

Conclusion. The themes and categories identified by the focus group discussion highlights that spirituality ought to be understood as a multilayered dimension. An appreciation of the spiritual dimension and it's implication in nursing may help to increase health and decrease suffering.

Relevance to clinical practice. Health professionals need to be cognizant of their own sense of spirituality to investigate the spiritual needs among their patients. This study's focus group discussions helped both patients and health professionals to improve their knowledge regarding the meanings given to the spiritual dimension.

What does this article contribute to the wider global clinical community?

- Gives meaning to spirituality by a Norwegian sample of healthy and sick individuals.
- Focus group discussion highlights that spirituality ought to be understood as a multilayered dimension.
- Is a contribution to clarify an important and complex concept in nursing care.
- Shows that there is an appreciation of the spiritual dimension in a secularised country.

Key words: health, nursing care, personal beliefs, religiousness, spirituality

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Introduction

Earlier studies have shown that a lack of competence and the complexity that surrounds the spiritual dimension means that a high proportion of health professionals do not identify the spiritual needs of their patients (Burkhardt & Nagai-Jacobson 2002, Ross 2006). Spirituality and religiousness are terms that are increasingly used in nursing but there exist problems about exactly what these terms mean and how they are interpreted and understood by both the nurses and the patients (McSherry *et al.* 2004).

Holistic nursing care means being attuned to the whole person, including giving physical, social, psychological and spiritual care. Rykkje *et al.* (2012) defend that caring for the entire patient must include the spiritual dimension and that all nurses should be able to provide spiritual care to some extent. They emphasise that spiritual care, including support for spiritual, religious and personal beliefs according to a patient's desires, may promote health and maintain human dignity. Boero *et al.* (2005) underlined that nurses believed that someone should take care of the spiritual dimension of a suffering person.

According to Baldacchino (2003), the connection between spirituality and disease had received very little attention by nursing researchers. However, Koenig (2012) explored the correlations between spirituality/religiosity and health/illness; he says among other things that there is plenty of evidence to date to suggest that they are related in one way or another. What is noteworthy is not the amount of research, but the inconsistency in the findings for example that positive influence on physical and mental health could be explained by genetic and developmental factors to some extent (Koenig 2012). A study conducted in Norway indicates that there is an enormous need for health professionals to prioritise and respond to the spiritual/existential needs of patients with serious cancer to ease their suffering and stimulate patients' health resources (Sæteren *et al.* 2010). Research among Singapore hospice nurses also clarifies the importance of spirituality in the care of terminally ill patients (Tiew *et al.* 2013). Similarly, Delgado (2005) suggests a connection between spirituality and health, based on a literature review and a discussion of the concept of spirituality. Delgado concludes with the realisation that there is a relationship between spirituality and health, which needs to be acknowledged and that spirituality is a powerful resource in holistic nursing care. Koslander *et al.* (2008) in their critical review of the literature, also argue that all human beings have existential and spiritual needs that must be met in order to experience health and well-being.

Other studies point to spirituality's important connection with quality of life and ability to cope with illness (O'Connor *et al.* 1990, Johnston & Spilka 1991) cited in O'Connell *et al.* (2006). O'Connell and Skevington's (2005) study, based on the focus groups of the healthy and sick individuals in the UK, confirms the relevance of spirituality, religion and personal beliefs to health-related quality of life. Their study showed that the main topics that give meaning to all groups are spiritual strength, meaning in life and inner peace. The researchers suggest that these themes should be included in generic health care assessments. Research on spirituality and health is modest in Norway (Rykkje *et al.* 2012), thus raising the need for research evidence towards a better understanding of the meaning given to the spiritual dimension to foster holistic care.

Background

This study is part of an exploratory qualitative study for translating the World Health Organization's Spirituality, Religiousness and Personal Beliefs (WHOQOL-SRPB) Field-Test Instrument into the Norwegian language. The overall study followed the standardised translation and focus group methodology recommended by the WHOQOL group (1995a). The translation methodology includes a forward translation, expert panel, back-translation, pretesting, cognitive interviewing by focus groups and the final version. This part of the study explores the focus groups' reflections and discussions on the meanings given to the words 'spirituality', 'religiousness' and 'personal beliefs', with the aim of establishing better understanding of the meanings given to these words in a Norwegian sample of healthy and sick individuals.

Norway has a population of 5·1 million, and 15·6% of them are immigrants or descendants of recent immigrants from neighbouring countries and the rest of the world (Statistic Norway 2015a, 2015b). Norway is also a country with a Lutheran Christian heritage and a state church. The church was separated from the state in 2013 and Norway is slowly becoming a secularised country, with a low rate of attendance to weekly church services, although 74·3% are members of the Lutheran church (Statistics Norway 2014). Norway maintains religious freedom and is multicultural with most of the world religions represented (Rykkje *et al.* 2012, Sørensen *et al.* 2012 & Haug *et al.* 2014).

The theoretical perspective

Within the nursing literature, there are a huge range and diversity of definitions regarding spirituality and religious-

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ness, some of which appear coherent, whereas others seem quite disparate and unconnected (Swinton & Pattison 2010).

'Spirituality' has been described as a broad concept, which is connected to the terms existentialism and religiousness (Koslander *et al.* 2008). Sivonen (2000) in her search to define spirituality concludes with the following: 'the word spiritual includes the human search for strength, meaning and goals, shared relationships, spiritual uplift, quality of life, a relationship with God and goodness' (p. 334). Thus, with such a broad array of different aspects, these can easily be overseen in caring. Spirituality has also been described as an existential domain, which is related to the essence of being human. Ross (2006) describes spirituality as the substance in human beings that contains meaning, purpose and satisfaction with life. This promotes a wish to live, having faith, having faith in yourself, in others and God. This is necessary in order to reach optimal well-being, health and quality of life.

'Religiosity', on the other hand, has been described as a means for individuals to express their spirituality through the adoption of values, beliefs and ritual practices that give answers to major questions about life and death (Chan *et al.* 2006). Religion was defined by Pargament (1997) as 'a process, a search for significance in ways related to the sacred' (p. 32). He means that the sacred encompasses the concepts of God, the divine and the transcendent, but it is not limited to notions of higher powers. It also includes objects, attributes or qualities that become sanctified by virtue of their association with or representation of the holy (Pargament 2007)

'Personal beliefs' depends on a person's background, culture and from the environment within which he/she was raised. Personal beliefs can help people to come to terms with different issues in their lives, which may affect their quality of life:

> Beliefs have been distinguished according to their degree of certainty: a surmise or suspicion, an opinion, or a conviction. It becomes knowledge only when the truth of a proposition becomes evident to the believer. (Belief 2015)

In studies where spirituality is investigated, it is important to have a holistic view of the human being. Eriksson (2002) views the patient as an entity made up of the body, soul and spirit, and she divides the spiritual dimension into existential spirituality, religious spirituality and Christian spirituality. Eriksson's (2002) caritative caring theory focus on the meaning of the spiritual dimension and health. The deepest ethical motivation for caring according to Eriksson involves respect for the absolute dignity of the human being.

Purpose

The purpose of this article is to explore the meanings given to the words 'spirituality', 'religiousness' and 'personal beliefs' in a Norwegian sample of healthy and sick individuals.

Methodology

Design

This study used an exploratory qualitative design, where qualitative data were collected based on real-life experiences brought out in focus group discussions. Focus groups were selected for enhancing the dynamics of discussions and ensuring that different perspectives would be expressed. The interactions and dynamics among the focus group members can generate important information in a data collection situation, which most notably would be less accessible without the focus group interaction (Flick 2006).

Participants and context

The selection criteria for participants looked for adults over the age of 18, although efforts were made to maximise homogeneity, including an equal balance between men and women, a variation in age and with a variation in religious backgrounds. The exclusion criteria were people with dementia, senility or other reduced cognitive disabilities, people receiving acute psychiatric treatment and people who were acutely ill or in other ways incapable of participating in a group interview lasting for 1–1·5 hours.

Convenience samples in southeast Norway were compiled, including both healthy and sick adults. From these samples, six focus group discussions were conducted as follows: three groups of healthy adults who were health professionals ($n = 18$), and three groups of unhealthy adults ($n = 15$) representing the following diagnoses: burnout syndrome, orthopaedic disease, heart disease, arthritis and gout. There were five to six participants in each group.

Data collection

The focus group participants were recruited from three nursing homes, two rehabilitation centres, and one hospital in southeast Norway. The first author informed the director of each institution about the project and requested access to conduct research in their institution. To maintain participant confidentiality, a contact person was recruited, which could be a head nurse or manager in the institution. The

contact person was the one who recruited subjects wanting to participate in the focus groups.

The first part of each group session was used to provide information and to remind about ethical considerations. This was followed by an open discussion of the meanings that the participants attached to the terms 'spirituality', 'religiousness' and 'personal beliefs' which were presented as separate concepts according to our interview guide. This guide had helpful questions that directed the discussion towards general reflections on spirituality and quality of life. Finally, basic socio-demographic data were gathered during the focus groups including religious affiliation.

Data analysis

Socio-demographic data were analysed by using SPSS version 17.0 (IBM SPSS, Chicago, IL), and they are expressed as frequencies together with religious affiliation in Table 1.

The interviews were recorded and transcribed by the first author directly after each focus group. The thematic content analysis method, which was developed from grounded theory and proposed by Burnard (1991) was followed. It is a step-by-step method that is suitable for manual analyses.

Burnard's (1991) method began when the researcher and the second author read the transcripts separately and repeat-

Table 1 Socio-demographic characteristics and religious affiliation (n = 33)

Variable	HProf groups $n = 18$	%	Patient groups $n = 15$	%
Gender				
Male	2	11·1	6	40
Female	16	88·9	9	60
Age				
31–50	10	55·6	1	6·7
51–70	8	44·4	2	13·3
71–90			12	80
Marital status				
Married	1	5·6	4	26·7
Single			2	13·3
Widowed	4	22·2	5	33·3
Divorced	13	72·2	4	26·7
Education				
Primary school			4	26·7
Secondary school	5	33·3	11	73·3
University/college	13	72·2		
Religious affiliation				
Lutheren church	5	27·8	9	60
Norwegian mission association	4	22·2	1	6·7
Others and missing system	8	44·4	4	26·7

*HProf, health professional group.

edly to become immersed in the data and to be able to understand the statements while making notes on general themes. The data were then read again, excluding any unusable issues that were not related to the topic, and the requisite number of headings were written down that described all aspects of the data. This is also known as 'open coding.' The next step was to reduce the number of categories by collapsing them into broader categories and subheadings. The transcripts were reread again separately and adjustments were made as necessary to the agreed list of categories and subheadings. Each transcript was checked against the list of categories and subheadings by using coloured highlighting pens. This was done again later by cutting out all of the items related to each code and collecting them separately. The cut-out sections were pasted onto sheets headed with the appropriate headings and subheadings. Photocopies were used to ensure that the contexts of the coded sections were maintained. Copies of the complete interviews were used while writing up the findings. Examples from the thematic content analyses method is presented in Box 1.

Ethical considerations

The overall study was examined and approved by the Regional Committee for Medical and Health Research Ethics, South-East, Norway. The ethical committee recommended that the participants should be encouraged by the groups' facilitator to reflect generally on spirituality, thus avoiding more personal issues. Participation was voluntary, and the participants' anonymity and confidentiality were ensured by the procedures described in the enclosed information letter. Participants were required to give written consent to participate in the study and formal oral consent regarding the confidentiality of any forthcoming information discussed in the focus groups. Permission to use an audio recorder was obtained verbally with the agreement that it would be turned off when requested. Participants were told of their right to dissuade the group, even during the focus group discussions. The audio recordings and transcribed data were stored in a locked cabinet, and the computer data were stored under a password, which was known only by the first author. After the research is completed, the data will be saved for 2 years before being destroyed.

Findings

The findings from the six focus group interviews were combined to generate a broader data set. The meanings given to spirituality, religiousness and personal beliefs were

Box 1. Examples from the thematic content analyses method by Burnard (1991)

Meaning unit	Condensed meaning	Subthemes/Categories	Themes
I think about spirituality as something more than what is here	Something more than what is here	Boundlessness	Something larger than oneself
Spirituality can be so many things, such as Christian beliefs, but it can also be other religions and those who do not believe at all	Spirituality can be many things such as Christians, other religious people and nonreligious people	Different opinions	Multidimensional

reported separately, although these areas are closely related. The findings are presented in Box 2.

Meanings given to 'spirituality'

Spirituality was connected to experiences that emotionally affected the participants. The following themes of spirituality emerged during the interpretation process: *something larger than oneself, experiences of spirituality, multidimensionality* and *understandings of beliefs.*

Something larger than oneself
This theme was connected to the categories of *boundlessness, eternity and power/energy.* Boundlessness was

Box 2. Presentation of the themes and categories identified in the six focus group discussions

Meanings given to	Themes	Categories
'spirituality'	Something larger than oneself	Boundlessness Eternal Power/energy
	Experiences of spirituality	Meaning and coping Experiencing spirituality Assessment of patients' spiritual concerns
	Multidimensionality	A broad perspective Different opinions
	Understanding of beliefs	General beliefs Specific beliefs
'religiousness'	Different opinions	Different expressions Religious deeds
	Religious conduct	Good deeds Good fellowships
	Faith in God	Equal to Christianity
'personal beliefs'	Personal value system	Personal choices of value system
	Development of value system	Creating your own value system

described in different ways: as a dimension beyond the ordinary; as something between one's feelings, body and environment, and also as beauty and freedom. Many participants considered spirituality to be related to something within them, something large and high, and something that transcends what is here. Others meant that it has to do with eternity and one asked: 'Is it easier to find meaning in life when you have the eternal life as a perspective'? Spirituality had to do with something immortal that goes beyond the aspect of time. Power and energy were words used by many participants to describe their meaning of spirituality.

Experiences of spirituality
This theme comprised the following categories: *meaning and coping, experiencing spirituality* and *assessment of patients' spiritual concerns.* The participants believed that our acts have an existential meaning. Experiences that gave meaning to life were considered personal and specific, and they differed among subjects. For one person, for instance, meaningful experience meant having a good life, while for another it was having a family and children. One participant expressed spirituality in this way:

> Sometimes I actually have a need to believe in something in order to understand what meaning it is for me being here; it gives me a dimension of life with a deeper meaning. Spirituality means wholeness and balance and it helps coping in crises.

One participant explained spirituality this way: 'I am depending on the spiritual, I have my own prayer room in my head, that makes me secure, I feel protected from the fear of death.'

The participants expressed several ways of experiencing spirituality such as, going to a concert and listening to music, reading a book, experiencing harmony, going to church and experiencing the church room, closeness to something good and experiencing thankfulness.

Assessment of the patients' spiritual concerns had to do with listening to the patients and trying to find out if they had a lot on their minds. One nurse said: 'I am trying to

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find the key to the single patient, in order for he or her to lower their shoulders and then we talk about spiritual concerns'. Spirituality was something that was unnatural to talk about and many were hesitant to take such an initiative. They were also afraid of hurting the feelings of others if they expressed their own views about spirituality. The importance not to press your own beliefs upon a patient was discussed.

Multidimensionality
This theme had two categories, one for a *broad perspective* and one for *different opinions.* A broad perspective was described as: 'something everyone has but uses more or less, it penetrates everything, it is connected with everything, it means many things, and it is universal'. Different opinions, was by one participant outlined as: 'something outside of me, from which I can draw strength, and I need spirituality to feel good'. Another participant said: 'I believe everyone has spirituality, and it is something we need to protect and it is also distinguishes us from animals'. Meditation and yoga were by some participants viewed as having spiritual meaning. One health professional reflected on how her own spirituality related to the patients, and said: 'I never think about it and I have therefore no opinion. If it does not mean anything to yourself, it will be very difficult to understand its importance for your patients'.

Understandings of beliefs
This theme had also two categories: *general belief in something* and *a defined specific belief in God.* Many informants said that they believe that there is something between heaven and earth. They considered that there is a need to believe in something, which could be nature, the sun or the moon, or God as the creator. One participant said: 'The spiritual comes closer to me now when I am older, I feel that my prayers becomes more sincere'.

Meanings given to 'religiousness'

Religiousness was described as something important in order to understand different views of life. The following themes emerged from the content analyses: *different opinions about religion, religious conduct,* and *faith in God.*

Different opinions about religion
This theme contained two categories related to the participants' concerns: that religion was *expressed in different ways* and that it could be recognised by *religious deeds.* The participants discussed how religion depends on the culture where you grow up. They said that the Christians have their beliefs, the Muslims have their own and so do others. Many participants expressed that religion gives an existential meaning to life. Religious deeds such as prayer, reading the bible and going to church were an expression of your religiousness. Some had their own philosophy of life which others did not believe at all, such as one participant who said: 'I do not think about religiosity or spirituality'. The participants also expressed: 'you need to be humble in order to respect the beliefs and religions of others'.

Religious conduct
This theme was for many participants viewed as something positive. For example, *to do good deeds* was one category. To show love, and wishing the best for people were mentioned as consequences of good spirituality. Another category from the theme religious conduct was related to *good fellowship.* Such as attending church where one experienced good fellowship. One participant described religiousness this way: 'Living standards are for me positive, but when they were forced upon me as compulsory actions, it felt no good'. However, most of the group discussions concluded with the agreement that religious conduct was something positive and good.

Faith in God
This theme was for some participants related to Christianity. One participant said: 'Christianity was totally natural for me because my faith was grounded early in my life'. Other participants stated that being religious meant belonging to a specific denomination, thinking of God, or believing that there is a God who intervenes. Many participants said that the Christian faith gave them strength during sickness and that it was comforting having God during difficult times.

Meanings given to 'personal beliefs'

Personal beliefs depend on your background, on the view that you have of life and your culture. Two themes were prominent among the informants: *personal value system* and *the development of a value system.*

Personal value systems
This theme involved ideas that were often too personal to talk about, and some felt that these beliefs were private matters. *Personal choices of a value system* was one category viewed by one participant who said: 'Believing or having a faith could be a calling from God, although it was a free choice to answer'. Personal belief gave comfort, as one of the participants expressed: 'My faith gives me strength

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and comfort when times are difficult'. Personal belief included also thinking about astrology, having agnostic thoughts, experiencing quiet times in nature and listening to music.

Development of value systems

This theme was for many participants related to a process that occurred while they were uncertain of their own view of life. Several participants said that they were learning by listening to others share their personal views of questions related to belief and faith. *Creating your own belief* was a category exemplified as one participant said: 'Today one can create one's own view of life by taking a little from here and there'.

Conclusions based on the findings

The focus group discussions revealed that the meanings of *spirituality*, *religiousness* and *personal beliefs* were difficult to define and put into words. The informants did not have a common terminology for expressing their meanings. Participants with a Christian or a Muslim background appeared to find it easier to talk about their faith/belief than those with a secular background. The participants considered spirituality and its meaning in today's health care settings to be very important. This study's focus groups caused both the patients and health professionals to talk about spirituality, and the participants recognised that this was helping them to improve their knowledge about the spiritual dimension.

Discussion

The findings of this study documented that even if the meaning of spirituality, religiousness and personal beliefs were difficult to articulate, it was important to find balance in life and cope with crises. This was also confirmed by the research findings of McSherry and Jamieson (2013) underlining the fact that spirituality and spiritual care should be fundamental aspects of the nurse's role. Spirituality in this study was expressed being an important element for a person to experience wholeness in life. Religion was said to give an existential meaning to life, while personal beliefs are impacted by your view of life and your culture. The participants talked about religiousness and personal beliefs as well when discussing spirituality showing how these dimensions overlap in the minds of many.

The participants' meanings about the terms were influenced by challenges in differentiating spirituality from thoughts regarding religiousness and personal beliefs. Rykkje *et al.* (2012) emphasise that there is a distinction between the concepts of religion and spirituality, where spirituality is the broader of the two and includes aspects of religion. The findings from this study showed that spirituality was something experienced in private, and thus rarely discussed. The participants expressed the problem of not having a common terminology, which further increased difficulties discussing the spiritual dimension. This problem has been confirmed by other studies as well (Ross 2006, La Cour & Hvidt 2010). These authors stated that there is no universally accepted definition for, or consensus on, the concept of spirituality, although there are studies, such as Rykkje *et al.* (2012), McLaren (2004) and Sivonen (2000) which explore conceptual definitions. Austin (2006) suggests the need to set minimum basic standards of care for spirituality, which could be facilitated by providing a common terminology. He points to the following categories: a sense of the holy, actions of the holy, beliefs and practices, affective responses, personal responsibility, community, meaning, vocation, hope, grief, humour, forgiveness, courage, virtue and beauty (Austin 2006). Many of these categories were also found in this study, such as meaning and coping, religious deeds, relation to belief and religious conduct.

The participants thought of spirituality as being fragile, although they had feelings of awe and respect for the spiritual dimension. One participant said that they were afraid of hurting the feelings of others if they expressed their own views. McSherry and Jamieson (2013) report similar findings, where some nurses felt vulnerable in today's secular society where there exists little room for expressing personal faith and beliefs.

The majority of the participants expressed the view that spirituality was a necessity in their lives. Spirituality was needed for understanding the meaning of life and was considered a strength as well as a resource during crisis or illness. Spirituality was something that one depends upon and something that gives one security. Religiousness on the other hand was connected with conduct such as doing good deeds, for example to show love. Pargament (1997) defines these positive aspects as helpful forms of religious coping. His study shows that people who reported more spiritually based coping, where those who were better adjusted to life crises.

In the research of both Reed (1991) and O'Brien (2003) the positive connection between spirituality and health have been acknowledged as cited in Delgado (2005). The relatedness between spirituality and health is also made visible in Eriksson's ontological health model. Eriksson (2002) defines health as a movement between three different levels:

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the external objective level of health as doing, the existential level of health as being and trying to find balance and harmony in life, and the level of becoming in health as reconciling oneself with life and becoming whole. The external objective level was identified in this study by examples from the participants defining religiousness as, meditation, yoga, not thinking about it, prayer, church attendance and doing good deeds. The existential level, was expressed by one of the participants, who said: 'For me spirituality is about balance in life, and it helped me to cope when life was difficult.' The level of becoming in health which is about striving to become whole was also recognised in this study and is expressed by one participant who said: 'Spirituality means wholeness and balance for me'. Sæteren *et al.* (2010) emphasise that experiencing health and wholeness in a deeper sense means that one has to experience holiness and the consciousness of being unique and responsible as a human being.

Notably, many of the participants in this study felt that personal beliefs including personal faith, astrology, agnostic thought, quiet times in nature, listening to music and even creating your own beliefs belonged to a private sphere where one does not intrude without being invited. Correspondingly, the study also unfolds a lack of assessment of spiritual needs among patients. Expressed by one participant in this way: 'Why can't they ask about how I feel inside, because they only ask about my leg?' This was supported by Sæteren *et al.* (2010) showing, that only few patients reported nurses taking the initiative to talk about existential and spiritual concerns. It does have consequences for clinical practice when nurses give minimal attention to the patients' spiritual needs (Ross 2006). When examining the Nordic countries, Koslander *et al.* (2009) points out that in the area of mental health care, the spiritual needs are very often not recognised. Also Berglund *et al.* (2012) shows that health care actions in Norway that neglect a holistic and patient-centred approach caused increased suffering. The participants in this study kept their values and beliefs private in order to not affect health care delivery, although they considered spirituality a resource, they did not show it in their daily life. Thus, the values and beliefs captured in this study contrast with those described by Eriksson and Nåden (2004), who suggest that the values and beliefs of the health professionals should be the principles that guide caring acts in nursing.

Limitations

The study is limited because of convenience sampling and small samples. The primary intention was that the sample should include people of different age groups, different faith communities and different genders. However, this representativeness was somewhat skewed by the overrepresentation of older people, participants belonging to Christian communities and females. An explanation can be that the patient groups were recruited from rehabilitation centres, nursing homes and nursing-care centres, where patients tend to be older and where the nursing staff tend to be female. The low representation of male professionals (11·1%) can be compared with relatively low gender distribution among health professionals with a higher education (23·84%) in Norway. The high percentage of people with Christian affiliation can be compared with the fact that 74·3% of the population in Norway were members of the Lutheran church (Statistics Norway 2014).

Relevance to clinical practice

This study agrees with Delgado (2005), who advocates that spirituality has a large impact on peoples' lives and health and should therefore, have major implications for nursing. To improve care and reduce unnecessary suffering, we need more knowledge about the perceptions of the meanings given to thoughts regarding spirituality, religiousness and personal beliefs among healthy and unhealthy people. Education about these terms needs to be strengthened in order to understand their importance for a person's healing process. The practical implications of the findings from this study, that spirituality was a private matter, was a major reason for why people did not discuss it, should it represent a challenge for practicing nurses. The finding, that focus group interviews were mentioned as being helpful in initiating reflections and discussions on spirituality, can be useful. Perhaps focus groups themselves could be a practical suggestion for helping to change nursing practice by providing a means where patients can find words for their spiritual needs and also make health professionals more aware of their own meanings and sense of spirituality.

Conclusion

This study shows that the dimension of spirituality should be understood as a multilayered dimension containing both religiousness and personal beliefs. Even if the participants conveyed difficulty in defining spirituality, they showed an appreciation for this dimension and found it important. Hopefully, focusing on the spiritual dimension in healthy and sick individuals, can increase health and decrease suffering. Becoming healthy is a dynamic movement towards integrity and wholeness (Eriksson 2002). In order for health

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professionals in general to consider the whole person, i.e. body, soul and spirit, when caring for patients, there needs to be a greater understanding of the spiritual dimension and its importance for health. Both in education and in clinical nursing, this need deserves increased understanding and insight.

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Contributions

Study design: KBT and BS; Data collection and analysis: KBT and MK; Manuscript preparation: KBT and BS.

Conflict of interest

There are no conflict of interest.

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