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**SPIRITUAL DISTRESS THROUGH THE LENS OF  
THEISM, MONISM, AND HUMANISM**

Maureen P. Ryan

University of Victoria

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SPIRITUAL DISTRESS

Spiritual Distress through the Lens of Theism, Monism, and Humanism

by

Maureen P. Ryan

**Supervisory Committee:**

Supervisor: Dr. Anne Bruce RN, PhD, Associate Professor, University of Victoria, School of Nursing

Committee member: Dr. Elizabeth Davies RN, PhD, CT, FAAN, Professor and Senior Scholar, University of Victoria, School of Nursing

Chair: Dr. Anastasia Mallidou, BSN, MScN, PhD, Assistant Professor, University of Victoria, School of Nursing

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**Abstract**

In modern cancer care, human spiritual suffering often remains unacknowledged. Time, inadequate knowledge about spirituality and care giver reluctance are contributing factors. Spiritual distress is not a physician priority and chaplaincy services throughout the provincial cancer care system have been eliminated. Nurses' ethic to provide holistic care implies that nurses may be in a position to assume responsibility, at minimum, for screening for spiritual distress. To do so, nurses require sensitivity to clues of spiritual distress and have an awareness of how to address it. This project examines select articles pertaining to spiritual distress published between 1995 and 2010 using a framework derived from the work of Dr. Barbra Pesut (2005). Pesut organized literature on spirituality by nine nurse theorists using the philosophic categories of monism, theism and humanism. This project explores the implications of each typology for nursing ontology, epistemology, competency, and ethics with regard to spiritual distress. While an overlap was found for each of the examined categories of publications, the framework clarifies perspectives toward spirituality as well as implications for nursing practice. It is hoped that this endeavor will help nurses better understand care of those experiencing spiritual distress in the context of advanced cancer.

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### **Spiritual Distress Through the Lens of Theism, Monism, and Humanism**

Due to the biomedical focus of modern cancer care, human suffering is frequently equated with one-dimensional pain, specifically physical pain (Arman & Rehnsfeldt, 2003). In reality, physical symptoms may be a mirror of psychological, spiritual, or social distress (Mehta & Chan, 2008). The concept of “total pain,” coined by hospice founder Dame Cicely Saunders, encompasses each of these dimensions and advances the notion that suffering may be present without physical causes. For instance, the diagnosis of a life-threatening illness such as cancer may precipitate a personal crisis as mortality is confronted. Spiritual concerns may peak with the approach of death (Albaugh, 2003; Ando, Morita, Lee & Okamoto, 2008; Blinderman & Cherny, 2005; Chaturvedi, 2007; Puchalski, 2002) to result in spiritual distress. The concept of spiritual distress has been somewhat narrowly defined as “the impaired ability to experience and integrate meaning and purpose in life through... connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself” (North American Nursing Diagnosis (2005) as cited in Saddler, 2005, p. 258). Certainly, discussions in the literature expand this notion as an element in suffering, total pain, or a consequence of past events, incongruence between values, worldview and circumstance or despair regarding the future (Mok et al., 2010; Wright, 2005).

Development of new cancer therapies means that, for many, their dying phase is prolonged, sometimes to several years. As a result, more individuals are in effect receiving end of life care in the ambulatory setting (Holland & Lewis as cited in Baumann & Englert, 2003; Puchalski, 2002). It follows that oncology nurses working in this area will encounter individuals who are experiencing some degree of the various dimensions of pain, including spiritual distress. A cursory examination of documentation by nurses in a provincial cancer care system revealed a

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primary focus on the physical effects of disease and treatment. This is contrary to the assumption that nurses are holistic care providers. More importantly, inattention to the multiple aspects of a person's cancer experience may increase his or her suffering. Oncology nursing practice, therefore, may benefit from increased sensitivity to possible indicators of spiritual distress and approaches toward its management. To that end, the central question for the major project presented here is as follows: "What does the literature offer in terms of identifying and addressing spiritual distress in adults experiencing advanced cancer?"

To begin, I will briefly discuss the current state of spiritual care within the provincial cancer care system leading to this project. Next, I will briefly discuss the significance of spiritual distress and barriers to spiritual care as they exist in nursing practice. I will then outline the methodology used to locate and select articles addressing spiritual distress. I will describe a framework derived from the work of Canadian nurse scholar Dr. Barbara Pesut (2005) which I used as a lens for the analysis of the articles. A discussion of findings will include both a summary of spiritual distress as viewed through Pesut's typologies of spirituality and a critique of the framework. A reflection on my personal spirituality is included in Appendix A as my biases have influenced my approach to this endeavor. It is my hope that this project will help oncology nurses who choose to include conversations about spiritual care in their practice. Through better understanding of and ability to articulate spiritual care, this hidden aspect of nurses' work may become more explicit.

### **Statement of Problem**

Spiritual well being is increasingly recognized as a component of health and well being (Ando, 2008; Astrow, 2007; Morrison, 2005; Sherwood, 2000). It follows that spiritual distress should be identified and addressed in nursing practice. Currently, the provincial cancer

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treatment agency's admission form contains a single check box inquiring about the need for spiritual care: "Would you like spiritual or religious support? Yes/ No. If yes, please specify."

This question is problematic as the assumption has been made that the person who is newly diagnosed with life-threatening illness understands what is meant by "spiritual or religious support." There is rarely any indication of a spiritual assessment beyond that initial question, despite the profound life changes that may result with treatment and disease progression. While nurses may enact caring spiritually, recognition of spiritual suffering is not reflected in documentation.

Research in the field of oncology indicates that spiritual distress is increased following diagnosis, time of recurrence, disease progression, and at end of life (Chaturvedi, 2007; Ferrell, 2007). Although spirituality plays a role in health care decision-making about treatment and care (Chaturvedi, 2007; Pesut, 2009), spiritual and religious beliefs are generally ignored unless decisions based on them are contrary to medical advice and present ethical challenges (Pesut, 2009). Despite an expectation in palliative care for "the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organization, 2011, para. 1), issues of coping, mood or unmanageable symptoms are most typically managed by psychiatric or psychosocial methods. Although reference is made to the concept of "total pain," the influence of spiritual well being is largely neglected in cancer care, I suspect, because this dimension of personhood lies outside the comfort zone of the involved care providers. Since the notion of the spiritual is open to doubt, spiritual distress is particularly minimized in an era of funding constraints and an ideology of efficiency. Henery (2003) says scientific and corporate ideologies deplete organizations of the moral resources required dealing with loss, suffering and death.

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Some authors have speculated that an increasingly “impersonal and dehumanizing” (Baumann & Englert, 2003, p.52) society and health care system fail to foster a sense of peace and healing (Carson & Koenig, 2004; Chaturvedi, 2007; MacLaren, 2004; Simon as cited in Baumann & Englebert, 2003). In this milieu, people may sense that their spiritual needs have no place (Ferrell, 2008). If nurses are unaware of the central role of spiritual needs throughout the cancer journey, these cannot be communicated to community partners. As a result, persons may die without access to spiritual care (Daaleman, 2008). As Puchalski (2002) states: “Dying people are not listened to- their wishes, their dreams, their fears go unheeded” (p.269). The challenge, then, is to understand spiritual distress and nurses’ role in addressing it.

### **Background**

#### **Implications of Spiritual Distress**

Spiritual distress is challenging in that it can stem from a wide variety of sources and manifest as multiple emotions and symptoms. Those with advanced cancer may be considered at high risk. Persons may experience overwhelming loneliness from the forced isolation resulting from their loss of usual roles, but also from the solitary nature of dying. It is widely acknowledged in the literature that health care professionals’ failure to acknowledge suffering exacerbates its severity, affects coping, and negatively impacts psychosocial well being (Burnard, 1987; Cassell, 1991; Kemp, 1994; McClain, Rosenfeld & Breitbart, 2003; Wright, 2005). This project is warranted as it seeks to help nurses understand and attend to the very important issue of spiritual distress. To do so, a discussion of the barriers to spiritual care is in order.

#### **Challenges in Attending to Spiritual Distress**

There are multiple reasons for nurses’ inattention to spiritual distress in the provincial

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cancer care system. One is a difficulty in recognizing it in practice. To begin, though nurses may spiritually care for a patient's physical, mental, and social needs (Carr, 2008; Morrison, 2005), care of the human spirit is marginalized in nursing education (Bradshaw as cited in McLaren, 2004; Carr, 2008). Researchers report that nurses feel they lack the aptitude, formal training, mentorship or personal characteristics to engage in effective spiritual care (Carr, 2008; Frick, 2006; Gilliat-Ray, 2003; McSherry et al., 2004; Oldnall, 1996; Pesut, 2009; Ross, 2006). Others believe nurses may simply misunderstand what is meant by such an abstract concept and directly associate it with religion (Gilliat-Ray, 2003; McSherry, 2002; Ross, 2006; Vachon, 2009).

The issue is complicated as multiple religious and cultural backgrounds preclude a single definition of spirituality that incorporates a variety of worldviews (Coyle, 2002; MacLaren, 2004; McSherry, 1998; McSherry & Ross, 2002; Reimer Kirkham et al, 2005). Furthermore, diversity exists not only within the population at large, but also within cultural and even family groups. Molzahn and Shields (2008) and Pesut (2009) consider that symbolic language is frequently used in discussions surrounding spirituality. Not only might this cause discomfort between persons of different faith traditions, but the deep significance of symbolism, stories, and rituals as expressions of spiritual distress may be lost if a particular worldview is not fully shared. Therefore, nurses may simply feel overwhelmed by the diversity among patients and families and so avoid the topic of spirituality altogether.

In the practice setting, there are a number of constraints to providing spiritual care even though nurses may value it and see that addressing it lies within their practice role. For instance, competing time and space demands render attending to spiritual issues a low priority (Baladicchino, 2006; Daaleman, 2008; Hermann, 2001; Kristeller et al, 1999; Tanyi, 2002). The model of delivery may negatively impact continuity of care and patient-nurse connections

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(Daaleman, 2008; Sherwood, 2000). Furthermore, discussions about spirituality may be regarded as unprofessional because spirituality lacks the scientific base valued by the medical community (Goddard, 1995; Highfield, 2000). Swinton (2002) observes that the net consequence is that important cues to spiritual issues are left to chance. Instead of patient need, the determinant for attending to spiritual distress may be the nurse's personal comfort and own spirituality (Abbas & Panjwani, 2008; Daaleman, 2008; Emblem and Pesut, 2001; Pesut, 2009).

While persons may experience spiritual distress as they encounter life-threatening illness, they may or may not seek to discuss it with health care professionals (Johnston Taylor, 2003a). There are a variety of reasons for choosing against participation in spiritual care, all of which must be respected (Abbas & Panjwani, 2008). Spirituality cannot be imposed on either patient or nurse (Chaturvedi, 2007)

Given these conditions, it is not surprising that spiritual distress remains largely unacknowledged. Nurses are well positioned within the health care system to embrace the spiritual aspect of personhood should issues arise in the course of daily practice. If nurses are to fulfill their mandate to relieve suffering, it is critical that we make sense of the literature on spiritual distress, and understand the implications for nursing in terms of ontology, epistemology, practice, competency and ethics.

### **Scope of Project**

The aim of this major project is twofold. The first is to answer the question: "What can we learn from the literature about how to identify and address spiritual distress in adults experiencing advanced cancer?" The second aim is to apply and critique the usefulness of Pesut's (2005) typologies of spirituality as an analytic framework for responding to the guiding question of this project.

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### **Methodological Approach**

A systematic approach was used to search for and retrieve twenty articles related to spiritual distress in adults experiencing advanced cancer. This number was selected from the large number of articles retrieved according to specific inclusion and exclusion criteria. A framework derived from Pesut's (2005) doctoral work was used as an organizing and analytical tool to better understand and critique the concept of spiritual distress. A description of this methodological approach follows.

### **Retrieval Process**

In the review of the literature I focused on publications from 1995 to 2009 on spiritual distress in adults experiencing advanced cancer. Relevant literature from a variety of disciplines including palliative care, nursing, psychology, religious studies, social work and medicine was also located. EBSCO host was used as the interface and the primary databases were from the Cumulative Index of Nursing and Allied Health Literature (CINAHL). Psychology Information (PsychInfo), Medline and Embase were searched through Ovid with librarian assistance. Google Scholar was also used. Initial primary search terms included the following: cancer, advanced cancer, neoplasm, oncology, palliative, end of life, total pain, existential pain, spiritual pain, spiritual distress, spirit\*, and spiritual. In conjunction, the secondary terms case study, descriptive study, ethnography, focus group, grounded theory, interview, narrative/ narrative analysis, naturalistic study, phenomenology, qualitative method, qualitative research, and quantitative research were applied.

I also used ancestry and descendancy approaches (Polit & Beck, 2008). Ancestry approaches involve a review of the references cited in each work and locating the "ancestor" references. Similarly, the latter involves searching for works stemming from a significant earlier

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publication to locate its “descendants” (Polit & Beck, 2008, p.109-110). I also hand searched relevant journals and books for content and reference lists. Conference proceedings, dissertations, theses and other grey literature were not included due to inaccessibility and cost of retrieving them from their home universities. A variety of palliative care texts were hand searched and reviewed for relevant content. I sought the works of certain identified authors based on previous knowledge of their expertise in the field of oncology- palliative care. I obtained full texts of articles through University of Victoria Gateway and the British Columbia Cancer Agency (BCCA) library systems.

### **Inclusion and Exclusion Criteria**

Over one hundred articles pertaining to spirituality, spiritual distress, assessment and interventions were retrieved. Articles included both theoretical and research reports. Three doctoral dissertations and approximately thirty books were also reviewed for relevance to the project. Twenty articles were eventually selected based on the following inclusion criteria: written by a scholar or professional with educational or extensive experience grounded in oncology/palliative and/or spiritual care, and having immediate relevance to the project question. The intended audience for each article was scholars, practitioners or students in the relevant field. The areas of disciplinary expertise included chaplaincy (3), physicians (3), health science academia (1), alternate health care provider (1) and nursing (9). Two articles incorporated interdisciplinary perspectives. All articles were written in English and focus on adult oncology patients with advanced disease. Though an effort was made to represent divergent perspectives, articles were selected on their perceived applicability to nursing practice and usefulness in addressing spiritual distress.

Exclusion criteria included articles not written in English, those focused on individuals

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with acute or chronic conditions other than cancer or articles concerning a population of individuals below 19 years of age. Similarly, popular literature anecdotal accounts, editorials or items written for the lay audience or lacking evidence of a literature review were omitted.

Dissertations and works that were costly to obtain or not easily accessible through the interlibrary system of the BC Cancer Agency or the University of Victoria were excluded from this project. As this project is not intended to be a comprehensive literature review, no extra effort was made to include research studies or articles written from worldviews other than the Judeo-Christian perspective.

### **Development and Organization of Analytic Framework**

Pesut (2005) developed a typology of spirituality using the philosophical categories of theism, monism, and humanism to organize the various conceptualizations of spirituality in relation to nursing practice. Acknowledging her Christian background, Pesut developed these categories of spirituality drawing from the work of nine nursing theorists. Looking at spiritual distress through each of these three lens allows for a better understanding of the perspectives that patients and families may have in regard to spirituality, and may also serve to heighten awareness of potential sources of spiritual distress. That said, I will now provide a brief description of how Pesut defines each of the three philosophical categories.

**Theism.** Theists share an assumption that spirituality begins with God. Humankind exists in order to share in a relationship with God, the Creator. It is through this relationship that ultimate well being is reached. Here, nursing is considered a vocation underpinned by service to Him. Pesut (2005) selected Bradshaw (1994, 1995, 1996, 1997, 1998, 1999, 2000), O'Brien (2001, 2003, 2004) and Shelly (1997, 1999) to elucidate the theistic category (while recognizing the variation among these theorists). Bradshaw and Shelly see humans as comprised of

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interrelated dimensions and in a covenantal relationship with the Creator. They view religion and spirituality as integrated. In the theistic category, theological knowledge provides the basis for ethics and values. Bradshaw considers the drive and ethic for nursing care based in religion. Shelly is described as “evangelical” (Pesut, 2005, p. 235) and believes she has a responsibility to share her faith with others. O’Brien, on the other hand, advocates for a more broad based response to individual spiritual needs. A self-identified Catholic sees spirituality as a need common to all humans and “related to transcendence, ultimate ends, and values” (Pesut, 2005, p.34).

**Monism.** Monism is a philosophic worldview that rejects belief in the existence of an external God. Time, space, cause and effect, and dualism are considered “illusory manifestations” (Leddy, 2000, p.225). Humankind is considered part of an “indivisible, universal consciousness that transcends space and time.” (Pesut, 2006, p.128). This group sees reality as comprised of “energetic consciousness” (Pesut, 2005, p. 41) and a “unified existence” (Pesut, 2005, p.52). All things are in constant flux and change, so they are only known relative to one another (Leddy, 2000). Pesut’s (2005) understanding of monism was shaped by Parse (1998, 1999, 2000, 2002, 2003, 2004), Watson (2000, 2001, 2002, 2003, 2005), and Barnum (2003). Theorists in this group propose a unitary view of the world that places the spirituality of the person, conceived of as energy, central to nursing care. From this perspective, higher levels of consciousness coincide with heightened levels of health and well being (Pesut, 2006). Parse’s human becoming theory considers spirituality in terms of life’s meaning, humans as co-creators of patterns and change with the universe, and reaching beyond the confines of time and space (Pesut, 2005, p.46). Watson focuses on “love as the universal healing energy” (Pesut, 2005, p. 43). She considers “transpersonal caring” in a climate of “consciousness, intentionality, and

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authentic presence” (Pesut, 2005, p. 44) critical for patient and nurse. Barnum sees humans as “energy and light” (Pesut, 2005, p.41) that can be influenced by nurses skilled in ancient modalities. Channeling and mystical experiences are considered valid. The monistic category considers knowledge inherent to the knower.

**Humanism.** Work by Narayanasamy (1993, 1995, 1999, 2001, 2002, 2004), Johnston Taylor (1995, 2000, 2001, 2002, 2003, 2005), and Burkhardt (1985, 1989, 1993, 1994, 2002) were selected by Pesut (2005) to typify the humanist group. Humanism focuses on the inherent worth of humans and their potential for self-determination without reliance on a deity (Mitchell & Cody, 1999). Meaning, purpose, connectedness are considered common spiritual needs; the existence of a deity may or may not be of significance. According to Pesut (2005), humanism views spirituality as one of several aspects of a person and that it is uniquely determined by the individual. Theorists consider whatever an individual values most as a possible expression of spirituality. From this perspective, spiritual care involves the application of the nursing process. Narayanasamy is unique in that he considers a “biological”, rather than theological, component to spirituality (Pesut, 2005, p.36). He considers spirituality as a universal human dimension and advocates for a scientific approach to inquiry. Narayanasamy also recognizes the importance of “spiritual and cultural sensitivity and awareness” (Pesut, 2005, p.37) in the delivery of care. Like Narayanasamy, Johnston Taylor and Burkhardt see meaning, relatedness and transcendence as spiritual needs. Johnston Taylor sees spirituality reflected in the everyday, so considers the outcomes for nursing interventions identifiable. Burkhardt, however, reserves judgment about the spiritual integrity of others.

To assist the analysis of the articles on spiritual distress, I developed a framework based on Pesut’s (2008) discussion of monism, theism and humanism. Within each of the three

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typologies, Pesut (2008) discussed the concepts of spirituality, religion, ontological and epistemological influences, and the social role of nursing. I expanded the initial framework in response to reading Pesut's (2005) full dissertation to incorporate issues of ethics, power relations, competency and education for each worldview. While the full table may be found in Appendix B, key elements of the framework are presented here.

### Framework derived from Pesut's (2005) typologies of spirituality

<b>TYOLOGY</b>	<b>MONISM</b>	<b>THEISM</b>	<b>HUMANISM</b>
<b>SPIRITUALITY</b>	We exist in energy. Ultimate goal of life is to merge with "cosmic consciousness" (p.52).	Spirituality begins with "knowledge of...God" (p.52); requires people be treat one another well.	Spirituality is "innate, subjective" (p.53), and diverse; "becomes recognizable when need arises" (p.53).
<b>RELIGION</b>	No external god. Humans are collectively "part of process of universal change" (p.55).	Theology & religion fundamental to spirituality as tell how to develop spiritual values such as "love, joy, peace, justice" (p.55).	Dispute notion of "correct version" of the truth (p.54). All persons are spiritual, including agnostics and atheists.
<b>ONTOLOGY</b>	"Evolving consciousness" of patient and nurse "central to nursing" (p.57). Energy based interventions focus on "soul", nurses become healers (p.57).	"Sacred and personal", cannot be subject to standardized approach. Spiritual care is a "way of being, an ethic" (p.56).	Spiritual is characterized by needs such as transcendence, "connectedness" (p.53), meaning & purpose. Spiritual care should be delivered systematically to ensure "ethical and standardized care" (p.56).
<b>EPISTEMOLOGY</b>	"Epistemology and ontology are united" (p.64). "Knowledge resides within us" (p.64). "Beliefs are integral to our	"Revelatory knowledge" (p.64) provides foundational "truths about nature of God, humankind, health and what it means to live well"	Humans are the "best source" of knowledge (p.63). Research through "inquiry" (p.63).

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	knowledge, not lesser” (p.64).	(p.64).	
<b>RELATIONSHIP TO OTHER DOMAINS</b>	“Humans... exist as physical bodies ...extend beyond to energetic, cosmic consciousness” (p.52).	Bodies are “temples of God...dimensions of person are interdependent” (p.57).	The spiritual is but one of several dimensions of the person that “are all connected” (p.73)
<b>SOCIAL &amp; INTERDISCIPLINARY</b>	Nurses can renegotiate current social role to become “autonomous healers” (p 61). Wellbeing & health are framed in terms of attaining a higher level of consciousness.	“Spiritual care... is about a way of being, an ethic and motivation” (p.56).	Physical care remains part of nursing role or “patient care will deteriorate” (p.61). Spiritual care focuses on patient priorities, values.
<b>ETHICAL RESPONSIBILITY</b>	Nurses need a stance of unconditional acceptance to “stand alongside, help to identify patterns and envision new possibilities” (p.73) through a shared “powerful and universal context” (p.72).	Nurses are in a role of “unself-conscious service” (p.82). Must guard against imposing beliefs on vulnerable patient. Requires nurses be aware of limitations- call on experts (chaplains, theologians) as appropriate.	Interventional approach with “needs always designed in partnership with patients” (p.77)
<b>POWER RELATIONS</b>	Therapies may be considered spiritually detrimental if not in alliance with patient’s worldview.	Potential for nurse to believe in obligation to proselytize or convert others to own particular beliefs.	Interventional approach. Religious & existential indicators. May be intrusive & objectifying. Nurse makes a judgment.
<b>COMPETENCY</b>	Certain worldview (unitary or energy based); “spiritual development of the nurse is foundational” (p.59). Knowledge of healing modalities.	Nurses’ engage in a “relational encounter that depends on the character of the nurse” (p.78) more important than assessment.	Assumption is that all nurses should be able to learn spiritual care.
<b>EDUCATION</b>	Need to be well established in philosophy or worldview,	Learned through mentorship/ role models.	In regular curriculum.

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	“concentrate on the development of own consciousness” (p.59)		
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The typologies are helpful not only because they provide a framework for understanding differences between and among a diversity of worldviews, but also because they offer a nursing lens for examining literature written by scholars in other disciplines. In addition to the framework, two series of questions developed by Pesut (2005) were used. The first helped to identify the philosophical underpinnings of each article (Pesut, 2005, p.131) while the second helped to further analyze the articles (Pesut, 2005, p. 81). These questions are included in Appendices C and D. I collapsed the twenty four questions into the following:

- (1) What are the author’s ontological assumptions about spirituality and/ or spiritual distress?
- (2) What is the influence of the author’s assumptions on nursing practice (nature, goal, scope, object, interventions, and outcomes)?
- (3) What is the relationship of spirituality or spiritual distress to the physical, psychological, social and emotional domains of personhood?
- (4) What are the epistemological assumptions influencing knowledge acquisition about spirituality (including research, competency and expertise)?
- (5) What are the ethical implications of the author’s stance for nursing (including power issues)?

The information pertaining to each question was organized using a synthesis matrix, a table used to organize ideas from multiple sources in order to facilitate the writing process (Ingram, Hussey, Tigani & Hemmelgarn, 2006). Notations were also made regarding the disciplinary background of the author, year of publication, country of origin, and key influences

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and features for each article. A sample is included in Appendix E.

For the sake of clarity, a definition of the above terms embedded in the questions is in order. Assumptions refer to unstated, taken for granted beliefs that may be unfounded or unconsciously based on biases (Elder & Paul, 2007). Those referring to ontology are those that pertain to nature of existence; reality is determined by one's perspective (Kikuchi, 2004). Epistemological assumptions pertain to assumptions regarding what is knowable, who can know and what criterion distinguishes beliefs from knowledge (Campbell & Bunting, 1991). Here ethical considerations are the potential issues in the context of the nurse- patient relationship that, among others, may be related to power, competency, confidentiality and choice.

### **Spiritual Distress Through the Lens of Pesut's Typologies**

While the focus of this project is on spiritual distress, an understanding of spirituality and religion through the lens of theism, monism, and humanism and how they relate to spiritual distress will add depth to the discussion.

#### **Theism**

The first typology, theism, is the most traditional approach to spirituality in Western culture. As stated earlier, Pesut (2005) defines theism as the philosophical worldview that achieves understanding of the spiritual through God. She says that theism centers spirituality on a God that exists independent of creation and humanity, yet also infuses all aspects of creation. Within theism, she considers humans in covenant with God. In response to a moral commitment to their God, humans seek to be good to one another. Individuals live in community and have the free will to act to either enhance or hamper the inherent spiritual health of that relationship. From the theistic perspective, religious doctrine and theology are considered core to spirituality and act as guideposts for correct living and determine understandings about right or wrong

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(Pesut, 2005). A theistic perspective considers humans' worldly existence has a significant bearing on an eternal life in the hereafter. Analysis of the selected articles pertaining to spiritual distress among adults with advanced cancer determined that articles written by Bartel (2004), Belcher (2006), MacInnis (2007), Mako, Galek, and Popito (2006), Millspaugh (2005a, 2005b), Okon (2005), Sumner (1998), and Wright (1997) were written from a primarily theistic perspective. Influences of the theistic lens are also located in discussions by Rousseau (2003) and Mount and Flanders (2003).

**Sources of spiritual distress.** Any aspect of spirituality may be a source of spiritual distress. Several writers in this category see spirituality as both the essence of a person and a broad concept that unifies humanity through a transcendent dimension. This is based on relationships with others and a Higher Power and a human search for meaning, purpose and self fulfillment (Belcher, 2006; MacInnis, 2007; Okon, 2005; Rousseau, 2003; Sumner, 1998). Millspaugh (2005b) discusses spirituality as a state of "being" defined by relationship with self, other, the environment, as well as to evil and holiness. Sumner sees spirituality as pertaining to both the experience of a meaningful earthly life and an eternal after life. In his theoretical essay, Bartel (2004) presents his view of spirituality in both religious and non-religious contexts. He maintains spiritual needs exist in five areas: "love (community, connection); faith (worldview); hope (vision); virtue (ethics); and beauty (renewal)" (p.188-9).

Several authors writing from the theistic perspective share the assumption that spiritual distress is a common human experience, all persons are vulnerable and it is one and the same with suffering (Bartel, 2004; Mako et al., 2006; Millspaugh; 2005a, 2005b; Wright; 1997). Bartel sees spiritual unrest and suffering as due to undefined needs. He also believes distress can be evoked by a life situation incompatible with personal values. Millspaugh considers that the

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perception of loss or an inability to interpret meaning in a given situation may result in suffering. For some, this may lead to a realization that an inauthentic life has been lived through an invented external self. Millspaugh (2005b) argues that patients' efforts to make meaning of their situation are based in theology. He (2005a, 2005b) states an internal locus of control is needed for an individual to draw on inner resources in order to maintain hope and achieve positive outcomes in a challenging situation.

Within the theistic category, the significance of advanced disease and spiritual distress is well recognized. MacInnis (2007), a Canadian chaplain, sees health care at "the juncture of suffering and individual spiritual search" (p.2), particularly in terminal illness where she considers that questioning of one's identity, beliefs and life emerges as a very real need. Rousseau (2003) regards spirituality as integral to the dying process and maintains that an individual's focus on a transcendent dimension of life increases as the end of life nears. In the face of life threatening illness, illusions about control over one's own life are shattered. In the theistic perspective, access to Divine power through prayer to influence life events and well being is common. Though religious faith may be a source of strength and enhance an individual's capacity to love, or forgive, Rousseau recognizes its role in the fear of eternal damnation should past actions contravene religious standards. Sumner (1998) considers spiritual distress in relation to angst about the meaning of life, pain, suffering and death, but also in regard to conflicted religious beliefs and anger toward God. As Okon (2005) reviews trends regarding spirituality in the literature, he comments on religious beliefs as "an effective coping framework to face the existential crises of life-threatening illness" (p. 394), to unite the existential, spiritual and religious. Though Mako et al. (2006) feel religion has no bearing on the frequency of spiritual distress, the authors feel the experience is impacted by religious beliefs.

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Like MacInnis (2007), Millspaugh (2005a) maintains that persons want to find meaning in their suffering in order to transcend it. In that way they can retain a sense of self and purpose and look towards a future. Millspaugh (2005b) asserts that the severity of spiritual distress depends on a personal view of suffering and the maturity of their faith. That is to say, the spiritual coping and development are determined to an extent by life experience, inner resources and capacity to move beyond immediate tribulations.

**Epistemological assumptions.** From a theistic perspective, Pesut (2005) asserts that God permits man to have a degree of personal, intuitive knowing about Him. Such knowledge is difficult to critique due to its sacred nature. Several authors consider that the mysteries of the spiritual will never be fully known, however they maintain that development of a common definition of spirituality may help movement toward that goal (Bartel, 2004; Mako et al., 2006). Millspaugh (2005b) points out that we cannot fully know another's suffering. He feels the best way to understand is to also reflect on one's own experience of spiritual distress as a means of determining what might be an effective helping strategy. Some authors in this category suggest that intuitiveness and sensitivity toward spiritual distress determine our ability as caregivers to witness and thereby decrease suffering (Belcher, 2006; MacInnis, 2007; Wright, 1997)

**Relationship to other domains.** All authors writing from a theistic perspective consider the inter-relatedness of spiritual, physical and psychosocial aspects of personhood. While spiritual distress may not be directly knowable, the embodied experience of loss and deterioration may hold clues to spiritual pain. The loss of independence and disturbed body image that accompanies advanced illness may be associated with a disrupted sense of identity (Millspaugh, 2005b). For instance, as persons with advancing cancer become more isolated from daily activity and relationships, they become more aware of their powerlessness over the

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progression toward physical non-existence. Spiritual pain is complex and may have a significant impact on persons with advanced illness (Mako et al., 2006; Okon, 2005).

Mako et al (2006) see existential suffering manifested during times of illness and dying in one of three dimensions: the intrapsychic, the interpersonal and the divine. They distinguish it as pain “deep in your being that is not physical” (p108). Wright (1997) extends suffering during illness to include both patient and family members in the struggle of trying to endure and fear of the unknown. Several other authors note that spiritual distress may manifest as physical or psychological symptoms like sleep disturbances, depression, anxiety, grief, or guilt (Bartel, 2004; MacInnis, 2007; Mako et al., 2006; Sumner, 1998). Based on her clinical experience, MacInnis considers that spiritual distress may manifest in any of four inter-related dimensions: physical/pain and symptom management needs, faith, religious issues and those related to inner resources (p.8-9). She points out that physical pain does not necessarily lead to suffering. Rather, its severity can be tempered by the meaning attributed to the pain and associated patient or family beliefs, a notion supported by Wright (1997).

MacInnis (2007), Mako et al., (2006), and Okon (2005) maintain that existential or emotional pain induced by isolation can be worse than physical pain. In turn, such pain may result in poorer treatment outcomes, prolonged recovery and higher mortality, and ultimately, increased suffering (Mako et al., 2006). Just as religious beliefs are integral in health care decision making, spiritual distress may result in resistance to treatment. In extreme cases, spiritual despair is insurmountable and the only escape is death.

Okon (2005) operates from palliative care discourse that spiritual well being is essential to quality of life and fundamental in the care of the dying. He considers that an absence of spiritual distress may improve quality of life and self-esteem for those with terminal illness.

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MacInnis (2007) cites Kearney and Mount who, like Wright (1997), maintain that the spiritual dimension is critical to full understanding of a person's response to illness.

**Influence of ontological and epistemological assumptions on nursing.** Pesut (2005) notes that nursing's concern with people, health and environment subjects it to religious and spiritual discourses. Many nurses draw an ethic of caring and service to others from a theological awareness (Pesut, 2005). From a theistic viewpoint, spiritual care infuses every aspect of care. Physical care is considered essential as it preserves the dignity of the ill person (Pesut, 2005). The alleviation of physical suffering is critical to fostering hope throughout terminal illness (MacInnis, 2007; Wright, 1997) and so may ameliorate spiritual distress.

The theistic perspective sees that character, spiritual make up and maturity of the nurse are central to effective holistic care since it is based on moral and personal qualities. Wright (1997) refers to this hidden dimension as "the soul of clinical work" (p.14). While none of the authors in this typology overtly discuss the influence of the sacred in nursing management of spiritual distress, the desirable qualities of care can easily be inferred. Among the values identified are compassion, respect for human dignity, non-judgment, acceptance of diversity, and empathy. Similarly, skilled communication, active and attentive listening, giving of oneself through true presence are cornerstones for excellent care. Wright advocates that nurses make space for the expression of spiritual distress through the illness narrative. In voicing beliefs, either religious or otherwise, persons may gain clarity, come to understand new possibilities, and begin healing.

**Competency.** In addition to personal characteristics as discussed above, several other attributes are necessary to address spiritual distress according to the others writing from a theistic viewpoint. Several authors underscore the importance of self-reflection in order to be aware of

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biases and opinions about others' belief systems before engaging in spiritual care (Bartel, 2004; MacInnis, 2007; Millspaugh, 2005b; Okon, 2005; Sumner, 1998). This might include contemplation about life's transcendent dimension, a personal perspective of spirituality, and its impact on life and relationships. While authors in the theistic group recognize the importance of considering religious worldviews, ethnicity, and cultural traditions as factors influencing care, they also caution nurses against making assumptions about groups (Belcher, 2006; Okon, 2005).

Recognizing spiritual distress is a challenge for health care providers. A theistic perspective requires that nurses understand that the experience of the "suffering other" may differ from their own. Pesut (2005) sees theism as recognizing the soul of each person as sacred and unique. An individualized approach to care is thus preferred. Thus, nurses must have a sense of the unique nature of spirituality that makes each person expert in his own care (Belcher, 2006). For instance, certain individuals may see suffering as a means towards being freed of guilt, a test for his or her spiritual strength or an assault by evil (Millspaugh, 2005b). However, this does not mean nurses require a thorough understanding of the theological principles.

While authors writing from the theistic tradition appreciate the unique nature of spiritual distress, some advocate for a more systematic assessment of persons receiving health care. While Bartel (2004) views the various dimensions of spiritual difficulties on a "spiritual spectra" (p.196-7) ranging from integrity to spiritual disintegration, MacInnis (2007) favors a more structured approach. Both believe that spiritual assessment should be an ongoing process from diagnosis until death. MacInnis refers to the importance of metaphor and symbolism as people seek to express their spiritual thoughts. Wright (1997) and MacInnis consider medical, illness and faith/belief narratives necessary for an accurate understanding of another's spiritual distress.

Caregivers must also be receptive to discussing spiritual issues (Bartel, 2004; Millspaugh,

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2005; Okon, 2005; Sumner, 1998). This implies a shift from task-based nursing to one focused on conversations. Most difficult, however, is a willingness to be present in the discomfort of true suffering (Millspaugh, 2005b). Caregivers must reach comfort with being powerless, their own vulnerability to life threatening illness and death, and be able to tolerate the unknowable.

As the goal of nursing is optimal well-being, the theistic perspective places issues like loss of trust, hope, beliefs, purpose within spiritual nursing care. (Sumner, 1998). However, one “cannot give purpose or meaning to the sufferer” (Millspaugh, 2005b, p. 1113). Instead it is by “journeying with” the other that persons are affirmed, understood and regain a sense of personal power (Millspaugh, 2005; Wright, 1997). Similarly, MacInnis (2003) maintains that by developing strategies that foster hope despite changing circumstances in terminal illness, transcendence becomes attainable.

**Ethical considerations.** From a theistic perspective each caregiver has a unique spirituality and experience of spiritual distress, just as the person receiving care. This means that each nurse may have a different worldview that influences the enactment of her or his approach to the management of spiritual distress. For nurses whose religion has a mandate to share faith with others, ethical concerns may arise since vulnerable patients may be subjected to pressure (Pesut, 2005). Therefore, nurses must be mindful of the ethical implications inherent in their privileged position (Sumner, 1998). Authors within this perspective similarly maintain that a prescriptive approach to spiritual distress is ethically challenging as it implies a power imbalance.

Equally important is nurses’ awareness that persons may be reluctant to accept spiritual care from a nurse as it is typically not considered a part of their role within the health care system. While some may consider the exclusion of the spiritual contrary to nurses’ self- image

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as holistic care providers (Emblem & Pesut, 2001), nurses must be cognizant of their own limitations in addressing spiritual distress and make appropriate referrals to chaplains (MacInnis, 2007; Mako et al., 2006). Okon (2005) cautions that “qualitative data suggest that naïve, proselytizing or unskilled conversations about prayer with patients with cancer may result in exacerbation of spiritual suffering” (p.406).

. Although it is acknowledged that a single worldview cannot capture the diversity of religious faiths, cultures or personal belief systems, MacInnis (2007) points to the avoidance of suffering and spiritual distress in a health care system singularly focused on research leading to cure. She points to “attitudinal, behavioral, economic, educational, and legal” (p.4) barriers to humane, culturally sensitive care. MacInnis maintains that by recognizing and addressing “total pain” and suffering in fact reduces demands on caregivers and healthcare resources. In doing so she addresses the failings of our society to adhere to a moral imperative to relieve suffering.

*Summary.* An examination of publications by authors writing from a theistic perspective reminds nurses of the possibility that religious beliefs, typically associated with comfort, may be a source of angst at end of life. Clearly, individuals’ use of symbolism and metaphor may help nurses to identify the presence of spiritual distress. Similarly, this discussion supports the notion that spiritual distress may manifest as physical or psychological symptoms. Literature in this category recognizes that the nurse may not fully know another’s suffering, but can witness by attending to illness narratives. As being present with profound suffering may be difficult, these writers advocate for nurses to be aware of their own spiritual issues so that they can more freely acknowledge the spiritual distress of patients and families under their care.

### **Monism**

Pesut (2005) relates the second typology, monism, to a postmodern challenging of theism

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as an accepted perspective. Though recent years have seen some adoption of New Age modalities in health care settings, none of the articles selected are exemplars of a monistic approach to spiritual distress. However, features of Pesut's discussion of the monistic tradition will be summarized as influences are evident in the articles by Agrimson and Taft (2009), Belcher (2006), Georgensen and Dungan (1996), Mount and Flanders (2003), Rousseau (2000), and Wright (1997).

**Sources for spiritual distress.** Monism shifts from traditional Western conceptualizations of spirituality. Here all that exists is of one substance; there is no external God (Pesut, 2005). According to Pesut, monists have a somewhat negative view of religion because it claims to have definitive answers about existence. Consequently, it has interfered in the acquisition of knowledge and universal connectedness. Monism is based on an ontological assumption that existence consists of one substance, "universal psychic energy" (Pesut, 2005, p. 27) where mankind, god and the universe are one. Within this universal joining, a collective humanity seeks to attain a higher level of consciousness. Spirituality is the essence of the unitary existence and connectedness of the universal energetic life force. The ultimate goal is the evolution of god and humanity into "a universal cosmic consciousness" (Pesut, 2005, p.13). To do so signifies movement toward spiritual health and well being. It may be inferred that circumstances that detract from this might result in spiritual distress.

Though predominantly humanistic in their approach, Mount and Flanders (2003) view of spirituality potential sources of spiritual distress in the context of three levels of relationships: to oneself; to others in the context of a united cosmos and on a psychic level; and at the transpersonal, I-thou level. In their concept analysis, Agrimson and Taft (2009) conceive of humans as primarily spiritual beings that possess a body as opposed to bodies with a soul. The

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spiritual is considered essential to well being; all persons are vulnerable to the suffering of spiritual crises. Agrimson and Taft see profound questioning as occurring in times of incongruence between values and life situation. Like Bartel (2004) who wrote from a theistic perspective, they consider that spiritual distress may arise in situations where a worldview becomes inadequate; a paradigm shift is required for resolution. However, Agrimson and Taft extend the experience of spiritual distress beyond that of an individual to that shared on a communal and societal level. Despite commonality, an individual's personal distress is seen as a complex phenomenon that cannot be fully known by another. They maintain that the process inherent to spiritual distress can eventually result in a new way of being.

**Epistemological assumptions about spirituality.** Pesut (2005) explains that the monistic perspective sees the ultimate level of knowledge as the spiritual merging of humans with the universe. Therefore, knowledge and being are united to reside within the individual. Monists consider beliefs to be valid as knowledge. Wright's (1997) attention to personal beliefs, reflected in illness narratives, in the context of illness and spiritual distress seems to support the notion that spiritual distress can be known through an exploration of these. Second to that are spiritual understandings that have visionary and creative expressions. Lastly, knowledge of the physical dimension, where biomedical knowledge resides, is lower level knowledge.

The underlying epistemological stance held by Agrimson and Taft (2009) is that all knowledge is tentative and that no single theory or religion can adequately capture truth hints at openness to many possibilities. Monists hold that critique of monistic knowledge must arise from a monistic perspective for it to be valid. They maintain that an acceptance of our innate understandings of the universe empower us to create change in the universe. Together mankind creates destiny.

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**Relationship to other domains.** As mentioned earlier, only monistic influences are apparent in the publications assigned to the monistic category. In their theoretical essay, Georgensen and Dungan (1996) see cancer as challenging the wholeness of the individual. An impact of cancer in one of the mind, body, or spirit, has a corresponding effect in the others. Conversely, energies directed toward any of the dimensions will have a bearing on the others. The authors assume that oncology patients, particularly those in pain, are at high risk for spiritual distress. Georgensen and Dungan illustrate their position that a holistic approach to pain management is essential and thus nurses must develop an understanding of spirituality within the context of total pain. Similarly, Rousseau (2000) sees the Cartesian mind-body split, non-existent in the monistic view, as a contributing factor in the neglect of spiritual suffering. He suggests possible indicators of spiritual distress: (1) unexplained physical symptoms that do not respond to usual intervention, (2) emotional responses incongruent with loss, and (3) unreliable adherence to therapy. Rousseau acknowledges the challenge of distinguishing spiritual angst from emotional or psychological issues. Like authors in the theistic category, Georgensen and Dungan and Rousseau consider the bidirectional nature of spiritual, psychosocial and the physical that complicates effective care.

**Influence of ontological and epistemological assumptions on nursing.** From the monistic perspective, health and well being entail a movement towards a state of higher consciousness with the universe. Spiritual care focuses on the features of personhood that transcend space and time. Both nurse and patient are co-participants in an energy exchange aimed toward healing and growth. Belcher (2006) conceives of spiritual care as a journey of discovery and refers to it as an “intuitive, interpersonal, altruistic and integrative expression” (p.9) centered on the patient’s reality but also dependent on the nurse’s character. Though they

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stray from a unitary view of the person, Georgensen and Dungan (1996) refer to the interaction occurring within the nurse-patient dyad as “dynamic integration” (p. 376). To help spiritual distress, monists advocate for the fostering of self-awareness and modalities like meditation, Reiki, music and art therapy, guided imagery, and therapeutic touch as these strategies may generate healing from within. Authors in this category tend to avoid a standardized approach to spiritual care. For instance, Rousseau (2000) offers an acronym (LET GO) that may serve to addressing spiritual distress: “Listening to the patient narrative; Encouraging the search for meaning; Telling of your concern/ acknowledgement of the suffering; Generating hope where able; and Owning your limitations” (p. 2001).

**Competency.** Pesut (2005) asserts that, like theism, monism reflects a foundational belief about the world; a commitment to this worldview is required to fully engage as a nurse from this perspective. The monistic perspective requires that the caregiver be aware of his or her spiritual dimension, and that narratives be the source of information about spiritual distress. In a shift from the biomedical model, nurses are required to develop their knowledge in the healing arts and possess spiritual maturity. While this perspective returns attention to the spiritual in nursing, Pesut also sees that a renegotiation of nursing’s social contract would be necessary. Unlike theism, monism removes nurses as providers of physical care, leaving it to less qualified health care providers.

**Ethical considerations.** From the monistic perspective, Pesut (2005) states choices are not made based on moral notions of right and wrong. Rather, decisions reflect movement towards the desired goal of universal connectedness. Ethically, notions surrounding care of spiritual distress must be subjected to scrutiny as a patient and nurse may not share the same worldview. In fact, some may equate the monistic tradition with the occult. As patients are in a

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vulnerable position, efforts to reduce power differentials must also be considered. In addressing spiritual distress, the facilitation of healing and growth through connection and energetic engagement would be considered an ethical mandate for nurses.

*Summary.* Authors influenced by a monistic perspective regard spiritual distress as embodied. Spiritual distress may be related to a variety of causes, including a forced paradigm shift as the reality of terminal illness evolves. It may be recognized through indirect expression such as uncontrollable symptoms, significant emotional stress, or difficulties following prescribed therapy. By virtue of shared humanity, nurses can better connect with the “suffering other”. The monistic perspective suggests that nurses embrace the arts, music, nature, healing modalities like Reiki and therapeutic touch to help individuals deal with spiritual distress.

### **Humanism**

The last of Pesut’s (2005) typologies, humanism, is by far the most common approach to spirituality in recent healthcare literature, perhaps a reflection of postmodern thinking. Here, spirituality is subjective and includes multiple worldviews. Articles by Ferrell and Coyle (2008), Mehta and Chan (2008), Puchalski, Lunsford, Harris, and Miller (2006), Puchalski, Ferrell, Virani, Otis-Green, Baird, Bull, and Chochinov (2009), Murata (2003), and Villagomez (2005), were classified in this category. Although theistic and monistic influences were detected in work by Agrimson and Taft (2009), Mount and Flanders (2003), Georgensen and Duggan (1996), MacInnis (2007), and Wright (1997), these authors also demonstrate a humanistic perspective. In contrast to monism, humanism is based on a dualistic worldview. Humanism conceives of persons as having distinct, interrelated biopsychosocial- spiritual dimensions. Its focus is on the more tangible aspects of spirituality as reflected in daily life.

**Sources of spiritual distress.** Pesut (2005) remarks that humanism does not subscribe to

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a singular truth; spirituality varies between individuals and spiritual distress is similarly unique. Within the humanistic perspective, religion may or may not be part of an individual's quest for spiritual well-being; all persons including agnostics and atheists have a spiritual dimension. A concept analysis of spirituality by Villagomez (2005), for example, included concepts of energy, harmony, connectedness, values, beliefs, meaning and transcendence. Puchalski et al. (2009) views spirituality as an essential human need since it provides a sense of wholeness.

Within the humanist perspective, spiritual distress is conceived of in various ways. An examination of life's meaning, impaired connectedness with oneself, others or a deity and lastly, a paradigm shift for the sufferer are among these. Agrimson and Taft (2009) correctly caution that a "diagnosis of spiritual crisis is complex and challenging" (p.459). They offer a tentative definition of spiritual crisis from a humanistic perspective: "A unique form of grieving or sense of loss, marked by a profound questioning of or lack of meaning in life, in which an individual reaches a turning point or juncture, leading to a significant alteration in the way oneself and life is viewed" (p.457). Mount and Flanders' (2003) consider man's relationships critical for his sense of cohesion and wholeness. The authors draw on Frankl's premise that the sources for man's meaning in life include accomplishments, legacy, belief systems, objects of love, and the experience of suffering. Mount and Flanders (2003) also consider the core issues of life as described by existential psychotherapist Irvin Yalom: death, isolation, freedom and meaning. Ultimately death cannot be reversed; it must be experienced alone, in complete absence of structure and with the risk that all is meaningless. MacInnis (2007) also regards spiritual issues central to the existential crisis of terminal illness (p.2).

In spiritual distress, then, individuals may experience a loss of hope, question values and beliefs and feel disengaged from any source of inner comfort (Agrimson & Taft, 2009; Bartel,

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2004; Villagomez, 2005). Murata (2003) adds the features of temporality, relationship and autonomy to a consideration of spiritual pain. Here, the illusion of a guaranteed future is destroyed by life-threatening illness. A meaningful present is lost as it is no longer lived in relation to a future. The loss of relationships that define the self also contribute to spiritual distress. Progressive illness affects self-determination as a sense of autonomy is lost.

American nurse scientists Ferrell and Coyle (2008) like Wright (1997) and Mount and Flanders (2003), recognize the sacredness of human suffering. They consider illness as a threat to human integrity that places persons at risk for spiritual distress. They too conceive of suffering as a process and a potential source of meaning, transformation and ultimately, healing.

**Epistemological assumptions.** Authors in the humanistic category are more explicit in their discussions of knowledge as this group sees spirituality reflected in daily life. This paradigm holds that spirituality is best studied through multiple research methodologies in order to capture its complexity (Pesut, 2005; Puchalski et al., 2009). Some writers feel spiritual distress can be quantified, while others consider that clinical experience, qualitative research, theoretical and wisdom traditions are also valid sources for knowledge (Ferrell and Coyle, 2008; Mount and Flanders, 2003). Villagomez (2005) supports qualitative research and also draws attention to the symbolic language of metaphor as a means to understand spiritual distress.

**Relationship to other domains.** Pesut (2005) explains that from the humanistic perspective, the spirit is one of several dimensions of an individual. Within this somewhat reductionistic view, spiritual distress arises when a sense of wholeness is disrupted. It is commonly recognized that a bidirectional relationship exists between spiritual, physical, emotional and social pain (Mako et al., 2006; Mehta & Chan, 2008; Puchalski et al., 2006; Villagomez, 2005).

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Since there is no common language to express matters of the spirit, spiritual distress is frequently expressed in physical or psychological terms (Mehta & Chan, 2008). Typically, it is signaled by symptoms. Some are unable to differentiate between physical and spiritual or existential suffering (Mako et al., 2006). As spiritual distress may be a component of physical pain, failure to respond to usually effective treatment is commonly regarded as a hallmark of “total pain” (Puchalski et al., 2009). Similarly, psychological manifestations like anxiety, depression, or relationship issues, such as an inability to forgive, are concerning (Mehta & Chan, 2008; Puchalski et al., 2006). In spiritual distress, the individual may experience a loss of hope, question values and beliefs and feel disengaged from usual sources of inner comfort (Villagomez, 2005). Spiritual distress may result in depression, anxiety, guilt or suicidal ideation (Agrimson & Taft, 2009; Mehta & Chan, 2008; Puchalski et al., 2006; Villagomez, 2005). To complicate matters further, these manifestations of the spiritual pain experience can be tempered by cultural and societal influences (Mehta & Chan, 2008).

A wide variety of factors can influence the intensity and duration of spiritual distress (Agrimson & Taft, 2009; Mehta & Chan, 2008). Several authors in this category believe that suffering, while it occurs across all domains of human existence, is primarily determined by the meaning attributed to the experience (Ferrell & Coyle, 2008; Mount & Flanders, 2003; Wright, 1997). Quality of life is unrelated to physical well being; spiritual suffering may arise at any point in the cancer journey from diagnosis, through treatment, and palliation (Ferrell & Coyle, 2008; Mount & Flanders, 2003). However, spiritual or existential distress is viewed to have a particularly negative impact on overall quality at end-of-life.

It is a tenet of palliative care that physical pain is addressed so that emotional and spiritual tasks can be addressed (Mako et al, 2006). Care that fails to address whole person

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suffering care may result in an inability withstand pain and be a determinant in individuals' desire for early death (Ferrell & Coyle; 2008; Mount & Flanders, 2003). Wright (1997) extends her discussion of spiritual distress to family members. Relief from spiritual distress can foster healing, growth and ultimately a peaceful death (Ferrell & Coyle, 2008; Puchalski et al., 2006; Wright, 1997). Puchalski et al. (2009) call for spiritual distress to be considered equally as important as other forms of suffering.

**Influence of ontological and epistemological assumptions on nursing.** Puchalski et al (2006) identify spirituality as a cornerstone for “competent and compassionate nursing practice” (p.405). Articles in this category draw attention to the neglect of suffering in a modern cancer care system that is overshadowed by a biomedical model (Ferrell & Coyle, 2008; Mako et al., 2006; Mount & Flanders, 2003). However, as Pesut (2005) points out, the humanistic perspective advocates for a standardized approach to spiritual care. A humanistic approach sees a consistent use of observation, subjective data, assessment tools, and appropriate interventions to address spiritual distress so in many ways resembles the nursing process.

Within this perspective, on-going spiritual assessment from diagnosis through to end of life is advocated. Agrimson and Taft (2009) support a movement to go beyond close-ended questioning regarding religious affiliation. Several authors in this group provide practical tools for the implementation of spiritual care. Okon (2005) also touches on effective communication strategies, indicators of spiritual distress; and formal and informal assessment strategies that can be adapted for daily practice. Other authors like Puchalski et al. (2006) regard the spiritual history as an important means to a deeper knowledge of the patients' beliefs and values that can influence the path of care. Okon (2005) recognizes that the act of taking a spiritual history may be therapeutic in itself as a way for patients and families to become aware of their own internal

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resources. Ferrell and Coyle (2008) support a systematic approach to spiritual care. Like Mehta and Chan (2008), they call for a comprehensive definition of pain that incorporates all components that may influence the pain experience.

Numerous authors in this category suggest a wide range of approaches to spiritual care. In her concept analysis, Villagomez (2005) presents an impressive listing of manifestations of spiritual distress. Puchalski et al (2009) offer an algorithm for decisions regarding spiritual “diagnoses”, in addition to sample care plans, and recommendations for documentation. The authors distinguish between spiritual screening, within the scope of nursing practice, and spiritual assessment, within the domain of experts; though the interdisciplinary team members are responsible to provide spiritual care, each enacts it in a different way. Ferrell and Coyle (2008) advocate that suffering is “witnessed, supported, accompanied, and borne with companionship and compassion” (Potter as cited in Ferrell & Coyle, 2008, p.246). Similarly, Wright calls for nurses to hear the suffering behind the illness narratives. Murata (2003) lists approaches in responding to spiritual pain that include respectful interactions with the “other”, expert symptom control; hearing a clinical narrative; determining sources of meaning for the individual and his family, the impact of illness; aiding in the redefinition of hope; examining fears, including those pertaining to the unknown; determining areas for reconciliation; acknowledging the transcendent dimension. Life review, discussion about fear, hope, feelings of regret or forgiveness, bereavement and legacy are among other suggestions. Actual “intervention” is reserved for instances where healing is stalled (Puchalski et al., 2006). Okon (2005) suggests meaning-centered and dignity psychotherapy approaches. Thus, writers categorized as humanistic offer a blend of different approaches to assessment ranging from visual analogues to therapeutic conversation. Documentation of spiritual care is viewed by

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some authors in this category to further interdisciplinary communication and a coordinated approach. Evaluation of the outcomes would serve quality control purposes. All of these may be seen to articulate nurses' role in the health care system.

**Competency.** An inter-disciplinary approach to spiritual distress is prevalent among writers with a humanistic worldview. Though the chaplain is seen as expert on religious issues, it is maintained that all members should have at least basic understanding of spiritual issues (Agrimson & Taft, 2009; Mehta & Chan, 2008; Puchalski et al., 2009). According to Pesut (2005), in the humanistic approach, because spirituality is innate part of human existence, all nurses are capable of spiritual care provided they receive adequate education. Like theists and unlike monists, humanists see competent physical care as integral to spiritual care and essential to nursing's social contract. Ferrell and Coyle (2008) regard physical care as a way to shield human dignity and therefore the spirit. Mount and Flanders (2003) quote Saunders: "Care in how it is given can reach the most hidden places" (p.42). Ferrell and Coyle (2008) and Villagomez (2005) support theoretical preparation, yet also see mentorship as critical. The notion that spiritual care can be taught as other dimensions of care, however is qualified by personal qualities.

The humanistic approach sees commitment to spiritual self-care by health care providers as enhancing an ability to engage in conversations pertaining to spiritual distress (Ferrell & Coyle, 2008; Mount & Flanders, 2003; Puchalski et al., 2009). Furthermore, nurses must be comfortable with uncertainties inherent in spiritual distress, acknowledge the suffering and be able to remain present despite its intensity (Mehta & Chan, 2008). Mount and Flanders (2003) consider that health care providers must possess the humility to see the role of patient as teacher. Similarly, the nurse must have a capacity for compassion and authentic presence that trumps

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efficiency in daily practice. Mount and Flanders (2003) refer to Kearney's viewpoint that healing is a venture in which care is based on connection enabled by the caregiver's creation of space. Compassionate care helps the sufferer discover the meaning in his experience, hope through new possibilities, and subsequently, healing (Mount & Flanders, 2003; Puchalski et al., 2006). For Ferrell and Coyle (2008), spiritual care is critical for the relief of suffering. Rather than an intervention, spiritual care is way of being. In this respect, humanism resembles theism. Spiritual care calls for the abandonment of professional agendas and relies on the practitioner being fully human and attentive to another. Intuitions, judicious use of silence, listening, being present and attending are key in providing spiritual care (Puchalski et al., 2006). It is nurses' privilege to give voice to the hidden suffering of patients and families in order to facilitate transformation and healing (Wright, 1997).

**Ethical considerations.** Humanists advocate for spiritual care based on the subjective view of the individual patient. While a humanistic perspective recognizes that an emphasis on science in modern health care settings detracts from the human experience of suffering, the standardization of spiritual care through the use of tools, education and policies is concerning as it may result in a prescriptive tendency to spiritual care. Clearly, certain authors hold care provider judgments as adequate grounds for interventions (Georgensen & Duggan, 1996; Villagomez, 2005). This places vulnerable persons at risk should a care provider decide on specific interventions based on an objective appraisal (Mehta & Chan, 2008; Villagomez, 2005). Such judgment might not only be intrusive, but harmful. As Mount and Flanders (2003) state, the power differential between patients and care providers must be eliminated for healing connections to occur.

The notion that spiritual distress is a concern of all disciplines and that it should be

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documented leads to issues surrounding patient confidentiality. This approach is also concerning for nurses not inclined to incorporate spiritual care in their practice. Villagomez (2005) for instance, operates from the assumption that nurses are obligated to provide spiritual care.

A humanistic perspective is concerned with ultimate values that form the basis for right and wrong (Pesut, 2005). Puchalski et al (2009) asserts that spiritual distress should be addressed “with the same intent and urgency as treatment for pain or any other medical or social problem” (p.891). This group considers spirituality a “vital sign” that must be incorporated into daily practice since it a determinant in decision making throughout treatment and at end of life. While Mount and Flanders (2003) call for a “third epoch of healthcare” (p.42) that focuses on whole person and interdisciplinary care, these are important implications for nurses to consider.

*Summary.* This discussion on the humanistic approach to spiritual distress reminds nurses of the subjective nature of spirituality and the necessity of remaining open to the many expressions of spiritual pain. Authors in this category recognize the bidirectional nature of spiritual distress and the other domains of personhood. Many suggest nurses, as members of an interdisciplinary team, adopt a standardized approach to care, while others highlight the importance of attending to the illness narrative. By creating space for such dialogue, nurses can help patients and families derive meaning from their experience and mitigate spiritual distress. It is through this that spiritual transformation and growth can be achieved.

### **Appraisal of Findings**

#### **Spiritual Distress**

An examination of spiritual distress reveals similarities among Pesut’s typologies of theism, monism, and humanism. Spiritual distress has been discussed as a person’s inability to derive meaning from suffering or life circumstance. It may occur as love, hope, or a sense of

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purpose is disrupted. For some, spiritual distress may involve impaired relationship with self, others, the universe or God. Spiritual distress may occur at any time in the cancer journey. It is a complex form of suffering that can exist apart from physical causes, yet can have physical manifestations (Wright, Watson & Bell, 1996; Wright, 2005).

This exercise has revealed important considerations for nursing practice. While it may be tempting to adopt set criteria for spiritual distress, this approach may in effect, conceal other indicators. Person-centered care is not a task; it calls on the spirit of the care provider. Respect for the inherent value of the person is foundational for the expression of spiritual concerns (Carr, 2008). Frick, Riedner, Fegg, Hauf and Borasio (2006) maintain that inquiry into spiritual matters may be an effective care measure on its own. Nurses cannot be expected to have the answers to existential questions. However, by virtue of their own humanity, they can offer authentic presence at times of spiritual questioning. The challenge for nurses in addressing spiritual distress includes an openness toward spiritual needs, acceptance of 'unknowing' and a willingness to be present (Hermann, 2001). By simply listening to illness narratives and coming to understand beliefs surrounding a situation, nurses enable reflection, deeper understanding and movement beyond a given circumstance (Halldorsottir & Hamrin, 1996; Wright, 1997). Individuals and families experiencing life-threatening illness can then draw on their own resources to alleviate hopelessness, loss of meaning, and demoralization. Therefore, an opportunity exists for nurses to promote new possibilities, meaning and healing at end of life (Kemp, 1994). That said, nurses must be keenly aware of their limitations in tending to spiritual distress and make referrals to appropriate resources as necessary.

If spiritual distress is accepted as within the scope of nursing practice, nurses must engage in their own spiritual work. Reflective practice safeguards against personal views being

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imposed on others. As spirituality represents a unique understanding of the world, nurses must avoid a prescriptive approach that implies a privileged knowing or worldview. Since the intangible nature of spirituality precludes a common language, nurses should be sensitive to the terminology and language of symbols and metaphors used by persons to express their spiritual distress (Abbas & Panjwani, 2008; Cassell, 1991).

### **Evaluation of Process and Framework**

The process of applying Pesut's typologies of monism, theism, and humanism to publications about spiritual distress has helped me to make sense of the vast body of literature on spirituality. Juxtaposition of the typologies allowed for the similarities and differences among these worldviews to surface. Although spirituality is fluid and so these categories are artificial, this exercise has allowed new understandings of the various perspectives of spirituality held by others. The typologies also helped me to identify inconsistencies of thought present in many of the articles. As a sort of philosophical inquiry, this exercise has also helped me to further my awareness of the role of assumptions in scholarly writing. Clearly, application of the framework helped me to develop insight into what is known in the literature about spiritual distress in terms of its etiology, manifestations, and particularly, approaches toward spiritual distress. An understanding of philosophical approaches has also allowed me to understand more clearly the implications of ontology and epistemology for nursing practice, education, research and ethics.

In her dissertation Pesut (2005) acknowledged that all typologies are limited in that they cannot possibly incorporate the multiplicity of thought that exists in the real world. However, as nurses draw on knowledge generated by other disciplines, it is important that their unique positioning in the health care system be taken into account. Although inferences from other disciplines' work can be made, their relevance for nursing care is subject to interpretive bias.

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The framework used here may also fail to do justice to the complexity of material presented by the authors. I touched upon only a few of the instances of overlap between perspectives found in the examined articles. I found the framework was more easily applied to theoretical essays than research reports.

In the future, a critique of Pesut's typologies in relation to reports on research on spiritual issues might be interesting. A critique of the historical, political or social influences of spiritual issues might also be included. For example, most articles adhered to a more humanistic approach, possibly in response to post modernity and an effort to be inclusive in a multi-faith society. The development of similar frameworks may prove useful in the study of other phenomena of interest to nurses.

### **Implications for Nursing**

Consideration of the spiritual dimension of people's lives has tremendous implications for the role of the Advanced Practice Nurse (APN). The APN can educate, role model, and mentor others toward including this dimension in care. Sensitizing nurses to the existence of spiritual distress has the potential to make spiritual care more explicit in practice. By including spiritual concerns in conversations, their significance in treatment decisions can be elucidated. Incorporating an awareness of spiritual distress in assessments can help interdisciplinary symptom management and palliative care teams to more effectively understand and address total pain.

The APN has the capacity to coach persons through difficult life transitions. By allowing persons and their families to express themselves holistically, the APN has the potential to give voice to hidden suffering. Documentation of spiritual distress may help to clarify nurses' role in a health care system that neglects the profound nature of human experience occurring daily

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within its walls. It is time we reflect on whose interests are being served in daily practice and work towards cultural change in our work environments. APNs may take the lead in articulating the role of nurses beyond a task focus. This might include policy development that reflects a valuing of this important dimension of nursing that contradicts the prevailing ideology of efficiency and scarcity. Research inquiry into care providers' own understandings about spirituality may help to eliminate barriers. Clearly, nurses have a role in determining whether persons will die with unmet needs (Ferrell, 2007). Simply put, it is a moral obligation to respond to the spiritual needs of those under our care. To neglect them puts nurses at risk for moral distress.

### **Conclusion**

This project has examined spiritual distress in the context of advanced cancer. The application of a framework derived from the work of Dr. Barbara Pesut has served to guide the examination of spiritual distress through the perspectives of monism, theism and humanism and their impact on nursing ontology, epistemology, practice, education and competencies. Exploration of this phenomenon points to the neglect of the spiritual needs of persons facing life-threatening illness as unethical. This is an area where nurses can excel by virtue of their commitment to caring.

At the outset of this project, I envisioned the development of comprehensive guidelines and interventions toward addressing spiritual distress. Through my readings and reflection I came to see that this endeavor was far more complex than anticipated given the current debates, intrinsic and extrinsic barriers and inherent ethical implications. This project represents a journey as characterized by T.S. Eliot (1944) in "Four Quartets"

We shall not cease from exploration

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And the end of all our exploring

Will be to arrive where we started

And know the place for the first time

In my search for a definitive approach to the identification and treatment of spiritual distress, I have come to understand it as ontology, a way of being and connection that I have known as a nurse but was unable to articulate. Nonetheless, more deliberate inclusion of the spiritual aspects of care may serve to improve the ethos of the cancer care culture by a return to the moral work of holistic, collaborative practice (MacLaren, 2004). Oncology nurses have the privilege and the honor to journey with people during the most critical life transitions. To ignore the most profound aspects of humanity is a disservice to the patients and families, nurses and the cancer care system (Albaugh, 2003).

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## Appendix A

### Personal Reflections About Spirituality

Reflection on my personal spirituality is important as my perspective has influenced my nursing practice, selection of the topic of spiritual distress for a major project, my approach to the literature and the analysis of articles pertaining to spiritual distress using Pesut's framework.

I was born to parents of Irish-French descent and raised in the tradition of the Roman Catholic faith, complete with a convent and nuns, in a small village in Saskatchewan. Our parish priest, a former lawyer, had founded a school in the middle of the Great Depression. "Pere" was affectionately nicknamed the "Whiskey Priest" and was not one to rely on the scriptures for his sermons. Rather, he passionately spoke of God, Canada, and the world from his pulpit. In response to a "wave of apathy in the way of culture in America with regard to God" (Gorman, 1977, p.114), he erected a small building and a twenty foot "Tower to God" in which each wall was devoted to articles depicted the "Three Great Religions of the World": Islam, Judaism and Christianity. His worldview was in sharp contrast to the town proper; despite a population of less than two hundred, Protestant and Catholic children were still educated separately. The boarding school I attended as a day student, however, was non-sectarian and attendees were from a variety of backgrounds. From an early age, I was exposed to the teachings of Aristotle, Aquinas, St. Augustine and other "great thinkers." I also learned that spirituality infused all aspects of life (including hockey), that adversity builds character and that the individual was in charge of building a life of significance and that "To he who does within him lies, God will not deny His grace."

This upbringing has had a strong influence on my view of spirituality. A strictly religious approach to spirituality pales in comparison to its dynamic nature in life. Spiritual values are

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meant to be lived in the everyday. An eternal hereafter is a certainty that imbues life with purpose along with the relationships I hold with family, friends and meaningful work. From my perspective, all persons share in a common humanity. Each has his own journey, yet all are united on a spiritual level. Most recently, I have come to consider spirituality as an integrative energy. I acknowledge others may approach this aspect of their lives much differently and effort may be required to gain adequate understandings. I acknowledge a difficulty comprehending the view that there is no spiritual dimension to human existence. I believe spiritual truths will ultimately be known in an after-life.

Parental role modeling reinforced the concept of “agape,” service to humankind (Pesut, 2009). While nursing is typically viewed as a service of others, its unique positioning enables nurses to see first hand the remarkable nature of the human spirit. However, I am also aware of the influence of the cancer care culture on my beliefs, behaviors and experience of spiritual care.

I have wondered about the incongruence between hospice-palliative care philosophies and practice as the spiritual and existential, possibly the most significant for patients and families, remain unexplored. I have wondered how spiritual issues could be identified, particularly in the challenging milieu of my workplace. I have wondered how to influence change within an organizational culture that does not care to acknowledge human suffering, let alone spiritual suffering. This major project is the result of these wonderings. I recognized my own gaps in understanding spirituality and spiritual distress, so it was from a position of uncertainty that I began this undertaking.

### Appendix B

#### Framework Derived from Pesut's (2005) Typologies of Spirituality

<b>TYOLOGY</b>	<b>MONISM</b>	<b>THEISM</b>	<b>HUMANISM</b>
<b>SPIRITUALITY</b>	<p>We exist in energy. Ultimate goal of life is to merge with “cosmic consciousness” (p.52). God is part of consciousness, not separate; humanity together evolves to a “higher level of consciousness” (p.52). Spirituality characterizes this unitary existence (universal connectedness). Assumption: universe consists of one unified substance (energy). Humans are part of an indivisible, universal consciousness that transcends space &amp; time.</p>	<p>Spirituality begins with “knowledge of...God” (p.52), requires people be good to one another. God “infuses and sustains all of creation...has the capacity to exist independently of creation... Spirituality is... power...we make choices that bring our power toward or away from that character of goodness” (p.52). Individuals retain “essential uniqueness” (p.52) while living in community. Power of God works within us; prayer can influence events. We are bound by “time, space, physicality” (p.53), but are aware of eternity. Worldly existence has bearing on hereafter. Assumption: origins of the spiritual lies not in the individual, but in God. The Creator and sustainer. Humans in covenant with God. Health</p>	<p>Spirituality is “innate”, “subjective”, and diverse; “brings integration and meaning to life” (p.53). Characterized by needs such as transcendence, meaning &amp; purpose; “multi-faceted” (p.53); Spirituality “becomes recognizable when need arises” (p.53). No need to adhere to particular reality. Spirituality is a universal human dimension. Assumption: persons subjectively define what is spiritual for them.</p>

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		and well being found in this relationship. In response humans seek to treat one another well.	
<b>RELIGION</b>	Religion negative, unchanging, claims to have all the answers. No external god. This view has alienated us from interconnected universe, peace and love. Humans are collectively “part of the process of universal change, and we collectively create a destiny by virtue of our participation in the energetic life force” (p.55).	Religion is ...integral as it... provides the content for the spiritual. It shows...the character of God, meaning of life, how we are to live (p.54). Theology & religion fundamental to spirituality as tell how to develop spiritual values such as “love, joy, peace, justice” (p.55). Religion “imperfect glimpse of divinity” (p.55) as its doctrines are influenced by humans.	Dispute notion of “correct version” of the truth (p.54). Humans, including agnostics and atheists, are spiritual.
<b>ONTOLOGY</b> <i>“How does [the understanding of each perspective] influence the nature, scope and object of nursing?” (p.56).</i>	“Evolving consciousness” of patient and nurse “central to nursing” (p.57). Energy based interventions focus on “soul”, nurses become healers (p.57). Scope needs to “move from a biomedical focus” (p.61) to awareness of human needs and great human potential plus alternative forms of healing. Shifts	“Sacred and personal” (p.56), cannot be subject to standardized approach. Spiritual care... is about a way of being, an ethic and motivation” (p.56). Nursing is “vocational service” (p.56). Spiritual care is “integral part of all care” (p.57). Different worldviews affect emphasis on service & sharing of	Nurses need to acknowledge & address spiritual needs. Spiritual is characterized by needs such as “meaning, connectedness and transcendence” (p.63). Spirituality must be subjectively driven by patient; Spiritual care should be delivered systematically to ensure “ethical and standardized care” (p.56). Use tools,

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	nature of nursing. Spiritual care directed toward that which transcends space & time “soul or consciousness” (p.57).	doctrine. Subjective experience of patient may be different than nurse. Nurse may not be correct person to address spiritual needs- nurse may be regarded as a “highly invasive... stranger” (p.58).	documentation, outcomes, to ensure follow up ethical and standardized care. Can be audited for quality improvement.
<b>EPISTEMOLOGY</b> <i>“What do we know, how do we know it, and how do we evaluate the claims that we make?(p.62 )</i>	“Epistemology and ontology are united” (p.64). “Knowledge resides within us” (p.64). “Beliefs are integral to our knowledge, not lesser” (p.64). “Internal knowledge, or consciousness, has levels, The lower...include experiences... higher levels... insight, vision, creativity... Ultimate level.. merge with the universal consciousness. The higher the level...the more we are open to the knowledge that resides within us, and the greater our effectiveness in the world” (p.65). Religion does not help discover knowledge as it “claims to be unchanging and to have all the	“Revelatory knowledge” (p.64) provides foundational “truths about nature of God, humankind, health and what it means to live well (p.64). God gives “intuitive or personal knowing” (p. 64). Should be “subject to critique” (p.64). Religious doctrine “has been misused over the ages” (p64). “Revelatory knowledge brings a moral ethos to practice” (p.66) and also helps in critique of other forms of knowledge. Requires critique when revelatory knowledge contradicts moral themes of “kindness, love, justice, freedom from oppression” (p.66). Sees nursing practice as serving “metaknowledge rather than visa	Humans are the “best source” of knowledge (p.63). Research through “inquiry” (p.63). Several lenses needed as so multifactorial & to achieve a “broader understanding for theory” (p.63). “Communal experience of spirituality...will reveal itself through multiple accounts” (p.63). “The outcomes, or hallmarks, of spirituality will look similar, but the process of arriving there may be highly diverse” (p.64).

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	<p>answers” (p.55). Inward journey is required. Biomedical is lower level knowledge. “Critique is... old paradigm thinking (p.65). “Belief is who we are- the knowledge resides within us by virtue of our place and connection within the universe... old beliefs need to be realigned along with unitary worldview” (p.65). “The universal consciousness... transcends time, space and physicality. Hence, it is real” (p.65). Critique needs to occur from within.</p>	<p>versa” (p.66).</p>	
<b>RELATIONSHIP TO OTHER DOMAINS</b>	<p>Humans “extend beyond their physical bodies as part of energetic, cosmic consciousness” (p.52).</p>	<p>Bodies are “temples of God...dimensions of person are interdependent” (p.57).</p>	<p>The spiritual is but one of several dimensions of the person that “are all connected” (p.73)</p>
<b>SOCIAL &amp; INTERDISCIPLINARY</b>	<p>Nurses can renegotiate current social role to become “autonomous healers” (p 61). Wellbeing &amp; health are framed in terms of ascending into a higher consciousness of human becoming.</p>	<p>“Excellent bodily care is a fundamental part of spiritual care” so “holistic argument” unnecessary (p.61). Physical care preserves person &amp; personhood of the sick individual as participant in God’s covenant. Chaplains are experts. Should</p>	<p>Physical care remains part of nursing role or “patient care will deteriorate” (p.61). Spiritual care focuses on patient priorities, values “Because spirituality is innate human characteristic concerned with meaning and</p>

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	<p>Need to push boundaries in healthcare. Open to the infinite. Incorporates caring science; unitary, energetic worldview; relational ethic, Return of the sacred to profession and science. “No room for interventionist approach to care” (p.68).</p>	<p>not be subjected to nursing process.</p>	<p>purpose, nurses are perfectly capable” (p.62) of spiritual care. Chaplains are needed for religious issues. Formalizing spiritual care promotes interdisciplinary communication and coordinated approach. Approached through nursing process.</p>
<p><b>ETHICAL RESPONSIBILITY</b> <i>Considers “safe, competent and ethical care; health and well-being; choice; dignity; confidentiality; justice; accountability; and quality practice environments” (p.71)</i></p>	<p>Nurses need a stance of “unconditional acceptance” (p. ) to “stand alongside, help to identify patterns and envision new possibilities” (p.73) through a shared “powerful and universal context” (p.72).</p>	<p>Nurses are in a role of “unself-conscious service” (p.82). Must guard against imposing beliefs on vulnerable patient. Requires nurses be aware of limitations &amp; consult experts (chaplains, theologians) as appropriate.</p>	<p>Interventional approach – “needs always designed in partnership with patients” (p.77)</p>
<p><b>POWER RELATIONS</b> <i>Perspectives on the spiritual have the potential to create power differences between nurses and patients; “...hidden biases shade our view of the world” (p.96).</i></p>	<p>Therapies may be considered spiritually detrimental if not in alliance with patient’s worldview.</p>	<p>Potential for nurse to believe in obligation to proselytize or convert others to own particular beliefs.</p>	<p>Nursing process has potential to be prescriptive as nurses make judgment based on objective and subjective data. Self- evaluation by patient.</p>
<p><b>COMPETENCY</b></p>	<p>Certain worldview (unitary or energy based); “spiritual development of the nurse is foundational” (p.59). Interventions related to soul work; nurses need</p>	<p>Nurses’ engage in a “relational encounter that depends on the character of the nurse” (p.78) which supersedes than assessment &amp; intervention. “The</p>	<p>Assumption is that all nurses should be able to learn spiritual care. Particular spiritual belief unnecessary, only an awareness that needs exist.</p>

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	<p>knowledge re: ancient healing and/or modalities such as Therapeutic, Healing Touch, and Reiki.</p>	<p>more spiritually mature nurses become in their faith and character, the more effective... with patients” (p.59). Theological background not required to enact caring ethic.</p>	
<p><b>EDUCATION</b></p>	<p>Need to be well established in philosophy or worldview, “concentrate on the development of own consciousness” (p.59)</p>	<p>Learned through mentorship &amp; role models. Basic understandings of nursing’s meta-paradigm concepts influenced by theological principles.</p>	<p>In regular curriculum</p>

**Appendix C****Template for Analysis of Articles (Pesut, 2005p.81-82)**

1. What is the foundational assumption of the author?
  - a) Monistic universal consciousness
  - b) Subjective human understanding
  - c) God
  
2. What is the nature of persons?
  - a) Covenantal relationship with a creator
  - b) Indivisible unitary beings connected to universal consciousness
  - c) Beings with a universal spiritual dimension characterized by needs
  
3. What is the nature and scope of nursing in relation to the spiritual?
  - a) Relationship to a creator
  - b) Care of evolving and expanding consciousness
  - c) Problem oriented interventional approach toward spiritual well being characterized by specific emotional states
  
4. How do nurses become competent in spiritual care?
  - a) Modeling service oriented ethic
  - b) Through understanding & expanding of their own conscious healing techniques
  - c) Standard curricular approach of content & self-reflection
  
5. How is knowledge of the spiritual acquired or constructed?
  - a) Theological, revelatory knowledge
  - b) From being one with the universal consciousness
  - c) Inquiry into the communal experience of spirituality
  
6. What is the relationship of the spiritual to ethics?
  - a) Does the spiritual provide the moral foundation for ethics?
  - b) Are they entirely unrelated with the spiritual being simply a culmination of choices which cannot be labeled good or bad?
  - c) Or are ethics socially constructed values that may or may not promote the good value of spirituality?
  
7. What characterizes the positioning of the nurse in the interactions with patients in the context of the spiritual?
  - a) Unself-conscious participant in an interaction of vocational service
  - b) Potentially powerful consciousness
  - c) Expert with authority & capacity to intervene in the spiritual dimension.

**Appendix D****Data Collection Questions (Pesut, 2005, p. 131)**

1. What are the underlying ontological assumptions about the spiritual dimension?
2. How do these assumptions influence the nature and goal of nursing?
3. How do these assumptions influence the scope of nursing?
4. How do these assumptions influence the object of nursing?
5. What spiritual interventions and outcomes are being proposed?
6. How is the spiritual being defined in relation to other domains of the person? How might this type of care differ from humanistic psychosocial interventions or physical care?
7. What are the underlying epistemological assumptions about the spiritual?
8. What knowledge is required to “nurse” another within the spiritual dimension?
9. What preparation is required to gain this knowledge?
10. What paradigms of inquiry are suitable to the development of this form of knowledge?
11. Are there some nurses who would be unable to nurse within this dimension?
12. Who is the expert according to this perspective?
13. Is there the potential for unique disciplinary knowledge within this dimension?
14. What is the nature of the spirituality? (i.e., positive or negative)
15. What are the ethically desirable goods, and upon what grounds are these goods constructed?
16. What are the inherent ethical problems or challenges?
17. How might this perspective accommodate or do justice to the variety of worldviews held by nurses and clients?

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### Appendix E Sample of Synthesis Matrix

Author, Country of Discipline; Type of article; Influences; Category	Ontological-assumptions re: spirituality	Influence on nursing (nature, goal, scope, object, interventions, outcomes).	Relationship to other domains	Epistemological assumptions/ expert/ competencies/ difficulty/	Inquiry Ethics
<b>MacInnis, 2003</b> <b>Canada</b> Chaplain; Kearney & Mount; Narrative Inquiry, Metaphor symbolism, I HOPE FOR. <b>THEISM</b>	Spirituality has physical/ social/ religious/ emotional – complex part of human experience and sense of otherness. Private, internal image. Suffering has a spiritual component. Questioning of beliefs, identity, purpose is a spiritual need esp. with diagnosis of terminal illness. Though relief of suffering is central to health care, the topic of suffering is avoided. Humans have a desire to transcend hardship & suffering; Way we care for dying is reflective of society we have created.	Alleviation of suffering is cornerstone of spiritual care and leads to healing. Requires meticulous attention to physical/ psychological/ spiritual needs. Compassion; human dignity; respect; community of service; social responsibility; excellent patient care. By exploring and identifying strategies that foster hope transcendence is often achieved. Multidimensional needs- medical/ illness/ faith narratives.	Pain does not necessarily lead to suffering- depends on meaning attributed to pain. Attending to suffering can also alleviate physical pain. Distancing can increase suffering. Existential, emotional pain may be more significant than physical. Pt & family beliefs influence depth of suffering.	Need to ask questions part of spirituality. Knowledge is understanding of a dimension of self. Cites Kearney & Mount (2000) - if ignore spiritual seriously limit our understanding & response to pt illness. Need to have deeper understanding about depth of pain to conserve dignity, alleviate distress and suffering. Must understand suffering, be able to listen and know each pt's perception of situation. According to author- understanding of theology & behave sciences; accurate assessment & integrate into goals of care; be able to discuss & involve self in ethical issues relevant to end of life & decision making. Provide appropriate spiritual care in multifaith, pluralistic content including emotional & spiritual support for agnostic/ atheist.	Narrative inquiry. Must not over-estimate skill. Compassion; human dignity; respect; community of service; social responsibility ; excellent patient care.