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## Spiritual care interventions to improve the quality of life in patients with advanced cancer receiving palliative care

Maria Ballen-Sanchez  
*University of Central Florida*



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SPIRITUAL CARE INTERVENTIONS TO IMPROVE THE QUALITY OF LIFE  
IN PATIENTS WITH ADVANCED CANCER RECEIVING PALLIATIVE  
CARE

by

MARIA A. BALLEEN-SANCHEZ

A thesis submitted in partial fulfillment of the requirements  
for the Honors in the Major Program in Nursing  
in the College of Nursing  
and in The Burnett Honors College  
at the University of Central Florida  
Orlando, Florida

Summer Term 2012

Thesis Chair: Dr. Norma Conner

## Abstract

**Title:** Spiritual Care Interventions and Quality of Life in Cancer Patients Receiving Palliative Care

**Background:** Despite the evidence supporting spiritual care in nursing and an increased quality of life among patients, patients feel that their spiritual needs are not being supported by medical professionals. Nurses agree that the role they play is significant in addressing the needs of cancer patients; however, they feel that they lack the knowledge for addressing spirituality concerns at the end of life. The purpose of this study is to identify spiritual care interventions that nurses can implement to improve quality of life (QOL) in patients with advanced cancer receiving palliative care.

**Method:** This literature review consisted of articles retrieved from several databases, including CINAHL, PubMed, and PsychINFO, PsychARTICLES, ATLA Religion databases using the key words “cancer\*” and “quality of life” “therapeutic communication”, “spirit\* therapy”, “relaxation therapy”, and “self-care”. Inclusion criteria consisted of research conducted after the year 2000, peer reviewed work and research studies written in the English language.

**Results:** Results from this literature review include recommended nursing interventions that provide spiritual care to patients with advanced cancer receiving palliative care for the purpose of improved quality of life. Spiritual care interventions identified in this study include Meaning Centered Group Psychotherapy (MCGP), Supportive Group Psychotherapy (SGP), mental relaxation, mental images, TM, art therapy, socializing, communicative acts, aromatherapy, massage, exercise, hatha yoga, meditation, and activities such as gardening, watching TV, resting/sleeping and socializing.

## Dedications

To Lisette , whose life inspired many and whose fight against cancer inspired me to take on this thesis topic.

To the Del Valle family in memory of their daughter and her dream to be an oncology nurse.

To my beautiful mother whose support and unconditional love has been and will continue to be the foundation for each of my endeavors.

To my family who encourage me to exceed my expectations.

To all my friends and classmates for their support through the program and for helping me take a break and relax once in a while.

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Thank you Burnett Honors College for the opportunity to dedicate this thesis to Lisette Del Valle, whom I love very much and whom I know is watching over us.

## Table of Contents

<b>Introduction</b> .....	<b>1</b>
<b>Problem</b> .....	<b>3</b>
<b>Purpose</b> .....	<b>4</b>
<b>Background</b> .....	<b>5</b>
<i>Spirituality</i> .....	6
<i>The Nursing Role and Spiritual Care Interventions</i> .....	7
<i>Spiritual Care and Quality of Life</i> .....	9
<i>Nursing Knowledge on Spiritual Care</i> .....	11
<b>Method</b> .....	<b>14</b>
<b>Findings</b> .....	<b>15</b>
<i>Reason and Reflection</i> .....	15
<i>Religion</i> .....	17
<i>Relationships</i> .....	19
<i>Restoration</i> .....	21
<b>Discussion</b> .....	<b>25</b>
<i>Reason and Reflection</i> .....	25
<i>Religion</i> .....	26
<i>Relationships</i> .....	27
<i>Restoration</i> .....	27
<b>Limitations</b> .....	<b>29</b>
<b>Recommendations for Nursing</b> .....	<b>30</b>
<i>Research</i> .....	30
<i>Education</i> .....	31
<i>Practice</i> .....	32

## Introduction

An estimated 577,190 men and women will die of cancer in 2012 (American Cancer Society, 2011). As defined by the National Cancer Institute, advanced cancers are cancers that cannot be cured (National Institute of Health, 2010b). The treatment for many patients with advanced cancer is palliative, as opposed to curative (Krouse, 2008). The National Cancer Institute defines palliative care as comfort care given to a patient who has a serious or life-threatening disease from the time of diagnosis and throughout the course of illness (National Institute of Health, 2010 a). Palliative care, specific to patients with cancer, is the relief of symptoms associated with the cancer process with emphasis in comfort and quality of life (Krouse, 2008). Therefore, the focus of palliative care among patients with cancer is on emotional, physical and spiritual issues in efforts to decrease suffering and improve QOL (Krouse, 2008).

The definition of spirituality as defined by Emblen (1992) and Govier (2000), encompasses an environmental aspect including the dynamic relationship between 1) person and a higher being, 2) person and others and 3) person and their natural environment (Emblen, 1992). The term religion is not limited to a formal institution, as it is often associated, but rather the term religion is defined as “faith, beliefs and practices that nurture a relationship with a superior being, force or power” (Emblen, 1992, p. 43).

The discipline of nursing encompasses a biophysical aspect of patients that includes human spirituality and other aspects of the human spirit especially determination, courage, beliefs, hopes and aspirations (Schlotfeldt, 1989). According to Schlotfeldt (1989), the biological, psychological, and sociocultural aspects of the human spirit are relevant to the natural

efforts humans make to attain optimal health. Schlotfeldt stresses the responsibility nurses have in advancing knowledge of these health seeking assets in order to provide nursing care that respects the uniqueness of an individual and that caters specifically to the needs of each person (1989).

Studies have shown the importance of spirituality in patients with advanced cancer and the effects of spiritual pain on quality of life. The importance of the spiritual dimension of the person has led to the discovery of spiritual care interventions. For example a life review is considered a spiritual care intervention that increases quality of life in patients with advanced cancer (Ando, Morita, Okamoto, & Ninosaka, 2008). A life review is an intervention that involves a review of an individual's personal life that includes re-evaluating, re-constructing, and appreciating one's life (Ando et al., 2008).



## Problem

The National Cancer Institute (2010a) states that palliative care addresses the emotional, physical, practical, and spiritual issues of cancer (NationalInstituteofHealth, 2010 a). Spiritual support provided by the multidisciplinary team including nurses, doctors, and chaplains has been significantly associated with patient QOL (Balboni et al., 2007). In patients with advanced cancer, high levels of faith combined with a high sense of inner-peace and meaning has been shown to decrease pain and improve physical functioning (Zavala, Maliski, Kwan, Fink, & Litwin, 2009). Spiritual support in the form of a life review was found to decrease anxiety, depression, and suffering and significantly increased happiness (Ando et al., 2008). In addition, positive religious coping, in the form of daily prayer, was related to better scores on the support and existential QOL dimensions (Tarakeshwar et al., 2006).

Although there is evidence supporting the influence of spiritual care on increased quality of life, patients feel that their spiritual needs are not supported by healthcare professionals (Balboni et al., 2007). Nurses agree that they play a significant role in addressing the needs of cancer patients; however, they feel that they lack the knowledge for addressing spiritual concerns at the end of life (Belcher & Griffiths, 2005).

## Purpose

The purpose of this literature review is to identify spiritual care nursing interventions to improve QOL in patients with advanced cancer receiving palliative care. The focus of this review is on the nurse's interventions in spiritual care with patients with advanced cancer.

## Background

Patients with advanced cancer who have spiritual support have improved QOL. Balboni et al. (2007) interviewed patients with advanced cancer on their religious or spiritual practices before and after diagnosis in order to examine religious and spiritual support and the associations with quality of life. The findings indicated that spiritual support received through religious communities or through the healthcare system is significantly associated with better QOL in patients with advanced cancer (Balboni et al., 2007).

In a recent study, the integration of spiritual care through the use of a life review was shown to directly improve the quality of life of patients with advanced cancer by decreasing depression, anxiety, and suffering (Ando et al., 2008). In addition, the use of a life review increased the sense of happiness in patients with advanced cancer.

Additional studies in the field show the negative emotional and psychological effects of spiritual pain. For example, a current study by Delgado-Guay, Hui, Parsons, Govan, Thorney, & Bruera (2011) indicated that half of cancer patients report spiritual pain that is associated with worse depression and anxiety.

Patients with advanced cancer whose illnesses have been confirmed to be terminal struggle with questions regarding their mortality, the meaning and purpose of life, and the existence of a greater power (McClain, Rosenfeld, & Breitbart, 2003). Due to the tendency of the questions to create psychological distress on a patient at the end of life, it is important that the patient develop and maintain his or her spirituality (McClain et al., 2003). Dignity is defined as the state of being worthy of honor or respect (Merriam-Webster, 2012a). Peace is defined as a state of tranquility and harmony (Merriam-Webster, 2012b). Meaning is defined as something

that is conveyed in language (Merriam-Webster, 2012c). In terminally ill patients the ability to sustain a sense of meaning and peace is crucial as they face the personal challenges they endure to maintain dignity and self-esteem (Nelson, Rosenfeld, Breitbart, & Galietta, 2002). In patients with an advanced illness, greater spiritual wellbeing consisting of meaning, peace, and purpose in life was associated with fewer symptoms of anxiety and depression (Johnson et al., 2011). Research suggests that the beneficial aspect of spirituality may be largely related to one's ability to search internally for strength and meaning (Nelson et al., 2002).

### Spirituality

Spirituality, as defined by Ian Govier (2000) is conceptualized in the 'Five R's of Spirituality': Reason and Reflection, Religion, Relationships, and Restoration. According to Govier, spirituality involves the process of reason and reflection. These two terms: reason and reflection are mentioned together because they encompass searching through life and finding meaning in life experiences (Govier, 2000). As an individual searches for meaning in the illness experience, the individual may ask questions such as "Why is this happening to me or my loved one?" The second aspect of spirituality is religion which can be defined as the "vehicle for expressing spirituality through a framework of values, beliefs, and practices" (Govier, 2000, p. 32). Although not always encapsulated by a specific institution such as Christianity or Judaism, religion is up to the interpretation of the individual considering it. Spirituality is the meaning of life found by the patient as well as the connectedness between patient and self, patient and others, patient and higher being, and patient and his or her environment (Govier, 2000). In effect, religion is simply one way in which a patient can express spirituality. As mentioned earlier in the definition of spirituality, the term "relationships" refers to a feeling of longing to relate to

one's self, others, and a deity or higher being (Govier, 2000). This desire to relate may be expressed through service, trust, hope, creativity, and/or love. The last aspect of spirituality is restoration, defined as the ability of an individual's spiritual dimension to improve their physical state.

### The Nursing Role and Spiritual Care Interventions

The nursing role in providing spiritual care involves assessment, planning, implementation, and evaluation. In a spiritual assessment, the following areas should be covered: the person's concept of God or deity, the person's source of strength and hope, the significance of religious practices, the person's perceived relationship between his or her personal beliefs, and his or her state of health (Stoll 1979). The goals of assessing spiritual history are to learn about the spiritual and religious beliefs, definitions, and goals of patients, identify spiritual and religious beliefs that might affect the patient's health care decision-making, and identify patients who need referral to a chaplain (Puchalski et al., 2009).

A spiritual assessment may involve asking questions that are very personal, therefore it is essential that nurses establish a trusting relationship before addressing sensitive spiritual issues (Lemmer, 2005). In addition, in order to provide spiritually sensitive care, nurses should become aware of their own spiritual beliefs and issues and set aside any personal beliefs or uncertainties when listening to a patient (Lemmer, 2005).

The following assessments are used to guide nurses in their spiritual assessment: A Spiritual Needs Protocol (Sumner, 1998), Assessment of Religious Needs and Assessment of Spiritual Needs (Hart & Schneider, 1997), Spiritual Assessment Scale (O'Brien, 1999), Spiritual Assessment Tool (Burkhart & Hogan, 2008; Lemmer, 2005).

Govier (2000) states, the nursing process is cyclical by nature, meaning the successful or unsuccessful completion of each stage provides useful information for the next (Govier, 2000). After the spirituality assessment is complete and needs are identified, the second step of the nursing process is to establish appropriate spiritual outcomes or goals for the patient. Once goals are identified, planning should be done to identify appropriate nursing interventions for the spiritual outcome (Govier, 2000). After selecting appropriate nursing interventions, the actual intervention is implemented. Following the intervention phase, the patient should be reassessed to evaluate whether or not the interventions were successful. Depending on the success of the goal, the spiritual care interventions may need to be changed.

In a consensus conference titled *Improving the Quality of Spiritual Care as a Dimension of Palliative Care*, Puchalski (2009) identified interventions that promote spiritual health. These spiritual interventions were divided into three categories: therapeutic communication techniques, therapy, and self-care (Puchalski et al., 2009). The key terms: therapeutic communication, self-care, and therapy; further divided for specificity into relaxation therapy and spiritual therapy were used in this study's database searches, further explained in the method section.

Therapeutic communication spiritual interventions include compassionate presence, reflective listening, query about important life events, support patient's sources of spiritual strength, open-ended questions to illicit feelings, inquiry about spiritual beliefs, values, and practices, life review, listening to the patient's story, and continued presence and follow-up (Puchalski et al., 2009). Therapy spiritual interventions include guided visualization for pain without meaning, progressive relaxation, breathing practice or contemplation, meaning oriented therapy which focuses on finding a purpose in life, referral to spiritual care provider, use of

storytelling, and dignity-conserving therapy which is the clinical focus on preserving a the way in which the patient wants to be remembered (Chochinov et al., 2005; Puchalski et al., 2009). Self-care spiritual interventions include massage, reconciliation with self or others, spiritual support groups, meditation, sacred spiritual readings or rituals, yoga, tai chi, exercise, art therapy (music, art, dance), and journaling (Puchalski et al., 2009).

### Spiritual Care and Quality of Life

Spiritual care has been recognized by organizations such as the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and American Association of the Colleges of Nursing (AACN). Since 2000, JCAHO has required a spiritual assessment to be completed at every admission, and that spiritual support be provided to patients that request it (Taylor, 2003). According to *the Essentials of Baccalaureate Education for Professional Nursing Practice* published in 2008, the AACN has included the patient's spirituality among its dimensions of care for which a nurse must learn to provide (AmericanAssociationoftheCollegesofNursing[AACN], 2008).

Although, quality of life is frequently mentioned in the literature the actual QOL measurement methodology and instrument design is more advanced than its theoretical work (Camfield & Skevington, 2008). A clear universal definition of quality of life is not available due to the personal nature of quality of life. However, as defined by the National Cancer Institute, quality of life (QOL) is the overall enjoyment of life and an individual's sense of wellbeing (NationalInstituteofHealth, 2010c). As mentioned by the use of the word "individual" in the definition above, it is important to understand that quality of life is a subjective opinion of life experiences that is continuously being conceptualized (Camfield & Skevington, 2008).

In a recent study to examine the prevalence and intensity of spirituality, religiosity, and spiritual pain, as well as their effect on symptom expression, coping and quality of life, 100 patients with advanced cancer from MD Anderson in Houston, TX were interviewed (Delgado-Guay et al., 2011). Results from the interview indicated that 98% of the sample considered themselves spiritual and religious, and 44% of the sample reported spiritual pain. Spiritual pain as defined by Millspaugh (2005) is an awareness of death, loss of relations, self, purpose, and control. Spiritual pain is also defined as part of total pain, yet not expressed physically but deep within consisting of an intrapsychic and intrapersonal loss or conflict in relation to the divine (Millspaugh, 2005). Patients reported that spiritual pain contributed to their physical/emotional symptoms. Findings also indicated a trend toward depression, anxiety, anorexia, and drowsiness in patients with spiritual pain (Delgado-Guay et al., 2011).

Patients confronted by advanced cancer acknowledge religion and the use of religious coping as a very important factor influencing their QOL (Tarakeshwar et al., 2006). In a recent study of 170 patients with advanced cancer it was found that the greater use of positive religious coping was associated with better overall QOL as well as higher scores on the support and existential quality of life dimensions (Tarakeshwar et al., 2006). According to this study, the use of positive religious coping such as prayer and benevolent religious appraisals of negative situations resulted in a greater report of physical symptoms. In contrast, those individuals who used negative religious coping such as viewing their illness as a punishment from God, or feeling abandoned by God resulted in a poorer overall QOL (Tarakeshwar et al., 2006). Additionally, they had lower scores on the existential and psychological QOL dimensions and reflected an



ominous view of life, and a sense of disconnectedness with a religious community (Tarakeshwar et al., 2006).

In terminally ill cancer patients, spiritual well-being has been negatively correlated with despair at the end-of-life. End-of-life-despair often predicts hopelessness, desire for hastened death, and suicide ideation, all which can affect the quality of life of a patient (McClain et al., 2003). In addition, as a patient approaches the terminal phase of an illness, feeling of depression, hopelessness, and anxiety are common (McClain et al., 2003).

#### Nursing Knowledge on Spiritual Care

Since the 1980's, there has been a movement to include spiritual care in the nursing profession. This movement has been supported by empirical research which suggests the necessary relationship of health and spiritual care (Taylor, 2003). Despite the holistic nature of the nursing profession and the need to incorporate the spiritual dimension, evidence suggests a lack of knowledge in the nursing profession regarding spiritual care at the end of life (Murray, 2010).

One study, consisting of 33 oncology and intensive care unit nurses, examined the spiritual care practices provided to patients at the end of life (Murray, 2010). The study found that these nurses felt a strong responsibility to assess the patients on a spiritual dimension. Contrastingly, data revealed that oncology and intensive care unit nurses were not performing spiritual assessments and there was a strong desire for education in addressing spiritual issues with their patients and their family members (Murray, 2010).

In a study that investigated the presence of spiritual dimensions in nursing faculty and nursing programs, Crewell (2008) studied 115 nursing school faculty and 8 baccalaureate

nursing programs in the Southern part of the U.S. (Crewell, 2008). In her analysis for spiritual dimensions, she found that faculty were unable to state the number of hours in the entire curriculum dedicated to spiritual nursing care (Crewell, 2008). In addition, comments from faculty regarding time spent teaching spiritual dimensions included “unsure”, “don’t know”, “I don’t teach those courses”. Crewell’s findings on the spiritual dimensions in the nursing curriculum showed that 93% of both groups reported a spiritual dimension of nursing care taught in their nursing curriculum in the form of course objectives or integrated in the nursing program’s philosophy. When asked about a program definition of spirituality and spiritual nursing care, 85% of both groups did not have a definition of spiritual nursing care. Over 92% indicated they did not have a required spiritual care course and 31% had a spiritual care elective course which was optional (Crewell, 2008).

Spirituality is a dimension of the patient along with his or her body and mind, which must be cared for by nurses. It is essential that nurses integrate spiritual care into their care in order to truly be holistic. A decrease in depression, anxiety and suffering contributes to a higher quality of life, dignity in a cancer patient, and increased ability to cope with illness (Delgado-Guay et al., 2011). Evidence suggests that nurses lack the spiritual care education and due to this lack of knowledge nurses are likely to not be abiding by JCAHO standards to provide spiritual care. Nurses express a high level of responsibility and desire to provide spiritual care to patients at the end of life, but they admit to not being prepared or equipped with the proper tools and knowledge.

Studies on hospice nurses suggest areas in which there is a spiritual learning need and on which future studies should be focused in order to adequately prepare nurses caring for patients

at the end of life (Belcher & Griffiths, 2005). Areas in which nurses have expressed and need for more knowledge include the difference between religion and spirituality and the basic understanding of various religions, faiths, and cultures. Also, areas in which nurses lack knowledge include, initiating discussion on spirituality and performing a spiritual assessment (Belcher & Griffiths, 2005). In addition, nurses expressed a desire for knowledge on spiritual issues at the end of life and on their role with the interdisciplinary team in providing spiritual support (Belcher & Griffiths, 2005).

## Method

A review of current research related to spiritual care interventions for patients with advanced cancer was conducted using the following interdisciplinary databases: Cumulative Index of Nursing and Allied Health (CINAHL), PubMed, and PsychINFO, PsychARTICLES, and ATLA Religion databases using the key words “cancer\*” and “quality of life” followed by individual searches with the key words “therapeutic communication”, “spirit\*therapy”, “relaxation therapy”, and “self-care”. Inclusion criteria consisted of research conducted after the year 2000, pertaining to spiritual care interventions in palliative care, peer reviewed work and written in the English language. Exclusion criteria included articles that were not relevant to nursing interventions in spiritual care for cancer patients receiving palliative care. References of the reviewed research articles were cross-referenced to ensure data saturation and were included in review. Refer to Appendix A for the studies used in this review of literature.

## Findings

The database searches using the key words “cancer\*” and “quality of life” followed by individual searches with the key words “therapeutic communication”, “spirit\* therapy”, “relaxation therapy”, and “self-care” resulted in 37 citations. The 37 citations were individually screened, and based on exclusion criteria 13 studies were included for review. The studies reviewed were chosen because they pertained to spiritual care interventions for patients with advanced cancer receiving palliative care. Studies that included patients receiving chemotherapy for cure were included due to its applicability to patients receiving chemotherapy for palliative care. The studies have been divided into Govier’s 5 R’s of Spiritual Care and Table-1 shows the interventions applicable to each spiritual care domain identified by Govier (2000).

### Reason and Reflection Domains

Reason and reflection pertains to the individual’s ability to find meaning in their current life experience (Govier, 2000). Three studies promoted the reason domain of spiritual care using the following spiritual care interventions: Meaning Centered Group Psychotherapy (MCGP), Supportive Group Psychotherapy (SGP), and mental relaxation and mental images. These interventions apply to the Govier’s reason domain of spiritual care by increasing meaning of life, promoting serenity and dignity, decreasing depression, and encouraging participants to finish uncompleted tasks (Borthwick, Knowles, McNamara, O’Dea, & Stroner, 2003; Breitbart et al., 2010; Elias, Giglio, & Pimenta, 2008).

Meaning centered group psychotherapy, developed by Breitbart and colleagues, consists of didactics, discussions, and experiential exercises that focus on enhancing a sense of meaning, peace, and purpose in life. On the other hand, Supportive Group Psychotherapy (SGP) consisted

of 90-minute open discussions on cancer coping themes which allowed participants to talk through concerns related to their diagnosis and experience (Breitbart et al., 2010). One study consisted of 90 advanced cancer (stage III or IV) patients from Memorial Hospital in New York City who were randomly assigned to an 8-week session of either Meaning Centered Group Psychotherapy (MCGP) (n=49) or Supportive Group Psychotherapy (SGP) (n=41) at a clinical setting (Breitbart et al., 2010). There were 49 participants in MCGP and 41 in participants in SGP and there were 45 males and 45 females. In this study participants were assessed at baseline, at the end of the 8-week intervention, and 2 months after (Breitbart et al., 2010). Results showed patients in receiving MGCP has an increase in meaning and peace, reduced psychological distress, and were more consistent in participation (Breitbart et al., 2010).

Relaxation and mental images also known as RIME, developed by Elias and colleagues (2008), is an intervention which consists of the integration of mental relaxation techniques and the use of mental visualization elements which represent spiritual experience of individuals who have had near death experience. In a study investigating the effects of RIME, 11 terminal ill cancer patients from the cities of Campinas, Sao Paulo, and Piracicaba, Brazil were interviewed before and after RIME intervention at multiple public hospitals (Elias et al., 2008). The study used descriptive qualitative and quantitative methods and did not use a control group. Information on the participants' gender was not available. Participants who received RIME intervention were shown to increase serenity and dignity before death, minimize pain in the dying process, and motivate participants to recover positive aspects of their life and encourage them to finish uncompleted tasks (Elias et al., 2008).

Progressive Muscle Relaxation (PMR) is an intervention that involves tensing and relaxing various muscle groups (Prince-Paul, 2008). In Guided Imagery (GI) participants are instructed to mentally guide themselves into a safe environment (Prince-Paul, 2008). A study by Sloman (2002) which consisted of 56 participants, 26 females and 30 males participants, who were randomly assigned to three treatment groups received 30 minute sessions of Progressive Muscle Relaxation (PMR), Guided Imagery (GI), or a combination of both provided by a nurse via a tape recorder at their residence (Sloman, 2002). The study included three treatment groups and one control group. Results showed that PMR and GI used separately or combined did not have effects on reported anxiety; however participants did have a decrease depression and an increase in QOL (Sloman, 2002).

#### Religion Domains

Religion emphasizes the way in which values, beliefs, and practices serve as vehicles for spiritual expression. Religion is not limited to institutions or denominations but rather it is the spiritual beliefs and practices of an individual (Govier, 2000). Three studies applied to the religion domains by promoting the following spiritual care interventions: Transcendental Meditation (TM), art therapy, massage, guided meditation and progressive muscle relaxation (PMR). TM and art therapy were shown to decrease the stress from existential issues, to provide a sense of empowerment and self-growth, and to create a positive difference in future perspectives (Hauser-Meyers, 2006; Svensk et al., 2009). The results from the studies on massage, guided meditation and PMR were inconclusive (Downey et al., 2009).

Transcendental meditation (TM) is a type of meditation based on Hinduism that involves deep concentration and contemplation on a set of mantras which allow individuals to

progressively reach a quieter level of thought process eventually reaching transcendental consciousness (Alexander, Langer, Newman, Chandler, & Davies, 1989). In a phenomenological study on the effects of TM on women with breast cancer, 7 women with stage III and IV metastatic breast cancer were interviewed at their residence regarding their practice of TM and the effects of TM on their cancer experience (Hauser-Meyers, 2006). Results showed the participants felt a sense of empowerment and four out of the six women reported transcending the fear of dying (Hauser-Meyers, 2006). In the theme of spiritual growth, all 7 participants identified faith and a connection to infinite reality, as well as reported peace or calmness related to the connection with a spiritual reality (Hauser-Meyers, 2006).

Betensky art therapy session consists of 4 sequences and 2 phases in which 1) the participant explores and plays with the materials, 2) the participant creates a phenomenon, 3) the participant analyzes his or her work in 2 phases: the perceiving phase and the what-do-you-see-procedure phase, and lastly 4) phenomenological integration or self-discovery (Rubin, 2001). In one study that investigated the effects of art therapy on patients with advanced cancer, 42 Swedish women with non-metastatic breast cancer were randomly assigned to an intervention or control group (Svensk et al., 2009). The intervention group received 5 art therapy sessions a week for 8 weeks at the Department of Oncology at Umea University Hospital in Umea, Sweden (Svensk et al., 2009). Results showed an increase in QOL, general health, psychological health and physical health using the World Health Organization Quality of Life Instrument-short form (WHOQOL-BREF), Quality of Life Questionnaire (QLQ-BR23) and a positive change in the body image and future perspectives domain (Svensk et al., 2009).



In a study on the effects of massage and guided meditation, 167 cancer patients living in Seattle, Washington with AIDS or stage IV cancer were randomly assigned into two treatment groups or a control group. The treatment groups consisted of a 30-60 minute back-and-neck massage (n=56), progressive muscle relaxation and guided meditation (n=56) and the control group consisted of friendly visits (n=55) by professionals trained to provide psychosocial support was investigated to find the effects on patients at the end of life (Downey et al., 2009). In the massage group there were 39 females and 17 males. In the Meditation group there were 36 females and 29 males. In the friendly visits group there were 31 females and 24 males. Patient's determined the location of interventions and most occurred at the participant's residence. Results from the study showed no significant effects of either massage or meditation compared to friendly visits on actual quality of life (Downey et al., 2009). However, friendly visits provided benefits equal to the benefits received from massage or guided meditation on overall quality of life and pain distress (Downey et al., 2009). It is important to note that in all three treatment groups there was a decline in QOL and low pain distress as the participants reached their death; however, the three treatment groups experienced stabilization and a slight improvement before decline (Downey et al., 2009).

### Relationship Domains

Relationships refer to our interaction with ourselves, others, and a higher being (Govier, 2000). Spiritual care interventions that supported the relationship domain included socializing, TM, and communicative acts. TM supported the relationship domain as participants reported a desire for more loving relationships, a sense of strengthened identity, and feelings of self-worth (Hauser-Meyers, 2006). The relationship domain was also supported by two studies that found a

correlation between the self-reported acts of social and communicative acts with QOL (Prince-Paul, 2008) and socializing with decrease in fatigue (Borthwick et al., 2003).

In the study that investigated the practice and experience TM in 7 women with stage II and IV metastatic breast cancer interviews were conducted at the women's residence (Hauser-Meyers, 2006). Results showed that 5 out of the 7 women reported that TM promoted the development of a more loving relationship (Hauser-Meyers, 2006). Results showed that all women reported a strengthened identity, and feeling of self-worth (Hauser-Meyers, 2006).

Communicative acts of love or gratitude include phrases such as "I love you" or "Thank you", "I forgive you" or "I'm sorry" (Prince-Paul, 2008). Another study investigated the association between communicative acts and QOL when controlling physical symptoms, 50 participants from a hospice program in Ohio were interviewed at their residence (Prince-Paul, 2008). Results of QUAL-E showed a positive association between communicative acts and QOL in patients whose physical symptoms were adequately controlled (Prince-Paul, 2008).

Fatigue and self-care strategies were investigated among patients receiving radiotherapy for stage I, II, and III non-small cell lung cancer, 53 participants (31 males and 22 females) from Scotland were asked questions and asked to rate fatigue, daily and social distress in a diary entry before, during, 1 week and 1 month post radiotherapy treatment in their diaries while at their residence (Borthwick et al., 2003). Analysis of the data supported that participants had an increase in fatigue, distress, and interference with daily activities during the period of treatment, 1 week post treatment in which it reached its peak and decreasing 1 month post treatment (Borthwick et al., 2003). Higher levels of fatigue were associated with more advanced stages and

these occurred more in women during and post treatment. In 57% of the participants, socialization was reported as a self-care activity that reduced fatigue.

### Restoration Domains

Restoration as defined by Govier is “the ability of spirituality to affect the physical aspects of an individual” (Govier, 2000, p. 33). Five studies were associated with the restoration domain and they involved the following spiritual interventions: rest/sleep, gardening, watching TV, socializing, aromatherapy, massage, mental relaxation, mental images, TM, exercise, and Mindfulness-Based Stress Reduction (MBSR) which included Hatha yoga and meditation. The spiritual care interventions mentioned were associated with the restoration domain as they were shown to decrease vital signs, pain intensity, and psychological distress (Borthwick et al., 2003; Hadfield, 2001; Schwartz, Mori, Gao, Nail, & King, 2001; Tacón, Caldera, & Ronaghan, 2004; Wilkie et al., 2000).

Hadfield (2001) explored the effects of aromatherapy massage (AM) on 8 participants with malignant brain tumors living in southwest Scotland received 30 minutes of their choice of message (foot, hand, or neck/shoulder) and aromatherapy while at the clinic (Hadfield, 2001). Results showed a decrease in blood pressure, heart rate, and respiratory rate (Hadfield, 2001). Although the results did not show to decrease anxiety, participants reported the following common themes: “relaxed” and “less tense” (Hadfield, 2001).

The use of exercise was studied to investigate its effects on fatigue (Schwartz et al., 2001). In this study by Schwartz and colleagues (2001), 72 women with breast cancer from Oregon did home-based aerobic exercise program that consisted of a 15 and 30 min session, 3–4

days a week (Schwartz et al., 2001). Participants were instructed to keep a fatigue and exercise diary. Results showed that the intensity of fatigue declined as the duration of exercise increased and that all four levels of fatigue declined: 1) fatigue at its worst in the past 24 hours, 2) fatigue at its least in the past 24 hours, 3) fatigue on average over the past 24 hours and 4) fatigue right now (Schwartz et al., 2001).

Mindfulness-based stress reduction (MBSR) is a program developed by Kabat-Zinn that consists of meditation and yoga (Kabat-Zinn, 2011). A study to analyze the effectiveness of MBSR involved 27 women diagnosed with breast cancer from Texas (Tacón et al., 2004). The interventions consisted of an 8 week program one night every week for 1 hour at the hospital on the following practices: MBSR which included hatha yoga, and sitting meditation (Tacón et al., 2004). Results showed a decrease in stress and anxiety levels as reported by patients (Tacón et al., 2004). Mental adjustment to cancer was studied and results showed a decrease in helplessness, hopelessness, and anxious preoccupation before and after MBSR (Tacón et al., 2004). In addition, the Health locus of control is a measure for which an individual feels his or her current condition was in control by internal forces, external (powerful others), or by chance. Results showed that at post treatment participants had moved to an internal health locus of control (Tacón et al., 2004).

Wilkie (2000) studied the effects of four massage session twice a week on pain intensity, prescribed IM morphine equivalent doses, hospital admissions and quality of life on 29 hospice participants from Washington (Wilkie et al., 2000). The 29 participants were randomly assigned to a control group (n=14) and a massage group (n=15) (Wilkie et al., 2000). Those in the massage group received massages from massage therapists, Results showed that pain intensity,

pulse rate, and respiratory rate decreased after the massages (Wilkie et al., 2000). All QOL scores decreased after the massage, but remained higher than the control group, although the QOL scores at baseline were higher in the massage group than in the control group (Wilkie et al., 2000).

The following are types of relaxation techniques: induction script, progressive muscular relaxation, passive neuromuscular relaxation, autosuggestion, guided visualization, and unguided visualization (Miller & Hopkinson, 2008). Induction script is the gentle awareness of breathing patterns and muscular tension (Miller & Hopkinson, 2008). Progressive muscular relaxation (PMR) is the tightening and relaxing of muscles groups in the body. Autosuggestion uses suggestion to educate the body to respond to simple, verbal commands such as heaviness in a certain limb. Passive neuromuscular relaxation is the tensing and relaxing of muscles without the use of active movement rather than by suggestion (Miller & Hopkinson, 2008). Guided visualization consists being guided to visualize oneself in a safe and pleasant environment. Unguided visualization is the unstructured form of guided visualization in which an individual chooses the scene he or she is visualizing (Miller & Hopkinson, 2008).

In one study to explore these various relaxation techniques using a retrospective clinical audit, 186 participants received four-one hour long sessions of the relaxation techniques mentioned above by Occupational Therapists in a rehabilitation centre in Sutton, United Kingdom (Miller & Hopkinson, 2008). Results showed an increase in tension scores from 2.92 in session one to 3.46 in session four and no significant difference in tension scores among the different techniques (Miller & Hopkinson, 2008).

In a study by Borthwick and colleagues (2003) mentioned earlier, 53 participants (31 males and 22 females) with stage I, II, and III non-small cell lung cancer from Scotland were asked questions and asked to rate fatigue, daily and social distress in a diary entry before, during, 1 week and 1 month post radiotherapy treatment in their diaries while at their residence. (Borthwick et al., 2003). Participants identified the following self-care activities as activities that would decrease their level of fatigue: resting (100%), sleeping (76.1%), gardening, watching TV (95.6%), and socializing (57%) (Borthwick et al., 2003).

## Discussion

The current research evidence on spiritual care interventions in advanced cancer patient receiving palliative care are outlined in TABLE 1. Spiritual care interventions identified in this study were categorized into five domains based on the effect the intervention had on the participant. The five domains were taken from Govier's Five Rs of Spirituality (Govier, 2000) . Spiritual care interventions identified in this study include Meaning Centered Group Psychotherapy (MCGP), Supportive Group Psychotherapy (SGP), mental relaxation, mental images, TM, art therapy, socializing, communicative acts, aromatherapy, massage, exercise, hatha yoga, meditation, and activities such as gardening, watching TV, resting/sleeping and socializing. A total of 798 participants across 13 studies were reviewed and the majority of the individuals were women.

### Reason and Reflection

After further research on the RIME intervention of mental images and mental relaxation a gap was found pertaining to the use and implementation of this intervention in a clinical setting specifically pertaining to time duration, materials used, and the intervention process. Due to the lack of data regarding the participant demographics and specific use of RIME, the use of RIME intervention is not generalizable and would be difficult to implement in clinical setting (Elias et al., 2008). High attrition is a common issue when studying participants with advance cancer. In the study by Brietbart and colleagues (2010) attrition affected the data, participation and interpretation of the results (Breitbart et al., 2010). Although in the study psychologists provided the MCGP therapy, nurses can trigger existential and meaning of life conversations while interacting daily with their patients. In a counseling setting, nurses might consider being certified

in MCGP and SGP for implementation in cancer support groups. Nurses may want to implement PMR and GI into the clinical or home environment as the results successfully showed applicability to these settings and were generalizable to men and women with advanced cancer (Sloman, 2002). Nonetheless, relaxation imagery might be worth investigating further with larger sample size for better generalizability. Spiritual care interventions that were not investigated and might prove fruitful to research include reflective listening, life review, storytelling, and journaling.

### Religion

All of the participants investigated in the religion domain were female, therefore future studies on patients with advanced cancer receiving art therapy or using TM should concentrate on men. Future studies on art therapy and TM with patients with advanced cancer should involve a larger population of women as the total population investigated for the religion domain was only 49 women (Hauser-Meyers, 2006; Svensk et al., 2009). In the study by Downey and colleagues (2009), two brief interventions of massage, guided meditation or friendly visits each week may not have a strong enough impact on quality of life. Therefore, nurses should investigate further in this area as the study was preliminary (Downey et al., 2009). In addition, due to the lack of research in other religious interventions such as sacred spiritual readings, religious rituals, music therapy, and prayer involving patients with advanced cancer receiving palliative care, future research should focus on these spiritual care interventions.



## Relationships

In providing spiritual care to patients with advanced cancer, nurses might consider the use of communicative acts of love and gratitude, and opportunities for socialization both in clinical and counseling settings. Studies in the relationship domain that investigated TM, communicative acts of love and gratitude, and fatigue after radiotherapy were all observational studies that consisted of interviews and questionnaires on past activities (Borthwick et al., 2003; Hauser-Meyers, 2006; Prince-Paul, 2008). Future experimental studies using a control group on patients with advanced cancer might want to focus on socializing, communicative acts, and TM. In addition, due to the small sample size which included only women, TM is not generalizable to men and future research with a larger sample is needed. Future studies in the relationship domain are recommended and particularly on the effects of reconciliation with self and others seems worthy of investigation as research lacked in this area.

## Restoration

The study by Hadfield and colleagues (2001) did not have a control group and had a small sample size therefore; future research should include experimental studies on aromatherapy massage in patients with advanced cancer. Nonetheless, nurses might want to consider the use of aromatherapy and massage as spiritual care interventions when caring for patients with advanced cancer who could benefit from relaxation in a clinical or home setting. In the study that investigated MBSR, although the study was experimental it did not include a control group (Hadfield, 2001). Future research on MBSR might want to include a control group and larger sample size. In the study by Schwartz and colleagues (2001), the last two weeks of post treatment data were missing due to subject burden of daily measures of fatigue. Future

studies might want to aim at simplifying the diary questions as well as including men in the study. When caring for women patients, nurses might want to consider mental relaxation, TM, Hatha yoga (MBSR) and exercise as spiritual care interventions to decrease stress and fatigue. In addition, nurses might want to encourage patients with advanced cancer to participate in rest/sleep, gardening, watching TV, and socializing as these self-care activities have been reported by patients with advanced cancer as activities that reduce fatigue (Borthwick et al., 2003). Nonetheless, future studies on self-care activities are needed which use an experimental design using rest/sleep, gardening, watching TV, and socializing as treatment variables as opposed to an observational approach involving participants' self-care activity reports (Borthwick et al., 2003). In the study by Wilkie and colleagues (2000), a small sample size was investigated and possible sensitivity issue was identified in current QOL and satisfaction tool. Future studies might want to use a larger sample size and find a more sensitive tool to measure current QOL and satisfaction. Nurses might want to consider the use of massage for promoting physical relaxation in clinical and home environments. In the study that investigated the use of various relaxation techniques by Miller and colleagues (2008), there may have been an increase in the participant's tension awareness which may have led to the report of increased tension among participants. Future studies with the various relaxation techniques are needed in order to make any conclusions on their effects on relaxation.

## Limitations

Due to the broadness of the topic, spiritual care interventions in patients with advanced cancer, and the key terms: “therapeutic communication”, “spirit\*therapy”, “relaxation therapy”, and “self-care” used, search results may have missed some studies. Due to high attrition rate of participants among studies involving advanced cancer, follow up was not possible. Difference in results among the studies involving relaxation techniques did not allow for a conclusion on the association between fatigue, anxiety, and tension. Also, no conclusions could be drawn regarding which relaxation technique resulted in lower tension scores. Explanation to the participants on how to measure fatigue may be necessary in future studies due to the risk of participants having increased awareness of fatigue and rating fatigue higher throughout the study. A possible decreased sensitivity to the Hospital Anxiety and Depression Scale may have led to the inability to conclude the effects of spiritual care interventions on anxiety, despite the participants’ report of lower anxiety. Art therapy, TM, exercise, and MBSR interventions were not generalizable to men, as the studies included only women. In addition, studies that involved RIME, TM, PMR, GI, MBSR, art therapy, and massage had a small sample size.

## Recommendations for Nursing

### Research

This literature review revealed that there is a limited amount of research in the religion and relationship domains of Govier (2000). Research in the areas of religion and relationship were not generalizable to men due to lack of research involving men in the areas of religion and relationship. Researchers might want to focus on spiritual care interventions to increase the quality of life in advanced cancer patients receiving palliative care that focus on the religion, reason and reflection, and relationship domain specifically using men. Specific spiritual care interventions in the religion domain that might be researched are sacred spiritual readings, religious rituals, music therapy, and prayer. Spiritual interventions in the reason and reflection domains that need further investigation include reflective listening, life review, storytelling, and journaling. In the relationship domain, spiritual interventions that might be researched are reconciliation with self and others and socialization. Nurses working with patients with advanced cancer interested in providing spiritual care might want to do so by using the spiritual care interventions identified in this review while being aware that future research is needed in art therapy, TM, MBSR, and exercise to investigate its effects on men with advanced cancer. In addition, future studies should focus on increasing the sample size in studies investigating the effects RIME, TM, PMR, GI, MBSR, art therapy, and massage performed by nurses on patients with advanced cancer receiving palliative care in both clinical and home setting.

## Education

Studies have shown a lack of spiritual care education in baccalaureate nursing programs (Belcher & Griffiths, 2005). In addition, nursing programs do not have spirituality or spiritual care defined (Belcher & Griffiths, 2005). Hospice nurses have expressed their need for spiritual care knowledge in assessments and interventions. In a study conducted to analyze the spiritual care provided by hospice nurses compared to other specialties, it was concluded that hospice nurses do not complete a spiritual assessment because they do not know what to ask or how to approach it (Murray, 2010). Hospice nurses admitted they felt embarrassed and awkward in asking about the patient's spirituality. In addition, they expressed they lacked tools for the assessment and they felt unsure about bringing up a personal subject. Lastly, hospice nurses did not complete a spiritual assessment because they expected the social worker or chaplain to do so (Belcher & Griffiths, 2005).

Areas for which nurses have expressed spiritual learning needs include the difference between religion and spirituality, initiating discussion about spirituality, spiritual assessment, and a basic understanding of various religions, faiths, cultures, spiritual practices, and rituals (Belcher & Griffiths, 2005). In addition, other learning needs include the integration of spirituality into total patient care, practical interventions for difficult circumstances, spiritual care for patients who are not religious, and the role of the nurse and the interdisciplinary team in providing spiritual support. Lastly, nurses showed a need in education issues related to end of life, spiritual crisis, spiritual conflict/ differences, role of spiritual care within the scope of hospice care, and spirituality and alternatives/augmentative healthcare practices (Belcher & Griffiths, 2005).

## Practice

Spiritual care interventions identified in this literature review that applies to Govier's reason and reflection, religion, relationship, and restoration domains should be implemented by nurses caring for patients with advanced cancer. The following are spiritual care interventions that nurses working with patients with advanced cancer might want to consider using: MCGP, hatha yoga and mental relaxation (MBSR), aromatherapy massage, and self-care activities such as watching TV, gardening, resting/sleeping, and socializing. Spiritual care interventions identified in this study that nurses working with women with advanced cancer might want to consider using include TM and art therapy.

Hospice nurses and oncology nurses who spend large amounts of time with patients with advanced cancer should especially become familiar with the interventions outlined by the studies so that they can correctly provide the spiritual care intervention to their patients. All nurses in general, but specifically hospice and oncology nurses are encouraged to read research involving spiritual care interventions and stay updated through professional nursing journals such as *Hospice Journal* and *Journal of Palliative Care*.

It is important that nurses are culturally competent, in other words able to provide holistic care to patients and families of various cultures. Nursing is patient-centered and it encompasses that patient as a whole including family, community, language, beliefs, and practices. Nurses should first analyze their own beliefs and practices or they might risk encouraging in their patients an individualistic perspective on their disorder rather than one that incorporates the social and cultural influences (Waite & Calamaro, 2010).

Nurses whose religious beliefs differ from those of their patients should not push their religious agenda on their patients. It is important that nurses do not pray in a way that is incongruent with his or her own beliefs, as doing this communicates insincerity from the nurse to the patient. Furthermore, behaving in a manner that goes against the nurse's beliefs may offend the patient and even destroy the trust the nurse had already created with his or her patient. Most importantly, some religious practices may harm the patient and in these cases nurses might want to educate their patients on the consequences of such activities on their health. However, on practices that do not interfere with the patients' health it is inappropriate for a nurse to ask a patient to stop such religious or spiritual practice (French & Narayanasamy, 2011).

The spiritual dimension of a patient is as important to patient's health as his or her physical body or psychological dimension. The holistic nature of nursing encourages nurses to provide spiritual care with the use of spiritual interventions. The spiritual care interventions outlined in this literature review are recommended to increase the quality of life of patients with advanced cancer receiving palliative care. As the science of nursing is ever evolving future research in the areas of spiritual care interventions are needed in order to establish a stronger foundation of knowledge to offer nurses working with patient with advanced cancer.

Appendix A  
Research Table



Articles	Purpose	Participants and Study Design	Intervention Details	Outcome measures	Results (or Key Findings)	Limitations	Nursing Implications
<p>Borthwick, D., Knowles, G., McNamara, S., O'Dea, R., &amp; Stroner, P. (2003). Assessing fatigue and self-care strategies in patients receiving radiotherapy for non-small cell lung cancer. <i>European Journal of Oncology Nursing</i>, 7(4), 231-241.</p>	<p>To assess and evaluate the perception of self-care behaviors for fatigue in patients receiving radical or high-dose palliative radiotherapy for stage I,II, or III non-small cell lung cancer.</p>	<p>53 (31 males and 22 females) participants with non-small cell carcinoma currently receiving radiotherapy for stage I,II or III.</p> <p>Study design was prospective and 11 of the study participants were chosen for interviews</p>	<p>The diary consisted of 9 questions, four visual analogue scales which assessed fatigue and distress in daily and social activities. A “yes” and “no” questionnaire addressing potential self-care activities and their perceived effectiveness. Patients completed diaries before, during, 1 week and 1 month post treatment.</p>	<p>Descriptive Data analysis of diary entries and the taped interviews were transcribed and both were categorized by common themes.</p>	<p>Participants showed to have a steady increase in fatigue, distress and interference with daily activities and hobbies during the treatment period, peaking at 1 week post treatment period and then decreasing 1 month post treatment. Men and woman showed to have equal fatigue prior to radiotherapy. Men showed to have less fatigue during and post treatment. Women’s distress and fatigue caused</p>	<p>Fatigue was not as distressing a symptom in this study population as other studies have reported. The importance of fatigue was not explored. High attrition.</p>	<p>Guidance, support and advice is required regarding the nature of fatigue when dealing with patients, caregivers, and nursing staff. Future research should aim to understand the patient’s interpretation of fatigue and appropriate assessment and management of fatigue.</p>

					<p>more interference in their daily life than men.  Higher levels of fatigue in more advanced stages. Fatigue scores for radical and high dose palliative were the same. Self-care activities that were chosen to decrease fatigue included rest (100%), sleeping (76.1%), gardening, watching TV (95.6%), and socializing (57%)</p>		
<p>Breitbart, W., Rosenfeld, B., Gibson, C., Pessin, H., Poppito, S., Nelson, C., . . . Olden, M. (2010). Meaning-centered group</p>	<p>To help patients with advanced cancer sustain or enhance a sense of meaning, peace and purpose in their lives with the use of Meaning-</p>	<p>90 advanced (stage III or IV) solid tumor cancers patients. Each was randomly assigned to either Meaning-Centered Group Psychotherapy</p>	<p>MCGP sustains or enhance a sense of meaning, peace and purpose in their lives.  Supportive group</p>	<p>Outcome measures included spiritual well-being, meaning, hopelessness, desire for death, optimism/pessimism, anxiety, depression and</p>	<p>MCGP participants were significantly more likely than SGP participants to report a focus on finding a sense of meaning.</p>	<p>High attrition due to illness</p>	<p>MCGP Has shown to be an important step in enhancing quality of life for patients at the end of life.</p>

<p>psychotherapy for patients with advanced cancer: A pilot randomized controlled trial. <i>Psycho-Oncology</i>, 19(1), 21-28. doi: 10.1002/pon.1556</p>	<p>Centered Group Psychotherapy (MCGT)</p>	<p>(MCGT) or a supportive group psychotherapy (SGP).</p>	<p>psychotherapy (SGP) encourages patients to share concerns related to the cancer diagnosis and treatment. It encourages patients to describe their experiences in coping with cancer.</p> <p>Patients were assessed before and after completing the 8-week intervention, and again 2 months after completion.</p>	<p>overall quality of life.</p> <p>The following tools were used: FACIT Spiritual Well-Being Scale (SWB), the Beck Hopelessness Scale (BHS), the Schedule of Attitudes toward Hastened Death (SAHD), the Life Orientation Test (LOT) and the Hospital Anxiety and Depression Scale (HADS)</p>	<p>Participants in MCGP attended significantly more sessions than SGP.</p> <p>Improvement was seen in spiritual well-being were greater at the 2-month follow-up</p> <p>Pre- to post-treatment were substantial and statistically significant for SWB and Meaning/Peace subscale.</p> <p>MCGP showed to reduce psychological distress</p>		
<p>Downey, L., Diehr, P., Standish, L. J., Patrick, D. L., Kozak, L., Fisher, D., . . .</p>	<p>To analyze the effects of massage and guided meditation on patients at the</p>	<p>167 participants included hospice or palliative care patients living in the Seattle, Washington,</p>	<p>Massage Therapy: 35 minutes, but that the visit could include up to 10 additional</p>	<p>Pain distress was drawn from the Memorial Symptom Assessment scale and quality</p>	<p>No significant effects of either massage or meditation, when compared with friendly</p>	<p>Two brief intervention visits each week, may not have a strong impact on quality of life</p>	<p>Massage, guided meditation compared to friendly visits may not improve quality of life</p>

<p>Lafferty, W. E. (2009). Might massage or guided meditation provide 'means to a better end'? Primary outcomes from an efficacy trial with patients at the end of life. <i>Journal of Palliative Care</i>, 25(2), 100-108.</p>	<p>end of life.</p>	<p>metropolitan area, who spoke English, were at least 18 years old, were mentally capable of providing reliable responses during a 60-90 minute baseline interview, were expected to survive for at least 3 weeks after enrollment,</p>	<p>minutes for introductions, information exchange, and paperwork. Massage therapists were to provide a light back-and- neck massage in a position of the patient's choosing, followed by effleurage and goodbye holding. Depending on need, they could spend some time focusing on areas of particular tension or stress.</p> <p>Meditation: providers were to lead the patient in progressive muscle relaxation,</p>	<p>of life was measured using a 0-10 rating scale</p>	<p>visits on the actual quality of life.</p> <p>Friendly visits provided benefits equal to that received from massage or guided meditation on overall Quality of life and pain distress.</p>	<p>Friendly visitors were somewhat more skilled in providing these services than the typical hospice volunteer</p>	<p>Further research is still needed as study was preliminary</p>
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			<p>mindfulness-based meditation, and guided imagery/visualization.</p> <p>Friendly Visits: Friendly visitors could spend the allotted time with the patient (e.g., reading to them, engaging in conversation, writing letters, doing light chores, running errands, or just spending time with them); alternatively, they could provide respite or other assistance to caregivers without directly interacting with the patient.</p> <p>A short follow-</p>				
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			up interview was conducted after every 2 treatments				
Elias, A. C. A., Giglio, J. S., & Pimenta, C. A. M. (2008). Analysis of the nature of spiritual pain in terminal patients and the process through the resignification relaxation, mental images and spirituality (RIME) intervention. <i>Revista Latino-Americana de Enfermagem (RLAE)</i> , 16(6), 959-965	To understand Spiritual Pain and the new meaning spiritual pain takes with the use of relaxation, mental images, and spiritual interventions.	11 patients with terminal cancer.  Experimental study design	Interventions consisted of integrating Mental Relaxation and Mental Images	Spiritual Pain was measured at the beginning and the end of each session using the Visual Analogue Scale (VAS) with colored facial expressions.  Evaluation consisted of 21 semi-structured interviews and eleven structured questionnaires	RIME intervention promoted quality of life in the dying process and increased serenity and dignity before death.  RIME Intervention minimized pain in the dying process of a diversified population.  RIME procedures motivated patients to recover positive aspects of their life and encouraged them to finish uncompleted	The study did not use a control group to compare RIME results with results from other interventions.  The sample size was small.  Results cannot be generalized.	Nurses working in areas such as intensive care, hospice or oncology can become trained and implement RIME to their terminal cancer patients who have spiritual pain.

					tasks.		
Hadfield, N. (2001). The role of aromatherapy massage in reducing anxiety in patients with malignant brain tumours. <i>International Journal of Palliative Nursing</i> , 7(6), 279-285.	To explore the effects of aromatherapy massage (AM) in reducing anxiety and promoting relaxation in patients with primary malignant brain tumors	8 participants Experimental design	Participants received 30 minutes of their choice of message (foot, hand, or neck/shoulder) and aromatherapy (lavender or roman chamomile) while listening to Enya -Blood pressure, pulse, and respiratory rate were taken before and after AM. HADS was filled out before and 24 hours after AM	Vitals, Hospital Anxiety and Depression Scale (HADS) and semi-structured interviews collected before and after AM.  Measurement of blood pressure, pulse, respiratory rate, HADS and semi-structured interviews	Decrease in blood pressure, heart rate, and respiratory rate after AM. Decrease in vital signs suggests relaxation  No significant difference in anxiety before and after interventions  Semi-structured interview revealed common themes such as: “relaxed”, “less tense”, and suggestions of decreased anxiety	Short study period. No control group	Future nursing research in aromatherapy to reduce anxiety and increase in relaxation  Use in holistic nursing practice.
Hauser-Meyers, C. C. (2006). <i>A study of the existential</i>	To explore the experiences of seven women with advanced	7 women with stage III and IV breast cancer.	Each woman had a meditation induction course in the technique	Interviews conducted to examine four different time	Participants describe that the practice of TM fostered	Small sample size No control group	The practice of TM shows to have spiritual, emotional,

<p><i>experiences of women with advanced breast cancer who practice transcendental meditation.</i> ProQuest Dissertations and Theses; 2006; ProQuest Dissertations &amp; Theses (PQDT)</p>	<p>breast cancer who practice Transcendental Meditation (TM)</p>	<p>Phenomenological study</p>	<p>for two hours a day for five consecutive days. Each women was instructed to practice TM twice a day for 15-20 minutes and keep a daily log noting experience, biweekly group meetings with a TM teacher over the first six months of intervention and then monthly .</p>	<p>periods: (1) life before the diagnosis of cancer, (2) the experience of learning about the diagnosis, (3) the existential experiences of living with cancer, (4) the existential experiences of living with cancer while practicing TM</p>	<p>existential shifts, spiritual growth, psychological transformation, and physiological well-being. Four of these six reported the transcendence of fear of death and dying. One patient consistently identified a "no change" however she reported psychological transformation.</p> <p>Reduced the stress associated with confronting existential Issues Improved sense of control Promoted more loving relationships Strengthened</p>	<p>Not generalizable to all age groups, male patients, or ethnic and socioeconomic groups.</p>	<p>psychological and physical implications.</p>
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					identity and feelings of self-worth. Provided a sense of empowerment		
Miller, J., & Hopkinson, C. (2008). A retrospective audit exploring the use of relaxation as an intervention in oncology and palliative care. <i>European Journal of Cancer Care</i> , 17(5), 488-491.	To explore the variety of relaxation techniques implemented and evaluate its general effectiveness	186 participants. A retrospective clinical audit using data from patient's relaxation treatment period provided by Occupational therapists.	Four sessions one-hour each using the following techniques: -Induction script -Progressive muscular relaxation -Passive -Neuromuscular relaxation -Autosuggestion -Guided visualization -Unguided visualization	Tension was recorded before and after relaxation using an adapted Visual Analogue Scale (VAS)	There was little difference in tension scores within the different techniques.  Tension scores increased.	Participants increased tension awareness which may have led to the increase in tension scores.	Future studies on the impact relaxation has on occupational performance. Future studies on the effectiveness of individual relaxation techniques.
Prince-Paul, M. (2008). Relationships among communicative acts, social well-being, and spiritual well-being on the quality of life at	To investigate the communicative acts of love, gratitude, forgiveness, and to explore the extent to which they predict overall	50 participants.  Retrospective audit	Data collected through structured, one-on-one patient interviews and assessment tools	Functional Assessment of Cancer Therapy– General (FACT-G) social/family well-being subscale, the JAREL Spiritual	Strong, positive correlations among social and spiritual well-being, communicative acts  64% of the participants	Did not address individual spiritual and social interventions.	Pain management allows patients to focus on other issues on end of life such as spirituality and social aspects of life

<p>the end of life in patients with cancer enrolled in hospice. <i>Journal Of Palliative Medicine, 11(1), 20-25. doi: 10.1089/jpm.2007.0119</i></p>	<p>QOLEOL when controlling for physical symptoms</p>			<p>Well-Being tool</p>	<p>rated forgiveness as not applicable.</p> <p>Spiritual Well-not altered by the terminal illness</p>		
<p>Schwartz, A. L., Mori, M., Gao, R. L., Nail, L. M., &amp; King, M. E. (2001). Exercise reduces daily fatigue in women with breast cancer receiving chemotherapy. <i>Medicine and Science in Sports and Exercise 33(5).</i></p>	<p>To examine the relationship between exercise and fatigue on women receiving the following chemotherapy (three cycles)</p>	<p>72 women with a diagnosis of breast cancer currently receiving chemotherapy.</p> <p>Experimental study</p>	<p>8-wk home-based aerobic exercise program that consisted of a 15 and 30 min, 3–4 d·wk<sup>-1</sup> while wearing the Caltrac, a device that measures calories burnt and oxygen uptake. In addition subjects kept an exercise and fatigue diary.</p>	<p>A pretest and posttest intervention.</p> <p>Functional ability, energy expenditure, and fatigue were measured at baseline and posttest using a visual analog scale.</p> <p>Diaries included the records of four types of fatigue 1) fatigue at its worst in the past 24 h, 2) fatigue at its least in the</p>	<p>Exercise reduced all four levels of fatigue.</p> <p>The intensity of fatigue declined as the duration of exercise increased.</p>	<p>Limited generalizability due to one study design</p> <p>Some women adhered to the exercise routine and some women did not. Typically the women who did not had been previously inactive.</p> <p>Last 2 week data missing possibly due to excessive subject burden of daily measures of fatigue</p>	<p>Nurse's should encourage the daily or at least every-other-day, low-to moderate-intensity, symptom-limited exercise in order to reduce fatigue in women with breast cancer receiving chemotherapy.</p>

				past 24 h, 3) fatigue on the average over the past 24-h, and 4) fatigue right now., and exercise duration, intensity, and type.			
Sloman, R. (2002). Relaxation and imagery for anxiety and depression control in community patients with advanced cancer. <i>Cancer Nursing</i> , 25(6), 432-435.	To explore the effects on Progressive Muscle Relaxation and Guided imagery used singly or together, on anxiety, depression, and QOL.	56 participants with advanced  The sample consisted of 26 women and 30 men with a mean age of 54.5 years and an age range of 27 to 79 years  3 treatment groups and a control group in the study.	Setting was the subject's homes  Community nurse trained in the use of relaxation and imagery techniques performed the interventions  The nurse explained the procedure and turned on a tape recorder with the taped instructions for their specific group.	The HAD and the Functional Living Index Cancer scales were administered as pretest.  Subjects met nurse twice weekly for a follow-up appointment.  The HAD and the Functional Living Index Cancer scales were administered as a post test 3 weeks after the initial session.	PMR, GI, and a combined technique failed to produce significant improvement in Anxiety.  Positive effects on depression and QOL.  No one treatment proved to be more beneficial than another	Small sample size. HAD scale may not have been sensitive enough to measure Small changes in anxiety.	Results of the study are consistent with Orem's Self Care notion and should be implemented in clinical setting

			<p>The three groups were the following: PMR, GI, or a combination of PMR and GI.</p> <p>Each session lasted approximately 30 minutes.</p> <p>The subjects were to keep the tape and practice the technique twice daily.</p>				
<p>Svensk, A., Öster, I., Thyme, K., Magnusson, E., Sjödin, M., Eisemann, M., . . . Lindh, J. (2009). Art therapy improves experienced quality of life among women undergoing treatment for breast cancer: a randomized</p>	<p>To evaluate the effect of art therapy during radiotherapy treatment on QOL</p>	<p>42 women with non-metastatic breast cancer. Randomized controlled study</p>	<p>The women were randomized into an intervention group and a control group. The intervention group had five individual art therapy sessions once a week for 5 weeks. The same material was provided in each art session and the art</p>	<p>WHOQOL-BREF, QLQ-BR23</p>	<p>6 months post first session women showed an increase in OOL.</p> <p>Positive difference in the body image , future perspectives and side effects</p>	<p>Small sample size</p>	<p>Nurses can implement art therapy into their care of patients with cancer to increase the QOL, increase body image and future perspectives.</p>

<p>controlled study. <i>European Journal of Cancer Care</i>, 18(1), 69-77. doi: 10.1111/j.1365-2354.2008.00952.x</p>			<p>therapy session were inspired by Betensky (1995, pp. 14-23). Before, after each radiotherapy treatment, 2 months after the study and 6 months after the study, the women completed an interview questionnaire assessing coping, QOL, symptoms and self-image. In addition, the women were to write in a weekly diary.</p>				
<p>Tacón, A. M., Caldera, Y. M., &amp; Ronaghan, C. (2004). Mindfulness-based stress reduction in women with breast cancer.</p>	<p>To analyze the effectiveness of mindfulness-based stress reduction and relaxation (MBSR) program on the following: -stress</p>	<p>27 women diagnosed with breast cancer  Experimental study</p>	<p>8 week intervention one night every week for 1 hour and a half at a hospital. Participants were trained in body scan, hatha yoga, and sitting</p>	<p>Stress was assessed on a 10 point scale. Anxiety was assessed with State-trait Anxiety Inventory. The mental</p>	<p>Decrease in stress and anxiety levels.  Beneficial change for mental adjustment to health care and</p>	<p>Small sample size Lack of control group  Limited generalizability due to sample's demographics</p>	<p>Nurses should encourage the use of meditation, body scan, and hatha yoga to their cancer patients receiving chemotherapy</p>

<p><i>Families, Systems &amp; Health: The Journal of Collaborative Family HealthCare</i>, 22(2), 193-203.</p>	<p>-anxiety -mental adjustment to cancer -health locus.</p>		<p>meditation.</p>	<p>adjustment to cancer was measured with a 40 item questionnaire. Health locus of control was assessed using the Multidimensional Health Locus of Control Scale (MHLC)</p>	<p>health locus</p>		<p>due to the ability to decrease stress and anxiety and well as positively affect the adjustment to cancer and the health locus.</p>
<p>Wilkie, D. J., Kampbell, J., Cutshall, S., Halabisky, H., Harmon, H., Johnson, L. P., . . . Rake-Marona, M. (2000). Effects of massage on pain intensity, analgesics and quality of life in patients with cancer pain: a pilot study of a randomized clinical trial conducted within hospice</p>	<p>To examine the effects of four massages on pain intensity, prescribed IM morphine equivalent doses, hospital admissions and quality of life (QOL).</p>	<p>29 participants (14 control group 15 massage group) 69%-male Average age-63  Experimental study</p>	<p>Massage group received four massages performed by licensed therapists administered twice a week.  Baseline and outcome measures were collected before the first massage and after the fourth massage.</p>	<p>Vital signs Pain Intensity Scale Graham's Quality of Life Tool Global Well Being Scale (GWBS)</p>	<p>Pain intensity, pulse rate, and respiratory rate decreased after the massages  All initial QOL scores were higher in the massage group than the control group  The massage group's current quality of life and satisfaction decreased after the massages, but remained</p>	<p>Decrease in current quality of life and satisfaction tool sensitivity  Small sample size</p>	<p>Massage when paired with pain management can decrease vital signs and promote relaxation which can increase the quality of life of the patient.</p>

care delivery. <i>Hospice Journal</i> , 15(3), 31-53.					higher than the control group's		
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Appendix B

TABLE 1



**Interventions for Govier's 5 R's of Spiritual Care**

<b>Reason and Reflection</b>	<b>Religion</b>	<b>Relationship</b>	<b>Restoration</b>
Meaning Centered Group Psychotherapy (MCGP) Supportive Group Psychotherapy (SGT) Mental relaxation Mental images	Meditation Mental relaxation Mental images Transcendental Meditation (TM) Art Therapy	Friendly visits Socializing Communicative acts	Rest/Sleep Gardening Watching TV Socializing Aromatherapy Massage Mental relaxation Mental images Transcendental meditation (TM) Exercise Hatha Yoga Meditation

Appendix C  
Consort Diagram

Key Terms: Cancer\* + Quality of Life  
Limiters used: Nursing, 2002-2012, English Language

Database (s) with relevant materials (CINAHL, PsychARTICLES, PsychINFO)  
(n=5461)

Studies retrieved after  
addition of key term  
Therapeutic  
Communication  
(n=48)

Studies retrieved after  
addition of key term  
Spiritual\* Therapy  
(n=68)

Studies retrieved after  
addition of key term  
Relaxation Therapy  
(n=48)

Studies retrieved after  
addition of key term  
Self-care  
(n=97)

Studies were hand reviewed for further  
relevance and application towards thesis topic  
(n=37)  
Total for Review (N=13)

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