Special Article

# Watson's Caritas Processes® as a Framework for Spiritual End of Life Care for Oncology Patients

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**Abstract**

Spirituality is an important aspect of care for the patient with advanced oncology illness, palliative care, and those at the end of life. Although patient care professionals understand the importance of spiritual care, many feel ill prepared to provide spiritual care. The ability to connect with and embrace the spirit or soul of the other as they face life limiting illness is at the heart of providing spiritual care. Jean Watson's theory of Caring Science and Caritas Processes® can provide a framework for the development of caring and healing practices that can facilitate spiritual care.

**Key words:** Watson's Caritas Processes®, palliative care, spirituality, oncological nursing, caring, Caring theory, compassion, spiritual care

## Introduction

Spirituality is a basic ingredient for the provision of compassionate patient and family-centered care (Puchalski, Vitillo, Hull, & Reller, 2014). Spirituality is defined as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their interconnectedness to the moment, to self, to others, to nature and or to the significant and sacred." (Puchalski, Ferrell, Virani, 2009, p.887). Spiritual care is defined as the interventions, individual or communal, that facilitate the ability to express integration of body, mind, and spirit to achieve wholeness, health, and a sense of connection to self and/or a higher power (American Nurses Association and health Ministries Association Faith and Community Nursing Scope and Standards of practice, 2005). Spiritual care encompasses aspects of humanity including the feelings, and experiences of being human. By providing spiritual care we, as the health care professional have an acute awareness of our own humanity and that others (Baird, 2010).

The diagnosis of a serious illness can lead to spiritual crisis for patients. In particular, patients with cancer often report high levels of spiritual distress. (Winkelman, et al., 2011). Despite the patients need for spiritual care, research indicates that health care providers do not feel adequately prepared to provide spiritual care to their patients (Balboni, et al.,2013). This paper will explore the barriers to spiritual care provision and the use of Jean Watson's Caring Science as a framework for providing spiritual care to oncology patients and their families.

## Spirituality and Patient Outcomes

Spiritual needs include needs related to love and belonging, hope, meaning and purpose, faith and belief, making the most of remaining time (Ross & Austin, 2015). A study of oncology patients with advanced cancer uncovered that the higher the number of spiritual concerns the patient expressed, the higher the level of psychological distress and the worse their overall quality of life were (Winkelman, et al., 2011). Likewise, a study of 727 racially and ethnically diverse oncology patients in an outpatient oncology clinic with 79 per cent reporting spiritual needs. it was found that the higher the client's spiritual needs, the greater the association between decreased satisfaction and lower perceptions of quality of care (Astrow, Kwok & Sharma, 2018)

Furthermore, a study by Steinhauser, Alexander, Byock, & Tulsky, (2009) found that 87 percent of patients identify the importance of spirituality in their lives, but more significantly correlated a strong positive relationship between spirituality and overall health and well-being. Likewise, in a systemic review of the association between spiritual wellbeing and quality of life for patients with cancer, Bai and Lazenby (2015) also found that most studies showed a positive association between spiritual well-being and quality of life. Other studies have also shown that spirituality positively increases the family's ability to cope with their loved one's death. In one study of 174 bereaved siblings of cancer patient, spirituality was the only coping strategy that the siblings significantly associated with their self-assessment of having worked through their grief 2-9 years after their brother's or sister's death (Lövgren, et al., 2017).

Another consideration in patient outcomes is that patients desire a trusting relationship with their nurse, and this relationship is a significant factor in patients disclosing spiritual concerns and revealing spiritual needs (Taylor, 2007). In a study of surgical oncology nurses who were identified by their patients as providing excellent patient care, the nurses reported that their physical presence and knowing the patient were the key aspects they contributed to their success (Costello, 2017).

With education, all health care providers can learn to address patients' spiritual needs on basic levels. An initial spiritual assessment plays an important part in early identification of patient spiritual needs, especially a crucial identification of urgent needs. A simple spiritual assessment tool can include the questions, "What gives you hope?" or "Are you at peace?" (Steinhauser, Alexander, Byock, George, Tulsky, 2009). Such questions will allow for open ended conversation to take place about the patient's deepest concerns and possible spiritual distress that needs further follow up beyond the capacity of basic care for spiritual needs. If a patient voices deep spiritual distress, such as the being fearful that their illness is the result of punishment for life choices or abandonment by their deity, then a chaplain is a more appropriate resource for a more comprehensive spiritual assessment (Ferrell, 2017).

**Barriers to Providing Spiritual Care**

Nurses and physicians often state that they consider spirituality to be important in the care of their patients yet receive little formal training in the provision of spiritual care (Balboni, et al.,2013). Health care providers experience disincentives once they begin work clinically due to time constraints and feel unprepared to provide spiritual care as a result (Balboni, et al.,2014; Phelps, 2012). It is documented that support of spiritual needs by the health care team can influence patient and family care outcomes (Balboni, et al.,2013). A study of 339 physicians and nurses examining the predictors of spiritual care provisions to advanced cancer patients found that spiritual care training was the main predictor of spiritual care provision. However, 88 percent of oncology physicians and 86 percent of nurses reported that they did not receive any spiritual care training (Balboni, et al.,2013).

Spirituality care is often a team effort. Lack of communication and resources can be a barrier. For example, if a health care provider encounters a situation on initial assessment that there are extreme levels of difference between the nurse and patient in religion, spirituality, or culture, to the point that the nurse does not feel equipped to address the spiritual needs of the patient, the patient should be referred to a spiritual care specialist, such as a board-certified chaplain (Ferrell, 2017).

The knowledge of spirituality is a key factor in the health care professional's ability to provide spiritual care to their patients. A study of palliative care physicians who considered themselves spiritual were more likely to have had training in spiritual care (Best, Butow, & Olver, 2016). The spiritual practice of health care professionals may influence the caring behaviors demonstrated to patients. A study of 619 nurses uncovered that spiritual health had a positive effect on nurses' professional commitment and caring.

The study also revealed that the more advanced the nurses' spiritual health, the better their attitude toward the spiritual care they provided to patients (Chiang, Lee, Chu, Han, & Hsiao, 2016).

**Table 1: Jean Watson's Caritas Processes® and caring practices which facilitate spiritual care to the patient and family**

| | Caritas Processes® | Caring practice |
|---|---|---|
| **1** | **Practicing loving-kindness and equanimity within context of caring consciousness.** | Center self-prior to patient interaction<br>Practice authentic presence,<br>Get to know the patient |
| **2** | **Being authentically present and enabling, and sustaining the deep belief system and subjective life world of self and one-being cared for** | Sit at eye level with patient.<br>Practice deep listening-be fully present<br>Resist impulse to fix patient problems<br>Develop a level of comfort sitting in silence |
| **3** | **Cultivating one's own spiritual practices and transpersonal self, going beyond ego self.** | Explore the meaning of spirituality in the life of your patient and the patient's family.<br>Develop understanding self-spirituality<br>Ask yourself- what gives your life meaning, hope what role does spirituality play in your life? |
| **4** | **Developing and sustaining a helping-trusting, authentic caring relationship** | Ask simple yet meaningful questions to understand the role spirituality plays in the patient's life. Questions such as "what gives you hope?" "Are you at peace?" |
| **5** | **Being present to, and supportive of the expression of positive and negative feelings** | Explore existential concerns including: life review, assessment of hopes, values, fears, meaning purpose, belief about the afterlife. |
| **6** | **Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices.** | Engage in care modalities designed to enhance the patients experience, such as guided imagery, reiki, music, progressive relaxation, therapeutic touch |

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|---|---|---|
| **7** | **Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference.** | Initial spiritual assessment should take place early during the patients care to identify patient needs. A simple spiritual assessment tool can include the question, "are you at peace" can elicit information about the patient's spiritual concerns.<br><br>Complex spiritual needs such as acute spiritual distress must be identified and referred to chaplaincy. |
| **8** | **Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.** | Attention should be paid to the patient's physical space to ensure comfort, such as soft lighting, encourage comfort items from home such as soft blankets and comforters, pictures and familiar objects from home, private rooms whenever possible. |
| **9** | **Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.** | Offer comfort care, swabbing the mouth, lip and mouth care, gentle repositioning, hand, and foot rubs, teach the family to provide this care |
| **10** | **Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared for; "allowing and being open to miracles** | Determine what gives your patient hope and support this hope. Be aware that not everything that happens in life can be explained. Help the patient to achieve the 5 tasks before the end of life. Recognize this work is difficult. Care for your own physical, spiritual, and psychological needs as you care for your patient. Help celebrate each day. |

Watson's Caring Science an interdisciplinary approach that includes concepts from the fields of philosophy, ethics, ecology, and mind-body-spirit medicine to describe a caring practice that extends the beyond the patient, the community, the world, and universe (Watson, 2008). Watson describes a healing practice that cares for the spirit or soul of the patient by being in authentic relation during that space in time (Watson, 2008). Compassion is a necessary element of the care patients require at the end of life. Jean Watson describes compassion as the "capacity to bear witness to, suffer with, and hold dear with in our heart the sorrow and beauties of the world" (Watson, 2008 p 78). Nurses are required to provide competent, compassionate, and culturally sensitive care for patients and their families at the time of diagnosis of a serious illness through the end of life (AACN, 2016). Watson's

Caring Science and her ten Caritas Processes®, evolving from her Theory of Human Caring, (table 1) provides a framework for nurses to foster the human-to-human connection that is so important in everyday interpersonal relationships and even more important for the patient and family at end of life (Watson, 2008).

Spiritual care highlights the role of compassionate presence. The clinician who while fully present, listens deeply creates an environment of trust which allows the patient to share deep concerns (Vandenhouten, Kubsch, Peterson, Murdock, & Lehrer, 2012). Investigators of a study involving 242 nurses working in a variety of settings, such as hospitals, nursing homes, clinics, and home care, found that nurses familiar with Watson's theory, compared with nurses who were unfamiliar with the theory, had higher levels of perceived caring behaviors, as indicated by scores on the Carative Factors and the Transpersonal Caring Scales (Vandenhouten, Kubsch, Peterson, Murdock, & Lehrer, 2012).

Research has identified that spirituality is positively correlated with psychological well-being and negatively correlated with depression (Yonker et al., 2012). Psychological and spiritual wellbeing is important for the health care professional as well as the patient. A key factor in Dr Watson's work is the importance of self-care. Nurses must develop healthy self-care practices to support the intensity of care they provide for their patients (Watson, 2008). The ability to care for the self allows the nurse to participate in a caring moment with the patient more readily. Jean Watson describes the caring moment as a deep connection to the patient on a human to human level transcending space and time (Watson, 2008). This spirit to spirit connections involves compassion, presence and authentic listening, and the creation of a healing environment (Watson, 2008).

The patient at the who receives a life limiting diagnosis is faced with a multitude of feelings and thoughts from the practical to the existential. Ira Byock describes tasks that a person must accomplish before the end of their life. These include asking for forgiveness, forgiving others, thanking others, saying "I love you" to those special people in our lives ad finally letting go and saying goodbye (Byock, 2013). Jean Watson provides a framework for nurses to put the theory of Caring Science into practice with the 10 Caritas Processes® (Watson, 2008). These processes are basic to the caring practices that will facilitate a transpersonal relationship.

## Conclusion

Spirituality is an important aspect of care for the patient with advanced oncology illness, palliative care, and those at the end of life. Although patient care professionals understand the importance of spiritual care, many feel ill prepared to provide spiritual care. The ability to connect with and embrace the spirit or soul of the other as they face life limiting illness is at the heart of providing spiritual care. Jean Watson's theory of Caring Science and Caritas Processes® can provide a framework for the development of caring and healing practices that can facilitate spiritual care.

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