Spiritual Assessment of Patients With Cancer: The Moral Authority, Vocational, Aesthetic, Social, and Transcendent Model

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Purpose/Objectives: To explore the nature of spiritual care in patients with cancer and discuss the Moral Authority, Vocational, Aesthetic, Social, and Transcendent (Mor-VAST) Model, a new theoretical model for assessment.

Data Sources: Published articles, online references.

Data Synthesis: Discussions regarding spirituality often do not occur for a variety of reasons but may affect physical and spiritual health of an individual.

Conclusions: Assessment of spirituality should be an integral part of cancer care. The Mor-VAST model can assist clinicians in discussing spirituality.

Implications for Nursing: Nurses should be aware of resources for referral to chaplaincy, but they can be a part of the process of spiritual support. Educational opportunities are available for nurses who wish to address their own spirituality so they can address spirituality comfortably and confidently with their patients.

Key Points . . .

➤ Spiritual care should be an integral part of cancer care.

➤ Assessment of spiritual beliefs is an important component of holistic nursing care.

➤ Educational opportunities are available for nurses to address their own spirituality so they can address spirituality comfortably and confidently with their patients.

Spiritual distress or spiritual suffering can be described as an emotional state in which people are unable to fulfill their basic human needs for love, hope, purpose, and connection with others or a situation in which conflict exists between individuals' core beliefs and their personal experience (Bartel, 2004). Patients with cancer may be most vulnerable to spiritual suffering at diagnosis, with a change in disease status, or when facing end-of-life issues. This article explores the nature of spirituality and spiritual assessment in patients with cancer. The term spirituality presents a challenge because it is very individual and intensely personal. Subsequently, it defies absolute definition, although multiple definitions have been offered. The National Cancer Institute (2006) defined spirituality as "having to do with deep, often religious, feelings and beliefs, including a person's sense of peace, purpose, connection to others, and beliefs about the meaning of life."

Spirituality encompasses both a subjective side, which resides in free will and understanding of the person experiencing it, and an objective side, which is the person's actual experience. It represents the part of a person's inner being within which resides basic humanity. Spirituality has been described succinctly as "that which allows a person to experience transcendent meaning in life, often expressed as a relationship with God, but can also be about nature, art, music, family, or community—whatever beliefs and values give a person a sense of meaning and purpose in life" (Puchalski & Romer, 2000, p. 129). Another view describes spirituality as a "web" of relationships that give meaning to life. People are unaware of the strands of the web until one breaks as a result of a life-changing event (Rumbold, 2003).

Common to all of the descriptions of spirituality are the concepts of meaning and wholeness or completeness, the absence of which results in spiritual distress. In response to that distress, the authors present a newly developed theoretical model that can be used in patients with cancer for assessment of spirituality. The model was created to provide clinicians with a concise yet comprehensive tool to assess the inner resources available to patients with cancer as they face a potentially life-threatening illness. In understanding assessment, spirituality and the place it holds in society and healthcare first must be understood.

Spirituality and Religion

A discussion of spirituality must include a discussion of religion. Spirituality and religion are distinct (Beery, Baas, Fowler, & Allen, 2002) but related concepts. Religion can be thought of as the shared experience of spirituality or as values, beliefs, and practices that people adopt to meet spiritual needs through religious affiliation, church attendance, prayer, religious beliefs, and religious practices (Highfield, 2000). Therefore, religious beliefs and practices focus more on the sacred, whereas the focus of spirituality is more on the self (Rumbold, 2003).

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Focus on the self can be quite isolating, especially in current Western culture. Religions provide an "antidote" to that individualism by promoting a network of relationships with other human beings and with God (Puchalski, Dorff, & Hendi, 2004). The network can provide critical support to patients with cancer throughout the disease continuum, from diagnosis to end of life.

Spirituality can be discerned as a more general term that includes what is commonly thought of as religion, but it also includes other belief systems. Discussion of religion, commonly defined in concrete terms (church, rituals, events), frequently carries preconceived ideas and meaning. In contrast, discussion of people's basic humanity through conversations about their spirituality can encourage patients to explore these beliefs either when they are not sure of their religious beliefs or when their beliefs are not addressed through organized religion. The term spirituality can be substituted for the term religion when the term religion holds a strong negative connotation for an individual (Bregman, 2004). Spirituality is able to cross cultures and faiths to provide a common ground for dialogue between patients and healthcare providers (Wright, 2002), but culture may have a significant impact on spiritual care during cancer treatment (Burhansstipanov & Hollow, 2001) and during the dying process (Mazanec & Tyler, 2003); therefore, sensitivity to the needs of specific cultures is critical.

The differences between spirituality and religion become important when reviewing current research. Research supports that quality of life and spiritual well-being do not necessarily correlate with religious practices (Beery et al., 2002; Flannely, Weaver, & Costa, 2004). Therefore, discussion of spirituality should acknowledge and inquire about religion but should not be explicitly religious in nature; otherwise, the connection with patients may be lost along with the opportunity to share valuable information.

Spiritual Care and Patients With Cancer

Spirituality is an individual experience, and it defines what it means to be human. Therefore, it can, and should, be addressed with all patients with cancer at some level and should be readdressed as their conditions changes.

Critical to Address

Providers are encouraged to think of patients with cancer as "whole people." This concept of holistic care is defined in palliative care as consisting of physical, psychosocial, and spiritual dimensions. The spiritual dimension of care is the fundamental act of "being with" another in need (Fackre, 1990; Friedman, 2001; Highfield, 2000; Kestenbaum, 2001; Nouwen, 1979). Because patients with cancer face a potentially life-threatening illness, they must negotiate some of the most spiritually threatening questions central to human existence (e.g., Why me? Why am I suffering? Why do I have pain? What will happen when I die?). Clinicians are ideally positioned to provide spiritual care because they are directly involved in experiences that profoundly affect patients' lives (Rumbold, 2003). When faced with patients struggling with these questions, most caregivers will refer those patients to chaplaincy for pastoral care. This is entirely appropriate because of the specialized knowledge and role of clinically trained chaplains. However, such resources may not always be available. Even when they are, cooperative attention of clinicians and chaplains can increase the benefit of spiritual care to patients. In addition, patients may have difficulty beginning a new relationship when they already have told their story to multiple care providers, are undergoing cancer treatment, or are at the end of life. Oncology care providers are obligated, as part of holistic care, to acknowledge and encourage exploration of spiritual issues, if patients choose to share that journey with them. Some providers may not be prepared to respond to this opportunity, or they may not agree with this responsibility, and in fact may see it as a burden (Walter, 2002). When that is the case, providers should be aware of and actively pursue resources for referral of their patients.

The strong relationships developed during the course of a cancer diagnosis offer cancer care providers a unique opportunity to establish a connection to assess and assist with spiritual development and growth. The personal insight gained through such growth can translate into spiritual resilience and strength with which a patient can face the disease. Additionally, these deep connections can serve to inform and influence medical decisions with respect to treatment planning and advanced directives. Discussing medical decisions with patients who have engaged in spiritual conversations with their providers is infinitely easier because both are operating from a place of mutual understanding of values and priorities in life (Koenig, 2002).

From providers' perspective, making spiritual care an integral part of cancer treatment enables them to deliver more than just physical care to suffering patients when medicine's ability to provide physical care is limited. Physical medicine can "fix" only a limited number of conditions for some patients. Fixing is part of training in a biomedical model, but spiritual suffering cannot be fixed with analgesics the way that physical pain can (Lo et al., 2002). Facing the limitations of medicine can lead to a loss of hope for providers. However, willingness and ability to provide spiritual care can help ameliorate the frustration that nurses frequently experience when physical care alone no longer can alleviate suffering. Therefore, the physical care perceived as limited or hopeless can evolve to include care of soul, restoring hope in patients and providers. This concept frees providers from the need to fix and the frustration of feeling as though "there is nothing else we can do." Providers always can do something else in caring for the human soul.

The act of providing spiritual care helps providers to reconnect with the reasons they chose jobs as healers. It addresses the part that chose to extend beyond the boundaries of themselves to give to others. Providing health care is not just a job; for some, it is a vocation (Ramondetta & Sills, 2004). However, keeping that perspective under increasing demands in the current healthcare environment is a formidable challenge (Puchalski & Romer, 2000), one that must be met for providers to survive and thrive as healers.

Barriers to Success

With such pressing reasons for addressing spiritual care, why do care providers hesitate to explore beyond such questions as "Do you belong to any organized religion?" A fundamental fragmentation of care in the current healthcare system and the lack of professional expectation to attend to spiritual needs are cited as some reasons why spiritual care is so difficult to address (Highfield, 2000). Many other reasons become apparent in the context of the lack of professional ex-

pectation. One basic reason is lack of education and expertise. Adequacy of training has predicted the frequency of, comfort with, and ability to provide spiritual care (Taylor, Highfield, & Amenta, 1999). Only half of oncology or hospice nurses have had training that addressed spirituality either in school or through continuing education (Highfield, Taylor, & Amenta, 2000). In addition, nursing textbooks lack content that addresses spirituality. In one study, the highest percentage of spirituality content in oncology nursing texts was 0.8%, and only 8.2% of hospice texts included content on spiritual care (McEwen, 2004).

Several issues must be considered when designing instruction on spiritual content, including experiential versus didactic teaching strategies, credentials of the instructor, and support mechanisms for instructors and students (McSherry, 2000). The paucity of education has many functional ramifications, which likely contributes to a lack of confidence among clinicians to provide spiritual care.

Other experiences can lead to a provider's crisis of confidence. As clinicians, nurses are trained to know all the answers. Questions such as "Why do bad things happen to good people?," "Why is this happening to me?," and "When am I going to die?" do not have answers. Being with a patient and not knowing the answers is highly uncomfortable; however, nurses need to develop the skill to be comfortable with not knowing.

Discussions that elicit answers about core values and meaning are by nature quite personal and intimate. Intimacy may be difficult for patients or providers. The ability to establish intimacy requires providers to have some awareness of their own spirituality, and the opportunity for that kind of growth may not have occurred. One study found that the personal spirituality of hospice and oncology nurses best predicted perspectives on spiritual care and their perceived ability to provide it (Taylor et al., 1999). In addition, patients or care providers may have had negative perceptions or experiences in the past about religious or spiritual beliefs. These preconceived ideas cause difficultly when providers talk with patients about issues of spirituality. Finally, the discussions are unpredictable in the amount of time they require. Time constraints imposed on the care of patients in the current healthcare system are a tremendous challenge to providing spiritual care. Nurses may not be able to make the time to really understand the core values that are important to patients within the context of a busy day. This situation can cause dissatisfaction on the part of patients and providers (Bub, 2004). Assessment of spirituality can be a time-intensive endeavor and requires an assessment tool for clinicians that is easy to remember and concisely comprehensive.

Spiritual Assessment of Patients With Cancer

Spiritual assessment begins with clinicians' self-awareness of their own spirituality, including the ability to care for personal spiritual needs, establish good relationships with patients, and initiate discussion with patients at the appropriate time (Anandarajah & Hight, 2001). Burton (2003) stated that assessment of spiritual pain depends "as much upon the spirituality of the caregiver, and upon their capacity for contemplation, for close listening, to narrative, for intuition, and for discernment, as it will upon the results of any neatly

developed questionnaire" (p. 442). Many providers may recognize spiritual pain intuitively but lack a clinically usable tool to elicit discussion that helps to validate patients' experiences. Providers must recognize when patients are undergoing spiritual distress to acknowledge and validate the experience as important.

Many assessments of spirituality and spiritual distress have been proposed (Fitchett, 2002; Hodge, 2001; Maddox, 2001) from a number of different disciplines. Galek, Flannelly, Vane, and Galek (2005) proposed an instrument to assess spiritual needs. Assessments of spirituality, such as FICA (i.e., faith or beliefs, importance and influence, community, address) (Puchalski & Romer, 2000) or HOPE (i.e., sources of hope, meaning, comfort, strength, peace, love and connection; organized religion; personal spirituality and practices; effects on medical care and end-of-life issues) (Anandarajah & Hight, 2001), are very useful and have been applied in many settings. The 7x7 Model for Spiritual Assessment (Fitchett) is very comprehensive, consisting of seven holistic dimensions. The spiritual dimension has seven components: beliefs and meaning, vocation and consequences, experience and emotion, courage and growth, ritual and practice, community, and authority and guidance.

Documentation of the assessment is also important. In the era of computer-based medical records and increased attention to privacy and confidentiality, the issue is a challenge. Documentation of spiritual discussions in the medical record should include necessary information for patient care but also continue to honor the trust that patients have with their clinicians because the information is exquisitely personal and sensitive in nature.

Five-Dimensional Model for Assessment of Spirituality

Spiritual assessment of patients with cancer is a delicate task that must be done with sensitivity and acceptance. It does not need to be completed in one session but instead may evolve over time. The issue of time is critical for clinicians and can be a major barrier in completing a spiritual assessment. An assessment tool is needed to assist clinicians in practice. The Moral Authority, Vocational, Aesthetic, Social, and Transcendent (Mor-VAST) Model was developed to give clinicians a framework with which to think about spirituality. The framework then was used to translate spirituality into an assessment tool for use in the clinical setting.

The Mor-VAST theoretical model maps spirituality into five dimensions (see Figure 1). The role of each dimension in spirituality is supported by examples from the literature. The degree to which each dimension is a strength or need is evaluated using questions such as those provided in Table 1. The questions are suggestions only. They illustrate the concept of each dimension and can elicit information specific to each dimension during the assessment. They are not meant to limit the concept of spirituality but rather to illuminate each dimension while conducting a spiritual assessment.

Moral Authority Dimension

The moral authority dimension is viewed as a sense of moral duty or "the right thing to do." It includes such experiences as guilt, remorse, resentment, forgiveness, compassion, righteousness, self-righteousness, and duty or obligation.
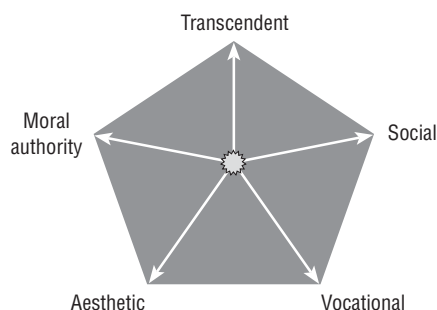
Figure 1. The Moral Authority, Vocational, Aesthetic, Social, and Transcendent Model

Note. Figure courtesy of J. Patrick McCoy. Reprinted with permission.

Moral obligation can be identified through authority ranking, one theory of how people order their social interactions that proposes that the most prominent aspect of authority in social relationships is the belief in a supreme being who is the creator, whose word is truth, and whose will is good (Fiske, 1992). This belief has the power to drive the behavior of an individual; therefore, people's sense of moral authority or guidance (or lack thereof) has profound consequences for the decisions they make with respect to treatment and advance directives.

Once people have a "sense of what to do," it follows that they also need to feel permission to do it. The idea of people having not only the authority, but the right, to make their own decisions about their own lives is supported in the literature (Galek et al., 2005) as a spiritual need. Clinicians must ascertain and respect the moral framework from which patients are operating to meet them on a place of moral common ground. People react more negatively in group discussions when other participants do not share their strong moral convictions (Skitka, Bauman, & Sargis, 2005). Group discussions are more tense and defensive when participants are trying to resolve a morally mandated issue. Therefore, when patients and clinicians work together from a place of mutual understanding, the discussion is more likely to be positive in nature. Patients are assured that clinicians truly care about what is important to them, and clinicians are assured that patients have made the best decision for themselves based on their core values and beliefs.

The moral authority dimension also becomes critical in the dying process. During this process, the potential exists for disconnection in relationships that play an important role in their lives. Patients may have a need to forgive or be forgiven to resolve feelings of having "done the right thing," so they can gain a sense of peace with their dying. Forgiveness opens up tremendous potential for healing and growth in this phase, making this dimension very important to address.

Vocational Dimension

An individual's sense of purpose in life is addressed by the vocational dimension. This may include a sense of service or accomplishment or a spiritual sense of vocational calling. Fitchett (2002) described this dimension as duties and obligations that a person feels called to fulfill, rather than the sense of duty or obligation described as part of the moral authority dimension. The emotional experience of vocation may be identified as experiences of pride, fulfillment, purpose, frustration, regret, grief (over losses related to one's work), satisfaction, or failure. Threats to patients' ability to fulfill the dimension can be profoundly distressing because those threats may affect their role within their family structure, community, or workplace. Vocation has deep roots to a sense of self and purpose in life.

Aesthetic Dimension

The aesthetic dimension apprehends beauty or expresses creativity. It is connecting with nature or the creative process (Galek et al., 2005). This connection may be observed through such activities as making or appreciating art, music, or written work. It is found in reading a poem and being moved by it, needlework, cooking, gardening, or tinkering. The aesthetic dimension is the domain of invention and pleasure and is characterized by delight, joy, humor, playfulness, inspiration,

Table 1. Sample Clinical Assessment Questions Based on the Model

Dimension	Leading Questions	Follow-Up Questions
Moral authority	Where does your sense of what to do come from? What principles of right and wrong guide you?	Have particular moral struggles challenged or strengthened you? Are there people you need to forgive? Do you need to be forgiven? Are there things you've felt you needed to do? Do you have someone you talk to for [spiritual or religious] guidance [matters]?
Vocational	What gives your life meaning? Has it changed for you? What kind of work has been important to you?	What have you been good at? What has given you satisfaction? How have you contributed to the wider world and the needs of others? What were the challenges and rewards of your "calling"?
Aesthetic	What things do you enjoy doing? Are you doing them now?	Has being sick affected your ability to do things that usually bring you joy or pleasure?
Social	Are you part of a religious or spiritual community? Are there any other groups or people you enjoy spending time with?	Is it a source of support? In what ways? Does this group provide help in dealing with health issues?
Transcendent	What sustains you during difficult times? Who is in control?	What do you hope for? Is religion or spirituality important to you? Has it been important at other times in your life? What aspects of your spirituality or spiritual practices are most helpful to you? How is your relationship with God?

or passion. The arts can keep imagination alive by reflecting and expressing the environment and surroundings while helping to meet basic emotional and spiritual needs of being creative, being able to give to others, and being remembered (Bailey, 1997).

Patients with cancer can find the dimension challenging. Pleasure, humor, and passion can be difficult to generate when feeling ill from treatment. Patients may find engaging in activities that require fine motor control physically challenging, and situational depression can dull their hunger for many forms of aesthetic expression. Despite the challenges, efforts should be made to find acceptable alternatives (e.g., listening to rather than creating music) for those who find this dimension nourishing to their spirits. Many efforts have been successful, such as exploring spirituality through music (Hogan, 2003); gardening (Unruh, Smith, & Scammell, 2000); art projects such as sculpture, either individually or in groups (Bailey, 1997); and poetry (Bates, 2005).

Social Dimension

The social dimension is particularly important for people with cancer and their families. People are inherently sociable and generally organize their lives in terms of their relations with other people (Fiske, 1992). The dimension describes family, friends, relatedness in a sense of community, and rituals and practices (Fitchett, 2002) that support the community. Relatedness can be achieved not only through a faith community but also through other groups such as quilting circles, social clubs, or routine gatherings. The relatedness is perhaps best described by the Greek word *parea,* which translates into "the people who sit at your table and enrich your life" (K. Anton, personal communication, May 16, 2005). These social connections engage us and enrich our lives and can include such feelings as unconditional acceptance, belonging, and connection to self, others, and the divine (Galek et al., 2005).

Spiritual resources in the social dimension are easily compromised in patients with cancer. Frequent trips for treatment, physical changes resulting from disease and treatment, and psychological challenges of facing cancer can contribute to social isolation. In addition, life events not related to patients' illness may affect the availability of spiritual resources in the social dimension. The death of a life partner, for example, can trigger long-lasting effects in the social aspect of an individual's spirit through feelings of sorrow, loneliness, and increased isolation. Resources for people needing support in this area can be found through support groups and events led by the American Cancer Society, family, neighbors, service clubs, and local religious communities.

Transcendent Dimension

The transcendent dimension represents valuation of aspects of reality that are not material and, therefore, not directly accessible to the senses. The realm reflects awareness of the sacred and experience of the holy. It is the dimension in which faith, worship, ritual, prayer, religious practices, meditation, beliefs about the divine (Galek et al., 2005), and beliefs about life after death define the character of people's spirituality. Transcendence is particularly reflected in emotions of awe, trust, gratitude, and peace. It is negatively reflected in feelings of doubt, despair, and anger (when focused on God or religion).

Most commonly in the United States, the spiritual experience is ascribed to God as derived from Hebrew, Christian, or Islamic scriptures. However, it also may include spirits of the natural world as defined by Wiccan or Native American religious traditions, the Higher Power of nonsectarian spiritual practices, or a nontheistic transcendence of mundane reality as reflected in Buddhist traditions (Puchalski et al., 2004). Common to all of these perspectives is a capacity to perceive something larger than oneself or to move outside of oneself.

In life-threatening illness, transcendence consists of patients' capacity to see themselves as belonging to and participating in something larger than the physical body and mind, thereby enabling them to find meaning and purpose in pain and suffering by relating them to a larger framework (Glannon, 2004). This capacity can be quite important in patients with cancer because it can lend hope and comfort in times of great distress during diagnosis and treatment or at the end of life (Meraviglia, 2006).

The Mor-VAST model is a way to describe individuals' spirituality. Clinicians can use it as a concrete method for assessing spiritual strengths and weaknesses and to build or bolster patients' sense of self. Discussions initiated during points of vulnerability in the cancer care continuum can present an opportunity for integrating these concepts into practice by initiating appropriate interventions. Addressing patients' experiences in the context of these dimensions provides an opportunity for meaningful discussion that develops a connection through which to validate their experience. The connection forms a basis for mutual understanding between patient and provider from which decisions for care can be made and needs for referral to chaplaincy can be made.

Implications for Practice

Identification of spiritual needs begins with a spiritual assessment. The Mor-VAST model is one way to assess spirituality in patients with cancer and could be applied to other populations because the questions are not diagnosis specific. Assessment questions are provided as a guide to clinicians for discussion but are not intended to be prescriptive. They should be worked into the natural context of a discussion, rather than being delivered without preparation. Value judgments cannot be placed on results of this assessment—"right or wrong" do not exist, just as "good or bad" do not exist. People are simply who they are and where they are spiritually at any given moment.

The idea of methodically assessing spirituality raises many questions (Gordon & Mitchell, 2004). When is the best time to do the assessment? What criteria should be in place for referral? What knowledge and skills do providers need so they can be sensitive to spiritual needs? Gordon and Mitchell explored these questions and described a model for spiritual care competencies. The model focuses on the abilities of the providers, rather than assessments of individual patients, to provide a more continuous level of spiritual care in a hospice setting (Gordon & Mitchell). Research with respect to spirituality and cancer is in its infancy. Answers to these and many other questions have yet to be determined because of the many challenges regarding methodology and terminology (Stefanek, McDonald, & Hess, 2005).

A diagnosis of cancer challenges spiritual integrity of providers as well as patients. Providers also have the opportunity to grow with each spiritual crisis. In fact, providers' awareness of their own spirituality is viewed as a prerequisite

to extend spiritual care (Puchalski & Romer, 2000; Wright, 2002). Therefore, providers have a responsibility to attend to their own needs for spiritual awareness (Anandarajah & Hight, 2001) so they can attend to patients' needs. Collegial opportunities to build connections to support spiritual care can be found through the Oncology Nursing Society's Spirituality Special Interest Group, local parish nurse programs, or regular meetings with other colleagues who have an interest in spirituality.

Several postgraduate educational opportunities are available for clinicians to explore and develop their spirituality. One such opportunity is clinical pastoral education (Allbrook, 2000; Tarumi, Taube, & Watanbe, 2003). A special track of this intensive course is available to healthcare providers and provides a means for spiritual formation as well as training in pastoral care. Other options also are available. One multidisciplinary group explored spirituality and how it informed their work as part of a peer group in a project that grew out of a doctoral research study (White, 2000). Lastly, continuing education programs have been developed across the country as the topic of spirituality in healthcare gains attention.

Clinicians are neither expected nor able to provide spiritual care alone. A team approach allows for a variety of relationships to develop that elicit provider experiences (Rumbold, 2003) and patient interventions (Dann & Mertenes, 2004)

directed toward meeting spiritual needs. In addition, opportunities for strengthening communication through collaboration with other colleagues, chaplaincy, and local clergy all can help to reduce the sense of distress and isolation that can develop in clinicians. Opportunities are found through interdisciplinary team meetings, sharing of worship, and educational activities.

Close referring relationships with pastoral care providers can be beneficial for patients and providers who are assessed as experiencing a spiritual crisis. Providers must know how to make use of pastoral care and chaplaincy services and have an up-to-date list of on-call clergy. Most importantly, people do not have to be religious to use a chaplain for spiritual care. Chaplains assist with spiritual issues of core values and meaning that cross cultural and religious boundaries.

In conclusion, respecting patients' spiritual growth by attending to "being" rather than to "fixing" is a fundamental premise. Nursing's job is not to lead the way but instead to support patients on the journey. That they get to where they are going does not matter so much; what does matter is the walk along the way. Most importantly, no one should be left to walk the journey alone.

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