SPIRITUAL DISTRESS: AN INTRODUCTION

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DEDICATION

Where to even begin?

To my family and friends who have watched me try and try again. Have sacrificed their vacations, holidays, and summers while I worked away on my computer. Who have listened to me talk of nothing but my project, and simultaneously not want to talk about it at all.

To TicTac, Leo, and Myla who have kept me company all the evenings as I wrote.

To my fiancée, Domenic, who encouraged me when I wanted to give up, and steered me straight when I wanted to boil the ocean, instead of my cup of water.

ABSTRACT

Spiritual distress is an important component of holistic nursing practice. Internationally, nursing competency to care for patients in spiritual distress has not been well established (Kasar & Nacak, 2021). The goals of this project are to provide a high-level introduction to the concept of spiritual distress, provide a session to teach nurses to identify spiritual distress in oneself and others, and motivate nurses to continue their education on spiritual distress after the session. A 30-minute lunch time educational session was developed and piloted to all employee designations at St. Michael's Health Centre in Lethbridge, Alberta, Canada. Data was collected from post-intervention surveys. Data analysis concluded that this educational intervention design was effective in educating learners on spiritual distress and that further education on this subject is desired.

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They say it takes a village; this could not be truer. I am sincerely grateful to my project supervisor Katherine Haight for her guidance, and patience, as this project came together. I am also eternally grateful to my editor Auburn Phillips for her invaluable editing of this project, it would not be possible without her. Finally, to all the staff at the University of Lethbridge who kept me on time, on track, and helped me re-discover my love of learning.

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LIST OF ABBREVIATIONS

ARECCI	A pRoject Ethics Community Consensus Initiative
ASSET	Actioning Spirituality and Spiritual care Education and Training
CNA	Canadian Nurses Association
EPICC	Enhancing nurses' and midwives' competence in Providing spiritual care through Innovative education and Compassionate Care
FICA	Faith/Belief, Importance/Influence, Community, Address
HOPE	Hope, Organized religion, Personal spiritual practices, and Effects of medical care and end of life issues
ICN	International Council of Nurses

SECTION 1: INTRODUCTION

Nursing practice problem

Spirituality is defined by the Canadian Nurses Association (CNA) as "whatever or whoever gives ultimate meaning and purpose in one's life, that invites particular ways of being in the world in relation to others, oneself and the universe" (CNA, 2010, para. 1). Treating the patient as a whole, including their spirituality, is integral to holistic nursing practice (CNA, 2010; Vincensi, 2019). An empirical body of research developed over the last 30 years of nursing shows a connection between spirituality and reduced suffering for patients (CNA, 2010). Conversely, when a patient feels distress in relation to their spirituality, it has tangible negative outcomes for them. These include prolonged suffering, heightened pain and anxiety, and an elevated risk of post-traumatic-stress-disorder (Erdoğan & Koç, 2021).

Despite growing interest in the role of nursing and spiritual distress, widely acknowledged barriers for translating research to nursing practice remain at both the undergraduate and professional levels of education (Kasar & Nacak, 2021). As a result, spiritual distress is often undiagnosed or misdiagnosed, resulting in real negative impacts for patients (CNA, 2010). Spiritual assessment tools such as the FICA (Faith/belief, Importance/influence, Community, Address) or HOPE (Hope, Organized religion, Personal spiritual practices, and Effects of medical care and end of life issues) have been developed to assist clinicians with identifying spirituality, but are not widely integrated in clinical settings and are not specific to the identification of spiritual distress (Anandarajah & Hight, 2001; Borneman et al., 2010). Nurses self-identify lack of education and awareness as barriers to utilizing tools to diagnose and treat this type of distress (Batstone et al., 2020; Borneman et al., 2010; Ghorbani et al., 2021).

Purpose of the project

The goal of this project is to provide a one-time 30-minute "lunch and learn" session giving a high-level introduction to the concept of spiritual distress, to teach participants to identify spiritual distress in oneself and others, and to motivate learners to continue their education on spiritual distress after the session. Drawing upon Krathwohl's (2002) revised Bloom's Taxonomy, this project meets participants at the first stage of "remembering" and progresses them through the levels of "understand[ing]" and "analyz[ing]". The project outcomes are trifold: first, to develop an understanding of spiritual distress; second, to be able to identify it in one's self and in others, and third, to develop a desire to continue to learn about spiritual distress after the session. This project uses the framework of chaos theory as a change theory to understand how small, seemingly random, changes to practice can have predictably "unpredictable" impacts in care for patients currently experiencing spiritual distress (Dombeck, 1996).

The education session is designed to be able to be replicated in all rural care settings and to be delivered to all employee designations. This is important because in small health centres, such as St. Michael's Health Centre in Lethbridge, Alberta, Canada, all employee designations have the opportunity to interact with patients and form meaningful relationships, facilitating discussions of spirituality and spiritual distress. Additionally, the benefit for high level spiritual care knowledge is such that there is no justification for withholding the knowledge from non-nursing staff.

Necessary stakeholders are not only the nurses for whom the session is designed, but also a variety of interdisciplinary team members, including St. Michael's site administrator and clinical nurse educator. While the long-term integration of this educational session into required

organizational programming is beyond the scope of this master's project, it will be necessary to work with these stakeholders for this to occur in the future.

SECTION 2: LITERATURE REVIEW

Search Strategy

This literature review utilized a variety of search strategies encompassing academic and non-academic work. The databases Google Scholar, CINAHL, Medline, and PSYCHinfo were searched using the key terms "nurs*", "attitude to death", "spirituality", "spiritual care", and "spiritual distress". The database Cochrane Reviews was searched using the term "spiritual care". A broad internet search was also performed using the terms "spiritual distress", "nursing", "spirituality", and "spiritual care". This search returned both academic literature and grey literature (including statements from governing agencies). A snowball strategy was then employed utilizing the results of this systematic search. Data collection was concluded when thematic saturation was achieved.

Definition of spiritual distress

Within the literature, there is an acknowledged deficit of conceptual clarity on clinical diagnosis of *spiritual distress* (Monod et al., 2010). Much of this confusion reflects the conceptual opacity surrounding the root word, spirituality. In the literature, authors' conceptual definitions of spirituality place varied emphasis on religiosity. A foundational lack of conceptual clarity on the term spirituality creates problems when trying to define its distress. It is a presumption that spiritual distress is a disturbance to patients' baseline spiritual health; one that can be "fixed" by spiritual care interventions.

> The complexity of many essential human experiences cannot be adequately conceptualized in terms of concepts from traditional general systems theory, because all systems do not behave in similar ways. While many systems behave with high levels of predictability, ranging from order and stability to disintegration, others considered to be chaotic and far from equilibrium often reorganize themselves into new, more complex pattern.
>
> (Dombeck, 1996, para. 2)

Spiritual distress is often assumed to follow other bio-psycho-social processes in that the concept of “distress” modifies the concept of “spirituality” in much the similar way that the concept of “distress” modifies the concepts of morality or psychological health (Monod et al., 2012). However, this presumed relationship has not been clinically tested.

The North American Nursing Diagnosis Association’s (NANDA-1) definition of spiritual distress is the most commonly used within nursing literature. It defines spiritual distress as “a disturbance in meaning and purpose in life; disturbance in connection to self, God/power greater than self, others, and world; and disturbance in transcendence” (Caldeira et al., 2013, para. 15). In 2014 the NANDA-1 definition was altered to “the impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself” (Caldeira, et al., 2014, para. 2). However, as critiqued by Caldeira et al. (2015), this diagnosis has not been clinically validated. The need to clinically validate this definition of a spiritual distress is important as the literature intermingles it with other terms such as “religious distress”, “spiritual well-being”, “spiritual agony”, and “spiritual pain” (King et al., 2017; Smith & Jackson, 2013).

In response to the critique of the NANDA-1 definition, Martins et al. (2021) proposed an alternate definition of spiritual distress as "a state of suffering associated with the meaning of his or her life, related to a connection to self, others, world, or a Superior" (para.3). This definition strives to reflect the conceptual separation of the term’s spirituality and religion. Other authors embrace the overlap between religion and spirituality. For example, King et al. (2017) proposed that spiritual distress be defined as:

> …religious or spiritual (R/S) tensions and struggles within oneself, with others, and with what one holds to be sacred, R/S distress may include feeling abandoned by God, being in conflict with others about R/S beliefs or practices, or struggling with ultimate meaning. R/S distress is also identified as R/S struggle, R/S pain, and negative religious coping.
>
> (para.1)

This definition emphasises the role of organized religion in a person's spirituality. Despite the differing emphasis given to religiosity, the root theme amongst all definitions is a patient's sense of their status quo becoming disoriented in a manner which causes distress.

The lack of conceptual consensus regarding the terms "spirituality" and "spiritual distress" is a major gap in the literature. Without conceptual clarity on the term "spiritual distress", it is difficult to design research with a high level of validity.

Scope of practice

Though major health centres employ spiritual care providers to tend to the spiritual needs of patients and residents, it is important for nurses to understand and be able to treat instances of spiritual distress amongst those in their care. This competency in spiritual care is a required proficiency by the International Council of Nurses code of ethics which states:

> Nurses promote an environment in which the human rights, values, customs, religious and spiritual beliefs of the individual, families and communities are acknowledged and respected by everyone. Nurses' rights are included under human rights and should be upheld and protected.
>
> (International Council of Nurses, 2021, section 1.2)

In their 2010 position statement, the Canadian Nurses Association states:

> The Canadian Nurses Association (CNA) believes that spirituality is an integral dimension of an individual's health.
>
> CNA recognizes that spiritual beliefs are diverse, reflecting both individual and cultural influences. To provide the best possible health outcomes, registered nurses are expected to respect this diversity in the same way they provide culturally competent care. Sensitivity to and respect for diversity in spiritual beliefs, support of spiritual preferences and attention to spiritual needs are recognized by CNA as required nurse competencies.
>
> CNA believes that being attentive to an individual's spirituality is a component of a holistic nursing assessment and nursing practice. When planning for and providing care,

> nurses have an ethical responsibility to be aware of and adjust for an individual's spiritual beliefs.
>
> (CNA, 2010, para. 2-4)

Spiritual care is an integral component of nursing scope of practice (CNA, 2010). Holistic nursing demands that the spiritual realm of a patient be included in nursing care (CNA, 2010). It is important for nurses to not only be able to identify spiritual distress but to have the capacity to care for these patients themselves. Spiritual care specialists, such as spiritual care providers or chaplains, are an integral member of the health care team, but it is not enough for the nurse to simply place a referral. The nurse must be aware of spiritual care interventions and know how to integrate and execute them in their care plan.

Nursing theory

The importance of spiritual care to nursing practice is evidenced by its presence in most major nursing theories; these include Jean Watson's Theory of Holistic Nursing (Watson, 2002), Theory of Caring Science (Watson, 2002), and Theory of Transpersonal Nursing (Watson, 2002), as well as Burkhart and Hogan's theory of Spiritual Care in Nursing Practice (Burkhart & Hogan, 2008).

The spiritual realm is one of four realms of a patient, to which nurses must attend according to Jean Watsons' Theory of Holistic Nursing Care (Watson, 2002). Watson's (2002) Theory of Caring Science states that basic human needs extend beyond the bio-physical and include psycho-spiritual realms of health. A nurse needs to think holistically and critically about a patients' spirituality in order to diagnose and treat potential spiritual distress (Riegel et al., 2018). Furthermore, in the Theory of Transpersonal Nursing, Watson (2002) states that nursing arises from the interpersonal relationships created between nurse and patient. This interpersonal relationship – this connection to others – is the spiritual realm of the patient. When distress

occurs to this relationship, it is the prerogative of nurses to translate theoretical knowledge of spiritual distress into nursing praxis (how theory informs practice).

Burkhart and Hogan (2008) build upon Watson's work with the Spiritual Care in Nursing Practice Theory. This theory states that spiritual care is an interactive practice between patient and nurse. As the nurse-patient relationship develops, it becomes bi-directional and the nurse is forced to self-reflect upon their own spirituality (Burkhart & Hogan, 2008). The nurses' approach will then change towards the patient, not only as the level of patient trust increases but also as the nurse becomes aware of how their own spiritual beliefs influence their practice. Nursing patients in spiritual distress goes beyond utilizing a list of assessment questions and interventions; instead, it includes dynamic, purposeful monitoring and compassionate responding to patient's spiritual needs (Burkhart & Hogan, 2008). When nurses treat the spiritual realm of the patient, they are able to actualize their full scope of practice and care holistically for the patient (Kudubes et al., 2019; Erdoğan & Koç, 2021; Riegel et al., 2018; Watson, 2002).

Importance of spiritual care

Nursing is uniquely positioned to address spiritual care due to frequent and extended contact with patients (Ghorbani et al., 2021). As such, nurses must have the competency to not only identify and make appropriate referrals to spiritual care providers, but to also be able to spiritually nurse themselves (Kudubes et al., 2019). Empowering nurses to actualize spiritual care in their practice improves nurses' own spiritual health and protects against occupational burnout, improving career satisfaction (Chiang et al, 2020; Rahman et al., 2020). Just as there is a direct connection between a person's spiritual and psychosocial health, there is a direct link between spiritual distress and psychological distress (Kwak, 2020). Spiritual care directly impacts patient care outcomes, reduces fear of death, decreases medication usage, lowers conflict

with staff, reduces pain, and lowers symptoms of PTSD (Ghorbani et al., 2021; Erdoğan & Koç, 2021; Roze des Ordons et al., 2020). Spiritual care also reduces vicarious distress amongst healthcare providers who are witness to traumatic situations (Smiechowski et al., 2021). Additionally, addressing patients' spiritual concerns can facilitate Goals of Care (GOC) conversations by helping patients and their families to understand what they (or their loved one) want, and by helping the care team to have empathy for the patient and/or family (Jeuland et al., 2017; Roze des Ordons et al., 2020).

Barriers and facilitators to care

Research shows that, internationally, nurses recognize that spirituality is important but do not feel competent to provide this type of care (Ghorbani et al., 2021; Tüzer et al., 2020). The main barrier to the provision of spiritual care is a self-identified lack of competency stemming from the absence of spiritual care education in nursing school (Karadağ, 2019; Kudubes et al., 2019; Kasar & Nacak, 2021).

In the last decade there has been a growing movement to research spiritual care praxis, revealing wide inconsistences in how it is taught in undergraduate programs (McSherry et al, 2020). A core textbook review of English language nursing textbooks showed only 38% included a definition of spiritual care and only 36% included an overview of nurses' roles in providing spiritual care (Chiang et al, 2020).

Beyond a lack of education on the subject of spiritual distress, undergraduate nursing programs also do not prepare students to self-reflect on their own spirituality (Ross et al., 2022). Such self-reflection is necessary as a nurse's own discomfort and fear of death can create a hesitancy or timidity to discuss same with their patients. This hesitancy has real consequences when combined with systemic and institutional barriers such as a lack of time caused by

inadequate staffing levels and lack of experience with spiritual distress. Internal barriers including fear of offending family, dialogue skills, and fear of getting "caught between" differences in family and clinician beliefs can also further prevent a nurse from engaging in conversations regarding spiritual distress (Dolan et al., 2022). A nurse who is uncomfortable with the concept of spirituality and death will be less likely to engage in therapeutic conversations with patients who are also hesitant to discuss this (Rahman et al., 2020; Kasar & Nacak, 2021).

Research has shown that a nurse's comfort with discussing spirituality and death is the main facilitator to providing care to patients experiencing spiritual distress (Gurdogan et al., 2016; Cura, 2020). While nurses who self-identified as having a strong personal religiosity were more comfortable to have these conversations, a lack of religiosity was not shown to be a barrier to having these conversations (Rahman et al., 2020; Cura, 2020). Rather it is the nurse's own self-perception of spirituality and/or religion that has been shown to correlate with comfort discussing spiritual care (Kasar & Nacak, 2021; Rahman et al., 2020, Cura, 2020). The use of self-reflection (e.g., journaling) has been shown to facilitate nurses' spiritual self-awareness (Hansen et al., 2022).

Additional facilitators include clinical experience and what nurses personally believe to be a "good death", exposure to death, the quality of that death (e.g., traumatic versus expected), and nurses' comfort level providing spiritual care (Hansen et al., 2022; Li et al., 2021). Demographics also can act as a facilitator for these conversations; in a study amongst Turkish nurses, Gurdogan et al. (2016) found that female nurses self-report being more comfortable having spiritual discussions with patients (although at 12.8% there was a low number of male participants which could impact the results).

International educational initiatives

Though scarce, spiritual care nursing education programmes for nurses have been shown to be effective at educating on importance of spiritual care to nursing practice, implications of spiritual distress to nursing practice, and nursing interventions for both spiritual care and spiritual distress (Chung, 2012; Burkhart & Hogan, 2008). The body of research shows that the best way to increase spiritual wellbeing is through direct educational and reflective programing (Burkhart & Hogan, 2008). Successful spiritual care education initiatives to date have focused on developing one of the two spiritual care competencies for nurses: ability to provide spiritual care to patients, and nurses' understanding of their own spirituality (Chiang et al, 2020).

The most common model for the development of educational programmes is the ASSET (Actioning Spirituality and Spiritual care Education and Training) model (Chung, 2012). The ASSET model guides students through an exploration of their own spirituality and how they can incorporate this knowledge into their practice. A second model named EPICC (Enhancing nurses' and midwives' competence in Providing spiritual care through Innovative education and Compassionate Care) is a proven best-practice framework to incorporate spiritual care research into nursing education (McSherry et al, 2020). The EPICC project was initiated by Staffordshire University in the United Kingdom and includes nursing and midwifery education competencies, education toolkits, and a gold standard matrix for educational programming (Staffordshire University, n.d.). Programming developed according to these models are long in duration and intense in dosage, taking the form of a weekend retreat or two hours a week for six weeks (Burkhart et al., 2019; Chung, 2012).

Pairing reflection with clinical experience is the most effective way to meaningfully teach how to care for those in spiritual distress (McSherry et al, 2020). To date, educational

interventions teaching students about spirituality and spiritual distress have been rare, but successful. Burkart et al. (2019) had success combining large didactic sessions with smaller group sessions focusing on reflection and examination of consciousness exercises. Van Leeuwen et al. (2008) in the Netherlands successfully developed a semester-long course to improve student abilities in assessing and providing care for those in spiritual distress. In China, Hsaiao et al. (2012) (as cited by Chiang, 2020) utilized an eight week long course to improve nursing student spiritual health and to reduce occupational stress. Baldacchino (2011) utilized the ASSET model successfully in a weekend retreat with Maltese students in a Christian education setting to implement a course on spiritual care training.

Current education initiatives, such as those discussed in this section, focus on undergraduate nursing education. Areas for further research on this subject include education initiatives both with adult undergraduate students and clinicians engaging in professional development. Additionally, the development, and validation, of spiritual distress specific assessment tools would benefit nursing staff.

Spiritual distress assessment tools

While spiritual assessment most often occurs by listening to patients' stories, instruments are available for nurses to assist with spiritual history taking, most predominantly the FICA or HOPE assessment tools (Burkhart et al., 2019). FICA is an acronym for Faith/Belief, Importance/Influence, Community, Address (Borneman et al., 2010). The FICA tool seeks to understand a person's faith or beliefs, what influences their behaviours, who their community is, and what is important for them to address. HOPE stands for sources of Hope, Organized religion, Personal spiritual practices, and Effects of medical care and end of life issues (Borneman et al., 2010).

It is important to note that these tools are broad spirituality assessment tools, and tools specific to spiritual distress do not exist (Burkhart et al., 2019). The nurse takes an inductive approach to identifying spiritual distress (assessing its presence from data gleaned from personal stories and more formal open-ended interview tools) and requires a spiritual self-awareness gained through reflexive practice (Burkhart et al., 2019; Ghorbani et al., 2021). Reflexive practice allows the nurse to separate their own subjectivity from data interpretation. Helpful signs and symptoms to reflect upon are expressions of well-being, being in control, feeling safe regarding care, and anxiety about care or the current status of the patient (Ghorbani et al., 2021).

Spiritual distress interventions

Many nurse interventions are available when attempting to address spiritual distress in patients. The goal of these interventions is to promote a connection with self, others, and a higher power (Burkhart et al., 2019). The most common spiritual care interventions according to a literature review by Ghorbani et al. (2021) include:

- Healing presence: showing kindness, compassion, talking with patient, showing interest in patients
- Therapeutic use of self: compassionate active listening
- Intuitive self: understanding patients' thoughts, feelings, making space for patient expression of feelings
- Patient centredness: recognising the uniqueness of the patients' own spirituality
- Meaning centred therapeutic interventions: supporting religious activities, encourage patient to develop positive relationship with self, creation of spiritually nurturing environment

When nursing for a patient in spiritual distress, it is the nurse's role to foster the patient's sense of connection (either with the nurse, the patient themselves, or their community). Jean Watsons' Theory of Transpersonal Nursing discusses the need to holistically treat the patient. The nurse must address the spiritual dimension of their wellbeing through the development of the nursing relationship (Watson, 2002). Because spiritual distress is so chaotic and unique to the person, a protocol-based approach to designing spiritual distress interventions is inappropriate; instead the nurse needs to develop an individual care plan for the patient. This prevents the nurse from being discouraged if a specific intervention appears ineffective. The use of Chaos theory (as discussed later) allows the nurse to understand that while the outcome of any single intervention may be unpredictable, it can be reliably assumed that presence of an intervention will have an effect on that patient. This allows the nurse to expand their care planning beyond standard nursing frameworks to develop a broader understanding of how this type of distress can develop and manifest, and which interventions are available and appropriate (Dombeck, 1996).

Gaps in the literature and areas for further research

The main gap in the literature is a lack of conceptual consensus on the terms "spirituality" and "spiritual distress". While definitions of these terms exist, they are varied and have not been clinically validated (Caldeira et al., 2015). Without conceptual clarity it is difficult to design research with a high level of validity. Current education on spirituality and spiritual distress in nursing focuses on the undergraduate levels (McSherry et al, 2020). Areas for further research on this subject include education initiatives specific to clinicians engaging in professional development. Additionally, the development and validation of specific spiritual distress assessment tools would benefit current nursing staff.

Though the International Council of Nurses (ICN) lists spirituality as a core competency in the nursing code of ethics (International Council of Nurses, 2021, section 1.2) and the CNA discusses it in their position statement, the College of Registered Nurses of Alberta (CRNA) only mentions spirituality once, in the legislated practice statement on the profession of registered nurse:

> In their practice, registered nurses do one or more of the following: (a) based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skill and judgment to (i) assist individuals, families, groups and communities to achieve their optimal physical, emotional, mental and spiritual health and wellbeing.
>
> (College of Registered Nurses of Alberta, 2023, page 5)

Spiritual care competence is not included as a practice standard for registration in Alberta. As such the practice standards for nurses in Alberta do not align with those set at the national level. Furthermore, the CNA's last publication on spirituality in nursing was a position paper in 2010 (CNA, 2010). Since this publication, no updates have been made. Nursing standards for spiritual care have not translated from the national level to the provincial level and these standards have not been updated in the last decade.

SECTION 3: PROJECT DESCRIPTION

Background and planning

The goal of this project was threefold. First, to deliver a professional development session on spiritual distress to increase staff understanding. Second, to increase awareness of spiritual distress symptoms and possible interventions to address spiritual distress in participants themselves, or in others. Third, to increase staff motivation to seek out more professional development opportunities related to spiritual distress. The lesson plan (Appendix A) moved participants through the levels "remember", "understand", and "apply" of Krawthol's revised (2002) Bloom's Taxonomy. This project took the form of two 30-minute "lunch and learn" sessions aiming to provide a high-level introduction to the concept of spiritual distress. The first session occurred in-person and the second was delivered via Microsoft Teams.

Project Goals

1) Develop a professional development session on spiritual distress to increase staff understanding.
2) Increase awareness of spiritual distress symptoms and possible interventions to address spiritual distress in others or themselves.
3) Increase staff motivation to seek out more professional development opportunities related to spiritual distress.

Target population

St. Michael's Health Centre is a small, urban, continuing care health centre in South-Western Alberta consisting of varied in-patient units including: complex mental health care, supportive living, long term care, post-acute rehabilitation, and a palliative care unit. The patient populations, acuity, and diagnoses are varied. There are two spiritual care providers at the health

centre, which belongs to a Catholic health system, Covenant Health. In addition to St. Michael's, this project is designed to be applicable in other small-scale centres and rural sites in the South-West zone. While the target population for this intervention is nursing, there is no staff designation exclusion criteria for this intervention.

Stakeholders

This project was conducted at St. Michael's Health Centre. As such, the site manager and clinical nurse educator were the two primary stakeholders. The site manager is responsible for approving all projects within St. Michael's Health Centre. As this project is an education initiative, it was delivered in consultation with the site educator. Permission from the site manager was obtained after an email containing the program logic model (Appendix B) and a timeline was sent. Buy-in from the clinical nurse educator occurred in-person and via email.

Ethical considerations

A pRoject Ethics Community Consensus Initiative (ARECCI) assessment was completed with a resulting score of 10 ("minimal risk") due to an inexperienced project lead (Appendix C). This voluntary professional development session was delivered at a facility where spiritual care providers are on site. Mitigation strategies included the instructor preparing scenarios based upon their own personal experiences that way the sharing of personal experience was not expected. Information to employer-provided counselling was also offered to participants. Lastly, a disclosure was read at the session's commencement indicating that nothing said in the training was to be repeated outside the room.

Though this project was designed for nursing staff, it was decided that the session be made available to all employee designations of St. Michael's Health Centre. Because St. Michael's is a small continuing care facility, all staff have the opportunity to form long-lasting relationships

with clients, residents, and patients. These relationships form trust and increase the likelihood that staff would encounter clients, residents, and patients in spiritual distress. As staff become close with those they care for, and witness their distress, they are also impacted and are at increased risk of experiencing spiritual distress themselves. As such, this information was deemed pertinent to all employee groups.

Theory informing project development

Chaos theory

Chaos theory can be used to understand the unpredictability of how a traumatic event will result in spiritual distress, and the need to personalize treatment of spiritual distress to the individual in order to foster resiliency (Dombeck, 1996). Chaos theory comes from the field of weather predictions, and is based upon the 1963 work of Edward Lorenz statistically computing the likelihood of weather events (Demir et al., 2019). In his weather forecasting calculations, he experimented with rounding to third decimal point, which completely changed the outcomes of his prediction models. The realization that a seemingly insignificant change had large scale knock-on effects was the impetus for the development of Chaos Theory. This theory outlines how behaviours in a chaotic system are not random and that small changes in the initial state can make large changes elsewhere. This theory is also known as the butterfly effect (Vicenzi, 1994).

There is growing understanding that emotional disorders are not fully the result of the person, and are instead impacted by a person's context. Chaos theory is used across several disciplines including nursing and psychology (Bussolari et al, 2009). In the field of nursing, Dombeck (1996) utilized Chaos theory to analyze the case study of a patient in spiritual distress. By acknowledging that there is no exact predictable cause and effect between behaviour and outcome (e.g., between trauma and spiritual distress, and intervention and reduced spiritual

distress) chaos theory promotes resilience to spiritual distress. It cannot be assumed that each patient who experiences trauma will automatically have the same spiritual distress requiring the same intervention (Demir et al., 2019; Dombeck, 1996). Dombeck addressed this by developing guidelines for nursing care of patients in spiritual distress so that the nurse can tailor their care plan to the patient. Chaos theory provides a useful framework for discussing nursing interventions. Instead of trying to eliminate the spiritual distress itself, nursing interventions can focus on giving the person tools to adapt and heal (Bussolari et al, 2009).

The use of Chaos theory allows the nurse to understand the non-linear causality of their interventions and evaluate the intended outcomes of their intervention,

> Because the client is also viewed as being in constant flux and change, one can surmise that change needs to happen in a way that causes the system [i.e. their spirituality] to remain close to equilibrium. Many of our observations and experiences corroborate this constancy of flux and change, as living systems evolve and develop, but this is not the only way that systems change. Not all systems remain close to equilibrium, nor do all systems become extinct as a result of extreme flux and turbulence far from equilibrium.
>
> (Dombeck,1996, para. 13)

Thus the goal of the nurse caring for a patient in spiritual distress should not be to "fix" the patient but to give them the tools to adapt to their new understanding of spirituality. As such, general systems theory approaches, which assume a linear relationship between cause and effect, are ill-suited for this dynamic and intangible phenomenon.

The nursing guidelines recommended by Dombeck (1996) were used to develop the lesson content, particularly the interventions available to healthcare staff. These included avoiding a paternalistic approach to care, avoiding the temptation to return the patient to their previous understanding of their spirituality, self-reflection, attention, and presence.

Bloom's Revised Taxonomy

Bloom's Taxonomy is a seminal pedagogical framework outlining a hierarchy of student learning (Krathwohl, 2002). It serves as a curriculum outline and a step-by-step process to advancing learners' knowledge on a particular subject matter. Bloom's Original Taxonomy presented the following six stages of learner advancement: knowledge, comprehension, application, analysis, synthesis, evaluation (Krathwohl, 2002). These categories were then subdivided as learners progressed through simple to complicated and concrete to abstract stages of learning (Krathwohl, 2002). This taxonomy has been used successfully to develop countless curriculum across the globe (Forehand, 2005). However, in the latter half of the 21st century, critiques developed that the taxonomy was outdated for modern education and that the labelling of its categories as nouns, instead of verbs, prevented mobility between the levels (Forehand, 2005).

In 2002 David Krathwohl presented a revised taxonomy (Appendix D) that changed the six stages from knowledge, comprehension, application, analysis, synthesis, and evaluation to remembering, understanding, applying, analyzing, evaluating, and creating (Forehand, 2005). This project is designed so that learners are introduced to spiritual distress at the remembering level, develop an understanding of it through discussion of interventions, and apply this knowledge to case studies and personal experiences, if desired.

Project deliverable

The project deliverable is a lesson plan for a one-time 30-minute lunch time drop-in educational session. Chaos theory informed the development of lesson objectives, and the lesson plan was developed according to Krathwohl's (2002) revised Bloom's Taxonomy. This educational session aimed to transform current practices related to spiritual distress, and to inspire change and motivation from within participants (Grossman & Valiga, 2017; Collins et al.,

2020). The session used three educational strategies: didactic teaching, case study, and self-reflection. It provided participants with resources for continued professional development. The session strove for accessibility; considering differing work schedules, it was offered twice.

The nature of both personal spirituality and distress is so multifaceted, complex, and unique to the individual that it is impossible to predict the ripple effect that any one trigger or intervention may have. As discussed in chaos theory, nursing care for spiritual distress must be flexible to account for the personalized journey each patient will have (Bussolari et al, 2009; Demir et al., 2019). After experiencing spiritual distress patients may never return to their prior state but, using the knowledge and motivation gained from this educational session, staff can give them tools to help adapt.

Didactic teaching

The first 10 minutes of the session were devoted to a high-level conceptual review of spiritual distress, its antecedents, its consequences, and interventions. These were delivered via PowerPoint and a summary was included in a take-away pamphlet (this pamphlet was emailed in the online session).

Case Study

Two case studies were provided by the session facilitator to apply principles learnt from the didactic portion. One case study was designed as an example of spiritual distress and other is designed to provide an example of ethical distress. These case studies required participants to analyze their learning of spiritual distress.

Self-reflection

Participants were guided upon a voluntary self-reflection. The instructor began by sharing their own personal experience of spiritual distress. Learners were then asked to identify a time in either their employment, clinical practice, or personal life where they witnessed or experienced spiritual distress. Participants were asked to self-reflect upon how they were spiritually distressed (e.g., what relationships or existential aspects of themselves were challenged), and how they could apply the learning of this session to this memory. Participants were able to share their experiences with the group if they wished but were informed that doing so was not necessary.

Professional development

At the end of the educational session, time was dedicated to exploring further professional development resources (consisting of both grey literature and academic). These resources were included in the end-of-session pamphlet.

Project implementation

Recruitment for the project consisted of two emails sent to the St. Michael's employee email list serve, posters in break and charting rooms, and informal discussions with staff. The session was designed to be delivered over the first half of the lunch hour. This was intentionally designed to coincide with unit breaks and allow non-nursing staff to eat their lunch in the second half of the break (COVID-19 precautions in continuing care facilities at this time prevented eating in congregate settings). The second session was pivoted to an online session after informal feedback from employees. These employees reported that attending online from home, or viewing a recording at a later time, would be more accessible to them. There were two requests for the project to be shared with teams external to the target audience, the Palliative Care Team and Senior Day Programs. The decision to share this presentation with these teams occurred after

consideration that due to the nature of the information provided, it would be pertinent to also share the presentation with these groups.

This project was originally designed to occur as two separate 30-minute lunch time sessions, with pamphlets handed to participants as they left the session and subsequently distributed throughout units. Due to low attendance at the first session (N=6), and repeated requests for the session to be made available online, the second session was offered as an on-line meeting using Microsoft Teams. Total attendance of the on-line session is unknown as the presenter view of Microsoft Teams did not display attendance and participation varied.

Evaluation methodology

Formative evaluation

Formative evaluation of the project deliverable was developed through coursework in the final semester of the Master of Nursing program as well as feedback from the course instructor and project supervisor, Katherine Haight, involved stakeholders, and through informal discussion with St. Michael's staff. The lesson plan for the educational session was shared with the classmates and instructor of the course, and feedback was incorporated into a finished draft of the educational content. This content was then piloted on two participants, a nurse and a layperson. This was done to ensure the subject matter was accessible to all professional backgrounds. The spiritual care provider reviewed the explanation of the concept, the chaplain confirmed that the definition included in the presentation was valid and should not be altered. This occurred after the in-person session.

Additional feedback was gathered through discussions with staff at the facility. Multiple requests were received for the second session to be delivered online. This feedback informed the

decision to deliver the second session via Microsoft Teams. The content for both in person and online sessions was identical.

Summative evaluation

This project was evaluated using a post-test survey design (Appendix E). Participants were asked yes/no questions related to their self-perceived knowledge of spiritual care. Participants were also asked questions related to their comfort in caring for spiritually distressed patients, recognizing it in themselves, and interest in additional information on a five-point Likert scale. Lastly the survey asked participants to list their employee designation (if they felt comfortable doing so).

The Likert scale was chosen due to its provision of the third neutral option for respondents who might not feel comfortable answering questions. Though the evaluation tool did request employees to disclose their designation, there were enough varied staff at the facility that they could not be identified from designation alone. Confidentiality was ensured by reminding staff to not repeat the stories shared in the recording. Participants were notified that the second session would be recorded, and implicit consent was obtained by participation. The in-person session was not recorded.

Data collection results

For the in-person session, the evaluation tool was distributed to participants immediately after the session ended. In the online session, the evaluation was distributed after the presentation via email. Evaluations were returned by 100% of in-person participants (N=7). One person from the online session returned their evaluation. Total participation in the on-line session was difficult to determine due to the presenter view on Microsoft Teams which did not allow me, as the presenter, to view the total participant numbers. After the session, some participants reached

out to state they had joined the meeting halfway through, or had left early, or had to leave for a portion of it. As such it cannot be determined the exact number of participants who were able to attend the entire session. This raises important questions about ensuring participation in online sessions.

Question 1

From the returned evaluations 100% of participants (N=7) responded "yes" when asked if they had a "good understanding" of spiritual distress. The results demonstrate that the intent of the session to increase understanding was effective.

Question 2

Based on a five-point scale from not comfortable to very comfortable, participants were asked "how comfortable would you feel identifying if someone was in spiritual distress?" with 100% (N=7) identifying "somewhat comfortable". This result demonstrates that participants met the project's short term outcome that they become aware of signs and symptoms of spiritual distress. That participants chose "somewhat comfortable" instead of "very comfortable" also suggests that continued education on spiritual distress would be of benefit.

Question 3

Based on a five-point scale from not comfortable to very comfortable, participants were asked "how comfortable would you feel speaking to someone in spiritual distress?" with five out of seven participants identifying "somewhat comfortable". This result demonstrates that while participants met the project's short term outcome of becoming aware of simple interventions to decrease spiritual distress, it also suggests need for continued education so that participants would feel "very comfortable" instead of "somewhat comfortable".

Question 4

Immediately after the presentation participants were asked “are you interested in more information on spiritual distress?”. One person responded they were somewhat interested, five reported that they were “very interested”, and one person wrote “no thanks, I have some at home”.

Question 5

As identified by the evaluation tool participant representation for both sessions included administration (n=2), pharmacy (n=1), licensed practical nurse (n=1), healthcare aide (n=1), registered nurse (n=1), spiritual care provider (n=1). Six people attended the in-person session, with all participants returning completed evaluation tools. Out of the on-line session, only one person returned a completed evaluation tool. Total participation for this session is unknown as attendance fluctuated throughout the session.

Analysis

Participation in both sessions was diverse and included representation from all employee designations including nursing, allied health and administration. I was surprised by how conversations evolved organically during discussions of the case studies and by how comfortable people were discussing the spiritual distress they had experienced in their life. Unexpectedly, in both education sessions, participants identified spiritual distress in the second case study which was designed to highlight ethical rather than spiritual distress. In doing so, participants reached the application level of Krathwohl’s revised Bloom’s Taxonomy (2002), applying their knowledge of the course material and exceeding the lesson expectations. The fact that participants were able to apply the session learning to their own personal experiences and generate unexpected outcomes demonstrates the academic difficulty with defining and clinically

validating the concept of spiritual distress itself (Caldiera, 2013). Though the standard accepted NANDA-1 definition of spiritual distress was presented to participants, they were most influenced by their own personal experiences when responding to the case studies.

Overall, participants were highly motivated to attend and engage in the sessions. When asked in their evaluation if they would be interested in more information, one participant responded that they were “always learning to keep striving to do better”. A video recording was sent to participants after the second presentation and was accessed by six people, indicating continued interest in the topic. This recording was sent to both in-person and online participants for later viewing, included in the email in which the evaluation tool was sent, as well as a copy of the PowerPoint presentation. Multiple participants reached out to via email and in person to express how they valued the project and that they were thankful for the opportunity to discuss this topic.

SECTION 4: REFLECTION

Project Development Process

The purpose of this project was to bring awareness of the importance of spiritual distress to the field of nursing. This project is an extension of my own previous research on the experiences of patients and family members in spiritual distress. This was fostered by my previous graduate work on spiritually distressing experiences of patients, families, and healthcare workers in the ICU as well as my career in various palliative settings (hospice, homecare, and as part of the palliative specialty team here in south-western Alberta). The project goal was for participants to leave with a foundational knowledge and appreciation of this type of distress.

This project had not initially included spiritual care providers as stakeholders as it was designed to utilize the present definitions available in nursing literature. As a result, I was concerned that identification of spiritual distress, in the ethical distress case study, was due to an error in educational content. I discussed my concern with spiritual care providers after delivery of the first session who validated the educational content of the session.

The emphasis of the presentation changed upon consulting the spiritual care provider after the first session. In the second presentation more emphasis was placed on the sensitivity of identifying spiritual distress, as opposed to the specificity of it. I implored participants to remember that spiritual distress is not constrained to religiosity, that people who are atheist are just as at risk of experiencing spiritual distress, and not to assume that someone religiously well supported, and strong in their faith, would not be at risk of spiritual distress (only the emphasis changed, the content did not change between the first and second presentations). This last point about the impact of religious support developed after the first session where I reflected upon my own assumption that someone who was religiously well supported would be at less risk of

experiencing spiritual distress. This experience consulting with the spiritual care provider has led me to reflect upon the fourth domain of the Canadian Association of Schools of Nursing national nursing education framework, that of communication and collaboration (CASN / ACESI, 2015). Both these skills are essential to deliver high quality patient care. While this project utilized the nursing definitions of spiritual distress, education on this subject cannot occur in a nursing silo. Future initiatives surrounding spiritual distress in nursing practice should collaborate with spiritual care providers so that both disciplines can learn from each other.

Strengths and weaknesses

Strengths

The strength of this project was the subjective understanding of the concept of spiritual distress. Every participant could relate to the project in a unique manner. Learners were able to apply the provided information to their own circumstances and generate meaningful discussions that exceeded the lesson expectations and challenged the instructor's own assumptions. I was personally inspired to deeply reflect on my assumptions, based on session dialogue. One of the most effective aspects of the session was the focus on sensitivity versus specificity I emphasized the importance of learners not applying exclusion criteria when assessing for spiritual distress and the importance of interdisciplinary collaboration by referring to a spiritual care provider for further assessment.

The case studies helped generate discussion and gave participants an opportunity to apply their learning. After the case studies were discussed, participants were invited to share their own experiences with spiritual distress. Participants became engaged after I (the instructor) shared my own experience with spiritual distress. By displaying vulnerability, the instructor encouraged

participants to share their experiences even if they weren't confident which type of distress it was that they had experienced.

This project could be easily scaled to other rural sites as it is an effective, low cost, low fidelity professional development educational session. Managers (beyond this project's stakeholders) expressed interest in scaling this project to their sites. As healthcare funding becomes increasingly strained, the low cost-high yield nature of this programme makes it a viable intervention to begin to teach about spiritual care in nursing practice.

Weaknesses

The strength of this project was also its weakness. The subjective understanding of spiritual distress meant that final evaluation of the teachings was difficult, as everyone applied their learning in an individualized manner. In both sessions, participants came to define spiritual distress in the case study designed to highlight ethical distress. It was difficult to create parameters as to what spiritual distress was, compared to other types of distress, as the conceptual definition of spiritual distress is itself unclear.

Prior to the implementation of this session, I believed conceptual clarity on the subject was achievable. I had written a conceptual analysis on spiritual distress and believed this project to be one of knowledge translation. Instead, it has turned into a knowledge creation project. Witnessing learners apply their own experiences to the provided definition of the concept and identify spiritual distress in the ethical distress case study (which was not designed to exhibit spiritual distress) was eye-opening. This presents challenges for future implementation and evaluation of the project. Future initiatives will need to be conscious that learners will apply their own experiences to the presented definition of spiritual distress and therefore will develop individualized understandings of the concept. This challenge in recognizing a conceptual

definition of spiritual distress echoes the difficulties previously discovered and discussed in the literature review of this paper (Caldeira et al., 2016; Martins et al., 2021; Monod et al., 2010).

A design weakness in the evaluation strategy of this project is the difference between in-person and online formats. In the in-person session, where participants returned evaluations to the instructor as they exited, the response rate was 100%. In the on-line session, where the evaluation was dispersed in a follow-up email containing the session recording which lowered the response rate considerably (Wu et al., 2022). Anecdotally many participants gave unsolicited feedback in-person or via email but did not fill out the official evaluation form.

A logistical weakness in this project was the absence of a session moderator. When presenting in Microsoft Teams, the presenter view prevents the presenter from seeing the chat or session attendance. Having an additional moderator would have allowed any questions put forward be brought to my attention and would have facilitated attendance tracking.

Lessons learned

Project development

On a personal level, the experience designing and implementing this project has taught me the importance of reflection. Often in academic work I am interested in tackling big picture issues and create my projects on a grandiose scale. This often occurs at the expense of details and building a strong foundation.

Initially it felt as if I was scaling back the project by creating an introductory session. However, as I came to develop the project, I realized that such an introductory session was in fact *more* daunting to create. How do you take such a complex concept, that even the experts struggle to define, and speak about it in terms that everyone will understand?

Through this project I have learnt the value of using a systematic approach to research and the importance of developing a plan to address a nursing problem based upon evidence garnered by synthesis of evidence and theory. Originally, this project was designed as an education session on utilizing a spiritual distress screening tool. However, over the course of this master's program I came to appreciate this through the lens of Bloom's Taxonomy and how inappropriate such an approach would be. Teaching nurses at the application level of Bloom's Taxonomy, without addressing the preceding "remembering" or "understanding" levels would be less effective. It was a difficult decision to revise the project design.

Importance of proper evaluation planning

It was not until analyzing my evaluation tool that I fully appreciated the importance of logical congruence between program logic model, lesson plan, and evaluation tool. Putting my goals, objectives, and outcomes side by side in a chart, and understanding the implications of this alignment for my analysis clarified the value of a strategic approach to project design. Initially my evaluation tool did not properly align with the project goal, which presented difficulty for my evaluation strategy and threatened the validity of my results. Re-examination of my literature reviews and the project goal helped align the objectives, outcomes, and evaluation and contributed to my confidence in the results.

Interest in online sessions

Another lesson learnt was that interest in online education still exists amongst health care professionals. I had assumed that due to the last two years of online education during the COVID-19 pandemic, participants would be more willing to come in-person than attend an online session. This proved to be incorrect as there were multiple requests for online education,

with participants stating that logistically it was easier to either watch from their home or office, or watch the recording at a later time.

Implications for nursing practice

This project is important to nursing practice as it brings attention to an overlooked element of the nursing scope of practice, spiritual care. Globally, nurses report a lack of competency, education, and institutional support to provide spiritual care. The ICN identified spiritual care as one of the four domains of holistic nursing practice (ICN, 2012). However, this international recognition has not translated to practice. The Canadian Nurses Association position statement on spirituality has not been updated since 2010 (CNA, 2010) and the College of Registered Nurses of Alberta does not list spiritual care as a competency (College of Registered Nurses of Alberta, 2023).

To date, nursing educational interventions have been successfully implemented internationally in Malta, the Netherlands, the United Kingdom, and China. This project aims to contribute to the body of evidence that educational interventions for spiritual distress are effective.

As our health system faces an ever-increasing strain related to age and acuity of patient comorbidities, increasing risk factors for spiritual distress. Alongside this nursing scope of practice is evolving and placing nurses in a leadership role to address the spiritual care needs of their patients. Nurses need to be equipped to practice competently and meet the demands of their patients to prevent negative health outcomes associated with spiritual distress.

Implications for future research

The highly personalized interpretations of spiritual distress that occurred in this project reveal theoretical weaknesses in current ontological definitions of spiritual distress and those

pedagogical interventions to teach them. If each participant defined and identified spiritual distress through the lens of their own experience, then can it be said that there is one true definition of spiritual distress? Will theorists ever be able to determine what is and what isn't spiritual distress? Does the conceptual definition of this term need to be grounded in its application? These questions warrant further investigation to determine if current approaches related to defining spiritual distress are theoretically sound.

Education programs related to spiritual care and spiritual distress have been trialed in the Netherlands, Matla, the United Kingdom, and China. These countries span diverse philosophical orientations and cultural attitudes towards spirituality. Further research would warrant an examination of similarities and differences in approach, underlying philosophies, and cultural reasons why these interventions occurred in these specific countries. Understanding the facilitators and barriers to these projects would be beneficial in designing similar interventions here in Canada, where such work is lagging.

Conclusion

Barriers to developing and implementation educational initiatives related to spiritual distress include difficulty defining the concept, a lack of institutional support, and a lack of awareness of the concept amongst the general population. Despite this, nurses recognize the importance of competency in caring for their patients spiritually. Internationally, there have been few, albeit successful, attempts to introduce spiritual care education programs for nurses. However, these are scarce and have not been integrated into domestic nursing education programs globally. The ICN lists spiritual care as a core practice competency. This has not been reflected in the standards laid out by professional nursing associations in Canada, particularly the College of Registered Nurses of Alberta (CRNA).

This project was designed to address the gap in spiritual care education programming in St. Michael's Health Centre in Lethbridge, Alberta, Canada. This project piloted an education session on how to identify spiritual distress in patients in a rural continuing care facility and provided information on available interventions. Results from this project highlight the interest displayed by all healthcare employees for this type of learning as well as the theoretical difficulties defining the concept of spiritual distress itself. Evaluation of this project shows that spiritual distress educational interventions are both desired by staff and effective knowledge translation initiatives.

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APPENDIX A: LESSON PLAN

Lesson title: An introduction to spiritual distress
Duration: 30 minutes

Lesson Objectives:

1. To provide a broad introduction to the concept of spiritual distress.
2. Participants will be aware of signs and symptoms of spiritual distress and simple interventions to decrease spiritual distress.
3. To motivate participants to continue learning about spiritual distress after leaving the session.

Lesson Outcomes:

1) Participants will have an increased understanding of the concept of spiritual distress.
2) Participants will discuss ways to identify spiritual distress and relevant interventions.
3) Participants will have motivation for continued learning.

Summary of tasks:

- Didactic teaching: PowerPoint slides with listed "main takeaways" for instructor to discuss
- Case study: Two scenarios, one scenario discussing ethical distress, one scenario discussing spiritual distress
- Discussion: Invite learners to share their own experiences
- Evaluation: One-page post-session evaluation

Delivery method:

- In-person
- Online (synchronous and recorded for asynchronous learning)

Materials:

- PowerPoint
- Handout
- Video sharing service (i.e. Microsoft teams or zoom)

Evaluation method:

- One page handout (5 questions mixed yes/no and 5-point Likert scale)

Lesson Outline:

Slide Number **1**	Implementation Time 30 seconds	Title Introduce session and instructor
Content: Instructor to discuss that learning session is a safe space and remind participants to remain confidential with others sharing their experiences, explain how employees can access occupational counseling, and they no one is expected to participate should they not feel like doing so.		

Slide Number **2**	Implementation Time 2 minutes	Title Objectives
Content: Instructor to read slide		
Main takeaway for instructor to emphasize: Purpose of session is for participants to have knowledge of spiritual distress, how to identify it, how to address it		
Slide Number **3**	Implementation Time 5 minutes	Time Definition of spiritual distress
Content: Spiritual distress can be hard to define as both the words spiritual and distress mean different things to many different people. Most often it is described as a state of tension, abandonment, conflict or struggle with previous religious beliefs, ultimate meaning, and the people they love. It is a state of distress to their connection around them. Most often we see spiritual distress when people are going through major changes in their life and their relationship to everything around them changes.		
Main takeaway for instructor to emphasize: Spiritual distress is very difficult to define. Everyone has a unique interpretation of spiritual distress. It is often described as a state of tension/abandonment/conflict/struggle. Distress in their connection to the world around them. Spiritual distress often occurs in times of change		
Slide Number **4**	Implementation Time 2 Minutes	Slide Title Identification of spiritual distress
Content: “Spiritual distress can look different in everyone because everyone displays it differently. Some people may appear to be more withdrawn, they could all of a sudden start asking questions about their life, their purpose on earth, what the “meaning of all this is”, they might often say they are scared, and will talk about losing hope.”		
Main takeaway for instructor to emphasize: While it can look different to everyone the main indicator of spiritual distress is a distressing and disruptive shift in how someone sees themselves in relation to everyone around them.		
Slide Number **5**	Implementation Time 1 Minute	Slide Title Importance of addressing spiritual distress
Content: It is important to realize that spiritual distress is just as valid a form of distress as other kinds of distress that we are more familiar with. It has very real outcomes for both our patients/clients/residents and their families. Research shows that spiritual distress can lead to an increase in pain, sorry, conflict with		

healthcare staff, and PTSD. When someone is distressed spiritually it is like any other type of distress, just like someone with psychological distress has more negative outcomes, so does someone with spiritual distress.		
Main takeaway for instructor to emphasize: Legitimate form so distress, leads to increased pain and anxiety, can result in PTSD		
Slide Number 6	Implementation Time 4 Minutes	Slide Title How to address spiritual distress
Script: It's very simple to support a spiritually distressed person, you treat it like any other type of distress. The best thing you can do is to give them "presence". This means being with them, it can be helpful to ask them questions about how they're feeling but even if they don't answer it's good to sit with them. Sometimes all a person needs is for someone to be with them, they may start talking on their own about what they're feeling. Don't be afraid to be direct in asking them questions about what scares them, what gives them hope, what they're feeling. You can always refer them to a spiritual health provider as well. (Instructor to provide contact for facilities Spiritual Care Providers)		
Main takeaway for instructor to emphasize: Learners do not need to leave this session as an expert in spiritual distress. Purpose of the session is for learners to have an awareness of the concept, know basic interventions, and know how to refer to a professional.		
Slide Number 7	Implementation Time 5 Minutes	Slide Title Spiritual Distress in the learner
Script: I also want you to come away from this presentation with an understanding of what to do if you think you yourself may be in spiritual distress. Recognize that this is a very valid form of distress, don't tell yourself that everything is fine. Reach out and speak to someone, if you're not comfortable talking with Prince or Reno then speak to your partner, friends, or co-workers. Talk about your feelings and what's on your mind. Self-reflection can really help with gathering your thoughts to talk about. You can do this many ways, either by journaling or even going for a walk. Whether you want to talk about your feelings or not it is always helpful to do calming activities when you are distressed. Spiritual distress is a disruption to your relationship with the world around you, you need to address this disruption. Pick up your hobby, read, go for a walk, spend time with family and friends.		
Main takeaway for instructor to emphasize: Spiritual distress has very real consequences for yourself, it is important to reach out and talk		

when you are distressed		
Slide Number 8	Implementation Time 5 Minutes	Slide Title Case Study #1
Content: Educator to read out case study in PowerPoint, ask learners if they believe spiritual distress present in case study. Educator to ask learners to explain their reasoning, educator to tie in definition and characteristics (slide 2 and 3) into discussion.		
Main takeaway for instructor to emphasize: Patty is in ethical distress; she does not know what the right action is. Her connection to her identity, her understanding of life and death, and her love for her husband remain intact. She is not in spiritual distress.		
Slide Number 9	Implementation Time 5 Minutes	Slide Title Case Study #2
Content: Educator to read out case study in PowerPoint, ask learners if they believe spiritual distress present in case study. Educator to ask learners to explain their reasoning, educator to tie in definition and characteristics (slide 2 and 3) into discussion.		
Main takeaway for instructor to emphasize: Frank is experiencing spiritual distress. He feels separated from (and is questioning) his identity, the meaning of his life, what he values in his life, and his connections to those around him.		
Slide Number 10	Implementation Time 5 Minutes	Slide Title Share experiences
Content: Instructor to show personal experience of spiritual distress and invite learners to discuss their own experiences.		
Slide Number 11	Implementation Time 1 Minute	Slide Title Key points
Content: Instructor to read slides.		
Slide Number 12	Implementation Time 1 Minute	Slide Title References
Content: Instructor to display slide, do not read contents, ask if learners have any questions		

Instructor Activities:
Review pamphlets with participants and highlight listed continuing education resources. Inform participants that you will be distributing slides via email. If the session is online, inform participants you will be distributing the email recording of the session via email.

APPENDIX B: LOGIC MODEL

<table>
<tr><th colspan="6">AN EDUCATION SESSION ON THE TOPIC OF SPIRITUAL DISTRESS</th></tr>
<tr><th rowspan="2">Program Goal</th><th rowspan="2">Inputs</th><th rowspan="2">Activity</th><th colspan="3">Outcomes</th></tr>
<tr><th>Immediate post intervention</th><th>1 – 2 year</th><th>2 - 5 years</th></tr>
<tr><td>1)To deliver a PD session on SD to increase staff understanding

2)To increase awareness of SD symptoms and possible interventions to address SD in others or themselves.

3)To increase staff motivation to seek out more professional development opportunities related to SD.</td><td>Participant time

Facilitator time

Funding to book room

Printing cost of materials</td><td>One time 45 minute “lunch-and-learn” educational session to provide high level understanding of concept and provide resources for further professional development. Includes didactic education, self-reflection, continuing education resources (academic and grey literature).</td><td>(1)Improved understanding of the concept and importance of spiritual distress
(2) Motivation for continued learning</td><td>(1)Increased level of spiritual care provision to patients and/or families by nursing and auxiliary staff.

(2) Continued education on how to care for spiritual distress.</td><td>(1)Reduced spiritual distress in patients and families.
(2) Increased emphasis on spiritual realm of patient care</td></tr>
<tr><td colspan="2">Assumption</td><td>Reach</td><td>Impact</td><td colspan="2">External Influences</td></tr>
<tr><td colspan="2">Education will change attitudes which will change behaviours</td><td>All staff designations of St. Michael’s Health Centre</td><td>Actualization of holistic nursing and care through provision of spiritual care</td><td colspan="2">Patient circumstance, organizational buy-in, Participant motivation, funding</td></tr>
</table>

Adapted from: Enhancing Program Performance with Logic Models, University of Wisconsin-Extension

APPENDIX C: ARECCI ETHICS SCREENING TOOL

ALBERTA INNOVATES

arecci

ARECCI Ethics Screening Tool Report

arecci.albertainnovates.ca

Form Submitted: 29/08/2023

This does not constitute / represent a formal ethics ruling. Individuals are advised to additionally follow the policies or consult their local ethics authority. ARECCI helps project leads address and mitigate ethical risks by providing decision support tools, training opportunities, and project ethics consultation. albertainnovates.ca/programs/arecci/

Scoring Explanation

Score Result	Risk & Recommended Ethics Review
47 or Greater	**Definitely greater than minimal:** Organization's recognized review process* using ARECCI Ethics Guidelines for Quality Improvement and Evaluation Projects. *Review by a duly constituted group independent of the project team, that is trained to do project ethics reviews and whose decisions are recognized by the organization.
8 - 46	**Somewhat more than minimal:** Second Opinion Review** using ARECCI Ethics Guidelines for Quality Improvement and Evaluation Projects. **Review by an individual trained to do project ethics reviews who has no vested interest in the outcome of the project.
0 - 7	**Minimal:** Project leader uses ARECCI Ethics Guidelines for Quality Improvement and Evaluation Projects

Project Details

Project Title: Spiritual Distress: An Introduction

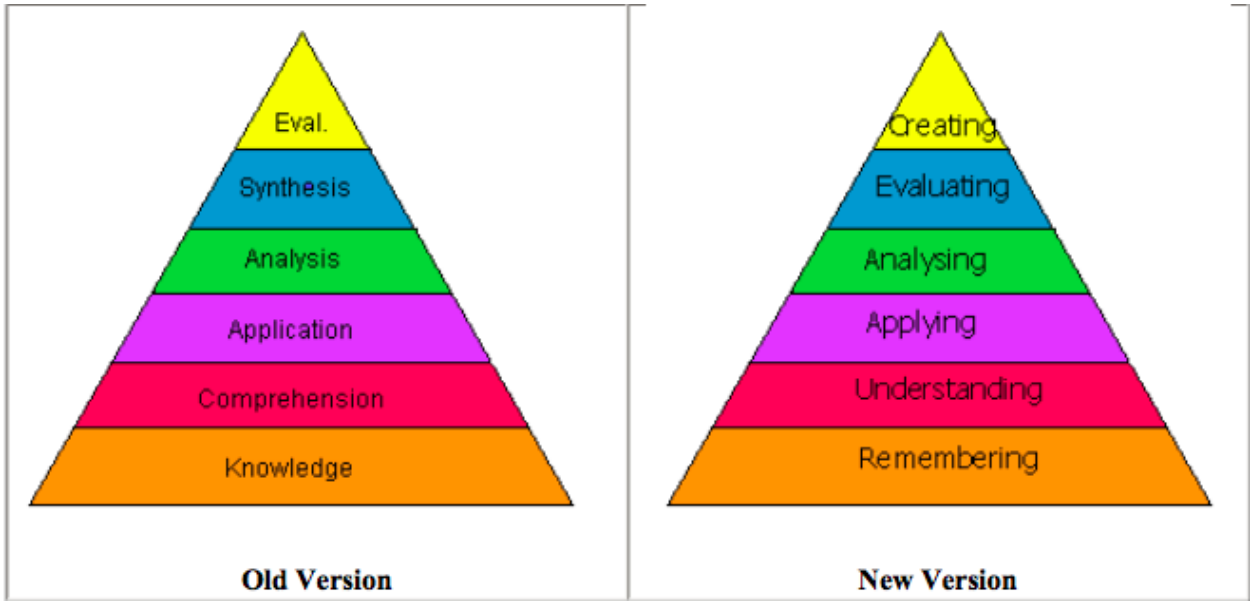
Your score is 10

The project involves Somewhat More Than Minimal Risk and should be reviewed by a Second Opinion Reviewer.

Type of Project
- Quality Improvement

Your Location
Lethbridge, Alberta
Canada

APPENDIX D: ORIGINAL BLOOM'S TAXONOMY AND KRATHWOHL'S REVISED TAXONOMY



APPENDIX E: SPIRITUAL DISTRESS EVALUATION QUESTIONS

- Do you feel you have a good understanding of spiritual distress after today?

  Yes No

- How comfortable would you feel identifying if someone was in spiritual distress?

  1- Not comfortable at all

  2- Somewhat uncomfortable

  3- No opinion

  4- Somewhat comfortable

  5- Very comfortable

- How comfortable would you feel speaking to someone in spiritual distress?

  1- Not comfortable at all

  2- Somewhat uncomfortable

  3- No opinion

  4- Somewhat comfortable

  5- Very comfortable

- Are you interested in more information on spiritual distress?

  1- Not interested at all

  2- Somewhat interested

  3- No opinion

  4- Somewhat interested

  5- Very interested