FRONTISPIECE

1. One dark night,
fired with love's urgent longings
- ah, the sheer grace! -
I went out unseen,
my house being now all stilled.

2. In darkness, and secure,
by the secret ladder, disguised,
- ah, the sheer grace! -
in darkness and concealment,
my house being now all stilled.

3. On that glad night
in secret, for no one saw me,
nor did I look at anything
with no other light or guide
than the one that burned in my heart.

4. This guided me
more surely than the light of noon
to where he was awaiting me
- him I knew so well -
there in a place where no one appeared.

5. O guiding night!
O night more lovely than the dawn!
O night that has united
the Lover with his beloved,
transforming the beloved in her Lover.

6. Upon my flowering breast,
which I kept wholly for him alone,
there he lay sleeping,
and I caressing him
there in a breeze from the fanning cedars.

7. When the breeze blew from the turret,
as I parted his hair,
it wounded my neck
with its gentle hand,
suspending all my senses.

8. I abandoned and forgot myself,
laying my face on my Beloved;
all things ceased; I went out from myself,
leaving my cares
forgotten among the lilies.[1]

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[1]John of the Cross, *The Dark Night of the Soul* in *The Collected Works of St. John of the Cross,* rev.ed. Translated by Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), Stanza 1-8.

ST. STEPHEN'S COLLEGE

RELEASE FORM

NAME OF AUTHOR:

Zinia Mary Pritchard

TITLE OF PROJECT DISSERTATION:

THE DARK NIGHT OF THE SOUL: A SACRED ANATOMY OF DYING

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YEAR THIS DEGREE GRANTED: 2014

_____

Signature

ST. STEPHEN'S COLLEGE

THE DARK NIGHT OF THE SOUL: A SACRED ANATOMY OF DYING

by

Zinia Mary Pritchard

A Project Dissertation submitted to the Faculty of St. Stephen's College
in partial fulfillment of the requirements for the degree of

DOCTOR OF MINISTRY

Edmonton, Alberta
Convocation: November 3rd, 2014

ST. STEPHEN'S COLLEGE
CERTIFICATION
DOCTOR OF MINISTRY PROGRAM

The undersigned certify that they have read, and recommend to the Academic Senate of St. Stephen's College for acceptance, a Project Dissertation entitled *The Dark Night of the Soul: A Sacred Anatomy of Dying* submitted by *Zinia Mary Pritchard* in partial fulfillment of the requirements for the degree of Doctor of Ministry.

Doctoral Committee Members:

_____
Dr Deborah Barrett

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Dr Barbara Rice

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Dr Leslie Gardner

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Dr Paul Humphries

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Dr Christina Puchalski
External Examiner

Date: November 3rd, 2014

DEDICATION

To My Beloved

ABSTRACT

This practical theology dissertation is grounded in palliative care practice, comprising an introduction, six articles, and implications. The main research question is: What is the spiritual experience of dying? Each article integrates the contemplative theology/spirituality of the Dark Night of the Soul with clinical palliative care questions: What is spiritual suffering? How does it differ from depression? How can it be assessed? How may it be best managed? "Nancy's Story" researched the contemplative journey of dying using the hermeneutical phenomenological method of Max van Manen. Four themes emerged: Lamenting the Impassable Why? ; Faith, Hope and Love: Moving Toward Transcendence; Experiencing Transcendence: An Unexpected Presence; and Experiencing the Gift of Insight Given within Transcendence. A spirituality study group yielded a contemplative spirituality definition grounding translation of Dark Night theology into accessible clinical constructs for spiritual assessment; resulting in a palliative spiritual assessment model. The study engaged two formal evaluations within medical education: the experience of residents' spiritual care education; and a focus group evaluation of palliative residents and fellows engagement with a palliative spiritual history. Article one commends the Dark Night as a single theoretical construct for suffering, identifying the signs of the Dark Night. Article two, examining differential diagnosis between the spiritual suffering of the Dark Night and depression, includes: a Dark Night Lexicon, a Clinician [Spiritual] Self-Assessment, similarities and differences between the Dark Night and primary depression, and a palliative patient narrative. Articles three, four, and five use a palliative case study to illustrate spiritual assessment. Products reflect Dark Night theology translated into clinical constructs: a language for spirituality and spiritual suffering, a palliative spiritual assessment model, and tool. Article six on managing spiritual suffering, builds upon the *CanMEDS* framework, contributes contemplative spiritual care competencies for the medical profession, and demonstrates their application in a case study. Spiritual suffering may be understood as the process of the Dark Night, differing from depression as a transformative form of suffering and non-pathological. This research introduced a language for spirituality at end of life, and can advance clinical practice –through tools that aid clinician's understanding, assessment, and intervention.

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attention to the heart and to the Beloved within; your vast inner spaciousness and receptivity—for sacred silence. You are a wise and true guide for the soul's journey.

My gratitude to my religious community, the Sinsinawa Dominicans, Wisconsin, USA. Your testimony to the spirit of Dominic gifted me so many years ago in discovering my spiritual identity as preacher and teacher. The spirituality of the order of preachers imbues the ensuing pages: may you receive the fruits of this contemplation as a work of the Holy Preaching, in fulfillment of my Life-Associate vow, and reflective of my solidarity in mission with you.

"Godhead here in hiding, whom I do adore/Masked by these bare shadows, shape and nothing more,/See, Lord, at thy service low lies here a heart/Lost, all lost in wonder, at the God thou art." [2] Beloved, thank you—for calling, loving, and sustaining me throughout.

[2] *Adoro Te Devote*, Saint Thomas Aquinas.

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LIST OF ABBREVIATIONS

CanMEDS	Canadian Medical Education Directives for Specialists
CASC	Canadian Association for Spiritual Care
COF-PHLI	Palliative Spiritual History
EZPCP	Edmonton Zone Palliative Care Program
TPCU	Tertiary Palliative Care Program
PP-SAT	Pritchard Palliative Spiritual Assessment Tool

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INTRODUCTION

This project-dissertation is a work of practical theology: a theology grounded in the practice of palliative care.[3] It finds its genesis in the vocational call to mission—specifically the call to mediate between the worlds I inhabit as a palliative spiritual care practitioner and as a Catholic contemplative pastoral theologian. The primary function of a practical theologian is to serve as a bridge between such worlds. As affirmed by Bernard Lonergan, the bridging work of communication is the primary task of practical theology.[4]

The true nature of this doctoral work is one of vocation: the threefold call to practical theology, contemplative care of the dying, and to mission[5]: "Let us set out for any place where the work is great and difficult, but where also with the help of the One who sends us, we shall open the way for the Gospel." [6] Vocational call is so aptly depicted in the words of Frederick Buechner: "the place God *calls you* to is the place where *your deep*

[3]Terry Veling, "Catholic Practical Theology," *Compass* 45 no.2 (2011): 36.

[4]Bernard Lonergan, *Method in Theology* (New York: Herder and Herder, 1972), 132-133. In Lonergan's words:

> Communication is concerned with theology in its external relations. These are of three kinds. There are relations with art, language, literature, and other religions, with the natural and the human sciences, with philosophy and history. Further, there are the transpositions that theological thought has to develop if religion is to retain its identity and yet at the same time find access into the minds and hearts of men of all cultures and classes

[5]*Ad Gentes,* "On the Missionary Activity of the Church," 4:23 (n.d.), http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decree_19651207_ad-gentes_en.html (accessed February 12, 2014).

> He [Christ] inspires the missionary vocation in the hearts of individuals, and at the same time He raises up in the Church certain institutes which take as their own special task the duty of preaching the Gospel, a duty belonging to the whole Church.

[6]Fr. Samuel Mazzuchelli, founder, Dominicans of Sinsinawa, Wisconsin, USA.

gladness and the world's deep hunger meet.”[7] My deep gladness is the Beloved (God) and the deep hunger I have attempted to meet is the desire for the spiritual within the health care setting of palliative care. The missionary nature of my call is summed up in my Dominican Life-Associate vow: “I promise with the grace of God, to be faithful to the work of apophatic contemplative theology; ‘to accomplish that which [God] has purposed and succeed in the thing for which he sent me.’”[8] The call to engage a work of practical theology prophetically arose out of my Master’s thesis which examined the nature and function of contemporary Catholic pastoral theology and concluded with the following statement:

> The academic is being called to come out of the world of academia and to serve the church and the world by being present to other professionals in other disciplines. As leaders they need to be able to facilitate theological reflection and ensure that theology does what it is meant to do, namely, to broaden horizons and extend the reign of God in real and actual ways.[9]

This doctoral work is the fruit of interdisciplinary collaboration—it responds to the spiritual need that specifically presents within the practice setting of palliative care: what is spiritual suffering? How can it be assessed? In what ways does it differ from depression? How may it be best managed? The purpose of this dissertation is to offer an intelligent response to the guiding research question: what is the spiritual experience of dying? As a result, it offers the answer that the spiritual experience of dying and the assessment and care of the dying may be better understood if perceived through the conceptual lens of the Dark Night of the Soul.

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[7]Frederick Buechner, *Wishful Thinking: A Theological ABC* (New York:Harper and Row, 1984),95.

[8]Isaiah 55:11 RSV (paraphrase)

[9]Zinia Pritchard, “The Nature and Function of Contemporary Catholic Pastoral Theology”(master’s thesis, Gonzaga University, 1998),73.

The Dark Night of the Soul (referenced more accurately as “Dark Night” and also referred to by the abbreviation "the Night”) is situated within the landscape of contemplative or mystical spirituality and is characterized by transformative suffering. The phrase *noche oscura* or “Dark Night,” originally coined by the Spanish priest-monk John of the Cross, (henceforth referred to as St. John) is a poetic metaphor for his mystical journey into union with a transcendent reality, alluded to as the Beloved, and the deeper union with self and others in and through the Beloved. This union is realized through a process of loss and deprivation (mortification) leading to spiritual suffering (purgation) and transformation (purification). The Dark Night refers also to St. John’s culminating poem of ecstasy and two theological treatises that attend to the profoundly relational matter of the spiritual life: *The Dark Night of the Soul*,[10] which places emphasis on the spiritual agency of the Beloved in the life of the individual (soul), and *The Ascent of Mount* Carmel,[11] which nuances the experience of human agency in the spiritual life. In his writing, St. John suggests the Dark Night as a metaphor for the entire spiritual journey. While facets of the Night, the Night of Senses and Night of Spirit, may suggest a linear progression, this is not so as an individual may often be living in and out of variant dimensions of the Night at any one time.[12]

The Dark Night is considered to be an apophatic form of contemplative spirituality referred to as the *via negativa* or “negative way” and may be better understood in contrast

[10]*The Collected Works of St. John of the Cross*, rev. ed. trans., Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh, *The Dark Night of the Soul* (Washington, D.C.: Institute of Carmelite Studies, 1991), 358-457.

[11]*The Collected Works of St. John of the Cross*, rev. ed. trans., Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh, *The Ascent of Mount Carmel* (Washington, D.C.: Institute of Carmelite Studies, 1991), 101-349.

[12]A.1.2.1.

to the kataphatic *via positiva* or "positive way." In the latter, emphasis is placed on concepts and images inspired by the senses as a means of knowing the spiritual and one's associated understandings of self and others. In contrast, apophatic spirituality highlights that such finite constructs are only representations of what is ultimately Real and not Reality that cannot be contained by virtue of the fact that it is Infinite. The apophatic spirituality of the Dark Night nuances on the direct or immediate communication of the Real largely through the unconscious—what is not rationally known.

The "dark" is used as a metaphor for the unknown, what is obscure and uncertain, relating to the unconscious dimension of the spiritual life that is beyond the senses, intellect, and imagination. It may be likened to the dark and protective cavern of the womb where knowing surpasses the intellect, and passivity and receptivity are authentic dimensions of being in relationship.

The metaphor of "night" alludes to the process of spiritual purification. Like nightfall, encountering of life impasses can plunge one into the darkness of night: the way ahead is obscured and the future is unknown. Disoriented on the level of intellect, this loss of bearings leads to feelings of being "at sea" or lost.

The "soul" refers to one's true inner self, [13] the indwelling of the Other [14] and one's eternal essence. As such the soul may not be understood as a "thing": "[it] is not a part of our being, like a motor in a car. It is our entire substantial reality itself, in its highest and

[13]James Finley, *Merton's Palace of Nowhere: A Search for God Through Awareness of the True Self* (Notre Dame, Ind: Ave Maria Press, 1978), 17.

[14]John of the Cross, *The Spiritual Canticle*, in *The Collected Works of St. John of the Cross*, rev.ed., trans. Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), 1.6-7.

most personal and most existential level."[15] The spiritual essence of the human person is demonstrated by its resemblance to transcendent Reality; who we truly are may be known by us or by others to a certain extent, but we are not completely known nor fully know the others in our lives—a part of us always remains a mystery, a compelling draw, a constant surprise.

The central process of the Night is the uncovering of this spiritual essence, purging all that is not authentic in one's ways of knowing and being to uncover the gold that is one's true identity. In and through this painful refining of one's images of self, others, and holy Other, the soul is led into more life-giving ways of relating on the intra, inter, and transpersonal levels of existence.

The following pages offer the reader an introduction to the origin of this doctoral study. It reviews the inter-related studies on the Dark Night within palliative care, the foundational research project that grounds the studies together with a summary of findings.

In my thirties I had exercised pastoral leadership within the context of a faith community. During that period, I suffered the pain of injustice as a lay woman in ministry, culminating in a feeling of abandonment from the One whom I loved and to whom I had committed my life. Paradoxically, in this very experience of vulnerability I was most wonderfully met: a compassionate, mystical union with the Beloved (God) afforded me peace, comfort, and insight into the larger mystery of life. At the time, I did not have any language to name the experience and had certainly not heard of the Dark

[15]Thomas Merton, *The Inner Experience: Notes on Contemplation*, with an introduction by William Shannon (San Francisco: HarperSanFrancisco, 2003), 6-7.

Night of the Soul. Later, when I became a tertiary palliative care chaplain I found that I seemed to have an intuitive understanding of patients' spiritual suffering, often helping them express the inexpressible. By happy chance, I encountered one day a segment of St. John of the Cross' Dark Night of the Soul and discovered an understanding of my own spiritual process as well as that of the patients.

Over time, in the process of serving as a palliative spiritual care giver, I discovered that my ongoing personal and professional journey through the Dark Night was often mirrored in the spiritual journey of the palliative patient/family. This indicated to me that there might be a correlation between the spiritual process of the Dark Night and the process of dying itself. This in turn led to a phenomenological research enquiry: What is it like for a dying patient to experience a spiritual awakening?

My education of Palliative and Family Medicine Residents and other collaborations with medical/nursing colleagues helped me to realize that often aspects of the Night would present at end of life but that the lack of a theological base left colleagues unsure as to how to assess and appropriately manage spiritual issues such as "why is this happening to me?" and "I don't know why God let this happen!" In my consultation with primary health care nursing and medical practitioners, it became clear that the most beneficial research contribution would be a means of assisting interdisciplinary health care colleagues to a) identify (assess/diagnose) spiritual suffering and to b) identify appropriate spiritual postures and processes in care (management) of suffering.[16]

[16]MD Noush Mirhosseini, interview by author, telephone conversation, Edmonton, Alberta, 2006. "It would be really helpful...we hear [these things] in the community, [we] don't know what it means and don't know how to help."

RN Brenda Hooper, interview by author, telephone conversation, Edmonton, Alberta, 2006. "Yes, it would be helpful…would be a checklist format to be aware of what symptoms you are listening for—what it is and where it fits."

Dying as a Dark Night Experience, the first of several articles which comprise this project-dissertation, offers a scientific review of spiritual suffering within health care literature. It identifies a significant gap in knowledge: the need for an overarching construct for spiritual suffering that can accommodate variant conceptualizations and empirical findings. The purpose of this initial study is to introduce the theological construct of the Dark Night of the Soul as an integrated conceptualization of spiritual suffering and to demonstrate its application to the process of dying. It applies the theology of the Night to a tertiary palliative care setting through analysis of insights gained from the research project, augmenting these with clinical anecdotes.

Clinical presentation of the Dark Night can often be conflated with depression. Recent health care literature has responded to the need for differentiation with varying levels of comprehension of the Night. Moreover, a differential diagnosis has yet to be offered within palliative care, where the specific mandate is to identify, assess, and treat spiritual problems, and in which context depression itself poses a diagnostic challenge. Article two, *The Dark Night of the Soul and Depression in Palliative Care: A Differential Diagnosis*, seeks to address this diagnostic need. As the Night is essentially known by navigating it, this study is guided by my own personal and professional cultivation in the Dark Night within the palliative context. Study objectives were met by providing the reader with a means of assessing the dynamics of the Night within one's own life,[17] the provision of a Dark Night Lexicon, reviewing both the Dark Night and depression, and offering a systematic analysis of the differential offered by John of the Cross placed in dialogue with notable contributors to the field.

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[17]Clinician's Self-Assessment: Pritchard Palliative Spiritual Assessment Tool (PP-SAT): A Dark Night Model for Spiritual Assessment.

A Dark Night Contemplative Model for Spiritual Assessment in Palliative Care parts I, II, and III address the area of spiritual assessment in medical education. These form the core unique contributions of this dissertation, highlighting the writer's work of mediating the palliative need for accessible spiritual language and the theological need for integrity in the translation of the Dark Night spirituality. The need for spiritual assessment in palliative care is a clearly identified competency for palliative residents in their role as medical expert.[18] Program evaluations of spiritual care within the writer's study context of the Edmonton Zone Palliative Care Program identified a distinct gap in this area of medical education. In place of a formal literature review, these inter-related studies trace the grass roots development of a palliative spiritual assessment model in response to the expressed clinical and educational needs of the program. The study's methodology documents assessed need for spiritual care education for palliative and medicine residents, interdisciplinary wisdom in the development of an inclusive definition of spirituality, delineation of contemplative spiritual theology for end-of-life, translation of Dark Night theological constructs into clinically useful constructs, and application of a Dark Night Model for spiritual assessment to a composite palliative case study.

As I wondered how I might best care for those I served, I discovered that the transformations and integrations yielded through my own spiritual journey became the source of insight in spiritual care and counsel of patients as they lived through their dying. [19] I also came to see that adoption of the spiritual processes of the Night such as

[18]Objective 1.2.16 (medical expert), Palliative Medicine Residents and Clinical Fellows, one year Enhanced Program of Added Competence in Palliative Medicine Objectives, University of Alberta

[19]As poignantly depicted in the preaching of Timothy Radcliffe O.P, this process of contemplation and sharing the fruits of contemplation is central to Dominican life and ministry:

kenosis (detaching from agenda) and the theological virtues of faith, hope, and love all served as ways to spiritually engage contemplative spiritual phenomenon within the dying context, resulting in the affirmation that spiritual care cannot be divorced from the spiritual life of the practitioner.

This insight inspired the development of the article *The Contemplative Practitioner: A Dark Night Model for Spiritual Care of the Dying*. In palliative medicine, the role of medical expert requires the physician to perform an appropriate assessment of patients; a palliative context nuances the competency required for identifying and attending to spiritual issues commonly arising at end of life. The purpose of this particular study is to offer the medical practitioner a Dark Night contemplative model for spiritual assessment and care of the dying. The core features of the Dark Night offer the clinician both a means of assessing and navigating spiritual issues within end-of-life care. The paper develops spiritual care competencies for physicians though the domains of self-awareness and attitudinal postures and demonstrates core dimensions of contemplative spiritual care through a palliative case study application.

The hermeneutic phenomenology research project that grounded the articles sought to offer a possible interpretation of a dying patient's lived experience of spiritual awakening. [20]It was conducted within the writer's ministry context of tertiary palliative

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> For us to live the apostolic life fully is to find that we too are torn open, stretched out. To be a preacher is not just to tell people about God. It is to bear within our lives that distance between the life of God and that which is furthest away, alienated and hurt. We have a word of hope only if we glimpse from within the pain and despair of those to whom we preach. Timothy Radcliffe, "The Promise of Life "(25 February, Ash Wednesday, 1998). http://www.dominicans.ca/Documents/masters/Radcliffe/promise_life.html (accessed February 12, 2014).

[20]Zinia Pritchard, *The Contemplative Spiritual Journey of the Dying: A Retrospective Phenomenological Study* (Edmonton, AB.: Saint Stephen's College, 2010), 1-27.

care at Grey Nun's Community Hospital, Edmonton, Alberta. This clinical setting encompasses a particularly vulnerable patient population whose disease progression can preclude or limit research participation. The research participant Nancy,[21] herself a researcher, recruited the writer to interview her and record her spiritual journey; the recorded interviews that span a period of time (Nov 2000-Jan 2001) provided a rich and privileged data source and constitute Nancy's generous legacy to palliative care. The project, hitherto referred to as "Nancy's Story," invites us into the life world of a dying patient and offers a depth understanding of spiritual processes that may be engaged at end of life.

Nancy's journey evoked a number of directions in which the research question could have been formulated. The focus on spiritual awakening was chosen for a number of reasons: the first being that it encompasses within it the many facets and dynamics of spiritual-suffering-transformation. The second being the hope it may offer for any who are in the darkness of their own suffering. Thirdly, it places the emphasis very much on where Nancy wished it to be placed: the good news of Spiritual Presence in seeming absence. The mystical or contemplative nature of Nancy's spiritual experience warranted a research methodology that attended to both depth and pre-verbal lived experience. In light of this, Max van Manen's phenomenological method was considered an appropriate fit for the task at hand.

[21]The research participant is identified by her first name (no last name).

ETHICS

Participant Selection

The research participant recruited the researcher who was her attending chaplain at the time to interview her and record her spiritual journey. The patient-chaplain relationship was a strong and trusting one. The quality of this relationship and the following facts: a) the patient initiated this study; b) she freely chose to share what she needed to and nothing else; and c) that it was conducted in direct response to patient need served to mitigate questions of coercion, withdrawal, and financial compensation:

> Interviewer: What do you want to call this process that we're engaged in Nancy?
>
> Patient: It's about my spiritual journey, that's what the focus is. But at the same time it's iterative that we're not just going back, we not just going back and me retelling my story we're actually living the story at the time. It's sort of an ongoing spiritual journey. …I'm not regurgitating it to you. We are doing that. But I'm also going through the spiritual journey as I'm doing this, capturing it in context. So, it's like lived, like a lived spiritual account, I don't know…Put it down as my spiritual journey…'living my spiritual journey.' Nancy's spiritual journey.[22]

An ethics application for this research study was completed through the Human Research Ethics Review Process (HERO) for Health Panel (B) review; it was submitted December 4th 2009. As a retrospective study, the study review was expedited under Secondary Analysis of Data. Approval for the study was granted by HERO January 18th 2010 and Operational/Administrative Approval was received from Covenant Health, January 20th 2010. [23]

[22]Zinia Pritchard, Transcribed Interview: Tape 3 Side B, December 4th 2000.

[23]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 15.

Patient Consent

A small caveat needs to be noted: the normative channels for obtaining patient written consent for a research study had not been obtained as the recorded interviews were intended as part of Nancy's legacy. However, the patient had given verbal consent which had been audio recorded, transcribed, and submitted with the ethics application and signed a Grey Nuns Hospital Audio Visual consent form allowing the audio recordings of her journey as well as verbally granting consent on tape indicating that her audio recorded journey be available for teaching and publication purposes. The ethics board deemed this cogent evidence to indicate Nancy's clear desire for her story to be accessed.

Validity/Trustworthiness

As this was a retrospective study with only one patient who is now deceased the researcher was unable to submit for Nancy's review the completed writing of the phenomenon in order to hear her resonance/dissonance with how she has tried to capture it in words, (recognizing, of course, that this is not fully possible). This is a key limitation to the study. However, the methodology being employed does not seek to describe Nancy's experience per se but to see how her experience can point a finger toward the larger phenomenon that many patients go through. To that extent it is not as limited a study as the researcher's own spiritual care of patients in this process is also a well from which she has drawn inspiration.

The study had both strengths and weaknesses. Its significant strength lies in the richness of the data it offered—its thick description of spiritual suffering and its transformative elements within the process of dying. However, as a retrospective study, it suffers from a lack of phenomenological intent in the data gathering process. While the

actual phenomenon of spiritual awakening had the quality of a lived experiential description (that is a description *of* spiritual experience), the bulk of the interview data was rich in *reflection upon* the experience and so somewhat removed from the immediacy of the experience itself.

In phenomenological research there is no "finding" as such. Instead, the writing or phenomenological text is considered to be the finding in response to the research question: What is it like for a dying patient to experience a spiritual awakening? Embedded within the text of Nancy's Story the following dynamics of spiritual awakening may be identified: (1) Lamenting the impassable why; (2) Faith, Hope, and Love: the movement toward transcendence; (3) Experiencing Transcendence: An Unexpected Presence; and (4) Experiencing the Gift of Insight Given within Transcendence. The reader is invited to begin the review of this dissertation by first reading this foundational text (below).

Taken as a whole, these articles, and their grounding in Nancy's story empower palliative practitioners to spiritually assess and care for patients at end of life.

NANCY'S STORY[24]

What is a dying patient's lived experience of spiritual awakening?

Lamenting the Impassable Why

Nancy, a single, divorced woman of 42 years of age is dying. We enter her story in her hospital room in the middle of the night as she lies awake and pain ridden:

[24]Ibid., 18-26.

> No one can find another drug that will work for me. Why? Why would God close every single door when it works for someone else? It's like being trapped in a cage. That God you trust and believe in, allowing that to happen. I'm asking, 'can you get me out of this?' But you can't get out of it. How do you understand something like that? Surely you're not the only person in the entire world there's no option for, that all the most common options don't work for, why?

Bewildered, anguished and feeling trapped by her illness, Nancy finds herself struggling in the irresolvable dissonance between what she thought to be reality – her trust and belief that God would protect and keep her from harm – and what is apparently real – she is dying from cancer despite God's power and her prayers. God, it seems, will not save her. "Nothing makes sense. The mind, while full on one level of a lifetime of knowledge, is in total darkness on another, the level of meaning." [25]

Plunged in to the darkness of unknowing, her why becomes a demand of God for meaning; a plea for some *sense* in the face of unanswerability. Dwelling within the murky depths of this furious and vocal "why?" there still remains her hope for Love's response: "Where have you hidden, Beloved, Why have you wounded my soul? I went out calling to you, but you were gone." [26] Her soul's silent song of abandonment is lament; grieving the loss of connection with the One she loves: the God in whom Nancy finds her security and support had felt so present and now feels so absent. Nancy's heart breathes in broken breath the paradox of spiritual suffering for: "the loved one, the very focus of her desire, has become the cause of her agony." [27]

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[25]Constance Fitzgerald, "The Transformative Influence of Wisdom in John of the Cross," in *Women's Spirituality*, 2d ed., ed. Joann Wolski Conn (New York: Paulist Press, 1986), 445.

[26]SC. 1.1

[27]Fitzgerald, "The Transformative Influence of Wisdom," 446.

How often our own whys are not questions to be answered but rather our soul's grieving the loss of what is precious for us:

> "When you are sorrowful look…in your heart,
> and you shall see that in truth you are weeping
> for that which has been your delight."[28]

Our whys, like concentric circles, move from the outer rim of anger and the struggle to make meaning: Why would God allow this to happen? To the closer and deeper circles of abandonment: Why are You allowing this to happen me? And isolation: Where are you! Reaching to the whispered lament lying at our very core: Who am I (now)? Like Nancy, our whys to God testify to a deep down belief that in the seeming absence the Other is still there.

Nancy is awakening to the jarring reality that the God she imagined she knew *does* allow the unfairness of life's premature ending. That a good person, for no seeming reason, *can* be cut down in her prime. That, in fact, it is not the fate of some innocent person, out there in the world, but her fate. To be hollowed out so, her innards scooped out like pumpkin seeds, Nancy is emptied of those assumptions and beliefs[29] built on perceptions she had honestly believed were true.

"No one can find another drug that will work for me. Why? Surely, you're not the only person in the entire world there's no option for, that all the most common options don't work for, why?" Nancy's anguish with inadequate pain control becomes a megaphone for her deeper struggle of coming to terms with her mortality. Like a

[28]Kahil Gibran, "On Joy and Sorrow," in *The Prophet* (New York: Alfred A. Knopf, 1923), 29.

[29]Thomas Attig, *How we Grieve: Relearning the World* (Oxford University Press, 2011), 107.

hologram in its part, it contains the greater whole[30] that is the drama of her dying journey: no matter how hard she strives to manage and control her outcome, she remains stuck, unable to "get out of it." With no seeming way out of her predicament, "trapped in a cage," Nancy tastes the fear of defeat. From the inside out, she feels the very real and finite walls of her physical existence. Nancy is facing her death.

Faith, Hope and Love: Moving Toward Transcendence.

> "It doesn't make sense. I keep coming back to that 'Why?" ... What's so strange, [about it is] I have to trust it…give myself to it…. [Death] is that total surrender…I can't push it away or run from it. I have to go through it. [In my prayer] I gave my soul over to God and said, 'You're will be done' and God's presence was with me then"

In the darkness of night, alone in her room, Nancy cries out: "Please God, I need you, to hug me and hold me! In the deep vulnerability of her meaninglessness, "stuckness" and utter helplessness, Nancy's hold on what she has known of her personal reality teeters on the edge of a cliff and finally relinquishes its grasp, abandoning herself to the Other, "Please God, I need you to hug me and hold me!"

How many of us have also felt the under tow of panic pull out of us an instinctual cry to the beyond: "Help!" "Please God!" In such moments, when the words have sprung out of our hearts and leapt from our lips, before we have had a chance to ponder if we even know who or what we are calling upon, before we remind ourselves of our agnosticism or atheism, or our particular images of God, the moment before we rationalize, "don't be ridiculous!" we have submitted to that which is greater than ourselves.

[30]Diarmuid Ó Murchú, *Quantum Theology* (New York: Crossroad Pub., 1997), 55.

We meet Nancy in the immediacy of her now moment: the moment of surrender. Stripped of the comfort of knowing, "It doesn't make sense. I keep coming back to that 'Why?" her heart's need for Love surfaces as emotional wisdom. Leaving behind her desire for meaning, Nancy awakens to a deeper desire: the need to *be known,* to be loved. In God's seeming absence, in his unknownnness to her, the light of her love for Him seeks him out.[31] Nancy slackens her grasp on rationalizing, that sharpened point of isolation and chooses, instead, to *move now toward her beloved,* "I can't push it away or run from it. I have to go through it." And offers up to him the gift of her whole being; "What's so strange, [about it is] I have to trust it. Give myself to it;" keeping nothing back, "dying is that total surrender." This movement into the "Mystery which is unimaginable, incomprehensible and uncontrollable," is Faith; the step taken by countless others into the Unknown.[32]

Nancy's abandonment to her Beloved goes beyond her need to understand Him, beyond the need to hold onto what is remaining of the knowns in her life. It is fuelled by love's desire to taste once more the sweetness of Divine Presence. This yearning that the Other may grant her what only he can give—the gift of himself is a "free, trustful commitment to the impossible, which cannot be built out of what she possesses." [33]It is the quality of hope.

Nancy's surrender, flows from her active free will: "I gave my soul over to Him and said, 'You're will be done.'" Unencumbered by her once childlike expectation that the Other would simply comply with her requests, her submission has the character of

[31]DN.2.4.1.

[32]Fitzgerald, "The Transformative Influence of Wisdom," 446.

[33]Ibid., 447.

unconditional love, preventing her from forcing the loved one into the constraints of her needs and taking the beloved as he is."[34]

Nancy's surrender, so described, is a dying to self-reliance and self-determination; beliefs that may have once steered her life but that are now wholly inadequate to navigate the Unknown. In the waters of uncertainty how many of us have also been confronted with the limits of such guiding assumptions: contrary to what our parents may have told us or what society may reinforce: life is *not* always what you make it, it is *not* always all up to you, and hard work and determination do *not* necessarily make us masters of our own destiny. With the light of this self-knowledge, in such depth places, we also can awaken to our woeful incapacity to meet our own needs. In her surrender, *both* emptied out of her prior convictions *and* choosing to detach from what had once been the secure moorings of her inner reality,[35] Nancy opens herself wide, readied to be filled, like the small rounded mouth of a baby at its mother's breast.

Experiencing Transcendence: An Unexpected Presence

> Suddenly, I feel an unexpected physical presence. An incredible calm takes over my whole body. I am with God. Incredible! Beautiful! Finding His voice, finding His presence in my bedroom and feeling it there and knowing that something magical has happened. I am with God – I haven't died yet but I'm with God! Cradled like this in His arms – I calm right down. All my fear is gone.

Suddenly, Nancy is awakened to the Fact[36] she is not alone! In this one, "magical" moment, the delusion of Nancy's isolation is dissolved and the deep hallowed out depths

[34]Ibid.

[35]Ibid.: "Then hope, forfeiting the struggle to press meaning out of loss, becomes a free, trustful commitment to the impossible, which cannot be built out of what one possess."

[36]Evelyn Underhill, *Practical Mysticism* (New York: E.P. Dutton & company, 1915).

of her inner void filled: Her thirst for the Beloved's presence is satisfied, "I feel an unexpected physical presence. Finding His voice, finding His presence in my bedroom and feeling it there." Her hunger for union with the Beloved is satisfied, "I haven't died yet but I'm with God! Cradled like this in His arms." Held in the protective darkness of the Divine womb Nancy is nurtured by Love's inflow[37] and lulled by it she "calms right down." How wonderfully she is met in her deepest need; Love's choosing to suffer-with-her: "I said to the surgeon, 'I feel like Christ being strapped to a cross, it's like being crucified.' And he said to me, 'He's with you and so are we.'" Nancy's thirst for wisdom is satisfied, that knowledge given through Love, tending to the deeper question of Who am I? "I am with God."

Her view is no longer obscured by the tapestry of perceptions she had thought to be Reality.[38] Now seeing "only what is there and nothing else," [39]her old assumptive world gives way to a new vision: Reality as it *really* is.

The curtains of Nancy's imagined reality now pulled apart, the windows of her mind behold, with startling clarity, the unveiled panoramic of what truly *is*: "Incredible! Beautiful!" She is fully awakened to the grandeur that charges life.[40] Time and space suspended, the dualism of *now* and *then*, *here* and *there* are collapsed into the paradox of the present moment, "I haven't died yet – but I am with God!"

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[37]DN.2.5.1

[38]Underhill, *Practical Mysticism*, 36.

[39]Anthony de Mello, *One Minute Wisdom* (New York: DoubleDay, 1985), 8.

[40]Gerard Manley Hopkins, "God's Grandeur," in *Gerard Manley Hopkins:Selection of his Poems*, ed. W.H. Gardner, The Penguin Poets (Middlesex, England: Penguin Books, 1963), 27

Experiencing the Gift of Insight Given within Transcendence

> [It] defined who I was *right then*, that I knew I was a spiritual being and all was well... The first time I realized that I still had ownership of the spiritual me…Such an awakening for me! I haven't been robbed of – I haven't lost me… The Spiritual Nancy!"

Within Nancy's union with her Beloved was the gift of Divine wisdom, "It defined who I was right then." This immediate apprehension both of Love and Love's meaning bequeathed to her marvellous good news: the knowledge of her true self as rooted in the Beloved, "I was a spiritual being." It was the self that she could never lose, "I haven't lost me" As an echo of the Divine, the "Spiritual Nancy" was also without end, and so "all was well."

To awaken is to have been asleep just moments before. Being spiritually awakened suggests a recognition of what has always been present albeit obscured from our vision. Being spiritually awakened is a surprising event, "suddenly I feel an unexpected physical presence" that saturates our body senses,[41] "an incredible calm takes over my whole body." It has an ''unbearably bedazzling" quality that "lands on us" [42]and evokes exclamation rather than impossible attempts at exhaustive descriptions, "Incredible!" "Beautiful!" "Magical!"[43] "[T]his awakening …is a movement of [Love] within the soul, containing such grandeur that all the powers …of heaven are moved and all the …graces of every created thing glow and make the same movement all at once."[44]

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[41]Jean-Luc Marion, *Being Given: Toward a Phenomenology of Givenness*. Trans. Jeffrey L. Kosky (Standford University Press: California, 2002), 229-298.

[42]Ibid.

[43]Ibid.

[44]John of the Cross, *The Living Flame of Love.* In *The Collected Works of St. John of the Cross,* rev.ed. trans. Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), Stanza 4 no.4.

Nancy experiences the spiritual awakening as a wonder of Divine givenness. The meaning of this union with Love as a revelation of her own eternal, undying essence is a *knowledge through love,* the gift of contemplation, "cradled like this in His arms – I calm right down." This knowledge has the character of revelation for its very givenness is an act of disclosure -- something secret, hidden from our sight has shown itself, made itself known to us, "The first time I realized that I still had ownership of the spiritual me."

Such enlightenment is not a knowledge that has been culled through thoughtful reflection or a simple intuition. It is not the result of Nancy's own creation. It simply dawns upon her, as the day dawns after the night.[45]Lifting the veil that has obscured her vision allows her the ability to recognize the gift of Love's Presence and her soul as Love's echo.

This knowledge through Love is the gift of clarifying wisdom, shelling former images, "God is a parent that protects and keeps you from harm" and heralding Love's true nature, One who suffers-with her, "I know He's there. He knows what I am suffering. I know He lives with me." Nancy's awakening changes her relationship with the Beloved, her authentic self emerges. No longer confined within the straightjacket of her need for Love to be for her what she needs Love to be, she is liberated to relate authentically:

> [I have discovered] that He loves me unconditionally...I can call him every dirty name…He can take it and He wants me to do that. He wants me to be honest with Him because He wants me to love Him, because it's coming from deep down inside. He doesn't want me to come to Him, because it's what I'm *supposed* to do; 'I have to be good so that I can go to heaven.' And that's the child-like belief I grew up with, and I've come to re-define [it] as an adult.

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[45]Francis Nemeck and Marie Coombs, *The Way of Spiritual Direction* (Wilmington, Delaware: Glazier, 1985), 93: "Discernment flows out of God's loving interchange with us and subtly impresses itself upon our consciousness. It is like opening our eyes, and there it is."

The energy Nancy once consumed in bargaining, "I can do more good for you here. The things that people tell me they're learning by my going through this. Why wouldn't [you] use me that way?" the feverish anxiety of her prayer, "I was consumed by it…I was using it as a crutch…24 hours a day," have now given way to the peace of simply *being*:

> I'm not praying as much as I used to. Actually, I'm not saying the words. …But in my living …I am …In my silence, I am speaking to him. No, I'm just being with God – I am in His presence….I have noticed that the silences are more frequent and more comfortable for me. I am at peace. [It's] surreal; you know you're being heard but you're not saying anything…he's in your body …and in the silence. It's about trust. You just trust that what you need is being heard and has been answered."

In being spiritually awakened Nancy is gifted by Love's showing, "you're so at peace with yourself " and called to witness to that which has been given, [46]"in reality, He would rather people believe that He exists because of my death: that I went to Him with a total faith and a peacefulness in knowing He's there."

May Nancy's echo accompany us and become the hope for our own journeys into lament, suffering and the search for Love's presence in the darkness of our unknowing.

[46]Marion, *Being Given*, 298.

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CHAPTER 1

DYING AS A DARK NIGHT EXPERIENCE

Introduction

The identification, assessment and treatment of spiritual suffering are integral to palliative care.[47] Spiritual and or religious issues can impact patients' pain and symptom expression, [48] [49] ability to cope with their illness [50] and quality of life.[51] [52] [53] The spiritual suffering discourse within the health sciences offers a variety of related concepts and terms for spiritual suffering: suffering,[54] [55]spiritual distress,[56] psycho-spiritual distress,

[47]World Health Organization, "Definition of Palliative Care" (n.d.), http://www.who.int/cancer/palliative/definition/en/ (accessed September, 2008).

[48]Kelly McConnell et al., "Examining the Links between Spiritual Struggles and Symptoms of Psychopathology in a National Sample," *Journal of Clinical Psychology* 62 (2006): 1469-84.

[49]Judith Hills et al., "Spirituality and Distress in Palliative Care Consultation," *Journal of Palliative Medicine* 8 (2005): 782-788.

[50]Kenneth Pargament, Harold Koenig, and Lisa Perez, "The Many Methods of Religious Coping: Development and Initial Validation of the RCOPE," *Journal of Clinical Psychology* 56 (2000): 519-43.

[51]Hills et al., "Spirituality and Distress in Palliative Care Consultation," 782-788.

[52]Kenneth Pargament et al., "Religious Struggle as a Predictor of Mortality Among Medically Ill Elderly Patients: A 2-Year Longitudinal Study," *Archives Of Internal Medicine* 161 (2001): 1881-1888.

[53]Kenneth Pargament et al., "Patterns of Positive and Negative Religious Coping with Major Life Stressors," *Journal for the Scientific Study of Religion* 37 (1998): 710-724.

[54]Eric Cassel, "The Nature of Suffering and the Goals of Medicine," *The New England Journal of Medicine.* 306 (1982): 639-45.

[55]Betty Ferrell and Nessa Coyle, "The Nature of Suffering and the Goals of Nursing," *Oncology Nursing Forum* 35 (2008): 241-247.

[56]North American Nursing Diagnosis Association (NANDA) International, *Nursing Diagnoses: Definitions & Classification 2012-2014* ed. T. Heather Herdman **(**Chichester, UK: Wiley-Blackwell, 2012), 410-411.

psycho-existential distress, spiritual pain,[57] [58]spiritual crisis,[59] spiritual struggle,[60] [61] negative religious coping,[62] and religious or spiritual problems.[63]

Empirical studies into spiritual suffering have yielded significant results. A study by Pargament and Ano demonstrated that religion can be both a source of distress as well as support for patients.[64] Religious distress identified as "spiritual struggle" operated within three relational domains: the intrapsychic domain engaged personal doubt regarding faith and values, the interpersonal domain pointed to strained relationships with one's religious community, and the transpersonal domain related to questions of the Divine.

The development and validation of the Religious Coping Scale (RCOPE) by Pargament et al. provided a theoretically based measure that was able to assess types of religious thought, feeling, behaviour and relationships used in coping. Two categories of

[57]Pam McGrath, "Creating a Language for 'spiritual Pain' through Research: a Beginning," *Supportive Care in Cancer: Official Journal of the Multinational Association of Supportive Care in Cancer* 10 (2002): 637-46.

[58]Caterina Mako, Kathleen Galek, and Shannon Poppito, "Spiritual Pain Among Patients with Advanced Cancer in Palliative Care," *Journal of Palliative Medicine* 9 (2006): 1106-1113.

[59]Laurie Agrimson and Lois Taft, "Spiritual Crisis: a Concept Analysis," *Journal of Advanced Nursing* 65 (2009): 454-461.

[60]Kenneth Pargament et al., "Spiritual struggle: A phenomenon of interest to psychology and religion," in *Judeo-Christian perspectives on* psychology, eds. W. Miller and H. Delaney (Washington, DC: American Psychological Association, 2005), 245–268.

[61]George Fitchett et al., "Religious Struggle: Prevalence, Correlates and Mental Health Risks in Diabetic, Congestive Heart Failure, and Oncology Patients," *International Journal of Psychiatry in Medicine* 34 (2004): 179-96.

[62]Pargament, "Religious Coping," 519-43.

[63]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* 4th ed. Text Revision (Washington, DC.: American Psychiatric Association, 2000), 741.

[64]Kenneth Pargament and Gene Ano, "Spiritual Resources and Struggles in Coping with Medical Illness," *Southern Medical Journal* 99 (2006): 1161-1162.

religious coping emerged identified as positive and negative.[65] The Brief RCOPE, a 14-item measure of positive and negative patterns of religious coping methods, determined that religious people, in a variety of populations, use a combination of both negative and positive religious coping methods in response to major life stressors. [66]

Hill et al. applied the Brief RCOPE within the palliative setting. Study outcomes identified that "negative religious coping" related to other scientific measures of distress: to the degree a patient may have negative religious coping (i.e. stating punishment or abandonment by God), he/she will also have symptoms of distress, confusion and depression; the more a patient may, for example, feel abandoned, the worse his/her physical and emotional well-being and quality of life will be. [67]

Mako et al. studied spiritual pain among patients with advanced cancer in palliative care. Of particular significance is the use of language in this study; "spiritual pain" was not limited to religious language but described to research participants as "a deep pain in your being that is not physical" subsequently eliciting participant descriptions of spiritual pain. Research findings identified spiritual pain as "emotional distress" that resulted from "rupture in relationship" across the intrapsychic and interpersonal domains and in relationship with the divine. Although these domains had been noted by Pargament in his study of religious coping, Mako et al. have captured how spiritual pain may present in ways not explicitly related to the divine. For example, the interpersonal domain acknowledges significant losses such as "leaving family and home" and the intrapsychic

[65]Pargament, Koenig, and Perez, "Religious Coping," 519-43.

[66]Kenneth Pargament, et al., "Patterns of Positive and Negative Religious Coping with Major Life Stressors," *Journal for the Scientific Study of Religion* 37 (1998): 720.

[67]Hills et al., "Spirituality and Distress," 782-788.

domain captures the loss of self, in particular, the physical loss of the self. Also noteworthy is the widened use of language in reference to the transpersonal domain: "the transcendent, God, Higher Power/Life/Nature." [68]

A further significant dimension of spiritual suffering has been the identification of growth or transformation: the Brief RCOPE revealed that in each of the study samples was a small but significant relationship between stress-related growth and negative religious coping.[69] Transcendence through suffering is also noted in Cassel's work [70] and identified as "regression in the service of transcendence" in the research agenda for DSM-V.[71]

What is missing from scientific study is an overarching construct that can accommodate the variant conceptualizations and empirical findings for spiritual suffering. The purpose of this study is to introduce the theological construct of the Dark Night of the Soul as an integrated conceptualization of spiritual suffering and to demonstrate its application to a tertiary palliative care setting within Western Canada. This will be conducted by analysis of insights gained through a research study of a tertiary palliative care patient self-identified as Nancy and her journey of spiritual awakening[72] augmented by clinical anecdotes. The peculiar applicability of the Dark

[68]Mako, "Spiritual Pain," 1106-1113.

[69]Pargament et al., "Patterns of Positive and Negative Religious Coping," 710-724.

[70]Cassel, "Suffering and the Goals of Medicine," 639-45.

[71]David Lukoff, Francis Lu, and C.Paul Yang, "DSM-IV Religious and Spiritual Problems," in *Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V*, ed. John Peteet, Francis Lu, and William Narrow (Arlington, Va: American Psychiatric Association, 2011), 171-198.

[72] Tertiary Palliative Care Program, Covenant Health - Grey Nuns Hospital, Edmonton, AB Canada.

Night to the palliative care context offers the perspective that dying may be perceived as a Dark Night experience.

Acknowledgment

The author respectfully acknowledges that although belief in a transpersonal dimension is shared by many, it is by no means universally accepted by those within palliative care. Additionally, the naming of transcendence widely differs within the field. However, it is noteworthy that in spite of these differences palliative scholars such as Pam McGrath still identify with the notion of spiritual pain regardless of a trans-personal realm.[73] What this study hopes to provide is an informed means by which a clinician may offer a patient-centered assessment of spiritual suffering. Ultimately, personal belief may or may not affect the credibility one assigns the Dark Night of the Soul.

Background to the Night

The Dark Night of the Soul (referenced more accurately as "Dark Night" and also referred to by the abbreviation "the Night") is a mystical or contemplative form of spirituality.[74] It presents across major world wisdom traditions in both theistic and non-theistic form. The Dark Night is a metaphor for the spiritual journey: [75] a phrase originally coined by the priest-monk John of the Cross. It is succinctly described by Carmelite theologian Constance Fitzgerald:

[73]McGrath, "Creating a Language for Spiritual Pain," 637-46.

[74]Dan Blazer, "Spirituality in Depression," in Peteet, *Religious and Spiritual Issues in Psychiatric Diagnosis*, 4.

[75]A.1.2.1.

> Night in John of the Cross, which symbolically moves from twilight to midnight to dawn, is the progressive purification and transformation of the human person *through* what we cherish or desire and through what give us security and support. We are affected by darkness, therefore, where we are mostly deeply involved and committed, and in what we love and care for most. Love makes us vulnerable, and it is love itself and its development that precipitate darkness in oneself and in the "other." [76]

The Dark Night has been identified within a number of contexts: midlife,[77] religious life,[78] societal impasses[79] and organizational leadership. The process of transformative-suffering that is characteristic of the Night may also be found in ancient mythology such as Homer's Odyssey,[80] the analytical psychology of Jungian individuation,[81] transpersonal psychology,[82] chaos or change theory, [83] and quantum theology.[84] The prevalence of the Night is not new; what is new is our awakening to it in this age.

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[76]Constance Fitzgerald, "Impasse and the Dark Night in John of the Cross," in *Women's Spirituality Resources for Christian Development*, 2d ed., ed. Joann Wolski Conn (Mahwah N.J: Paulist,1996), 414-415.

[77]Joyce Rupp, *Dear Heart, Come Home: The Path of Midlife Spirituality* (New York: Crossroad, 1996).

[78]Sandra Marie Schneiders, *Finding the Treasure: Locating Catholic Religious Life in a New Ecclesial and Cultural Context* (New York: Paulist Press, 2000), 153-209.

[79]Fitzgerald, "Impasse and the Dark Night," 422-425.

[80]Homer, *The Odyssey*, trans. Robert Fagles (New York: Viking, 1996).

[81]Julie Patton, "Jungian spirituality: A developmental context for late-life growth," *American Journal of Hospice & Palliative Medicine* 23 (2006): 304-308.

[82]Elizabeth Smith, "Addressing the Psychospiritual Distress of Death as Reality: A Transpersonal Approach," *Social Work* 40 (2005): 402.

[83]Daryl Conner, *Leading at the Edge of Chaos: How to Create the Nimble Organization* (New York: John Wiley, 1998).

[84]Diarmuid Ó Murchú, *Quantum Theology* (New York: Crossroad, 1997).

Mystical Reality

The Night as a mystical Reality may not be appropriately perceived of as a distinct component or domain of the human person. It has a more pervasive quality, manifesting within the intra-personal, inter-personal and transpersonal dimensions of being. It may be better imagined as lymphatic tissue. In the lived experience of the Night and in writing and reading about it one encounters seeming repetition as one "strand" of the Night appears to touch on, overlap or present within another strand. This points to its mystical nature, where like the hologram the Night's wholeness is present in each of its parts. [85]

The Problem of Language

It is noteworthy that two significant studies on the Night within the field of mental health have alluded to it through various expressions: "spiritual distress," "existential issue," "psychological suffering," [86] and "emotional distress."[87] All the words aptly apply to the Night and reflect the very nature of mystical spirituality as elusive and beyond the grasp of concepts:

> Said a traveler to one of the disciples, "I have traveled a great distance to listen to the Master, but I find his words quite ordinary." "Don't listen to his words. Listen to his message." "How does one do that?" "Take hold of a sentence that he says. Shake it well 'till all the words drop off. What is left will set your heart on fire." [88]

[85]Ibid.

[86]Glòria Durà-Vilà and Simon Dein, "The Dark Night of the Soul: Spiritual Distress and Its Psychiatric Implications," *Mental Health, Religion and Culture* 12 (2009): 543-559.

[87]Glòria Dura-Vila et al., "The Dark Night of the Soul: Causes and Resolution of Emotional Distress Among Contemplative Nuns," *Transcultural Psychiatry* 47 (2010): 548-570.

[88]Anthony deMello, *One Minute Wisdom* (New York: Doubleday, 1986), 125.

A shared lexicon for spirituality is absent in healthcare discourse largely due to variant perceptions of both spirituality and religion and the relationship between the two. A number of authors posit that religion and spirituality are synonymous[89] though most view them as distinct entities. The defining characteristic of spirituality is posited by some to be the relationship with God/Higher Other [90] and by others to be the existential.[91] Conversely, there are those who consider spirituality to exclude the existential[92] or to include both the existential and religious.[93] Rather than perceiving this as a lack of coherence, mystical spirituality offers the insight that there is no one way to adequately express the spiritual. The mystic masters invite us, instead, to listen for the meaning conveyed through language. This invitation is extended to the reader as the Dark Night is introduced through the language and lens of a 16th century mystic, John of the Cross.

The Story of John of the Cross

John of the Cross, baptized John de Yepes y Alvarez, was born in the Spanish town of Fontivoros in 1542. As a young boy he suffered the loss of his father Gonzalo de

[89]Harold Koenig, *Spirituality in Patient Care: Why, How, When, and What* (Philadelphia: Templeton, 2002), 40.

[90]David L. Coulter, review of "Scientific Research on Spirituality and Health: A Consensus Report," ed. by David B. Larson, J. P. Swyers, and M. E. McCullough, *Journal of Religion Disability and Health* no.3 (1999): 79-82.

[91]Robert Buckman, *Without God a humanist's personal story* (Carson City, NV.: Filmwest Associates, 2004), DVD.

[92]Koenig, *Spirituality in Patient Care*. Not that the author identifies "meaning and purpose, cultural beliefs and social supports" as alternatives *to* rather than dimensions *of* spiritual expression, 45-46.

[93]Christina Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Health Care* (West Conshohocken, PA: Templeton, 2010), 24.

Yepes following a gruelling two year illness.[94] His widowed mother Catalina Alvarez struggled to make ends meet with three children to care for. Against this backdrop of abject poverty and grief we meet the adolescent who discovered meaning in his compassionate care for the dying at the Hospital de la Concepción.

John's deep love for God eventually led him to join the Carmelite Order of Castile, a religious order of monks. Over time, he began to realize that his single minded commitment to spirituality could not be facilitated within the environment of his religious order. However, John's struggle was also a commentary on the spiritual state of the Carmelite Order whose institutional dimensions had become an impediment to fostering the spiritual life.[95]

Before John was able to leave the Carmelites for the more conducive spiritual environment of the Carthusians he met Teresa of Avila who convinced him to join forces with her in the reform of the Carmelite Order. John was to establish new friars' communities adopting the "Teresian life," a spirituality that was devoted to recollection or contemplation.[96] These reformists, known as the "Discalced Carmelites," implemented significant changes that better fostered the development of the spiritual life. [97] Such actions, however, challenged the existing superiors of the "Carmelites of the observance" who perceived the discalced group to be in flagrant disregard of their authority.

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[94]Robert Herrera, *Silent Music: The Life, Work, and Thought of St. John of the Cross* (Grand Rapids, Mich: Eerdmans, 2004), 35.

[95]John of the Cross, *Dark Night of the* Soul, trans. with an introduction by Mirabai Starr (New York, NY: Riverhead Books, 2002), 4.

[96]John of the Cross, *John of the Cross: Selected Writings,* Classics of Western Spirituality ed., trans., with an introduction by Kieran Kavanaugh (New York: Paulist Press, 1987), 10.

[97]Ibid

Conversely, the power of the reform lay in its spiritual integrity and many were drawn to join it much to the chagrin of the Carmelite authorities.[98]

John's holiness was evident as was his ensuing success as a spiritual director at the discalced convent in Avila. Unfortunately, his ministry position rightfully belonged to the jurisdiction of the Carmelites of the observance who resented his incumbency. [99] As soon as an opportunity presented itself, they captured John, interrogated and tortured him in a concentrated effort to force him to denounce the reform. Arraj offers an insightful psychological assessment as to the why of John's capture:

> Not only was St. John intimately associated with the beginning of the Reform movement…but St. John's personality itself provoked them. He had a reputation from his earliest day in the order for austerity and perfection of life. At the same time, he possessed none of the extraverted masculinity that would have made him popular in the communities he lived in. He was the antithesis for any desire for authority and power, while he was maddeningly self-directed and motivated.... All these factors combined to make him the ideal victim of their projections.[100]

John's refusal to renounce the reform was a punishable crime. It resulted in his nine month confinement in the monastery prison: a tiny dark closet with a toilet and a high slit in the wall.[101] He suffered poor sanitation, infestation, poor diet, and acute diarrhea. His only contact with others was to be dealt physical, psychological, and spiritual abuse from the very people whom he had once known as brothers. This period of acute deprivation precipitated in John an all-pervading experience of personal disintegration:

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[98]Jim Arraj, *St. John of the Cross and Dr. C.G. Jung: Christian Mysticism in the Light of Jungian Psychology* (Chiloquin, OR: Tools for Inner Growth, 1986), 114.

[99]John of the Cross, *John of the Cross: Selected Writings*, Classics of Western Spirituality ed., trans., with an introduction by Kieran Kavanaugh (New York: Paulist Press, 1987), 18.

[100]Arraj, *St. John of the Cross and Dr. C.G. Jung*, 116.

[101]Starr, *Dark Night*, 5.

> cramped in darkness, utterly alone, loss of freedom and contact, [where] human desire [was] jammed: nothing would be satisfied by anybody or anything...an absence of an avenue of recourse...total abandonment, hopelessness and fear of certain death. The words used by John are "hopelessness," "abandonment," and "rejection." The monastery prison was a space of radical human isolation and deprivation.[102]

Paradoxically, John's experience of profound limitation, powerlessness and confrontation with mortality became a pathway to spiritual integration, transformation and transcendent union. His poem "The Dark Night" is written from this perspective, the pinnacle of the spiritual life:

> 1. One dark night,
> fired with love's urgent longings
> - ah, the sheer grace! -
> I went out unseen,
> my house being now all stilled.
> . . . . . .
>
> 3. On that glad night
> in secret, for no one saw me,
> nor did I look at anything
> with no other light or guide
> than the one that burned in my heart.
>
> 4. This guided me
> more surely than the light of noon
> to where he was awaiting me
> - him I knew so well -
> there in a place where no one appeared.
>
> 5. O guiding night!
> O night more lovely than the dawn!
> O night that has united
> the Lover with his beloved,
> transforming the beloved in her Lover.[103]

[102]Constance Fitzgerald, *The Meaning and Recognition of the Dark Night Experience*, lecture by Constance Fitzgerald, Alba House Cassettes (audiocassette), 1991.

[103]John of the Cross, *The Dark Night of the Soul* in *The Collected Works of St. John of the Cross*, rev.ed. Translated by Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), Stanza 1-8.

John's poem, void of creedal language, traces the heart's ardent quest for fulfillment of "the more" that is Divine Love. Resonance with John's meaning is heard at the level of holy longing,[104] the "ground of the soul."[105]

The Soul

Soulful questions are native to the contemplative landscape of palliative care:[106] "who am I?" "what is my meaning?" "how can I leave?" The depth and ultimate nature of such questions reflect the essence of soul as *who* one "most deeply is": [107]a spiritual entity. The soul's gravitational pull is toward that which fulfills and makes one whole: a yearning for connection, communion and the desire to be intimately known. The soul, like the ocean, is deep and vast and full of mystery. The spiritual work of the Dark Night is conducted at the level of soul.

Origin and Purpose of the Dark Night

The Night is initiated by transcendence [108] and has a clear purpose: to purge the self from anything that is contrary to what is whole/holy.[109] Integration is fostered through

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[104]Ronald Rolheiser, *The Holy Longing: The Search for a Christian Spirituality* (New York: Doubleday, 1999).

[105]Meister Eckhart, *Meister Eckhart, Teacher and Preacher*, ed. Bernard McGinn, Frank Tobin, and Elvira Borgstadt, trans. Bernard McGinn and Frank Tobin (New York: Paulist Press, 1986).

[106]Christina Puchalski, *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying* (New York: Oxford University Press, 2006), 49.

[107]Gerald May, *The Dark Night of the Soul: A Psychiatrist Explores the Connection between Darkness and Spiritual Growth* (San Francisco: HarperCollins, 2005), 42.

[108]DN.1.9.2

[109]Ibid.

disintegration of the false aspects of the self [110] that widens the soul's capacity [111] for the in-pouring of spirit known as contemplation.[112] While John of the Cross' main focus is the intra-personal/transpersonal dimensions, specifically the experience of God in prayer, Dark Night scholars contend that the experience of the Night relates along inter-personal and social life trajectories.[113] [114] The application of the Dark Night within the palliative context is made with reference to this wider sense of the Dark Night as a metaphor for the entire spiritual journey. [115]

An "Anatomy" and "Physiology" of the Spiritual Life

The Dark Night offers an anatomy and physiology of spiritually transformative suffering. The word 'purgation' in the Night refers to the experience of suffering and the spiritual means of transformation is referred by the word "purification." John of the Cross names three phases of the Dark Night: the Night of Sense [116] which serves as a gateway [117] to the Night of Spirit (also called the Night of Faith)[118] and the Transition phase between the nights in which transpersonal experiences can occur. John describes the

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[110]Schneiders, *Finding the Treasure,* 153-209.

[111]DN.1.9.8

[112]DN.2.5.1

[113]Fitzgerald, "Impasse and Dark Night," 416.

[114]Schneiders, *Finding the Treasure,* 153-209.

[115]A.1.2.1

[116]DN.9.2-8; A.1.13.2-4.

[117]DN.2.2.1.

[118]DN.2.21.11-12; A. 2.6.6.

intensity of the purification process between the night of sense and spirit as "the difference between pulling up roots or cutting off a branch, rubbing out a fresh stain or an old, deeply embedded one." [119] All phases of the Night are inter-related: the process of deconstruction and integration occurring within one dimension may be more deeply at work within another.[120] Each phase has a "passive" and "active" dimension that operate in concert. Simply put, the passive dimension refers to transcendent agency and the active dimension refers to what feels like one's own effort. [121]

Dark Night of Sense: The purpose of the Dark Night of Sense is to transform motivation. This is accomplished through an intentional deprivation of the pleasure principal as a motivation for relating. The principal suffering in the Night of Sense is that of dryness/emptiness, also a sense of abandonment, loss of spiritual blessing, and a "growing suspicion that [one] has lost [one's] way." [122] John provides 3 simultaneous sets of signs for the discernment of the Dark Night of Senses (Table 1 below). All signs need to be present if one is to be properly assessed to be undergoing the purification of the Night as opposed to the experience of an illness, lukewarm attitude, or depression. [123]

[119]DN.2.2.1.

[120]Schneiders, *Finding the Treasure*, 160.

[121]May, *Dark Night of the Soul*, paraphrased 77.

[122]DN.1.10.1

[123]A.2.13.5.

TABLE: THREE SIGNS OF THE DARK NIGHT OF THE SENSES

Passive Dimension (P)[124] and Active Dimension (A)[125]
1st Set of Signs • P1: Lack of satisfaction and consolation in all dimensions of life.[126] • P2: Dryness and distaste/lack of appetite for one's usual spiritual, creative or re-creative practices[127] • A1: Realization that one cannot meditate, imagine or take pleasure from one's usual spiritual, creative or re-creative practices. [128] *2nd Set of Signs* • P3: Guilt and solicitous concern that one is not serving God/living a spiritual life: a sense that one is "off track" because of an awareness of distaste for spiritual things[129] • P4: Dissatisfaction with things in general and yet concerned about God/spiritual life[130] • A3: Realization that one lacks the desire to meditate on anything.[131] *3rd Set of Signs* • P5: Powerlessness due to fruitless endeavour to meditate or imagine. [132] • A1: Pleasure in solitude [133] • A4: Waiting with loving attentiveness upon the Other without meditation, thinking, doing, without particular understanding, simply at rest with inward peace.[134]

[124]DN.1.9.2-8

[125]A.2.13:2-4

[126]DN.1.9.2.

[127]DN.1.9.4.

[128]A.2.13.2

[129]DN.1.9.3

[130]Ibid.

[131]A.2.13.3

[132]DN.1.9.8

[133]A.2.13.4

[134]Ibd.

The outcome of this purification of the senses is that an individual will engage self, others and transcendence without the need for satisfaction as a driving force. There is also a distinct shift in spiritual practice: one grows quiet and passively receives contemplation, the self- communication of the life of the spirit. [135] This is what John means by contemplation and it serves to both bring about the purification of motivation and spiritual union:[136]

> I'm not praying as much as I used to. Actually, I'm not saying the words. …But in my living …I am …In my silence, I am speaking to him. No, I'm just being with God – I am in His presence….I have noticed that the silences are more frequent and more comfortable for me. I am at peace. [It's] surreal; you know you're being heard but you're not saying anything…he's in your body …and in the silence. It's about trust. You just trust that what you need is being heard and has been answered.[137]

Dark Night of Spirit: The purpose of the Dark Night of Spirit is to transform ways of understanding, relating and loving which is accomplished through an intentional disabling of the mind. The suffering incurred is the loss of image of self, others and Other and the accompanying pain of desolation, anguish and unworthiness. The outcome is that an individual will truly know, freely relate and unconditionally love self, others and what is transcendent.

Evidence of the intentional disabling of the senses and intellect in the Night may be traced in understandings of spiritual crisis, spiritual distress and spiritual pain. Agrimson and Taft identify spiritual crisis as acute events that:

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[135]DN.1.10.6; 12.4; DN.2.5.1; SC. 13.10; LF.3:49.

[136]Kevin Culligan, "The Dark Night and Depression," in *Carmelite Prayer: A Tradition for the 21st Century*, ed. Keith Egan (New York: Paulist, 2003), 122.

[137]Zinia Pritchard, *The Contemplative Spiritual Journey of the Dying: A Retrospective Phenomenological Study* (Edmonton, AB.: Saint Stephen's College, 2010), 26.

> lead to an impairment in any one of the following areas: sense of trust in God or the world, sense of purpose or meaning, sense of inner peace, sense of reality, feelings of connectedness, sense of values and ability to transcend oneself.

Nursing diagnoses understands spiritual distress as an "impaired ability to experience and integrate meaning and purpose in life through a person's connectedness with self, others, art, music, literature, nature, or a power greater than oneself." [138] Villagomeza similarly perceives spiritual distress as "impairment" within the dimensions of "connectedness, faith and religious belief system, value system, meaning and purpose in life, self-transcendence, inner peace and harmony, and inner strength and energy." [139] McGrath, although not acknowledging the transpersonal dimension, still notes spiritual pain as a "break with …satisfactions with life." [140]

Psychology of Desire

Underpinning the Night is St. John's understanding of the spiritual journey as a gradual purification of desire:[141] although good in itself, human desire can often be directed toward a finite object and is contingent upon it. Such dependency upon gratification is a deep psychological impediment to apprehending Reality and to a deeper commitment to living, loving and serving.[142] The evidence of the shadow of desire is

[138]North American Nursing Diagnosis Association, *Nursing Diagnoses*, 410.

[139]Liwliwa Villagomeza, "Spiritual Distress in Adult Cancer Patients: Toward Conceptual Clarity," *Holistic Nursing Practice* 19 (2005):285-294.

[140]McGrath, "Creating a Language for 'Spiritual Pain,'"637-46.

[141]Fitzgerald, *The Meaning and Recognition of the Dark Night Experience*.

[142]Ibid.

regularly played out in the palliative context. The following anecdote is offered by way of illustration:

> A spouse desires peace for a dying patient, "if only he had faith [as I do] he would be at peace." However, her desire is contingent upon some -"thing" namely, the patient sharing her faith. Hence, the spouse's desire for peace actually functions as an attachment and an anxiety. St. John would counsel that the way of "peace in all" is to desire peace in "no-thing." Indeed, it was only after the spouse was able to relinquish her desire for the patient to 'have faith' and freely love him for his own sake that she actually came to experience the peace she so deeply desired. [143]

The Darkness of the Unknown

As an apophatic form of mystical spirituality the Night nuances all that is unknown about life, death and what is Infinite. Darkness is a metaphor for the mysterious, unconscious depths of the spiritual life which are inaccessible to our senses, thoughts and imagination:

> There were tears in the patient's eyes.
> "I'm afraid of the future," she shared.
> "You mean death?" I asked.
> "Yes," she replied. "I don't know how to get ready."

This clinical encounter with patient "Joan" illustrates how "the mind, while *full* on one level of a lifetime of knowledge, is in total darkness on another, the level of meaning." [144] Darkness also relates to the felt experience of deprivation: the loss of pleasure or gratification, hopelessness, meaninglessness, abandonment and rejection.[145] This deprivation manifests along the intra-personal, inter-personal, and transpersonal relational domains. The suffering character of the Night finds clear resonance with the spiritual

[143]Based upon Zinia Pritchard, "The Dark Night of the Soul: An Introduction," *Alberta Region Canadian Association for Pastoral Practice and Education* 9 (2008) 2, 8-12.

[144]Fitzgerald, "The Transformative Influence of Wisdom," 445.

[145]A.1.3.1;4.3;DN.2.3,3;2.7.7

suffering discourse embracing all identified dimensions: separation, [146] [147] [148][149] loss,[150] [151] disconnection,[152] isolation,[153] rupture,[154] alienation, [155] and abandonment.[156]

Antecedents of the Night

The Night begins at the point when one touches upon one's own limitations and that of others:[157]

> No one can find another drug that will work for me. Why? Why would God close every single door when it works for someone else? It's like being trapped in a cage. That God you trust and believe in, allowing that to happen. I'm asking, "can you get me out of this?" But you can't get out of it. How do you understand something like that? Surely you're not the only person in the entire world there's no option for, that all the most common options don't work for, why? [158]

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[146]Christina Puchalski, Elliot Dorff, and Yahya Hendi, "Spirituality, Religion, and Healing in Palliative Care," *Clinics in Geriatric Medicine* 20 (2004): 689-714.

[147]Ferrell, "Suffering and the Goals of Nursing," 241-247.

[148]Mako, "Spiritual Pain," 1106-1113.

[149] North American Nursing Diagnosis Association, *Nursing Diagnoses,* 410

[150]Agrimson,"Spiritual Crisis,"454-461.

[151]Ferrell, "Suffering and the Goals of Nursing," 241-247.

[152]McGrath, "Creating a Language for 'Spiritual Pain,'" 637-46.

[153]Puchalski, "Spirituality, Religion, and Healing," 689-714.

[154]Mako, "Spiritual Pain,"1106-1113.

[155]North American Nursing Diagnosis Association, *Nursing Diagnoses,* 410.

[156]Mako, "Spiritual Pain," 1106-1113.

[157]Fitzgerald, "The Meaning and Recognition of the Dark Night Experience."

[158]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 18.

In this vignette Nancy encounters limitation on several levels: the limits of pain and symptom management, the seeming limits of God to rescue and the very real and finite walls of one's physical existence.

Impasse: Powerlessness and Meaninglessness

Impasse is marked by the patient's profound experience of limitation, powerlessness and meaninglessness.[159] There is a sense of being trapped by one's predicament. A patient may expresses a loss of satisfaction in self, God and or others, including the medical profession.[160] There is a realization that one can no longer make sense of things and the power of the intellect offers no pleasure.[161] A distinctive feature of impasse is that questions raised cannot be rationally resolved:[162] "a genuine impasse situation is such that the more action one applies to escape it, the worse it gets. The principles of "first order change" – reason, logic, analysis, planning – do not work…"[163]

Memory has a central role in the search for meaning:

> In times of uncertainty …one can have recourse, through remembrance of all one knows and has experienced in the past, to this pool of conviction. But in the passive night of sense this synthesis unravels. One cannot put things together in a meaningful whole…The way disintegrates into ever-branching dead-ends. One cannot situate oneself and the way forward and the way back look the same. There is an almost desperate sense of being lost, going in circles, getting nowhere. [164]

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[159]DN. 1.9.8.

[160]DN.1.9.2,4

[161]A.2.13.2.

[162]Puchalski, "Spirituality, Religion, and Healing," 689-714.

[163]Fitzgerald, "Impasse and Dark Night," 413.

[164]Schneiders, *Finding the Treasure,* 188.

Normatively, when a new experience presents in life an individual applies the lens of knowledge and wisdom gained from past experience (memory) to bear upon the new experience and to make sense of it. However, with the experience of the unknown that is one's own dying the individual is confronted with a reality that is so large the lens of memory offers too small a frame to adequately perceive it. The storehouse of wisdom can no longer serve as a compass to orient an individual to the current experience and to help find meaning: "There must be a reason." The patient shared. "I must have done something." I asked her "What do you think you have done?" She replied, "Nothing."

In the impasse of the Night of Spirit assumptive beliefs are challenged: "I didn't believe this could happen to me…but it has." A poignant example is that of the athletic patient who respectfully tends his body and enjoys the benefit of fitness and health. An implicit belief may have been that the care of one's body will lead to health. While this belief may have proven true over a lifetime, the patient's present encounter with terminal illness reveals that such a belief cannot be *absolutely* true. The edifice of meaning that one has constructed in life is now being shaken and can feel "as if someone is knocking on our grip of life."[165]

The suffering dimension of the Dark Night finds strong resonance within the spiritual suffering literature. Powerlessness in the Night is clearly identified as an aspect of suffering: "suffering people often feel helpless and trapped, unable to escape their circumstances." [166] The search for meaning so central to the Night features largely in the spiritual suffering discourse: questions of impasse are framed by some as "unanswerable

[165]Fitzgerald, *The Meaning and Recognition of the Dark Night Experience*.

[166]Ferrell, "Suffering and the Goals of Nursing," 241-247.

questions" [167] and by others as the need to find "...answers for that which is unknowable."[168] Dark Night understanding of the role of memory in the search for meaning also finds resonance: nursing diagnosis clearly identifies spiritual distress as a result of the "difficulty in applying prior beliefs and values to the new situation." [169]

The Three Spirits of the Night

The Spirit of Confusion

The loss of meaning with the resulting loss of orientation is known in the Night as *the Spirit of Confusion.*[170] In the palliative context it is most often marked by patient's relentless striving to make sense of the predicament of a terminal illness: "It doesn't make sense. I keep coming back to that 'Why?"[171] The purpose of this spiritual dynamic is to bring an individual to a place of willful submission to the Other. [172]

The Spirit of Blasphemy

Anger may be a justifiable response within the illness experience. In Nancy's case it is evoked by her lack of satisfaction she suffers in relation to both God and her doctors: "No one can find another drug that will work for me….That God you trust and believe in allowing that to happen!" Nancy's anger is identified in the Night as the *Spirit of*

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[167]Puchalski, "Spirituality, Religion, and Healing," 689-714.

[168]Ferrell, "Suffering and the Goals of Nursing," 241-247.

[169]North American Nursing Diagnosis Association, *Nursing Diagnoses.*

[170]DN.1.14.3.

[171]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 21.

[172]May, *Dark Night of the Soul,* 149.

Blasphemy[173] and is considered both a phase and an agent of purification. [174] Evidence of this dimension of the Night is recorded in the RCOPE's "negative coping" of "Spiritual Discontent" whereby a patient expresses "confusion and dissatisfaction with God."[175]

The Spirit of Fornication

"I was consumed by [prayer]…I was using it as a crutch…24 hours a day." [176] The Spirit of Fornication[177] refers to an individual's ardent attempt to find the personal gratification lost[178] in relation to life and spiritual/creative practices. At the heart of this dynamic of the Night is the way in which a patient relates with others: so focused on securing the former benefits of relationship, one can treat the other as an "It"—there to meet one's needs rather than a 'Thou" to respectfully engage.[179] Examples include the patient's relationship with self: sometimes pushing a severely compromised body beyond its capabilities in an effort to regain feelings of independence and control.

[173]DN.1.14.2.

[174]Fitzgerald, *The Meaning and Recognition of the Dark Night Experience.*

[175]Pargament, "Religious Coping,"519-43.

[176]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 26.

[177]DN 1.14.1

[178]May, *Dark Night of the Soul*, 143-145.

[179]Martin Buber, *I and Thou* (New York: Scribner, 1958).

Loss of Images

> These are the losses of the dark night of the spirit: persons are forced to let go of cherished self-images and long-held God images that are no longer tenable in the contemplative light of what they now see. [180]

A central revision of Nancy's belief was her image of God as "the ultimate power" who would not allow her innocent suffering: "God is a parent that protects and keeps you from harm. ….Why would God close ever single door?" [181] These words nuance the loss of who the patient imagined God to be. A central dynamic of the Night is the deconstruction of images of self, others and the Transcendent. Such images are often spun out of the threads of personal desire: what one needs others, God or even oneself to be for one rather than to perceive what is really there. This feature of the Night may be understood as a transformation of Nancy's assumptive world, where her "belief system [was] re-examined and expanded to accommodate the loss experience." [182] Nancy is later able to revise her perception of suffering through the identification of her suffering with the vulnerability of Christ, "I said to the surgeon, 'I feel like Christ being strapped to a cross, it's like being crucified.' And he said to me, 'He is with you and so are we.'" Pargament's study evidences this as part of a religious movement to find meaning where one undertakes a "reappraisal of God's Powers- redefining God's power to influence the stressful situation."[183]

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[180]Culligan, "The Dark Night and Depression,"125.

[181]Pritchard, *The Contemplative Spiritual Journey of the Dying,* 18.

[182]Susan Furr, "Spirituality and Grief," in *Religious and Spiritual Issues in Counseling: Applications Across Diverse Populations*, ed. Mary Burke, Jane Chauvin and Judith Miranti (New York: Brunner-Routledge, 2005), 135-145.

[183]Pargament, "Religious Coping," 519-43.

Purification in the Night of Spirit

> "Don't look for God," the Master said. "Just look —and all will be revealed."
> "But how is one to look?"
> "Each time you look at anything, see only what is there and nothing else."
> The disciples were bewildered, so the Master made it simpler:
> "For instance: When you look at the moon, see the moon and nothing else."
> "What else could one see except the moon when one looks at the moon?"
> "A hungry person could see a ball of cheese. A lover, the face of his beloved." [184]

The medium of one's senses, concepts, thoughts and imagination both reveal and conceal Reality.[185] Purification in the Night is likened to a fire that purges or burns away limiting paradigms so that one sees what is really there. [186] Individuals can be sorely challenged in this Night of Spirit when "…they see clearly the self-seeking in even their most altruistic motives..."and "often feel an interior emptiness that no diversion can possibly relieve."[187]

Kenosis: Emptiness and Transformation

In the process of dying the ego is no longer able to construct a sense of identity and worth that is dependent upon the satisfaction of independence, functionality, self-sufficiency and productivity. The palliative experience of deprivation and progressive diminishment resonates strongly with kenosis, a central process of the Dark Night:

> Now, dressed in the working clothes of aridity and desolation, all her earlier lights darkened, the soul shines more clearly in the virtue of self-knowledge...She finds absolutely no satisfaction in self. She knows that on her own she neither does

[184]Anthony De Mello, *One Minute Wisdom* (Garden City, N.Y.: Doubleday, 1986), 8.

[185]Rolheiser, *Shattered Lantern*, 92.

[186]DN.2.12.1

[187]Culligan, *The Dark Night and Depression*, 125.

nor can do anything. [188]

The kenotic experience of being emptied out of oneself finds strong resonance in the spiritual suffering literature: suffering is identified as involving "the threat of disintegration,"[189] leaving a person "diminished and with a sense of brokenness."[190] Spiritual pain may be initiated through "an embodied experience of …existential annihilation…a powerful realization that one is separating from life as one ebbs toward death."[191] As an acute form of suffering it results from the disconnection from "the normal or expected relationships and satisfactions with life."[192] Spiritual distress includes the loss of independence and dignity that can lead to suffering.[193] Psycho-existential distress (referred also to as "soul pain" or "agent-narrative suffering")[194] articulates the deep fear of dependency and loss of control.[195]

Paradoxically, the transformative work of the Night is accomplished through kenosis. Through the dying of the ego the false self is dissolved and the true self emerges; a self that has often been written in the margins of one's life:

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[188]DN.1.12.2

[189]Eric Cassell, "The Nature of Suffering and the Goals of Medicine," *The New England Journal of Medicine* 306 (1982): 639-45.

[190]Ferrell, "Suffering and the Goals of Nursing," 241-247.

[191]Mako, "Spiritual Pain," 1106-1113.

[192]McGrath, "Creating a Language for 'Spiritual Pain,'" 637-46.

[193]Puchalski, "Spirituality, Religion, and Healing," 689-714.

[194]James J. Walter, "Terminal Sedation: a Catholic Perspective," *Update* 18 (2002): 6-8.

[195]Timothy Quill and Ira Byock, "Responding to Intractable Terminal Suffering: the Role of Terminal Sedation and Voluntary Refusal of Food and Fluids. ACP-ASIM End-of-Life Care Consensus Panel. American College of Physicians-American Society of Internal Medicine," *Annals of Internal Medicine* 132 (2000): 408-14.

> The false self sensing its fundamental unreality, begins to clothe itself in myths and symbols of power. Since it intuits that it is but a shadow, that it *is* nothing, it begins to convince itself that it *is* what it *does*….[196]The self that begins [the journey] is the self that we thought ourselves to be. It is this self that dies along the way until in the end "no one" is left. This "no one" is our true self. [197]

This integral and transformative process of the Night finds clear resonance in Kuhl's end of life study:

> "When you're dying, you're stripped of everything that's important to society, money, image – so all you have left is honesty…[The person other people expect you to be, falls away]…When you come close to death, all that crap just flies off of you; it just sort of comes off you like layers of skin. All of a sudden, you're starting from scratch, like when you were born." [198]

An apparent state of demoralization may actually be a Dark Night dynamic of refining one's true identity.

Lament

"I am a psychologist and I am consciously aware that I am losing my cognition." It is a painful paradox of the Night that what is loved, "the very focus of desire, becomes the cause of one's agony." [199] Lament is the grief response to the loss of what the individual holds precious or sacred:

> "When you are sorrowful look…in your heart,
> and you shall see that in truth you are weeping

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[196]James Finley, *Merton's Palace of Nowhere: A Search for God Through Awareness of the True Self* (Notre Dame: Ave Maria Press, 1978), 35.

[197]Ibid.,17.

[198]David Kuhl, "What Dying People Want" in *Handbook of Psychiatry in Palliative Medicine,* 2d ed., ed Harvey Chochinov and William Breitbart (Oxford: Oxford University Press, 2009),151.

[199]Fitzgerald, Constance. "The Transformative Influence of Wisdom,"446.

for that which has been your delight."[200]

Lament is most often conveyed through emotional expression. The dynamic of lament is noted in varying ways in the spiritual suffering discourse: Ferrell and Coyle identify that suffering is companioned by "a range of intense emotions";[201] Mako et al. characterize spiritual pain as "emotional distress" communicated "through the language of emotions, 'despair, regret, anxiety'";[202] Agrimson and Taft define spiritual crisis, in part, as "grief or a deep feeling of loss";[203] nursing diagnosis of spiritual distress understand it to be partially manifested in a broad range of emotions,[204] and Cassell similarly identifies emotional expression as a consequence to suffering.[205]

Letting-go

How does a patient cope with the impasse of dying? Paradoxically, by actively participating in self-emptying (kenosis):

> Nan-in, a Japanese master during the Meiji era (1868-1912), received a university professor who came to inquire about Zen. Nan-in served tea. He poured his visitor's cup full, and then kept on pouring. The professor watched the overflow until he no longer could restrain himself. "It is overfull. No more will go in!" "Like this cup," Nan-in said, "you are full of your own opinions and speculations. How can I show you Zen unless you first empty your cup?"[206]

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[200]Kahil Gibran, "On Joy and Sorrow," in *The Prophet: Kahil Gibran* (New York: Alfred A. Knopf, 1923), 29.

[201]Ferrell, "Suffering and the Goals of Nursing," 241-247.

[202]Mako, "Spiritual Pain," 1106-1113.

[203]Agrimson, "Spiritual Crisis,"454-461

[204]Lynda Juall Carpenito-Moyet, *Handbook of nursing diagnosis* (Hagerstown, MD: Wolters Kluwer/Lippincott Williams & Wilkins Health, 2012), 410.

[205]Cassel, "Suffering and the Goals of Medicine," 639-45.

[206]"101 Zen Stories" (n.d.), http://en.wikipedia.org/wiki/101_Zen_Stories (accessed July 27, 2010).

This widened capacity [207] for the in-pouring of the spiritual life into one's core,[208] allows the individual to truly know, freely relate and unconditionally love self, others and the Other.

> "It doesn't make sense. I keep coming back to that 'Why?" ...What's so strange, [about it is] I have to trust it…give myself to it…. [Dying] is that total surrender…you can't push it away or run from it. You have to go through it. [In my prayer] I gave my soul over to God and said, 'You're will be done' and God's presence was with me then." [209]

At the heart of this active means of coping is the posture of surrender. Nancy's actions introduce the notion of surrender as an active and free-willed choice: "[Dying] is that total surrender…you can't push it away or run from it. I gave my soul over to God…." It challenges the notion of "giving-up" which has more the passive tone of a subdued or beaten spirit that submits to the inevitable: [210]

> Spiritual surrender is a deliberate act of the will, not a breaking of the will…it does not come without resistance – a good indication that it has everything to do with our active free will. We experience a loss of our ego-self, the self that we possess when we freely choose to place our complete trust in the Other. It's like taking a breath in and then jumping out of a plane in the firm hope (never certainty) that the parachute will open and carry you safely down. [211]

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[207]DN.1.9.8.

[208]DN. 2.5.1.

[209]Pritchard, *The Contemplative Spiritual Journey of the Dying,* 20.

[210]Therese A. Rando, *Grief, Dying, and Death: Clinical Interventions for Caregivers* (Illinois:Research Press, 1984), 256.

[211]James Krisher, *Spiritual Surrender: Yielding Yourself to a Loving God* (Mystic, CT: Twenty-Third, 1997), 7.

How to Navigate Impasse

The pathway through the impasse of one's suffering may be navigated through the spiritual practices of faith, hope and love which are inter-related.

Spiritual Posture of Faith

"[Dying] is that total surrender…you can't push it away or run from it. You have to go through it." Nancy is no longer trying to conceptually understand the unknown. Instead, she chooses to relate to it in a radically different way, by moving into it with an act of trust. The dynamic of "taking one step at a time" into the unknown, so familiar for patients at end of life, is identified in the Night as faith: "it is faith that moves us into the Mystery which is unimaginable, incomprehensible and uncontrollable." [212] To adopt the posture of faith is to adopt the stance of the seeker on quest, open and receptive to what may be revealed. Some truths can only be learnt through the experience of dependency in faith:

> A blind man, if he be not quite blind, refuses to be led by a guide; and, since he sees a little, he thinks it better to go in whatever happens to be the direction which he can distinguish, because he sees none better…In the same way a soul may lean upon any knowledge of its own, or any feeling or experience of God, yet, however great this may be, it is very little and far different from what God is; and, in going along this road, a soul is easily led astray, or brought to a standstill, because it will not remain in faith like one that is blind, and faith is its true guide.[213]

[212]Fitzgerald, "The Transformative Influence of Wisdom," 446.

[213]A.2.4.3.

Spiritual Posture of Hope

In the impasse of dying one's security in what one has, the 'knowns' in one's life, can no longer afford comfort or reassurance. It is as if the hold on what is known of personal reality teeters on the edge of a cliff and finally relinquishes its hold:

> Hope comes into play when we are really radically at the end, unable to find any further resources to connect memories, feelings, images, and experiences of life in a meaningful pattern or promising future. Then hope, forfeiting the struggle to press meaning out of loss, becomes a free, trustful commitment to the impossible, which cannot be built out of what one possess. [214]

Hope is to surrender security in the known with a choice to entrust oneself to that which one does not fully understand: "… I have to trust it…give myself to it." [215]

Spiritual Posture of Love

> "[l]ove prevents us from forcing the loved one into the constraints of our needs and so takes the beloved as he or she is."[216]

Love is to surrender expectations of self, others and the Other companioned by an unconditional acceptance; "I gave my soul over to God and said, 'Your will be done.'"[217] One's love for God is no longer dependent on what one believes God ought to do for one. This capacity to love without condition is a sign of the purification of desire. It may also be illustrated in the inter-personal domain, e.g. when a patient surrenders the need to have

[214]Fitzgerald, "The Transformative Influence of Wisdom," 446.

[215]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 21.

[216]Fitzgerald, "The Transformative Influence of Wisdom," 446.

[217]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 22.

a family member accept his/her impending death and allows the other to be in a place of non-acceptance.

Ivancovich and Wong, alluding to the concept developed by Robert Marrone, insightfully identify these movements of soul as part of a 'psychospiritual transformation' that "occurs when loss shatters our assumptions about life and death…a process that requires us to set aside pre-existing needs for order and control and replace them with faith in a higher order, structure, and meaning." [218] The spiritual posture of surrender is identified in Pargament's RCOPE as a beneficial coping method named as "active religious surrender": doing what one can and surrendering the rest to God.[219] It is noted to be particularly useful in the face of uncontrollable events. [220]

Transition: Experience of Contemplation

St. John speaks of a transition phase between the passive Night of Sense and Spirit. It is in this space that one is gifted with contemplation, the "inflow of God" into the soul.[221] Like a child held within the dark and protective cavern of the womb, one's spiritual life may be marked by ways of knowing that surpass the intellect and ways of being that suggest passivity and receptivity as authentic dimensions of the spiritual life:

> Suddenly, I feel an unexpected physical presence. An incredible calm takes over my whole body. I am with God. Incredible! Beautiful! Finding His voice, finding His presence in my bedroom and feeling it there. Cradled like this in His arms – I

[218]Debra Ivoncavich and Paul Wong. "The Role of Existential and Spiritual Coping in Anticipatory Grief," in *Existential and Spiritual Issues in Death Attitudes*, eds. Adrian Tomer, Eliason Grafton, and Paul Wong (New York: Lawrence Erlbaum Associates, 2008), 218.

[219]Pargament, "Religious Coping,"522.

[220]Ibid., 539.

[221]DN.1.10.6.

calm right down. All my fear is gone.[222]

Nancy's experience of being spiritually awakened is a rare window into the nature of contemplation. While the language and lens of meaning is theistic, experience of spiritual union may be expressed in non-theistic ways. The salient features of contemplation are as follows: an unmediated and unexpected gift "which no desire, no effort and no heroism of ours can do anything to deserve or obtain;" [223] an embodied experience lifting one up and out of oneself into a larger and broader Reality; an awakening to a deepened sense of connection or communion companioned by the gift of insight.

A more sedate example of contemplation within the palliative setting may be offered through this clinical anecdote:

> In the course of the spiritual care visit a patient's attention turned to the IV line that was transfusing blood into her arm. She suddenly exclaimed: "This blood that's running into me has come from all these people…all these people have their blood running into me." She looked up in wonder, "I'm somehow connected with all these people...like a web."

Contemplation for this patient was a moment of deepened awareness and connection with the web of life. The experience of union for each patient offered a momentary insight into Reality: any illusion of separation has dissolved. The windows of one's mind behold with startling clarity the unveiled panoramic of what truly is. There is an awakening to the grandeur that charges life. [224]

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[222]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 23.

[223]Thomas Merton, *Seeds of Contemplation* (Norfolk, Conn: New Directions, 1949), 149.

[224]Gerard Manley Hopkins, "God's Grandeur," in *Gerard Manley Hopkins:Selection of his Poems*, ed. W.H. Gardner, The Penguin Poets (Middlesex, England: Penguin Books, 1963), 27

The Gift of Insight within Contemplation

Contemplative knowledge is what the mystics name "secret or hidden wisdom" having the character of insight or enlightenment: [225]

> I am with God – I haven't died yet but I'm with God! [It] defined who I was *right then*, that I knew I was a spiritual being and all was well... The first time I realized that I still had ownership of the spiritual me…Such an awakening for me! I haven't been robbed of – I haven't lost me… The Spiritual Nancy!"

Contemplative knowledge is revealed knowledge: its very givenness [226] is an act of disclosure: something secret, hidden from our sight has shown itself, made itself known. Nancy's earlier impasse of isolation and limitation is now resolved in this act of transcendence:

> The quality of paradox is at the heart of 'second order change.' It implies the unexpected, the alternative, the new vision, is not given on demand but is beyond conscious, rational control. It is the fruit of unconscious processes in which the situation of impasse itself becomes the focus of contemplative reflection. [227]

Evidence of spiritual transformation through suffering finds some support in the literature. Agrimson acknowledge spiritual crisis to have the "positive consequence" of "spiritual awakening" or renewal;[228] Cassel identifies the restorative experience of transcendence as the restorative agent for suffering; "when experienced, transcendence locates the person in a far larger landscape...The sufferer is not isolated by pain but is brought closer to a transpersonal source of meaning";[229] Waldfogel notes, "through

[225]William Johnston, *Mystical Theology: The Science of Love* (London: HarperCollins, 1995), 164.

[226]Jean-Luc Marion, *Being Given: Toward a Phenomenology of Givenness* (Stanford, Calif.: Stanford University Press, 2002).

[227]Fitzgerald, "Impasse and Dark Night,"413.

[228]Agrimson, "Spiritual Crisis," 454-461.

transcendence the ill person experiences a 'rising above' limited conditions…the person feels part of a greater whole, nature, cosmos or higher being…Sometimes, in revealing a whole new order of things, it profoundly transforms life."[230]

Discussion and Implications

The overarching theological construct of the Dark Night of the Soul has implications for spiritual assessment, tool development, and care of patients. Its ability to hold the tension, addressed in the literature, of both suffering and transformation challenges a dualistic undercurrent in health care that perceives distress as pathological. The evidence on stress related growth augments the wisdom of the Night in offering a more organic paradigm: the seed of life may be buried within the soil of suffering. The Night normalizes patient statements of abandonment as a common albeit painful process in the landscape of spiritual development. The emotional expression associated with loss if perceived as lament may be understood as a necessary work of the soul in the wilderness of the unknown. The features of spiritual deprivation in the Night may easily be mistaken for pathology of some kind and so begs the question of differential diagnosis.

The Night also challenges a dualistic assessment of spirituality that can divorce the religious from the existential. It accommodates for the expression of the spiritual life along any trajectory of relating and in both creedal and non-creedal language.

The all-inclusive nature of the Night has implications for tool development. Spiritual measurements may benefit from assessing not only spiritual suffering associated with the

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[229]Cassel, "Suffering and the Goals of Medicine," 639-45.

[230]Shimon Waldfogel, "Spirituality in Medicine," *Primary Care* 24 (1997):963-76.

relationship with God but also the relationship with others and oneself, e.g. measuring the spiritual pain that is associated with loss of the image of oneself and of others.

The Dark Night paradigm for suffering has significant implications for care. It suggests that appropriate response to matters of the soul is in fact soulful engagement which calls for an integration of the practitioner's spiritual life with the practice of medicine. The Night offers contemplative postures for care of patients: practice of kenosis invites the clinician to deliberately empty out of his/her knowns in order to fully receive what the patient is disclosing. The spiritual practices of faith, hope and love suggest proceeding into the impasse of patient suffering with a movement into the unknown, in a posture of trust and detached from an agenda, in particular, the agenda that one can relieve, solve or fix suffering. The experience of enlightenment within the Night suggests that the burden of resolution of spiritual suffering is not entirely dependent upon what the patient or the practitioner can *do*. The knowledge that resolves impasse is not the result of one's own creation - simply dawning upon the person (patient or practitioner) as day dawns after the night.[231]

Conclusion

The palliative mandate to assess and address spiritual distress is complicated by the lack of a shared understanding of the nature and function of spiritual suffering. The discourse within healthcare offers a variety of insights but no integrated construct has yet been proposed. This paper has sought to demonstrate that the paradigm of Dark Night offers such a construct. It is a powerful spiritual lens through which to perceive the

[231]Johnston, *Mystical Theology,* 164.

suffering-transformative process of dying. Taken seriously, the Dark Night has the potential to guide tool development that holistically captures the paradox of distress and well-being at end of life. Furthermore, the care pathway embedded in the Night commends the palliative clinician's shared humanity as the primary therapeutic tool in care of the soul.

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CHAPTER 2

THE DARK NIGHT OF THE SOUL AND DEPRESSION IN PALLIATIVE CARE: A DIFFERENTIAL DIAGNOSIS

Introduction

The Dark Night of the Soul (referenced more accurately as "Dark Night" and also referred to by the abbreviation "the Night") is a mystical or contemplative form of spirituality acknowledged within the psychiatric literature.[232] A term coined by the Christian Spanish mystic John of the Cross, the Night has begun to be examined within health care with varying levels of comprehension. Perceptions of the Night sometimes suffer a false dichotomy between the relationship with what one considers ultimate (Other, "God") and the rest of life.[233] It can be easily misunderstood[234] and pathologized: some studies having posited the Night as a "salutary" form of "religious depression" as

[232] Dan Blazer, "Spirituality and depression : a background for the development of DSM-V," in *Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V*, eds. John Peteet, Francis Lu, and William Narrow, (Arlington, Va: American Psychiatric Association, 2011), 1-21.

[233] Michael O'Connor, "Spiritual Dark Night and Psychological Depression: Some Comparisons and Considerations," *Counseling and Values* 46 (2002): 137-48.

[234] Richard Kinnier et al., "Deliverance from the 'Dark Night of the Soul,'" *Journal of Humanistic Counseling, Education and Development* 48 (2009): 110-119.

opposed to a "pathological religious depression."[235] [236]Such a perception is clearly challenged by the original differential offered by John of the Cross in his treatises *The Ascent of Mount Carmel*[237]and *The Dark Night of the Soul.*[238]

Both depression and spiritual suffering have been empirically shown to negatively impact health. Palliative researchers Rayner et al. provide an informed summary of the risks associated with depression: "reduced adherence to treatment, increased disability, poor prognosis, higher mortality and a predictor of desire for death in the terminally ill." [239]Researchers into spiritual health have demonstrated how spiritual and religious issues can impact patients' pain and symptom expression, [240][241]ability to cope with illness, [242]quality of life,[243] [244] and also be a predictor of mortality.[245]One qualitative research

[235]Glòria Durà-Vilà and Simon Dein, "The Dark Night of the Soul: Spiritual Distress and Its Psychiatric Implications," *Mental Health, Religion and Culture* 12 (2009): 543-559.

[236]Glòria Durà-Vilà et al., "The Dark Night of the Soul: Causes and resolution of emotional distress among Contemplative Nuns," *Transcultural Psychiatry Mental Health* 47 (2010):543-559.

[237]John of the Cross, *The Ascent of Mount Carmel*, in *The Collected Works of St. John of the Cross*, rev.ed.trans.Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), 101-349.

[238]John of the Cross, *The Dark Night of the Soul*, in *The Collected Works of St. John of the Cross*, rev.ed. trans. Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), 353-457.

[239]Rayner L., et al., "The Clinical Epidemiology of Depression in Palliative Care and the Predictive Value of Somatic Symptoms: Cross-Sectional Survey with Four-Week Follow-Up," *Palliative Medicine.* 25 (2011): 229.

[240]Kelly McConnell et al., "Examining the Links between Spiritual Struggles and Symptoms of Psychopathology in a National Sample," *Journal of Clinical Psychology* 62 (2006): 1469-84.

[241]Judith Hills et al., "Spirituality and Distress in Palliative Care Consultation," *Journal of Palliative Medicine* 8 (2005): 782-788.

[242]Kenneth Pargament, Harold Koenig, and Lisa Perez, "The Many Methods of Religious Coping: Development and Initial Validation of the RCOPE," *Journal of Clinical Psychology* 56 (2000): 519-43.

[243]Judith Hills et al., "Spirituality and Distress in Palliative Care Consultation," 782-788.

[244]Kenneth Pargament et al., "Patterns of Positive and Negative Religious Coping with Major Life Stressors," *Journal for the Scientific Study of Religion*37 (1998): 710-724.

study has specifically examined how the Dark Night presents within a tertiary palliative patient experience.[246] Differentiation of the Dark Night from depression is nothing new to the practice of spiritual direction and psychiatric leaders within the field of spirituality, such as John Peteet, have already included the Dark Night within assessment through his suggested "algorithm for making initial treatment decisions in patients with depressed mood and spiritual concerns." [247] However, what is missing is a differential offered from the vantage point of a Dark Night scholar who is also a palliative practitioner in spiritual care. In service to the palliative imperative to alleviate suffering and to promote quality of life through "identification…impeccable assessment and treatment…of spiritual problems,"[248] this study offers palliative clinicians an informed means by which to assess the presence of a spiritual phenomenon at end of life and to enhance the "integrat[ion] of the psychological and spiritual aspects of patient care."[249]

Study objectives will be met by the provision of general overviews of the Dark Night and depression followed by a close examination of St. John of the Cross' differential of the Night from what appears to be endogenous depression and what he refers to as [250]"melancholia," better understood in today's psychiatric terms as melancholic

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[245]Kenneth Pargament et al. "Religious Struggle as a Predictor of Mortality Among Medically Ill Elderly Patients: A 2-Year Longitudinal Study," *Archives Of Internal Medicine*.161 (2001): 1881-1888.

[246]Zinia Pritchard, *The Contemplative Spiritual Journey of the Dying: A Retrospective Phenomenological Study* (Edmonton, AB.: Saint Stephen's College, 2010), 1-27.

[247]John Peteet, *Depression and the Soul: A Guide to Spiritually Integrated Treatment* (New York: Routledge, 2010), 98.

[248] World Health Organization, "Definition of Palliative Care" (n.d.), http://www.who.int/cancer/palliative/definition/en/ (accessed September, 2008).

[249]Ibid.

depression.[251]The paper will critically address the areas of etiology, purpose, symptoms, signs, and implications for care. It will draw-upon the *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR.,*[252] Dan Blazer's contribution to the *Research Agenda for DSM-V,* and clinicians that offer both an informed understanding of the Dark Night and a proposed differentiation from depression: psychiatrist/researcher, Glòria Dura-Vila,[253] [254] psychologist, Michael O'Connor,[255] and Dark Night spiritual directors: psychiatrist, Gerald May,[256]and priest-psychologist, Kevin Culligan.[257]

The author respectfully acknowledges that although belief in a transpersonal dimension is shared by many, it is by no means universally accepted by those within palliative care. Additionally, the naming of transcendence widely differs within the field and personal belief may or may not affect the credibility one assigns spiritual suffering. What this study hopes to provide is an informed means by which a clinician may offer a patient-centered assessment of the Dark Night.

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[250]Denys Turner, *The Darkness of God Negativity in Christian Mysticism* (Cambridge: Cambridge University Press, 1995), 235.

[251]John Peteet, *Depression and the Soul* (New York: Routledge, 2010), 74.

[252]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* 4th ed. Text Revision (Washington, DC.: American Psychiatric Association, 2000); Thomas Widiger et al., eds. *DSM-IV Sourcebook* (Washington, DC: American Psychiatric Association, 1994).

[253]Gloria Durà-Vilà et al.,"Spiritual Distress and Its Psychiatric Implications."

[254]Durà-Vilà and Dein, "Causes and Resolution of Emotional Distress."

[255]Michael O'Connor, "Spiritual Dark Night and Psychological Depression: Some Comparisons and Considerations," *Counseling and Values* 46 (2002): 137-48.

[256]Gerald May, *The Dark Night of the Soul: A Psychiatrist Explores the Connection between Darkness and Spiritual Growth* (San Francisco: HarperCollins, 2005).

[257]Kevin Culligan, "The Dark Night and Depression," in *Carmelite Prayer: A Tradition for the 21st Century*, ed. Keith Egan (New York: Paulist, 2003).

Dark Night Lexicon

The Dark Night may be assessed in the palliative context through the specific diagnostic features offered by John of the Cross or also understood to operate in a more general way as a metaphor for the entire spiritual journey. [258] How dying specifically may be perceived as a Dark Night journey is addressed in a prior study.[259]For the purposes of this paper a lexicon is offered as an introduction to the sacred anatomy of the Night (Appendix A).

Disclosure

This study is informed by the author's own personal and professional cultivation in the Dark Night within a tertiary palliative care context. As with spiritual directors May and Culligan, her care of the soul is nourished by her own life in the spirit:

> My yearning for the Beloved is my primary desire. In the holy darkness of the Night I experience myself suspended and held; within the protective cavern of the Divine womb I believe myself to be closest to the One in whom I live, and move, and have my being. I bear the journey of the Night by the grace and strength of the One who bears me.[260]

Diagnosis of the Dark Night requires a conscious awareness of one's spiritual desires, experiences and resulting beliefs. Such self-awareness allows the clinician to identify individual biases and peculiarities and to set them to one side in a patient-centered

[258]A.2.1.

[259]Zinia Pritchard, "Dying as a Dark Night Experience," (D.Min. diss., article, Saint Stephen's College, 2012), 25-66.

[260]Zinia Pritchard, "The Mystic Way of Knowing" (paper written for The Mystic Way, Saint Stephen's College, 2005), 1-31.

assessment. In listening closely to one's own spiritual life the clinician is also enabled to hear the resonance or echo of what is spiritual for the patient: the other's deep desires, experiences of connection, and attending beliefs. Diagnosis of the Night in a patient is greatly facilitated by the clinician's willingness to trace Dark Night processes within his/herself and to draw upon this self-awareness to inform patient-centred assessment and care. For readers who are interested a Dark Night Clinician's Self-Assessment Tool is included in Appendix B.

Diagnostic Challenge of the Dark Night

The Dark Night and depression each pose a diagnostic challenge. St. John begins by noting that core symptoms of the Night such as dryness or loss of pleasure may be caused by spiritual malady, one's mental/emotional state ("bad humor") or illness ("bodily indisposition)."[261] However, the lack of somatic disturbances can differentiate the Night from depression: "as a rule, the dark nights of sense and spirit do not, in themselves, involve eating and sleeping disturbances, weight fluctuations, and other physical symptoms (such as headaches, digestive disorders, and chronic pain)."[262] That being said, diagnosis of the Night is further complicated by the nature of mystical knowledge, and the apophatic phenomenon (the latter is defined in the Dark Night Lexicon, Appendix A). In the Night, mystical knowledge has a "dark" quality, "we *know it*, but we cannot think it, express it, or even *feel* it clearly. In that sense, mystical experience is, by definition, always partly ineffable, dark, inchoate, too huge to properly conceptualize and speak

[261]DN.1.9.1.

[262]Culligan, "The Dark Night and Depression,"130.

about."[263] The apophatic nature of the Night demands more from the clinician than a theoretical understanding as the Night is a "process in which one is engaged, a process in which one must be engaged in order to grasp its interpretation in any depth." [264] These two diagnostic challenges actually offer a key differential between the Night and depression: the clinician's subjective experience of the Night serves as a guide that informs the diagnostic process.

Diagnostic Challenge of Depression

For the purpose of this study a comparison will be made between the Night and the symptoms of Major Depressive Disorder (MDD) as delineated in Appendix C. Diagnosis of pathological depression is dependent upon the following diagnostic criteria: five or more depressive symptoms present of which at least one is a core symptom (depressed mood or loss of interest or pleasure), symptoms persist nearly every day for at least a two week period, there is a change in previous functioning,[265] and symptoms are not due to side effects of medication.

In spite of these guidelines, somatic symptoms, inclusive of loss of energy/tiredness and diminished ability to think or concentrate, can overlap with disease symptoms [266]

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[263]Ronald Rolheiser, *The Holy Longing: The Search for a Christian Spirituality* (New York: Doubleday, 1999).

[264]Michael Buckley, "Atheism and Contemplation," *Theological Studies Baltimore.* 40 (1979), 690.

[265]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 356.

[266]Martine Meyer, Claire Sinnott, and Paul Seed, "Depressive Symptoms in Advanced Cancer. Part 1. Assessing Depression: the Mood Evaluation Questionnaire," *Palliative Medicine.* 17 (2003): 596.

[267]or with effects of medication which makes diagnosis difficult within the medically ill. [268]To this end, palliative clinicians may be guided by Endicott's suggestion that in the cancer patient the neurovegetative symptoms of depression be substituted with the following psychological or cognitive symptoms: tearfulness/ depressed appearance (in place of weight loss or gain), social withdrawal/decreased talkativeness (in place of insomnia or hypersomnia), brooding/self-pity/pessimism (as opposed to fatigue/los of energy) and lack of reactivity/blunting (in place of diminished capacity to think, concentrate or make decisions). [269] Others may be guided in their clinical judgment by Block's suggestion that the following emotional symptoms function as better diagnostic indicators: hopelessness, helplessness, worthlessness, guilt and suicidal ideation.[270][271]The practice of palliative medicine can also be guided less by the symptom guide in the DSM-IV and more by clinicians' clinical judgment and understanding of their patient's personality, history and context.[272]The palliative community is both sensitive to the stigma of unwarranted psychiatric diagnosis[273]and to the ethical dilemma of contributing

[267]Lauren Rayner et al., "Antidepressants for the Treatment of Depression in Palliative Care: Systematic Review and Meta-Analysis," *Palliative Medicine*25 (2011):366.

[268]Ibid.

[269]Jane Endicott, "Measurement of Depression in Patients with Cancer," *Cancer* 53 (1984): 2243-9.

[270]Susan Block, "Assessing and Managing Depression in the Terminally Ill Patient. ACP-ASIM End-of-Life Care Consensus Panel. American College of Physicians - American Society of Internal Medicine," *Annals of Internal Medicine.* 132 (2000): 209-18.

[271]Susan Block, "Perspectives on Care at the Close of Life. Psychological Considerations, Growth, and Transcendence at the End of Life: the Art of the Possible," *JAMA : the Journal of the American Medical Association* 285 (2001): 2898-905.

[272]Franca Warmenhoven et al. "How Family Physicians Address Diagnosis and Management of Depression in Palliative Care Patients," *Annals of Family Medicine.* 10 (2012): 330-336.

[273]Lauren Rayner et al., "Antidepressants for the Treatment of Depression," 36-37.

to the burden of patient suffering by under-diagnosis and non-treatment.[274]In fact, recent palliative research urges that somatic symptoms of depression "should not be omitted indiscriminately, even in palliative stages":[275] examining the diagnostic significance of somatic and non-somatic symptoms within a cancer cohort, Mitchel et al. discovered that the most accurate diagnostic symptoms were somatic.

The challenge of a depressive diagnosis is further complicated by the overlap of some symptoms with the expected emotional and behavioural expressions of anticipatory grief at end of life or with the debated symptoms of a proposed pathological form of existential distress identified as "demoralization syndrome."[276277]Adding to this complexity is the broader discourse on depression which acknowledges its latent soulful or spiritual dimensions.[278]Unsurprisingly, the lack of clinical consistency leads to variable statistics regarding the prevalence of depression within the palliative population (ranging from 4.5-58%) [279] and the type of care offered.

[274]Ibid, 37.

[275]Alex Mitchell, Karen Lord, and Paul Symonds, "Which Symptoms Are Indicative of DSMIV Depression in Cancer Settings? An Analysis of the Diagnostic Significance of Somatic and Non-Somatic Symptoms," *Journal of Affective Disorders* 138 (2012):137-148.

[276]David Kissane et al., 'The Demoralization Scale: a report of its development and preliminary validation," *Journal of Palliative Care* 20 (2004): 269-76.

[277]Juliet Jacobsen et al, "Depression and Demoralization as distinct syndromes: Preliminary data from a cohort of advanced cancer patients," *Indiana Journal of Palliative Care* 12 (2006):8.

[278]Blazer, "Spirituality and depression," 7-9.

[279]Meyer, Sinnott, and Seed, "Depressive Symptoms in Advanced Cancer," 596.

Etiology of the Dark Night

Existentially, the Night begins at the point when one experiences one's own limitation or that of others. As Dark Night scholar Constance Fitzgerald elucidates:

> John assumes satisfaction in prayer, joy in relationships, pleasure in ministry and romance in married life. It is through our experience of the good things of this life that our desire for God gains momentum and grows. When the pleasure is somehow withdrawn… we confront the limitations of self, God and the human other. [It is] only when we reach the limits of good things, good prayer, good relationships, that we begin to experience the Dark Night.[280]

In the experience of dryness the individual encounters all that he/she is not and all that the other/Other is not. There is a rude awakening as the person discovers having been caught in the web of personal desire: imagining oneself, the other/Other to be who one *needs* them to be and not as they are. It is at this precipice of loss that one falls into the Night.

Dura-Vila's ethnographic study of Dark Night experiences within a community of contemplative nuns identified the trigger point to often be "an unwanted event that led them to a state of emotional and cognitive tension." Such an event, within the clinical setting, may well be the impasse of poor pain control as described by one palliative patient:

> No one can find another drug that will work for me. Why? Why would God close every single door when it works for someone else? It's like being trapped in a cage... I'm asking, 'can you get me out of this?' But you can't get out of it. How do you understand something like that?[281]

[280]Constance Fitzgerald, *The Meaning and Recognition of the Dark Night Experience*, lecture by Constance Fitzgerald, Alba House Cassettes (audiocassette), 1991.

[281]Zinia Pritchard, *The Contemplative Spiritual Journey of the Dying*, 18.

The patient's trigger point of poor pain control is intensified by the spiritual meaning ascribed to her experience – "why would God close every single door?" The actual origin of the Night is, in fact, transcendent and clearly identified as such by John of the Cross.[282]This understanding is also shared by May, Culligan and O'Conner. Although Dura-Vila et al.'s study evidenced spiritual growth in the Dark Night and acknowledge the nun's connection with the Divine, they do not appear to lay emphasis on Divine agency. Instead, they accord the Night the status of a "religious narrative" or a "religiously motivated coping strategy" for emotional distress. Human agency, namely the nun's use of this narrative, is firmly credited for the transformative work.[283]Unfortunately, this denotes a clear departure from the classic understanding of the Night and, in fact, flags a key diagnostic issue: the question of belief. Patient-centered care, as Peteet prudently notes, can be significantly impacted by a clinician's personal perspective on spirituality. [284]Ultimately, the work of differentiating between the Night and depression requires the clinician to be open to an understanding of a patient's belief and investment in spiritual agency.

Etiology of Depression

The etiology of depression is not completely understood: it may be the result of a chemical imbalance with no known external cause (endogenous) or it may be a reactive/situational response to a stressful event such as a terminal illness (exogenous).

[282]DN.1.9.2

[283]Gloria Durà-Vilà et al., Causes and resolution."

[284]Peteet, "Depression and the Soul," 98.

However, as suggested by Blazer (in reference to Charles Darwin), depressive syndromes such as a "mild" or a "sub-threshold" depression may actually be healthy adaptive responses "to assist the organism in withdrawal from unexpected stressors." [285] Current palliative practice appropriates the biopsychosocial model,[286]acknowledging a multi-factorial etiology. That being said, one needs to also acknowledge the lack of consensus in relation to the psychological causes of depression. Interestingly, the symptom replacements offered by Endicott and Block reflect the historical divergence in understanding the etiology of depression to be either cognitive or emotional respectively.[287]

Also pertinent to our discussion is mention in the psychiatric literature[288] of the theory of socially constructed emotions posited by philosopher Martha Nussbaum: "We learn how to feel. . . . The social context surrounding the person gives meaning to feeling and behavior and provides criteria for judging his or her own emotions and the emotions of others."[289]This view is credited by Dura-Vila et al.'s study where monastic nuns assessed their own emotional distress (all symptomatic of depression) through the religio-cultural lens of the Dark Night, perceiving the emotions as somatic heralds of transformation, "distressed people today…miss the chance of realizing that something may be wrong in their lives that needs change." It is important to note that their

[285]Blazer, "Religious and Spiritual Issues," 12

[286]Linda Emanuel and Lawrence Librach, *Palliative Care: Core Skills and Clinical Competencies* (Philadelphia: Saunders), 2011.

[287]Mary Jo Meadow, "The Dark Side of Mysticism: Depression and the Dark Night," *Pastoral Psychology.* 33 (1984):109-110.

[288]Martha Nussbaum, *Upheavals of Thought: The Intelligence of Emotions,* (Cambridge: Cambridge University Press), 2001.

[289]Blazer, "Spirituality and depression," 6.

perception of being in a Dark Night experience did not remove their emotional distress. As Dura-Vila's identifies, the meaning of Dark Night played a cathartic role for the nuns.[290]However, it would be misleading to also suggest that attribution of ultimate meaning may resolve suffering.[291]Perhaps, it is more true to say that such meaning helps to facilitate, what researchers Rehnsfeldt and Eriksson have identified as, the movement from unbearable suffering to bearable suffering.[292]Although one does continue to suffer in the Night, beneath this experience of one's undoing is the sense of rightness [293]that "things are as they ought to be" This sense of an essential rightness further differentiates the Night from depression: there is an absence of pessimism and hopelessness; [294]no cry for "deliverance"[295] or "pleading for help"[296] ; nor a desire "to recover completely"[297]as this would suggest a return to what has been.[298]

[290]Glòria Durà-Vilà et al., "Causes and Resolution," 566.

[291]Durà-Vilà and Dein , "Spiritual Distress," 559.

[292]Arne Rehnsfeldt and Katie Eriksson, "The Progression of Suffering Implies Alleviated Suffering," *Scandinavian Journal of Caring Sciences* 18 (2004): 264-272.

[293]May, *Dark Night*, 156.

[294]Glòria Durà-Vilà, et al., "Causes and resolution,"543-559.

[295]Kinnier, "Deliverance from the "Dark Night of the Soul," 110.

[296]Gerald May, *Care of Mind, Care of Spirit: A Psychiatrist Explores Spiritual Direction* (San Francisco: HarperSanFrancisco, 1992), 110.

[297]Durà-Vilà and Dein, "Spiritual Distress," 557.

[298]Turner, 244.

Prognosis: Dark Night and Depression

Both Dark Night and depression relate to the experience of the disintegration of the self but they differ in the meaning of such demise and its expected course and outcome. Religious philosopher Denys Turner offers this differentiation: the self in depression may be understood as in "revolt…in despair at its disintegration"[299]with the desired therapeutic outcome to be recovery: a restoration and rehabilitation of one's emotional life.[300]Conversely, the Dark Night is one's realization that in loss of one's self, nothing is lost.[301]A desired outcome would be transformation rather than recovery as, according to Turner, there is no aspiration to recover a self that one realizes to have been an illusion rather than one's true self."[302]

Perhaps the essential difference between the Night and depression, as understood in the DSM-IV, is the clarity of the Night's purpose and benefit: to purge the self from anything that is contrary to what is whole/holy.[303]The process of an individual's deeper integration is actually fostered through the disintegration of the false aspects of self: widening the depth self (soul)[304] for the in-pouring of spiritual life, known as "contemplation."[305]May, Culligan, O'Connor and Dura-Vila all affirm the spiritual

[299]Turner, 243.

[300]Ibid.

[301]Ibid.

[302]Ibid, 244.

[303]Ibid.

[304]DN 1.9.8.

[305]DN 2.5.1.

growth that is effected through the Night and concur regarding its non-pathological status. Palliative research further attests to the transformative nature of such suffering:

> Not all, but most people wear a mask of what they think people want them to be…When you're dying…the person other people expect you to be, falls away… to death…all that crap just flies off of you; it just sort of comes off you like layers of skin. All of a sudden, you're starting from scratch, like when you were born."[306]

> I am with God – I haven't died yet but I'm with God! [It] defined who I was *right then*, that I knew I was a spiritual being and all was well... Such an awakening for me! I haven't been robbed of – I haven't lost me… The Spiritual Nancy![307]

As these patient examples portray, evidence of the Night, such as the discovery of one's abiding essence, may be conveyed in either psychological or religious language. Indeed, the issue of language highlights the potential for underdiagnoses of the Dark Night: it may be present but go undetected if the clinician assumes it will be identifiable only through religious concepts and phrases—spirituality is not confined to religious language.

Although depression is clearly identified as pathology within the DSM-IV, the research agenda for DSM-V gives consideration to the latent benefits of depression, citing such authors of the soul as Thomas Moore.[308] The broader discourse also challenges the traditional perspective: "…If we think in terms of a chaos model of psychological growth, we view symptoms positively as indicators of far-from-equilibrium states that foreshadow transformative change…[309] This chaos view of

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[306]David Kuhl, "What Dying People Want" in *Handbook of Psychiatry in Palliative Medicine*, 2d ed., ed. Harvey Chochinov and William Breitbart (Oxford: Oxford University Press, 2009), 151

[307]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 24.

[308]Blazer, "Religious and Spiritual Issues,"8.

[309]Andrea Nelson, "Chaos Theory and Depression: Disintegrating into a New Life," in *Sacred Sorrows: Embracing and Transforming Depression*, eds. John Nelson and Andrea Nelson (New York: Putnam, 1996) 31.

depression is complimented by archetypal psychology's perspective on the soul work engaged in depression as the descent to the depths of psyche.[310]It is noteworthy that the psychology espoused in these views is resonant with the spiritual-psychology of the Night and the healing pathway of descent into suffering identified in the palliative literature by Michael Kearney through the myth of the mortally wounded hero Chiron:

> A move from the surface to the deep mind is a psychological way of describing the shift involved in Chiron's changing from the heroic stance to the way of descent. This shift is pivotal in the dying process....If this downward movement does occur...such individuals experience a new peace, a richness, and a depth in their living and their dying. [311]

If depression engages such spiritual processes, then one may understand how the Dark Night can, indeed, be at work in depression. It may also serve to throw light upon Dura-Vila's appropriation of Font's perspective of according the Night the status of "salutary depression" rather than "pathological depression." [312]The perception of spiritual processes within depression challenges the apparent dualism of a pathological viewpoint: does mental suffering necessarily exclude the benefits of mental health? The Night offers a perspective on reality that is one of paradox; psychological suffering may be both painful and life-giving:

> If we look at the etymology of suffering – it means 'to carry; also to bear children.' The word suffering is also associated with the word fertile, which suggests that within the experience of suffering may lie the seeds of new birth, an opening to a new dimension of self. So within the word itself lies a feminine way

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[310]Zweig, Connie, "Meeting the Shadow at Mid-life: The Changing of the Gods," in *Sacred Sorrows: Embracing and Transforming Depression,* eds. Nelson and Nelson (New York: Putnam, 1996), 33-49.

[311]Michael Kearney, *Mortally Wounded: Stories of Soul Pain, Death, and Healing*. (New York: Scribner, 1996), 63.

[312]Glòria Durà-Vilà, et al., "Causes and resolution,"543-559.

> of carrying and bringing forth new life, (in other words, the possibility for transformation).[313]

Barrett's insightful and eloquent summation of suffering surely mirrors the lived paradox of living in dying: the co-existing desire to both live and to die; to let-go and to hold on.[314] Depth experiences, such as the dying space, uncover the complexity of Reality.

Diagnostic Differential

Interestingly, the medical literature identifies a key diagnostic differential for depression to be the clinician's subjective response to the patient.[315] Culligan and May both echo this clinical wisdom and identify it as a differential between dark night and depression:

> …one does not generally speaking feel frustrated, resentful, or annoyed in the presence of a person undergoing a dark night experience. While such feelings are common in working with depressed people because of their own internalized anger, one is more likely to feel graced and consoled with someone experiencing the dark night.[316]

The impact of the Dark Night on others suggests the more appreciative and contemplative qualities of darkness: the expansiveness of the Night sky, the quiet germination of seed in dark and fertile soil, the protective and nurturing darkness of a mother's womb.

[313]Deborah Barrett, "Suffering and the Process of Transformation," *Journal of Pastoral* Care 53, no. 4 (1999):461-472.

[314]Ira Byock, *Dying Well: Peace and Possibilities at the End of Life* (New York: Riverhead Books), 1998.

[315]Susan Block, "Assessing and Managing Depression in the Terminally Ill Patient," 211.

[316]May, *Care of Mind, Care of Spirit*, 110.

Differentiating the Dark Night of Sense from Depression

Dark Night of Sense: The purpose of the Dark Night of Sense is to transform motivation. This is accomplished through an intentional deprivation of the pleasure principal as a motivation for relating. The principal suffering in the Night of Sense is that of dryness/emptiness, a sense of abandonment with loss of spiritual blessing and a "growing suspicion that [one] has lost [one's] way." [317]John of the Cross provides three simultaneous sets of signs for the discernment of the Dark Night of Senses (Appendix D).All signs need to be present if one is to be properly assessed to be undergoing the purification of the Night as opposed to the experience of illness, lukewarm attitude, or depression. [318]

First Set of Signs

The first set of signs for assessment of the Dark Night of Sense are as follows: a lack of satisfaction and consolation in spiritual and all dimensions of life,[319] dryness and distaste or lack of appetite for one's usual spiritual, creative or re-creative practices and [320] a realization that one is no longer able to meditate, imagine or take pleasure from one's usual spiritual, (creative or re-creative) practices:[321]

> For the longest time I did not have the appetite for prayer … I would say it was a dry time when I no longer yearned for the things of God. What normally I

[317]DN.1.10.1

[318]A.2.13.5.

[319]DN.1.9.2.

[320]Ibid.

[321]A.2.13.2.

> would savour and delight in no longer was able to touch or feed me… [for example] I did not desire a retreat for myself. As I said, it had lost its savour for me. I think that I keep using that word savour meaning it had lost savouriness and that I did not savour it but the word flavour does not cut it for me. To savour is to enjoy. It no longer held enjoyment for me. That's what I mean.[322]

The cited text lays emphasis on the sensory nature of deprivation in the Night through the use of the word "savour." It also indicates the search for words to appropriately convey one's experience which is a normative challenge in mystical experiences: "I want to say something – but I do not know how to express it." [323]

This first sign of the Night shares a key similarity with one of the major symptoms of depression identified in the DSM-IV as loss of interest or pleasure in usual activities. John is aware of the similarity cautioning that "want of satisfaction in earthly or heavenly things could be the product of some indisposition or melancholic humor, which frequently prevents one from being satisfied with anything."[324] Hence, lack of satisfaction/pleasure with one's spiritual life and life in general cannot stand alone in a discernment of a Dark Night experience. Another overlap with depression is the disabling of the rational and imaginative intellect in one's spiritual practice which recalls the depressive symptom, "impoverishment of thoughts" but not a slowing down of thought or movement (psychomotor retardation).

This first sign gives an indication of the transformative purpose of the suffering of the Night: an intentional weaning from relating spiritually primarily through

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[322]Zinia Pritchard, self-interview, 2004, Edmonton, typed script, Doctor of Ministry, Saint Stephen's College, Edmonton.

[323]Mother Teresa, *Mother Teresa: Come Be My Light: the Private Writings of the Saint of Calcutta,* ed.Brian Kolodiejchuk (New York: Doubleday, 2007), 164.

[324]DN 1.9.2

"autonomous effort" [325] through the medium of concepts and images. Union with ultimate Reality lies beyond conceptual constructs. The experience of being weaned from self-reliance and control in the Night is a process known as purification.

Second Set of Signs

A second set of signs is offered by John of the Cross. The individual will suffer guilt and solicitous concern that he/she is not serving God or living a spiritual or virtuous life. One has the impression that one is "off track," interpreting a personal distaste for spiritual/virtuous things as a turning away from the Other ("God" or what one believes to be ultimate in one's life).[326]And yet, in spite of dissatisfaction with things in general the individual will still be concerned about the Other.[327]The accompanying sign is the realization that one lacks the desire to meditate on anything, exterior or interior; the soul remains "deprived, dry and empty:"[328]

> Another marker of that time was my relationship with the Lord. I had a chapel in my home… Each morning I would pass by the open door and hear the Lord Jesus calling me, inviting me to come away awhile…But I didn't. I could not, somehow, get there…I remember even saying to him on several occasions "yes Lord, I'm coming" but I never did come.[329]

This text reveals the central and painful paradox of the Night: that which attracts and pulls an individual into relationship has now become what he/she resists and has no

[325]May, *The Dark Night*, 100.

[326]DN.1.9.3.

[327]Ibid.

[328]A.2.13.3.

[329]Pritchard, self –interview.

desire to engage. And yet, the person is deeply concerned about the life with this other/Other; there is anxiety that one is not relating as one ought. This dynamic of guilt in the Night bears the quality of "self-reproach" in depression.

In this second sign John further addresses how the loss of pleasure in the Dark Night is to be differentiated from the loss of pleasure in depression: if the latter is "the entire cause, everything ends in displeasure and does harm to one's nature, and there are none of these desires to serve God that accompany the purgative dryness."[330] Unlike the self-absorption of depression, one experiences in the Night an innate reaching out beyond self for a connection with what gives life.

John of the Cross also identifies that the Night may be intensified by the presence of depression that both Dark Night and depression may co-exist - "the dryness may be furthered by melancholia or some other humor – as it often is." Even so, the efficacy of the Night is not impacted, "it does not, thereby, fail to produce its purgative effect in the appetite, for the soul will be deprived of every satisfaction and concerned only about God."[331]

The following depressive symptoms are identified by John of the Cross: "the sensory part of the soul is very cast down, slack, and feeble in its actions because of the little satisfaction it finds." These suggest DSM-IV symptoms of "loss of energy, fatigability, or tiredness, psychomotor retardation and nonverbal manifestations of depression such as tearfulness or sadness." John, however, emphasizes that the presence of depression is not an indicator of what is occurring on a deeper level of soul, "even though in this purgative

[330]DN 1.9.3

[331]Ibid.

dryness …the spirit is ready and strong."[332]At this stage has already begun the inflow of contemplation "which is secret and hidden from the very one who receives it," for the dryness and emptiness is now companioned by "an inclination to remain alone and in quietude. And the soul will be unable to dwell on any particular thought, nor will it have the desire to do so." [333]This sign is an indication of spiritual development: "…now in this state of contemplation, when the soul leaves discursive meditation …it is God who works in it…At this time a person's own efforts are of no avail." [334]What may be perceived as a depressive movement of withdrawing and disconnecting from others may, in fact, be the gift of solitude: a necessary turning inward to be fully present to the Other and to oneself.

Third Set of Signs

John of the Cross begins his next section by adding a cautionary note: that the impoverishment of thoughts and the lack of desire to meditate on anything characteristic of the second sign may actually be the result of depression, "which habitually produces a certain absorption and suspension of the senses, causing the soul to think not at all, nor to desire or be inclined to think, but rather to remain in that pleasant state of reverie."[335] This sign also hints at the depressive symptom of a "lack of motivation."

In the third set of signs he identifies the sense of powerlessness one experiences due to a fruitless endeavour to meditate or imagine [336] or solve one's impasse. The experience

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[332]Ibid.

[333]DN 1.9.6

[334]DN 1.9.7

[335]A.2.13.6

of powerlessness may or may not be linked with further DSM-IV symptoms of depression: feelings of helplessness[337]and loss of self-confidence. [338]However, the clear signs that suffering (purgation) has given way to purification and transformation are marked by one's pleasure in solitude [339] and in an unattached or mindful state that may need to be distinguished from Endicott's suggested depressive symptom of "social withdrawal/decreased talkativeness."[340]In the Night this may actually be a sign of contemplation whereby the individual has come to "a new and deeper level of appreciation of God and/or the 'other' in a quiet, loving attentiveness." [341] John describes it as the ability to wait with loving attentiveness upon the Other without meditation, thinking, doing, without particular understanding, simply being at rest with inward peace. [342] Relentless striving to make sense of one's predicament or to determine one's culpability give way to "surrender in faith and trust in the unfathomable. Mystery that beckons onward and inward beyond calculation, order, self-justification, and fear." [343]A deep, interior silence opens up, emptiness now filled with the Other that allows one to simply be-in-communion, dispelling any illusion of separation. In the life of prayer the

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[336]DN.1.9.8

[337] Block, "Assessing and Managing Depression," 210.

[338] Widiger et al., "ICD-10 symptoms for depressive episode," in *DSM-IV Sourcebook,* 160.

[339]A.2.13.4

[340]Endicott, "Measurement of Depression."

[341]Fitzgerald, "Impasse and Dark Night," 419.

[342]A.2.13.4

[343]Impasse, 420.

use of words becomes increasingly displaced by silence as described by one palliative patient:

> I'm not praying as much as I used to. Actually, I'm not saying the words. …But in my living …I am …In my silence, I am speaking to him. No, I'm just being with God – I am in His presence….I have noticed that the silences are more frequent and more comfortable for me. I am at peace. [It's] surreal; you know you're being heard but you're not saying anything…he's in your body …and in the silence. It's about trust. You just trust that what you need is being heard and has been answered.[344]

For John of the Cross contemplation is the direct inflow of spirit into the individual.[345] Sacred self-disclosure is no longer mediated through the power of analysis and synthesis of thoughts; rather, "there is no discursive succession of thought."[346]The clinician is not left to simply trust that this is what is actually happening for the individual as the mystic doctor offers a final differential from depression: if this inability to engage with thought is the work of depression, should the depression lift one would be able to return to one's former ways of functioning. That is not so if it is the work of contemplation as the "powerlessness to meditate always continues."[347]O'Connor offers a clinical example:

> In my experience, dark night journeyers may also neglect their diet and exercise in their desolation. However, the reinstitution of a healthy diet and exercise routine does not affect the spiritual journeyers' sense of loss, whereas similar changes in a depressed person's health regime are often associated with notable positive results. [348]

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[344]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 26.

[345]DN 2.17.3

[346]DN 1.9.8

[347]DN 1.9.9

[348]O'Connor, "Spiritual Dark Night and Psychological Depression," 144.

This observation poignantly highlights the difference between mental health and spiritual health: in depression one seeks recovery and restoration, in the Night the continued incapacity to connect with the Other through one's own efforts is actually a progression in the spiritual life and not something one would require recovery from. The Night is not a disease or illness and cannot be understood as comorbidity in the same way as depression. Instead, the Night appropriates the broader definition of the concept of comorbidity originally posited by Feinstein: a clinically relevant *phenomenon* rather than disease that is separate from the patient's primary disease. [349]

Dark Night of Spirit and Depression

Dark Night of Spirit: The purpose of the Dark Night of Spirit is to transform ways of understanding, relating and loving which are accomplished through an intentional disabling of the mind. Suffering in the Night of Spirit relates to the loss of image of self, others, and the Other, the pain of desolation and anguish, and a humble awareness of one's own shortcomings accompanied by a sense of unworthiness:

> "You've walked away from God, haven't you?" the patient asked me.
> "We've all walked away from God," he urged.
> "Yes," I replied.
> "I wonder how He must have felt when we did that. Perhaps, we know now what it's like to have someone walk away from us."[350]

This palliative patient encounter briefly touches upon the sense of culpability suffered in the Night companioned by the hallmarks of abandonment and betrayal of trust:[351] "…at

[349]Robert Krueger and Kristian Markon, "Reinterpreting Comorbidity: a Model-Based Approach to Understanding and Classifying Psychopathology," Annual Review of Clinical Psychology 2 (2006): 113.

[350]Personal patient encounter, Tertiary Palliative Care Unit, Edmonton, Alberta. (date unknown).

the deepest levels of night, in a way one could not have imagined it could happen, one sees the withdrawal of all one has been certain of and depended upon for reassurance and affirmation."[352]The transformative work of the Night is actually wrought through this painful experience of loss:

> Night in John of the Cross, which symbolically moves from twilight to midnight to dawn, is the progressive purification and transformation of the human person *through* what we cherish or desire and through what gives us security and support. We are affected by darkness, therefore, where we are most deeply involved and committed, and in what we love and care for most. Love makes us vulnerable, and it is love itself and its development that precipitate darkness in oneself and in the "other."[353]

The therapeutic work (purification) of the Night of Spirit is "to heal persons from unconscious self-seeking" and "neurotic fixations;" to clear away that which one "clings to or resists" and prevents one from "centering energy on" and experiencing union with "the more" that one seeks. The emphasis in this darkness is on the work of divine agency and the loss of control over one's destiny companioned by many letting-goes.[354] Compassion is a key manifestation of the purification as individuals awaken to their deep connectedness with the suffering of others in the midst of their own suffering[355]; a phenomenon regularly witnessed in palliative patients.

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[351] Constance Fitzgerald, "The Transformative Influence of Wisdom in John of the Cross," in *Women's Spirituality,* 2d ed., ed. Joann Wolski Conn (New York: Paulist Press, 1986), 445.

[352]Constance Fitzgerald, "Impasse and the Dark Night in John of the Cross," in *Women's Spirituality Resources for Christian Development*, 2d ed., ed. Joann Wolski Conn (Mahwah N.J: Paulist, 1986), 414-415.

[353]Ibid, 420-421.

[354]Kevin Culligan, *The Dark Night of the Spirit: the Healing of the Soul*, (Washington, D.C.; Carmel Clarion Communications, 2012) CD-105-AD.

[355]Fitzgerald, "Impasse," 421-422.

A core symptom of depression is loss of meaning and by association a loss of hope.[356]Lack of meaning is also a core dimension of the Night. In John of the Cross's anthropology the function of memory plays a central role in the ability to make meaning:[357] when new experiences present in life, one usually applies the lens of knowledge and wisdom gained from past experience (memory) to bear upon the new experience and to make sense of it. However, with the experience of unknown that is one's own dying the individual is confronted with a reality that is so large the lens of memory offers too small a frame to adequately perceive it. Subsequent questions of impasse such as "Why?" "How can I leave?" or "What will happen to me?" highlight the thwarting of the intellect: "a genuine impasse situation is such that the more action one applies to escape it, the worse it gets. The principles of 'first order change' – [which are] reason, logic, analysis, planning – do not work."[358]The difference from depression lies in the fact that the disabling of the intellect does not include "complaints or evidence of diminished ability to think or concentrate, or indecisiveness."[359] Instead, the experienced disorientation will often evoke a patient's naked cry of spiritual poverty: "I feel so lost!"

The loss of hope in the Night, closely aligned to the loss of meaning, is replaced by trust or entrusting of self in surrender:

> Hope comes into play when we are really radically at the end, unable to find any further resources to connect memories, feelings, images, and experiences of life in a meaningful pattern or promising future. Then hope, forfeiting the struggle to

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[356]Blazer, "Spirituality and depression," 8.

[357]Schneiders, *Finding the Treasure,* 188.

[358]Fitzgerald, "The Dark Night and Impasse," 413.

[359]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 356.

> press meaning out of loss, becomes a free, trustful commitment to the impossible, which cannot be built out of what one possess.[360]

Hope is to surrender security in the known with a choice to entrust oneself to that which one does not fully understand.

Perhaps, the most painful loss of this second dark night is that one is emptied of who one imagined oneself, others, and or the Other to be. One patient example can illustrate this dynamic:

> No one can find another drug that will work for me. Why? Why would God close every single door when it works for someone else? ….It doesn't make sense. I keep coming back to that Why?...That God you trust and believe in, allowing that to happen![361]

This patient, Nancy, is attached to a concept of God in the impasse of poor pain control: God has the power to bring about pain relief so why does God not do this for her now? God has failed to meet her expectations. A similar dynamic can present also in relation to a patient's way of understanding and relating to self, "the most confusing and damnable part of the dark night is the suspicion and fear that much of the darkness is one's own making." [362]There is a painful awakening to the reality of who one is or who one has failed to be, "a painful awareness of one's own incompleteness and imperfection."[363] Similarity here lies with the depressive symptoms of "feelings of self-reproach or

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[360]Fitzgerald, "The Transformative Influence of Wisdom," 446.

[361]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 18.

[362]Fitzgerald, "Impasse and Dark Night," 420.

[363]Culligan, "The Dark Night and Depression," 130.

excessive and inappropriate guilt[364] and preoccupation with feelings of inadequacy. However, the difference lies in the fact that "one seldom utters morbid statements of abnormal guilt, self-loathing, worthlessness…that accompany serious depressive episodes." [365]The related depressive symptoms: thoughts of death or suicide, or suicidal behavior [366]need to also be considered. Culligan confirms that "thoughts of death do indeed occur in the Dark Night of Spirit such as 'death alone will free me from the pain of what I now see in myself' or 'I long to die and be finished with life in this world so that I can be with God.'"[367] The difference, however, is that in the Night "there is no obsession with suicide or the intention to destroy oneself that is typical of depression."[368]

The process of kenosis (being emptied out) while impacting the intellect does not impact an individual's ability to engage spiritual postures that actively assist in navigating the unknown. Paradoxically, we see by the example of this same patient, Nancy, a choice to self-empty:

> It doesn't make sense. I keep coming back to that 'Why?" ...What's so strange, [about it is] I have to trust it…give myself to it…. [Dying] is that total surrender…you can't push it away or run from it. You have to go through it. [In my prayer] I gave my soul over to God and said, 'You're will be done' and God's presence was with me then.[369]

Nancy's experience illustrates both the passive and active dimensions of kenosis: being emptied (passive) and choosing to empty (active). Her words indicate a transformation in

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[364]Widiger, "ICD- 10 symptom," in *DSM-IV Source Book*, 160.

[365]Culligan, "The Dark Night and Depression," 130.

[366]Widiger, "ICD-10 symptom," in , *DSM-IV Source Book*, 160.

[367]Culligan,"The Dark Night and Depression," 130

[368]Ibid.

[369]Pritchard, *The Contemplative Spiritual Journey of the Dying*, 21.

her way of understanding, relating and loving by means of three distinct yet inseparable movements: faith, hope and unconditional love. Nancy moves from her intellect to faith by letting-go her self-reliant desire to make sense of things, opening herself to be receptive to given knowledge: "I gave my soul over to God and said, 'You're will be done.'" She moves from memory to hope by choosing to entrust herself to that which she does not fully understand: "...What's so strange, [about it is] I have to trust it…give myself to it…" And she moves from a conditional to unconditional love: choosing to love the Other/other as is and without a need for her expectations to be met: "I gave my soul over to God and said, 'You're will be done.'" All three movements signify freedom from attachments and an inflow of peace.

Contemplation

In the transition space between the Night of Sense and Spirit a patient may experience a sense of connectedness with Other, self, and/or others. This is often companioned by the gift of insight or enlightenment; a knowing identified in the mystic literature as "secret wisdom." The quality of contemplative union and insight together with aspects of purification of images of oneself and of God are illustrated in the palliative patient narrative "Joe" (pseudonym) in Appendix E. This narrative highlights the quality of awakening or realization at work in the Night along with the dispelling of the illusion of separation. Also of note is that the loss of the patient's false self-image resulted in a transformative fruit of the Dark Night namely the liberation to love and be loved. Clearly illustrated are the inter-related relational domains and complexity of Dark

Night experiences. Contrary to what O'Connor advances, the relationship with God is not separate from other "secular" relationships in life[370]: the patient's image of God directly resulted from his childhood experience of parental relationship and a resulting wounded self-image. The narrative also identifies how the clinician's embodied receptivity to the patient's story became a discerning light to guide her assessment.

Self-pity or Lament?

The depressive symptom of "self-pity" is a term that, at least within western culture, carries negative connotations. In consideration of Nussbaum's socially constructed theory of emotions, how may one assess the inclusion of such an item as a symptom of pathology when such identification may itself be a cultural bias? The expression of self - pity is a regular occurrence within the palliative setting: clinicians daily witness patients sorrowing for their loss of selves even if such sorrowing is mute and embodied through somatizing behaviours:

> "When you are sorrowful look…in your heart,
> and you shall see that in truth you are weeping
> for that which has been your delight."[371]

The depth quality of such sorrowing may be understood as lament. This is the language of the soul and is most often the means by which the felt losses of the Night are communicated. The classic understanding of lament is rooted in the Hebrew tradition. However the psychological, social, and spiritual benefits of the psalms of lament, as

[370]O'Connor, "Spiritual Dark Night," 142.

[371]Kahil Gibran, "On Joy and Sorrow," in *The Prophet: Kahlil Gibran* (New York: Alfred A. Knopf, 1923), 29.

identified by Harrington,[372] may equally apply within the context of a therapeutic relationship in which the clinician is understanding, accepting, and comfortable with lament as a natural sorrowing of soul. Psychologically, this would allow the patient to feel free to "express intense emotions" and be able to address these to God, to life or to the other "without censorship." Socially, through the clinician's acceptance and normalization of such expression the patient will recognize that he/she is not alone but among many others who lament their life ending. Resonance with a "community of sufferers" can reduce the sense of existential isolation that so often accentuates patient suffering. Spiritually, patients are able to engage the reality of their inner suffering and allow themselves to give voice to their questions.[373]

Discussion and Implications

A table summarizing the differential diagnosis between the Dark Night and Clinical Depression is offered in Appendix F. The review offered of these phenomena invites questions for further exploration regarding the etiology and conceptualization of depression, the spiritual assessment of the Dark Night, and the role of a clinician's personal belief in patient-centered care.

In light of the demonstrated overlap between depression and spiritual suffering, ought the biopsychosocial model of the etiology of depression to be expanded to include spirituality? Ought depression then be, necessarily, pathologized? This question appears to be seriously entertained in the research agenda for DSM-V which cites Thomas Moore

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[372]Daniel Harrington, *Why Do We Suffer?: A Scriptural Approach to the Human Condition*(Franklin, Wis: Sheed & Ward, 2000), 6.

[373]Ibid.

insightful challenge: "…If we pathologize depression, treating it as a syndrome in need of cure, then the emotions…have no place to go except into abnormal behavior and acting out."[374] Moore's statement identifies the power of naming something pathology when it is not: it negates and silences legitimate emotional processes and causes harm. This raises a serious consideration regarding the ethics of practice. Dura Vila et al. also challenge the practice of modern medicine "where psychiatrists have a tendency to convert patient's emotional difficulties into diseases rather than opportunities for reflecting on their lives and as potential agents for beneficial change…"[375] Their study evidences the reality of misdiagnosing a spiritual reality for pathology, and captures the distress caused to those who are not understood:

> [Sr. Teresa] argued that the Mother Teacher …did not understand that she was living her own *Dark Night of the Soul*, "wrongly taking it for depression" to the point of taking her to see a psychiatrist. The psychiatrist, who was also a priest, was "luckily very understanding" and became instrumental in her spiritual restoration as he reassured her that she was *not* clinically depressed. He explained to her that what she was going through was part of her own religious transformation."[376]

Ought the dark night to be considered a salutary rather than pathological religious depression? The discussion above notwithstanding, the fact remains that a pathological view of depression dominates the field of medicine. As noted in an earlier discussion, one may advance a spiritual/transformative view of depression and, in this sense perhaps, identify a salutary process at work within a perceived pathology. However, to accord such activity as the presence of the Dark Night clearly runs contrary to the classic understanding of the Night: St. John takes great pains to differentiate the Night from any

[374]Thomas Moore, *Care of the* Soul, p.147, qtd in Dan Blazer, "Spirituality and depression," 8.

[375]Glòria Durà-Vilà, et al. "Causes and resolution," (2010):567.

[376]Ibid, 558-559.

pathology. Gerald May offers the clarification that the depressive symptoms of the Night are actually an expected *psychological response* to the Night and not to be confused with the Night itself which has no psychological causation. [377] Strictly speaking, therefore, when one speaks of a differential diagnosis one is speaking of the similarities and differences not between the Dark Night and depression but between the psychological responses to the Night and depression.

What then is the relationship between Dark Night and depression? The experience of loss is the common denominator. Loss in the Dark Night may lead to depression "even if most of the [Dark Night] experience feels liberating, it still involves loss, and loss involves grief, and grief may, at least temporarily become depression." [378] Or loss may be manifest concurrently as Dark Night and depression. Culligan offers an example:

> A middle-aged father might concurrently be dry in his prayer and also struggling with feelings of worthlessness, losing sleep, and too preoccupied to enjoy downtime with his children or sexual relations with his wife due to a sudden and unexpected loss of employment that has placed his family's financial security in serious jeopardy.[379]

In terms of appropriate care in the Night – can offering a patient the narrative of the Night relieve emotional suffering as suggested by Dura-Vila et al? [380]Clinical experience has suggested not necessarily so: a patient for whom such an explanation is acceptable can be helped by knowing about the Dark Night of the Soul. However, another patient may not connect at all with such an assessment. One cannot simply superimpose upon a patient's experience the meaning structure of the Night precisely because it is a matter of

[377]May, *Care of Mind, Care of Spirit,* 109.

[378]May, *Dark Night,* 156.

[379]Culligan, "The Dark Night and Depression,"131-132.

[380]Durà-Vilà and Dein, "Spiritual Distress and Its Psychiatric Implications,"556.

belief as is the nature of all matters related to spirituality. A further consideration is that Dura-Vila et al.'s study is of a sample of those who have a conscious awareness of living a dark night experience. Again, clinical experience paints a different picture: the Night relates to the unconscious dimension of the spiritual life, and for most patients, is often something they would not be aware of or simply be unable to voice: "

> …I don't remember ever talking about this pain with folk. It was deep in my heart. I could not articulate my pain…[381]

In regards to the question of self-pity – if this may be understood as lament then it becomes an imperative that the clinician be self-aware regarding his/her own meaning and valuing of the term. Is pity for oneself permissible? It would be important not to assess the patient by one's own culturally shaped beliefs and assumptions but to seek to elicit the meaning of lament for the patient. Clinical practice has regularly indicated that many, though not all patients, desire to have a space and permission to express their pity for self. The implications for care are significant: lack of tolerance or negative appraisal of self-pity may thwart the expression of sufferers and silence them, thereby intensifying their suffering. Alternatively, one's valuing of such self -expression may result in a lack of respect for patient dignity should a patient culturally have no desire for lament.

The question of assessment of the Night may well necessitate a paradigm shift in one's understanding of "spirituality." Such a shift is alluded to in the parable of *The Little Fish*:

> "Excuse me," said the ocean fish.
>
> "You are older than I, so

[381]Pritchard, self-interview.

can you tell me where to find
this thing they call the ocean?"
"The ocean," said the older fish, "is the thing
you are in now."
"Oh, this? But this is the water. What I'm seeking
is the ocean," said the disappointed fish
as he swan away to search elsewhere. [382]

Evidence of the Night may be clearly present and yet missed if it presents in psychological language. The same may be said for depression: spiritual processes may be at play yet simply not acknowledged if other depressive symptoms overshadow them. An appreciation for the spiritual dimension of depression would also suggest an expansion of treatment choices to include modalities that are expressive of the soul such as contemplative spiritual care or the mindfulness approach to depression [383] in addition to the experiential modalities of focus therapy, art and music therapy.

The role of spiritual-psychotherapy and contemplative spiritual guidance is paramount in patient care of both the depressed person and one undergoing the Night. In the case of the Night, appropriate clinical care cannot be a simple application of a Dark Night narrative upon patient experience; an ethic of practice requires, as indicated by John of the Cross, a discerning, learned companionship from one who is experienced in the way of the Dark Night.

[382]Anthony de Mello, *The Song of the Bird* (New York: Doubleday, 1982), 12.

[383]Mark Williams et al. *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness* (New York: Guilford Press, 2007).

Conclusion

The palliative mandate to provide impeccable assessment of spiritual problems is challenged by the presentation of the Dark Night, a spiritual phenomenon that can easily be conflated with depression. This paper has sought to offer a palliative perspective on the differential between Dark Night and depression. The arguably inherent spiritual dimension of depression and the phenomenon of the Dark Night stress the need for the clinician's development of core competencies in the promotion of spiritually integrated patient-centered care: the ability to trace spiritual processes within the clinician's personal and professional life, and the ability to identify spiritual processes that clinically present regardless of one's personal spiritual perspective.

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CHAPTER 3

THE DARK NIGHT CONTEMPLATIVE MODEL FOR SPIRITUAL ASSESSMENT IN PALLIATIVE CARE PART I: INTRODUCING THE DARK NIGHT OF THE SOUL

The Dark Night of the Soul (referenced more accurately as "Dark Night" and also referred to by the abbreviation "the Night") is a mystical or contemplative form of spirituality[384] presenting across major world wisdom traditions in both theistic and non-theistic form. The Dark Night is a metaphor for the spiritual journey: [385] a phrase originally coined by the priest-monk John of the Cross, it is succinctly described by Dark Night theologian Constance Fitzgerald:

> Night in John of the Cross, which symbolically moves from twilight to midnight to dawn, is the progressive purification and transformation of the human person *through* what we cherish or desire and through what give us security and support. We are affected by darkness, therefore, where we are mostly deeply involved and committed, and in what we love and care for most. Love makes us vulnerable, and it is love itself and its development that precipitate darkness in oneself and in the "other." [386]

The reader is invited to review "A Dark Night Lexicon" (Appendix A) as a means of orienting to the theology of the Night.

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[384]John Peteet, Francis Lu, and William Narrow, *Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V* (Arlington, Va: American Psychiatric Association, 2011).

[385]A.1.2.1.

[386]Constance Fitzgerald, "Impasse and the Dark Night in John of the Cross," in *Women's Spirituality Resources for Christian Development*, 2d ed., ed. Joann Wolski Conn (Mahwah N.J: Paulist, 1986), 414-415.

Dying as a Dark Night Contemplative Space

The Dark Night Contemplative Model for Spiritual Assessment offers the integrative framework of Dark Night spirituality as one interpretive lens for conceiving the spiritual journey of the dying. The thesis that dying may be perceived as a Dark Night journey has been comprehensively addressed in a prior paper.[387]The present study, through the use of metaphor and images, offers a window into how dynamics regularly encountered in the clinical setting may be perceived through a Dark Night lens. It will also illustrate how these contemplative dimensions concretely present through application of a longitudinal composite patient case study entitled "Anthony's Story: A Palliative Patient Narrative" which the reader is now invited to review in Appendix G.

Dark Night Contemplative Spirituality

> *The world is charged with the grandeur of God.*
> *It will flame out, like shining from shook foil.*[388]

In contemplative understanding, life is drenched in the holy; Infinity paradoxically manifests within the embodied and finite. Contemplative spirituality is wide, open, receptive, and inclusive of paradox writ large at end-of-life—living in dying and dying in living. The Dark Night as an apophatic form of contemplation nuances the passive, receptive, and unconscious depths of the spiritual life – the Unknown. It may be imagined as the dark and fertile cavern of the womb: a place where one is held, nurtured,

[387]Zinia Pritchard, "Dying as a Dark Night Experience" (D.Min. diss., article, Saint Stephens College, 2014),1-39.

[388]Gerard Manley Hopkins, "God's Grandeur," in *Gerard Manley Hopkins:Selection of his Poems*, ed. W.H. Gardner, The Penguin Poets (Middlesex, England: Penguin Books, 1963), 27.

protected, loved; where one grows simply through "'living, moving, and having one's being'"[389] in the Other.

In the darkness of the Night, knowing is not a product of the intellect but a given wisdom; one simply awakens to enlightenment; [390]in the void of the Night, the primordial voice of the sacred resounds – Silence.

The Dying Space as a Contemplative Space

The dying space may be likened to the ocean: an underworld filled with the wildness and wonder of the deep. One has to learn to breathe with gills; to navigate the dark and mysterious world of Unknown. Pulled to the sea bed bottom by looming questions of identity and meaning, the individual engages the paradox of what is both deep and ultimate: Who am I? Whose am I? What have I loved? How have I loved? What do I leave? How do I leave? [391]

Limits of Language and the use of Images in Medical Education

The Dark Night as a mystical reality cannot be fully grasped by the intellect, and the medium of language, as a linear construct, falls far short of imparting its dynamic wholeness. In seminars, using images to illustrate dimensions of the Night engages residents in a more holistic way, pulling them into an embodied, felt, and imagined experience of the dynamism of the Night. This means of engagement parallels the multi-layered texture of patient-centered care where assessment employs clinical skill but also

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[389]Acts: 17:28

[390]Francis Kelly Nemeck and Marie Theresa Coombs, *The Way of Spiritual Direction* (Wilmington, Del: M. Glazier, 1985), 93.

[391]Adapted from Wayne Muller, *Touching the Divine* (Boulder, CO: Sounds True Audio, 1994).

an intuitive or emotional intelligence. Residents are invited to explore what they perceive in a given image; their responses are then used to guide the teaching on how a particular dimension of the Night clinically presents at end of life.

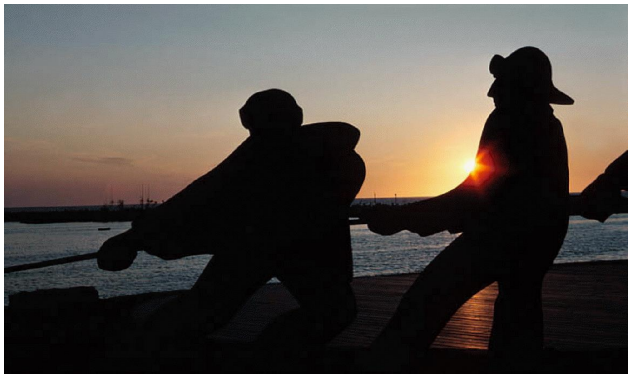
Fig.1

The image of the fishermen pulling on their net (Fig.1) speaks to the life of a patient prior to a terminal diagnosis. It suggests active engagement with life. For some, the energy invested was considerable with many pressures and little time. For others, it may have been the love lavished upon grandchildren or simply the activities of daily living. Whatever this life prior to serious illness, it was a life in which a person knew themselves. It nourished or reinforced the individual's particular image of self.


Fig.2

The image of an imploded volcano (Fig.2) speaks to the clinical expressions of being "hollowed out" in the dying experience: physical pain, cognitive impairment, constipation, shortness of breath, tiredness, fatigue, drowsiness, loss of appetite, edema, and cachexia syndrome.[392]By the time a patient is encountered in the tertiary palliative care setting his/her energy has dissipated to varying extents and mobility may be decreased or severely impacted. As independence recedes, the patient slowly relinquishes active agency and moves toward a place of passivity and increasing receptivity. Initially, it is a movement that is companioned by a crisis of meaning, namely, the often unspoken, yet lived question "who am I now that I can't do this or that?" But eventually, for many, it gives way to a place of being at rest with "simply being."

A Dark Night perspective suggests that this movement presses a person to no longer relate to self as a "doing-being." The individual's diminishment of ego, a spiritual process of being emptied known as *passive kenosis,* compels the individual to reconsider a self-identity that is grounded purely in being thus awakening to who he/she truly is. The painful burning away of all that is untrue about oneself, all that is false about who one imagined, believed, and or sensed oneself to be is known as the process of purification. What is left, as a result, is the nugget of pure gold, known as the true self:

> …the self that begins the journey is not the self that arrives. The self that begins is the self that we thought ourselves to be. It is this self that dies along the way until in the end "no one" is left. This "no one" is our true self. It is the self that stands prior to all that is this or that. It is the self in [the Other], the self bigger than death.[393]

[392]Jóse Pereira, *The Pallium Palliative Pocketbook: A Peer-Reviewed, Referenced Resource* (Edmonton : The Pallium Project, 2011).

[393]James Finley, *Merton's Palace of Nowhere: A Search for God Through Awareness of the True Self* (Notre Dame: Ave Maria Press, 1978), 35.

The inner self or true self refers to the deepest and transcendent authentic self—the self one truly *is.* Grounded in Ultimate Reality, the true self has an eternal essence: a sense of abiding beyond space and time. In the clinical setting this presents as a belief in a life after death and or a belief that one's essence lives in and through one's relationships and life's accomplishments (generativity and legacy). It is the self that remains in spite of physical diminishment and the self that is held in memory by others after one's death. In Anthony's story, it is expressed in the vision of reconciliation with Eden, his deceased son.

The dynamic of purification and awakening to the true self is depicted in Anthony's story in relation to his self-image, and his relationships with Eden and his wife. To briefly review the salient parts of the narrative: Anthony was a self-contained man who had suffered the loss of his son Eden and the resulting loss of his marriage to Joanne. His core suffering resided in his perceptions of having abandoned his child in Eden's hour of need, and his associated perception of God as having abandoned him. Through the facilitation of his soul's lament Anthony experiences a profound spiritual encounter; the bequeathing of liberating insights within this contemplative experience propels Anthony toward reconciliation, peace, and love at his life's end.

At the beginning of the narrative, Anthony perceived and valued himself in terms of his helpfulness and productivity. His sense of self was largely determined by his independence. Over time, Anthony's diminishing capacity dissolved any illusion of self-sufficiency and control. In the words of St. John of the Cross, Anthony's soul,

(classically referred to by the feminine pronoun), "knows that on her own she neither does nor can do anything."[394]

In relation to his son Eden, Anthony had upheld the image of being a father who would "always be there" for his son. His subsequent inability to save Eden shattered Anthony's self-image.

In the fourth and pivotal spiritual care encounter in Anthony's story, he is wonderfully met in the experience of union with God in his suffering. This contemplative awakening afforded him insight into how his false image of self manifested both in his relationship with Eden and his wife. He recognized that, likened to the divine father, the act of not saving his own son from death was not necessarily an act of abandonment. In relationship to Joanne, his wife, Anthony now realized how his self-understanding as "a giver and not a taker" had severely impacted the mutuality needed in his marriage. It is Anthony's expression of his authentic self that subsequently engages Joanne in the necessary work of forgiveness and reconciliation.


Fig. 3

The proverbial saying "it's like hitting your head against a brick wall"(Fig. 3) speaks to the phenomenon regularly witnessed at end of life – patients' relentless and often fruitless attempts to make sense of their predicament: "Why is this happening to me?"

[394]DN 1:12:2

"Where am I going?" "How can I leave?" Individuals are confronted with a sense of the intellectually impenetrable.

A Dark Night lens identifies these "unanswerable" [395]questions as those of impasse: "nothing makes sense. The mind, while *full* on one level of a lifetime of knowledge, is in total darkness on another, the level of meaning." [396]Impasse speaks to a patient's profound experience of meaninglessness and powerlessness in the sea of uncertainty.

In Anthony's story, impasse relates to his wrestle with the meaning of his cancer and the rationalization of erroneous self-condemnation: perceiving the cancer as deserved suffering for the spiritual offense (sin) of having abandoned his child. This meaning-making endeavor bestowed no peace. The Dark Night notes that "a genuine impasse situation is such that the more action one applies to escape it, the worse it gets. The principles of 'first order change' – reason, logic, analysis, planning – do not work."[397]The experience of impasse also existed on the part of the clinician who, in respect of Anthony's wishes, was rendered powerless to engage him in further reflection upon the distressing rationalization of his cancer as a deserved punishment.

[395]Puchalski, "Spirituality, Religion, and Healing," 690.

[396]Constance Fitzgerald, "The Transformative Influence of Wisdom in John of the Cross," in *Women's Spirituality,* 2d ed., ed. Joann Wolski Conn (New York: Paulist Press, 1986), 445

[397]Constance Fitzgerald, "Impasse and the Dark Night in John of the Cross," in *Women's Spirituality Resources for Christian Development*, 2d ed., ed. Joann Wolski Conn (New York: Paulist Press, 1986), 413.

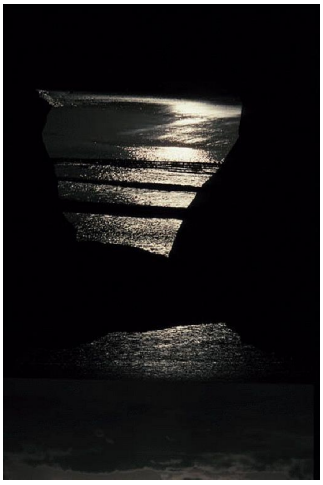
Fig.4

The image in figure 4 is difficult to perceive. Is it water, mountains, a face? The darkness obscures one's vision. Often when residents are asked what they see they screw up their eyes and lean forward trying to make out what is there and their answers are varied. The experience of being in the dark speaks to the clinical reality of patients navigating what is Unknown at end of life.

A Dark Night lens normalizes this experience; the encountering of life impasses plunges a person into darkness. When new experiences present in life one usually applies the lens of memory, that is, knowledge and wisdom gained from past experience to bear upon the new experience and make sense of it. However, with the experience of unknown that is one's own dying the individual is confronted with a reality that is so large the lens of memory offers too small a frame to adequately perceive it. The contemplative spirituality of the Night acknowledges that the very experience of Unknown is an allusion to the "more" that is Ultimate Reality.

Anthony's confrontation with the unknown of his cancer experience saw him applying the known of his faith to make sense of his predicament; his cancer was a result of a transgression against God in his failure as a father to save Eden from death.

However, Anthony's interpretation was guided by his myopic understanding of what he knew of the Divine: a God only of strength. In the experience of lament a far broader understanding of Ultimate Reality was made known to him: that of the vulnerable God. The profound resonance with Divine vulnerability offered Anthony a sense of felt connection—the experience of One who intimately shared his pain and not of One who far transcended his human experience. The healing of this existential gap and the insight it offered him healed Anthony of the spiritual anguish of believing Eden's death was a result of his abandonment of him as a father. Moreover, it served to heal his pre-morbid spiritual pain: his perception of Eden's death as a personal abandonment by God with the resulting felt loss of connection and dryness in his spiritual life.

Paradox

During the Invasion of Iraq (2003) the *New Internationalist* Magazine published a provocative image: a marine physician sitting in the sands of Iraq cradling a bleeding Iraqi child with his eyes closed in prayer. This image is particularly potent for medical practitioners – it evokes the impartial nature of the healer; the call to save life—any life. The image is also a powerful portrayal of the nature of paradox: the "both…and" reality of depth-experience where seemingly conflicting truths are held in tension together; the child is caringly held by the very force that has felled her. In the dying journey it can relate to both the death-dealing onslaught of cancer cells and yet also the life-giving gifts within a patient's journey such as love, compassion, self-awareness, wisdom, and reconciliation. And toward the end of life a most common experience of paradox is the desire to both let go of life and hold onto life.

In Anthony's story paradox first presents, as indicated, in his image of the Other: moving from that of One who was all powerful and whose presence meant the absence of suffering to One who was also vulnerable and present in suffering. A later paradox presents in Anthony's desire to both die (and so enjoy the anticipated experience of reunion with his son in the life after) and his concomitant desire to stay (and enjoy the experience of reunion with his wife).

Lament

Palliative patients actively grieve the many and varied losses in their dying. Sometimes, these expressions are evident and verbal; other times, they are mute or in the guise of somatizing behaviors such as Anthony's frequent requests for breakthrough medications. The depth quality of such sorrowing may be understood as lament; the language of the soul. Anthony's lament also has the religious character of abandonment often witnessed in the clinical setting: "Why did God allow this?" "Where is God?" Such suffering points to what is theologically understood as "the problem of theodicy." Namely, how can an all-powerful, all-loving, and good God allow innocent suffering?

The notion of lament, examined by biblical scholars such as Westermann and Brueggemann, identify the core need of a sufferer to voice to the Ultimate the pain of deprivation however it is experienced. In Anthony's story, his participation in the Divine lament marks this evocative expression as an authentic dimension of the spiritual life. As poignantly identified by liberation theologian Dorothy Solle, "[t]o become speechless, to be totally without any relationship, that is death." [398] Anthony's story illustrates the transformative power of bringing silent suffering to voice. The understanding of lament

[398]Dorothee Soelle, *Suffering*, trans. Everett R. Kalin (Philadelphia: Fortress Press, 1975), 76.

as an antidote to silence has been addressed in Hebrew studies by the work of Brueggemann. [399] The benefits of lament have been identified by biblical scholar Harrington[400] who identifies the psychological, theological, and social needs that are met by lament: to be able to voice anguish, within a cultural context that permits it, allows individuals to experience themselves as part of a community of sufferers. As Brueggmann advances, the wilderness experience is matrix for the cry of lament[401] and so may be considered normative for the experience of unknown and uncertainty that is the palliative journey. The capacity to lament is pivotal for what nursing researchers Rehnsfeldt et al have identified as the shift from "unbearable suffering" to "bearable suffering."[402] In the words of Breuggmann, the courage and evoking of spiritual agency in the act of lament allow "the suffering ones, uncowed and unsilenced, to take the first step in having wilderness-exile...transposed into a viable arena of life."[403] The character and function of lament underscores the imperative of facilitating lament in spiritual care of the dying.

[399]Walter Brueggemann, "Lament as Antidote to Silence," *Living Pulpit* 11, no. 4 (2002):24-5.

[400]Daniel Harrington, *Why Do We Suffer?: A Scriptural Approach to the Human Condition* (Franklin, Wis: Sheed & Ward, 2000), 6.

[401]Brueggemann, 25.

[402]A.Rehnsfeldt and K. Eriksson, "The Progression of Suffering Implies Alleviated Suffering," *Scandinavian Journal of Caring Sciences* 18, no. 3 (2004): 264-72.

[403]Brueggemann, 25

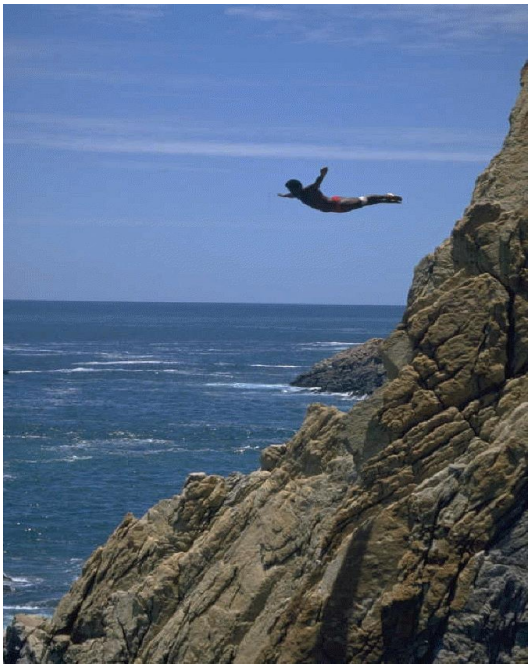
Fig. 5

The energy of free-fall of a swimmer diving off a cliff (Fig. 5) relates to the active "letting-goes" that make up the dying journey. There are countless references to this movement made by family, clinicians and patients alike: "he's let go," "she needs to let go," "he's not ready to let go yet," "how can I let go?" "I'm ready to go."

The Dark Night lens offers the spiritual perspective of letting-go as a chosen self-emptying known as *active kenosis* or surrender:

> Spiritual surrender is a deliberate act of the will, not a breaking of the will…it does not come without resistance – a good indication that it has everything to do with our active free will. We experience a loss of our ego-self, the self that we possess when we freely choose to place our complete trust in the Other. It's like taking a breath in and then jumping out of a plane in the firm hope (never certainty) that the parachute will open and carry you safely down. [404]

The dynamic of letting-go is one that both patient and family engage at end-of-life. Anthony's story depicts Joanne's experience as a reconciled spouse struggling to relinquish the very intimacy of love lost now found. The experience of suffering-love is a

[404]James Krisher, *Spiritual Surrender: Yielding Yourself to a Loving God* (Mystic, CT: Twenty-Third, 1997).

central drama in the dying journey: Anthony, like many patients, is clearly tired with the fight for life but he suffers in love for his wife choosing to continue with aggressive therapies because of her emotional need; Joanne, as is the case of many family members, is confronted with the invitation to surrender that which she wishes to dearly hold onto.

Letting go requires the free-fall of three inter-related spiritual virtues: faith, hope, and love. By faith, one chooses to let-go of the need to make sense of things chiefly through one's own efforts and steps into the darkness of the unknown, receptive to what may be made known. In hope, one surrenders the security of what one knows from past experience (memory) and chooses to relate to what is Unknown to one by freely entrusting oneself to it. In love, there is an unconditional care for the other without a demand that one's own needs and expectations are met.

Both Anthony and Joanne navigate the end-of-life journey in faith, hope, and love. Joanne does not know what life will be like without Anthony in it and yet, in faith and hope, she moves blindly into the Unknown by entrusting herself to that which she does not fully understand. Anthony entrusts himself to the mystery of desiring to both live and die by his movement into life with Joanne and into death with Eden. In love, Joanne surrenders her need to make Anthony stay and chooses to love him for himself and not for a need in her that he can fulfill. Anthony, similarly, surrenders any need he may have that Joanne be ready and willing to let him go. There is a mutual surrender of the need for control.

Contemplation


Fig. 6

The image of the baby suspended in the darkness of its mother's womb (Fig. 6) is a poignant depiction of contemplation: the union of one in the Other and the Other in one. Over time in the palliative journey there is a movement among many patients toward stillness and silence as the tide of questions recedes and the patient appears at peace with simply being. This inner space of receptivity is marked also by the increased physical needs of care, and eventually total care as the patient enters into the active phase of dying. Simply being is a hallmark of the contemplative life. The Dark Night understands contemplation as the direct inflow of the Other into the individual. It does not require conscious knowing and doing on the part of a person; it is simply given. As a loving union it may also be accompanied by the gift of insight or enlightenment—the surprise of an awakening or awareness that often resolves a patient's questions of impasse.

The character of contemplation in Anthony's story strikes both a major and minor chord. On the one hand, the facilitation of his lament gave way to a dramatic felt union and insight into his interior struggle. On the other hand, the striving of the intellect to resolve two seemingly conflicting truths of wanting to both stay and leave receded, resulting in a quietening of the mind and a comfort with simply being. How this change

was actually effected in Anthony is not known; it is as if soundless music plays in the soul touching and tending it.

The Dark Night of the Senses

In Anthony's story we witness the dynamics of the "The Dark Night of the Senses" and the "Dark Night of the Spirit." While the former is how one normally begins the journey of the Night to be followed by the latter, the two dimensions are intimately related. As the purification of self is an ongoing spiritual work of transformation, individuals can be concurrently living in and out of these Dark Night dimensions at any given time.

The Dark Night of Sense is comprised of three sets of signs, each of which have a passive and active dimension. By passive, John of the Cross intends to nuance spiritual agency [405] and by active he lays emphasis on one's personal efforts.[406]

In the Passive Night of Sense the individual experiences a lack of satisfaction and consolation in all dimensions of life. John of the Cross identifies three signs. Sign one is an experience of emptiness or[407] dryness companied by a distaste or lack of appetite for usual spiritual, creative or re-creative practices,[408] and dissatisfaction with things in general. In spite of this, sign two is concern about one's moral/spiritual life:[409] a guilt and solicitous concern that one is not serving God or living a moral/spiritual life; a sense

[405]DN.1.9.2-8.

[406]A.2.13:2-4.

[407]DN.1.9.2.

[408]DN.1.9.4.

[409]DN.1.9.3.

that one is "off track" because of an awareness of distaste for spiritual things.[410,411] Sign three is the experience of powerlessness due to the fruitless endeavour to meditate, imagine, or rationally resolve an experience of impasse.[412] Prior to the resolution of his impasse, Anthony believed that he had displeased God, his prayer life had changed, he lost his desire for the spiritual activities he normally engaged in, no longer identified himself as a religious man, and in spite of all his doing for others he could not fill the void within himself.

The first sign of the Active Night of Sense is when the individual realizes that he/she is no longer able to meditate, imagine or take pleasure from usual spiritual, creative or re-creative practices. [413] The second sign occurs when this inability is also accompanied by a lack of desire to meditate on anything,[414] However, the third sign marks the transformation of the Night of Sense when, the individual is seen to take pleasure in solitude, [415] able to simply wait with loving attentiveness upon the Other without meditation, thinking, doing, understanding, or anxiety. The individual is able to simply be at rest with inward peace.[416]

In Anthony's story we note that toward the end of his life he grew quieter, that his prayer life had changed from one that placed emphasis on doing (spoken prayer) to

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[410]DN.1.9.3.

[411]Ibid.

[412]DN.1.9.8

[413]A.2.13.2.

[414]A.2.13.3.

[415]A.2.13.4

[416] Ibid.

simply being, and that he favoured solitude. There appeared to be no anxiety, no wrestling for ultimate meaning or understanding; he seemed to be at peace. Instead, it was Joanne who needed to navigate spiritual issues at the close of Anthony's life.

The Dark Night of the Spirit

Anthony's story also bears testimony to the contemplative dynamic of the "Dark Night of the Spirit." In this, the individual's often unconscious beliefs and understanding of self, others, and of ultimate Reality is challenged by experience.

> These are the losses of the dark night of the spirit: persons are forced to let go of cherished self-images and long-held God images that are no longer tenable in the contemplative light of what they now see. The loss of these images is for the person an experience of death, with all the consequent feelings of anger, sadness, guilt, and grief.[417]

Early in his admission Anthony suffers the loss of self-image as an independent co-worker; in the Night one's ego is no longer able to construct a sense of identity and worth that is dependent upon the satisfaction of independence, functionality, self-sufficiency, and productivity. Core to Anthony's story is his loss of image as a father: he had experienced, thought, and imagined himself to be someone who would always be there for his child. Anthony implicitly believed that this would mean that his child would not come to harm; the reality that Eden did, in fact, die was interpreted by him, on this implicit level, as a failure on his part to protect his child—an act of abandonment.

In this initial study introducing the Dark Night of the Soul, Anthony's story has illustrated the potent meaning offered by a Dark Night understanding of end-of-life spirituality. It is this lens that guides the author's contemplative model for spiritual

[417]Kevin Culligan, "The Dark Night and Depression," in *Carmelite Prayer: A Tradition for the 21st Century*, ed. Keith Egan (New York: Paulist, 2003), 125.

assessment further examined in the second and third parts of this work: *The Dark Night Model for Spiritual Assessment in Palliative Care Part II: The History of the Model's Development* and *The Dark Night Model for Spiritual Assessment in Palliative Care Part III: Model Review and Case Study Application.*

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CHAPTER 4

THE DARK NIGHT CONTEMPLATIVE MODEL FOR SPIRITUAL ASSESSMENT IN PALLIATIVE CARE PART II: HISTORY OF THE MODEL'S DEVELOPMENT

This Chapter is the second in a three-part study on the Dark Night Contemplative Model for Spiritual Assessment in Palliative Care. The first part of the study (Chapter Three) offers an examination of dying as a Dark Night experience. The last part of the study (Chapter five) provides a detailed model review and application; both studies draw upon a longitudinal patient case study entitled *Anthony's Story*. The focus of this Chapter is to offer the reader the background and rationale for the model's development and to provide a synopsis of the model. It will begin with a brief introduction to the spirituality of the Dark Night and how this study is situated within the practice of a practical theology.

The Dark Night of the Soul (referenced more accurately as "Dark Night" and also referred to by the abbreviation "the Night") is a mystical or contemplative form of spirituality[418] presenting across major world wisdom traditions in both theistic and non-theistic form. A term coined by the priest-monk St. John of the Cross,[419] the Dark Night nuances the unknowns in life and the process of transformation through suffering. As

[418]John Peteet, Francis Lu, and William Narrow, *Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V* (Arlington, Va: American Psychiatric Association, 2011).

[419]John of the Cross, *The Dark Night of the Soul*, in *The Collected Works of St. John of the Cross*, rev.ed. trans. Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), Prologue.

such, the Dark Night particularly commends itself as a metaphor for the spiritual journey[420] at end-of-life.

The author stands at the cultural crossroads between the worlds of palliative medicine and contemplative spirituality as a clinically grounded practical theologian and medical educator.[421]A bridging between these worlds has been necessary for the author's cultivation of an appropriate model for spiritual assessment at end-of- life: the model appropriates both the theological wisdom of the Dark Night and the clinical wisdom of palliative practitioners. In so doing, it offers a Dark Night perspective on spirituality at life's end and is also guided by an inclusive definition and language for spirituality emerging out of the interdisciplinary dialogue. The product of this cross-cultural exchange is the translation of the Dark Night into clinical constructs that can practically guide assessment and care. The following parts of this chapter will trace the background and rationale for the development of the Dark Night model for spiritual assessment within palliative care.

Need for Inter-professional Assessment of Spirituality

The ability to assess spiritual health and manage spiritual issues is emerging as a multi-layered inter-professional competency. [422] [423] Spiritual histories have been formulated, mainly by the medical profession, as a response to the need for assessment.

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[420]A.1.2.1.

[421]A Certified Specialist within the Canadian Association for Spiritual Care, (CASC)

[422]Christina Puchalski, "Spirituality and Medicine: Curricula in Medical Education," *Journal of Cancer Education*. 21 (2006): 14-18.

[423]Christina Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Health Care* (West Conshohocken, PA: Templeton, 2010).

These tools are situated between a basic spiritual screening [424] and a spiritual care professional's assessment.[425] Spiritual histories incorporate questions that are employed in a patient interview; a notable example being "FICA"— a versatile spiritual history developed by palliative practitioner and medical educator Christina Puchalski.[426] Spiritual assessment, on the other hand, offers an interpretive framework that allows the clinician to situate a patient's story within the landscape of spirituality.[427] Emphasis is placed upon the clinician's attitudinal postures (i.e. relevant dispositions and skills) in engaging a patient and his/her story and marked by the core spiritual health competency of self-awareness.[428] In spiritual assessment, the clinician is the primary therapeutic tool.

Need for Spiritual Care Education among Family Physicians

Patient-centered care is a shared focus for both palliative and family medicine. The Edmonton Zone Palliative Care Program (EZPCP, formerly known as the Regional Palliative Care Program), Edmonton, Alberta demonstrated leadership in holistic care by choosing to provide family medicine residents rotating through the Tertiary Palliative Care Unit (TPCU) with an introduction to spiritual care of patients at end-of-life. The one and a half hour educational session entitled "Spiritual Care in Palliative Care" was facilitated by the author with learning further augmented by ongoing exposure to her

[424]George Fitchett and James L. Risk, "Screening for Spiritual Struggle," *Journal for Pastoral Care and Counselling* 63(2009).

[425]Ibid

[427]Christina Puchalski and A. Romer, "Taking a spiritual history allows clinicians to understand patients more fully." *Journal of Palliative Medicine* 3 (2000):129-137.

[427]Puchalski and Ferrell, *Making Health Care Whole*,95.

[428]Zinia Pritchard, "The Contemplative Practitioner: A Dark Night Model for Spiritual Care of the Dying"(D.Min. diss., article, Saint Stephens College, 2014),179-208.

practice of spiritual care as an integral member of the TPCU interdisciplinary palliative care team.

A five-year program evaluation study of this educational experience ensued. The evaluation comprised individual participant completion of a questionnaire: five quantitative questions and two qualitative. A total of 143 evaluations were received from session participants between January 2003 and February 11th 2008. The five quantitative questions posed measured responses using a Likert scale where a measurement of agreement ranged from 0 "not at all" to 10 "highest possible." The questions were as follows: (1) My exposure to spiritual care on this rotation has impacted my awareness of the spiritual dimension to palliative care medicine; (2) My exposure to spiritual care on this rotation has impacted my approach to the medical care of my patient; (3) My exposure to spiritual care on this rotation has caused me to reflect upon my own spiritual values, beliefs, and issues; (4) I would recommend education in spiritual care to be an integrative part of the rotation; and (5) The palliative chaplain mentor has facilitated learning in the area of spiritual care.

An additional two qualitative questions were posed; question six identified the respondents' key learning points and question seven invited the respondents' to name how the learning process could have better met their needs.

The program evaluation resulted in participants identifying gaps in medical education and learning needs summarized in the table below. The full evaluation report is available in Appendix H.

TABLE: **Resident Program Evaluation of Spiritual Care Educational Session "Spiritual Care in Palliative Care"**

Identified Learning Need	**Quantitative Analysis** **Percentage of individual questionnaire evaluations received from 143 Residents**	**Qualitative Analysis** **Representative Comments**
Education in Spiritual Care	30%	• "Being exposed to an area that gets no attention in our medicine training."
Clinical Mentoring	40%	• "Being present during a spiritual care consult." • "Maybe going over individual patients I am caring for with the chaplain."
Identity and Role of the Spiritual Care professional	34.2%	• "spiritual care within healthcare/in hospital is inclusive and holistic." • "In interdisciplinary team meeting, seeing how spiritual care affects every aspect of palliative patient's care – including the medical aspect."

Identifying the Need for Education in Spiritual Assessment in Palliative Medicine

Building upon the Canadian Medical Education Directives for Specialists (CanMEDS) [429] and in support of a palliative physician's role as medical expert, the

[429]Royal College of Physicians and Surgeons of Canada, "CanMEDS 2005 Framework" (n.d.), http://www.royalcollege.ca/portal/page/portal/rc/canmeds/framework (accessed December 11th 2012).

following spiritual assessment competencies were identified within the one year Enhanced Program of Added Competence in Palliative Medicine (and recorded within the Tertiary Palliative Care Unit (TPCU) Program Goals and Objectives for resident training):

> To perform and communicate a spiritual history; to identify spiritual issues common in palliative patients and their families and demonstrate strategies for addressing them[430]

Such competencies reflect the holistic vision of palliative medicine: the underlying belief that the work of spiritual care is a shared enterprise, faithfulness to the palliative mandate to provide assessment of spiritual problems, and the integration of spirituality within patient-centered care.[431]

In 2010/2011, the author developed a palliative spiritual history as an outgrowth of her assessment model known by the acronym COF-PHLI. Its precursor was piloted with palliative residents and fellows within the one year Enhanced Program of Added Competence in Palliative Medicine, University of Alberta. In a subsequent Formative Evaluation, these physicians identified the role of the medical expert as compromised due to the lack of formal education and training in the clinical competency of spiritual assessment. The following are representative comments from three palliative residents:

> (1) Spirituality is not something we're formally trained in…I could certainly see why someone would be a bit hesitant to delve into this.

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[430]Objective 1.2.16 (medical expert); 3.2.1 (collaborator); and 2.2.5 (communicator), Palliative Medicine Residents and Clinical Fellows, one year Enhanced Program of Added Competence in Palliative Medicine Objectives, University of Alberta.

[431]World Health Organization, "Definition of Palliative Care" (n.d.), http://www.who.int/cancer/palliative/definition/en/ (accessed September, 2008).

(2) I think sometimes I am comfortable to ask but when the patients answer back … I don't know what they're talking about. I don't know what to say… I don't know what I should do next... It's easy to ask but when they start to talk...
(3) Because it's new…it's different. I mean, I likened it to the same way when we were medical students and learning all the terminology; it's like learning another language. In the same way that we're sometimes taken out of palliative care and we're put into a different environment you struggle…It's outside your comfort zone.[432]

This gap in medical education highlighted the need to build interdisciplinary capacity for spiritual assessment in palliative care. As a concrete response to this need a practical theological approach was employed to develop a clinically grounded model for assessing spirituality at end-of-life. Practical theology refers to a way of doing theology that begins by turning to clinical practice. Out of this context it identifies a question for discernment, in this case, how do we spiritually assess and care for the dying? It first consults the wisdom of palliative practitioners including the author's own palliative spiritual care practice. Only then does it consult the wisdom of sacred tradition, in this instance, the Dark Night of the Soul. Placing these two sources of wisdom in dialogue with each other, it then moves into a process of mutual critical reflection which generates insights that can inform and guide best practice.[433]

The Clinical History of the Model's Development

The Dark Night Model for Spiritual Assessment reflects the wisdom of inter-professional care-givers garnered through the author's facilitation of varied learning

[432]Zinia Pritchard, "A Formative/Process Evaluation Report: Palliative Medicine Residents and Fellows Experience of Implementing the Spiritual History Tool: Appendix." Submitted to Program Residency Director, Division of Palliative Medicine, University of Alberta, Edmonton, Alberta, June 15, 2010.

[433]The author is depicting the *sapiential* (wisdom) model for practical theology as illustrated in the text by Patricia O'Connell Killen and John De Beer, *The Art of Theological Reflection*.

opportunities and reflective practice over the past decade: (i) the interplay between spirituality and religion was specifically addressed within the Family Medicine Rotation through the TPCU, Edmonton; (ii) the translation of the theology of Dark Night into clinical constructs was grounded in a definition for spirituality identified through a spirituality study group comprised of palliative care givers drawn from nursing, occupational therapy, and social work within EZPCP; (iii) the cultivation of self-awareness as a core spiritual care competency was fostered through a personal and support group style reflective process with palliative residents and fellows entitled "Physician as a Therapeutic Tool"; (iv) the work of translating the world of theology to palliative medicine was further cultivated through educational venues, in particular web-based rural physician[434] and inter-professional learning courses,[435] physician retreat venues, Palliative Residents National academic half-day presentations,[436] Palliative Rounds presentations,[437] and the author's ethics contribution[438] and national peer evaluation of a palliative spiritual care curriculum.[439]

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[434]Zinia Pritchard and José Pereira, "The Human Experience: One Person's Story"(spiritual care and medicine team presentation, End-of-Life Care: Reflections, Rimrock Hotel, Banff, Alberta, April 15-16, 2000).

[435] *Palliative Care: An On-line Course for Health Care Professionals. A MAINPRO-C Course*, (Edmonton, Alberta: University of Alberta, October 2000).

[436]Zinia Pritchard, "A Dark Night Model for Spiritual Assessment" and "Taking a Palliative Spiritual History" (power point presentations, Palliative Medicine Residents' National Academic Half-Day, Edmonton, Alberta, 2009 – 2012).

[437]Zinia Pritchard, "The Dark Night of the Soul and Depression: A Differential Diagnosis" (power point presentation, Edmonton Zone Palliative Care Program, Edmonton, Alberta, 2011).

[438]Zinia Pritchard, "Ethics in the Practice of Spiritual Care at End of Life," in *Developing Spiritual Care Capacity for Hospice Palliative Care: A Canadian Curricula Resource*, ed. Dan Cooper and Jan Temple-Jones (Edmonton: The Pallium Project, 2006), 81-90.

[439]Dan Cooper, Michael Aherne, and José Pereira, "The Competencies Required by Professional Hospice Palliative Care Spiritual Care Providers." *Journal of Palliative Medicine* 13 (2010): 869-875.

Examining spirituality and religion

The translation of Dark Night theology into a clinical construct for spiritual assessment began with a theoretical and clinical exploration of the terms "spirituality" and "religion." How clinicians understand spirituality determines how they assess for signs of spiritual wellness and suffering. If clinicians perceive spirituality as exclusively expressed through religious practice and or language, they risk overlooking spiritual issues that may present within the intra-psychic and inter-personal domains of relating.

A number of authors posit that religion and spirituality are synonymous[440] though most view them as distinct entities. The defining characteristic of spirituality is posited by some to be the relationship with God/Higher Other, [441] and by others to be the existential.[442] Conversely, there are those who consider spirituality to exclude the existential[443] or to include both the existential and religious.[444]

Clinically, an inductive understanding emerged from family medicine residents' intuitive responses to the following questions: What does spirituality mean to you? What does religion mean to you? Inviting intuitive responses allowed residents an opportunity to become critically aware of personal beliefs around "spirituality" and "religion" and how these dimensions may be related.

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[440]Harold Koenig, *Spirituality in Patient Care: Why, How, When, and What* (Philadelphia: Templeton, 2002).

[441]David L. Coulter, review of "Scientific Research on Spirituality and Health: A Consensus Report," ed. by David B. Larson, J. P. Swyers, and M. E. McCullough, *Journal of Religion Disability and Health* no.3 (1999): 79-82.

[442]Robert Buckman, *Without God a humanist's personal story* (Carson City, NV.: Filmwest Associates, 2004), DVD.

[443]Koenig, *Spirituality in Patient Care*. Note that the author identifies "meaning and purpose, cultural beliefs and social supports" as alternatives *to* rather than dimensions *of* spiritual expression."

[444]Christina Puchalski and Betty Ferrell, *Making Health Care Whole*, 22.

A noteworthy concession made by residents was that most of the terms they defined as belonging to "spirituality" would also be authentic expressions of "religion." This surprising realization cautioned against placing spirituality and religion into a dualistic relationship and against the application of a reductionist mindset toward religion. What appeared to distinguish religion *per se* from spirituality were the following characteristics: (1) the formal "institutional" element, meaning the organizational and structured aspects inclusive of rules and regulations; (2) the "communal" element, that is the identity, beliefs, practices, values, morality, mission, and purposes that are shared or held in common; and (3) the resulting accountability of membership.

In frank discussions, residents often acknowledged an element of resistance to institutionalism *per se*. For a number of participants, there appeared to be a serious disconnect between how religion is experienced or perceived and how a personal spirituality is experienced. This observation was echoed by the late contemplative monk Thomas Merton: "…few religions ever really penetrate to the inmost soul of the believer, and even the highest of them do not, in their social and [worship] forms, invariably reach the inmost 'I' of each participant."[445] In spite of the critique, some residents expressed an ability to engage a personal spirituality within the constructs of religion, which would suggest that belonging to a religion does not exclude individual expressions of spirituality.

Residents' intuitive understandings of spirituality and religion suggest the following three possibilities for a conceptual understanding of the relationship between spirituality and religion. One understanding is that spirituality and religion are essentially distinct

[445]Thomas Merton, *The Inner Experience: Notes on Contemplation*, with an introduction by William Shannon (San Francisco: HarperSanFrancisco, 2003), 26.

entities that share some common elements. Another understanding nuances spirituality as the broadest term, allowing for both communal expressions of spirituality (that is, religious) and non-communal expressions of spirituality. Whilst a further interpretation argues that religion is the more appropriate umbrella term as personal spiritualties reflect one or more religious influences: original personal formation within a religious community, appropriation of wisdom originating in one of the world religions, or a personal belief that may have developed independently of any explicit knowledge of religious wisdom yet bears remarkable similarity to a religious wisdom. The discussion so far suggests that the relationship between spirituality and religion is complex and highlights the need for an inclusive understanding of spirituality in guiding clinical assessment.

In 1999, the author facilitated an informal Spirituality Study Group within EZPCP comprised of twelve self-selected interdisciplinary palliative care practitioners, six of whom described themselves as religious and six of whom described themselves as spiritual but not religious. Participants were invited to share their personal stories of spirituality through symbol, story, music or any other medium acknowledging that the chosen symbol functioned as a window into the soul of the practitioner. As with the poetic expression of the Dark Night, this process ultimately resulted in a definition of spirituality that was void of religious language and yet could accommodate all stories and expressions participants held as spiritual, whether these were religious, theistic, non-theistic, or philosophical:

> spirituality is the experience of relationship with self,
> the experience of relationship with others, and

the experience of relationship with Other/Ultimately Real.[446]

The relational and inclusive framing of spirituality reflects what is known in religious and philosophical wisdom as a distinctly *contemplative* understanding. The definition also offers accessible language to guide the ensuing work of translating Dark Night theology into clinical constructs that could assess spiritual well-being and suffering.

As noted by John Shea, the resulting language for a theologically informed spiritual assessment is significantly different from the language of its religious "homeland" [447]— whenever possible, it uses everyday language rather than the language of religious faith, e.g. the theological word "deprivation" is intentionally replaced by the word "loss." To the degree that it can, the language for contemplative spiritual assessment relinquishes attachment to creedal language in its expression of the spiritual.

A Synopsis of the Dark Night Model for Spiritual Assessment in Palliative Care follows the Table below. The model builds upon the contemplative definition of spirituality, which encompasses the experience of relationship on the intra-personal, inter-personal, and transpersonal levels. In keeping with the paradoxical integrity of the Night, it identifies both experiences of connection in relationship (the domain of spiritual resources) and disconnection (the domain of spiritual suffering) as authentic dimensions of spirituality. The domain of spiritual orientation accommodates salient aspects of an individual's spiritual identity in relation to what he/she considers Ultimate.

[446]To the best of the writer's recollection, this definition emerged in or by way of an informal telephone conversation with RN Dennie Hycha, (date unrecorded).

[447]John Shea, *Spirituality & Health Care: Reaching Toward a Holistic Future* (Chicago: Park Ridge Center for the Study of Health, Faith, and Ethics, 2000), 19.

TABLE

SYNOPSIS OF A DARK NIGHT MODEL FOR SPIRITUAL ASSESSMENT

DOMAIN	DIMENSIONS
Spiritual Orientation **How one is positioned in relation to what one considers Ultimate**	**Who/What is identified as Other/Ultimate Reality** e.g. "God," "the Universe" **Significant spiritual/philosophical beliefs:** spiritual identity incorporates spiritual, philosophical, cultural beliefs **Vocational Identity:** spiritual identity expressed through a particular type of work and/or way of life, e.g. teacher, parent, soldier **Core Values/Beliefs:** e.g. "treat others as you would want to be treated" **Sense of meaning and purpose/mission** **Spiritual language:** identification of ultimate meaning through religious or everyday language **Community of Belonging:** spiritual identity/soul connected to meaningful community membership, e.g. religious congregation, spirituality group, recreational and or service group **Faith of Origin:** spiritual identity connected with religious tradition but not membership with a religious community
Spiritual Resources **Experiences of connection in relationship**	❖ **Self:** The experience of **connection** in relationship with self ❖ **others:** The experience of **connection** in relationship with others ❖ **Other:** The experience of **connection** in relationship with Other

Spiritual Suffering **Experiences of loss of connection in relationship**	❖ **Self:** The experience of **loss of connection**/disconnection in relationship with self ❖ **others**: The experience of **loss of connection**/disconnection in relationship with others ❖ **Other**: The experience of **loss of connection**/disconnection in relationship with Other

This Dark Night contemplative assessment has served the purpose of providing clinicians with a model that is accessible, inclusive, and portable:

> Pritchard (2012) uses a multidimensional approach by looking at a number of ways spirituality is expressed in life (i.e. with self, others, Other)....I feel that it is a holistic model for spirituality as it provides a framework that examines the three key areas in a person's spiritual life. The real strength of this model lies in the ability to use it to assess spirituality whether a person identifies themselves as religious or not…A strength of this model is that it can be used in any setting (i.e. community, hospital, assisted living)... Extensive training is not needed to be able to use the model... [and it] includes detailed comprehensive clinical tools for spiritual assessment.[448]

Discussion and Implications

The need for an interdisciplinary assessment of spiritual health is a sign of the times.[449] The practical theologian, by inhabiting both the worlds of palliative medicine and contemplative theology, is uniquely positioned to understand the need and to facilitate the work of cross-cultural communication in meeting it. The resulting development of the

[448]Mary Elizabeth Thuss, "Spiritual Assessment" (paper written for Spiritual Assessment in The Promotion of Health INTD577, University of Alberta, Edmonton, Alberta, August 20, 2012), 10-11.

[449]*Gaudium et Spes,* "Pastoral Constitution on the Church in the Modern World," in *Vatican Council II : the Conciliar and Post Conciliar Documents,* trans.and ed. *Austin Flannery,* (Northport, N.Y. : Costello, 1988), para. 4.

Dark Night model for spiritual assessment, as a product of practical theology, highlights the significant contributions that a health-based practical theologian can make in collaboration with and empowerment of spirituality leadership within health today.

Conclusion

This Chapter has delineated why and how the Dark Night Model was developed for spiritual assessment in palliative care as a process of practical theology. A detailed analysis of the model's constituent parts and its case study application will be the focus of the following chapter: *The Dark Night Contemplative Model for Spiritual Assessment in Palliative Care: Review and Application.*

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CHAPTER 5

THE DARK NIGHT CONTEMPLATIVE MODEL FOR SPIRITUAL ASSESSMENT IN PALLIATIVE CARE PART III: REVIEW AND CASE STUDY APPLICATION

This chapter is the last in a three part series on The Dark Night Contemplative Model for Spiritual Assessment in Palliative Care. It builds upon the illustration of how dying may be perceived as a Dark Night spiritual experience (chapter three), and the background and rationale for the model's development (chapter four). The focus of the current study is to provide a detailed review of the domains that constitute the model, together with a case application.

The ensuing work is divided into three distinct sections. Part I reviews the domains of the model—the translations of Dark Night theology into clinical constructs. This section makes reference to the inventory of items that fall within each domain by reference to the tool form of the model —the Pritchard Palliative Spiritual Assessment Tool (PP-SAT) situated in Appendix I; Part II presents *Anthony's* Story, a composite palliative longitudinal case study; and Part III demonstrates the application of the model appropriating the detailed inventory of the PP-SAT.

Part I: Review of the Domains of the Model

The following illustrations graphically depict first the entry points for a Dark Night Contemplative Model for Spiritual Assessment (Fig. 1) and then its three constituent domains: Spiritual Orientation (Table), Spiritual Resources (Fig. 2), and Spiritual Suffering (Fig. 3).

Fig. 1 offers a conceptual overview of the model and highlights the entry points for spiritual assessment, which may be along any of the three relational trajectories in a patient's story, namely the experience of relationship with self, the experience of relationship with others, or the experience of relationship with Other. Regardless of the original point of entry, (most often the relationship with self or others), the assessment usually covers all the relational trajectories.

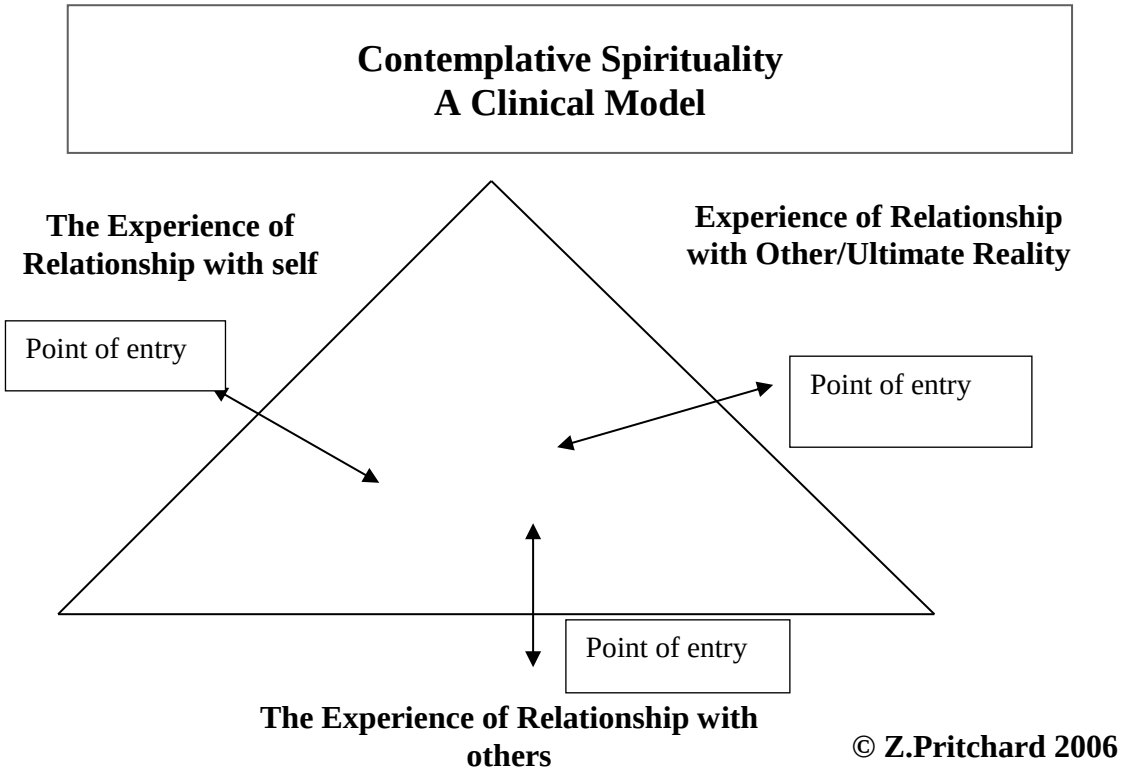

Fig. 1

Spiritual Orientation (Table) refers to how a person is positioned in relation to what he/she considers Ultimate. It is comprised of: who or what is identified as Ultimate Reality; significant spiritual and or philosophical beliefs; vocational identity; core values

and or beliefs; sense of meaning and purpose; spiritual language; community of belonging; and faith of origin (historical religious grounding).

TABLE: SPIRITUAL ORIENTATION

Spiritual Orientation **How one is positioned in relation to what one considers Ultimate**	**Who/What is identified as Other/Ultimate Reality** e.g. "God," "the Universe" **Significant spiritual/philosophical beliefs:** spiritual identity incorporates spiritual, philosophical, cultural beliefs **Vocational Identity:** spiritual identity expressed through a particular type of work and/or way of life, e.g. teacher, parent, soldier **Core Values/Beliefs:** e.g. "treat others as you would want to be treated" **Sense of meaning and purpose/mission** **Spiritual language:** identification of ultimate meaning through religious or everyday language **Community of Belonging:** spiritual identity/soul connected to meaningful community membership, e.g. religious congregation, spirituality group, recreational and or service group **Faith of Origin:** spiritual identity connected with religious tradition but not membership with a religious community

Spiritual Resources (Fig.2) refer to the experiences of connection in relationship. The corresponding dimensions are as follows: the experience of connection in

relationship with self, the experience of connection in relationship with others, and the experience of connection in relationship with Other.

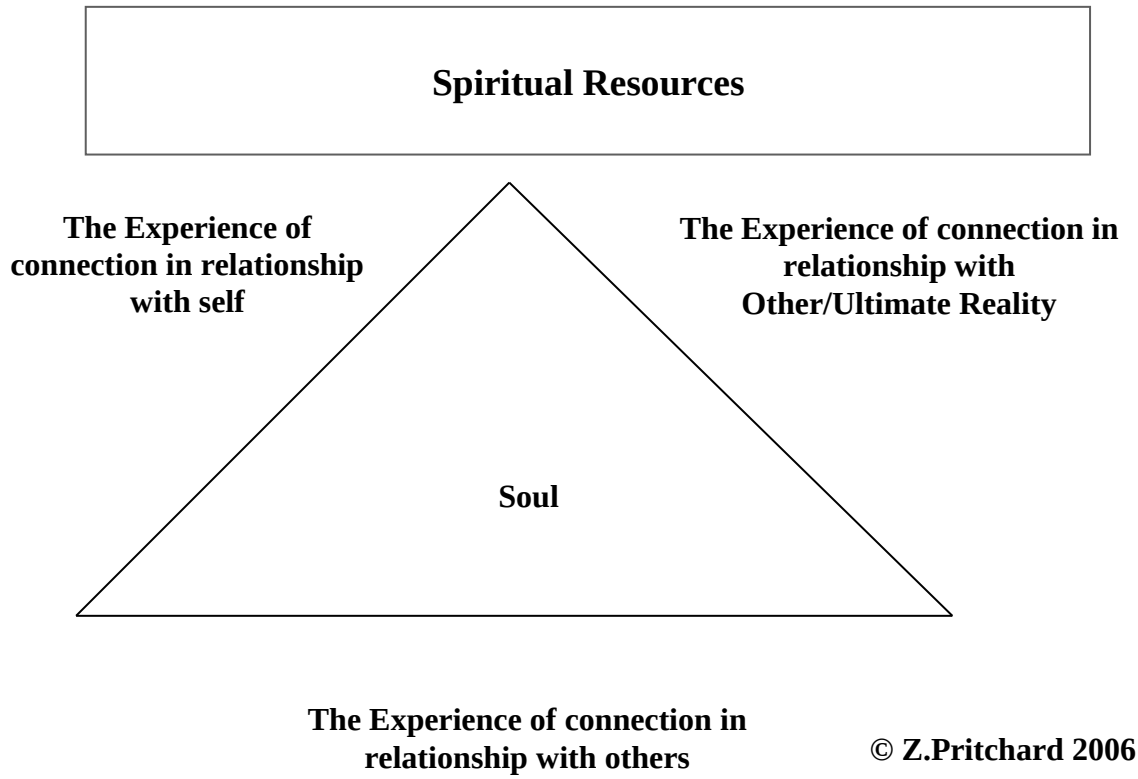

Fig. 2

While spiritual resources refer to experiences of connection, Dark Night wisdom identifies that the experience of loss of such connection can result in the experience of suffering: "the loved one, the very focus of desire, becomes the cause of one's agony."[450] Spiritual Suffering (Fig.3) relates, therefore, to the experiences of disconnection/loss of connection in relationship with self, with others, and with Other. The expressions of loss may be understood as lament: a sorrowing of soul that may be articulated and/or embodied through somatising behaviours.

[450]Constance Fitzgerald, "The Transformative Influence of Wisdom," in *Women's Spirituality Resources for Christian Development*, 2d ed., ed. Joann Wolski Conn (Mahwah N.J: Paulist, 1996), 446.

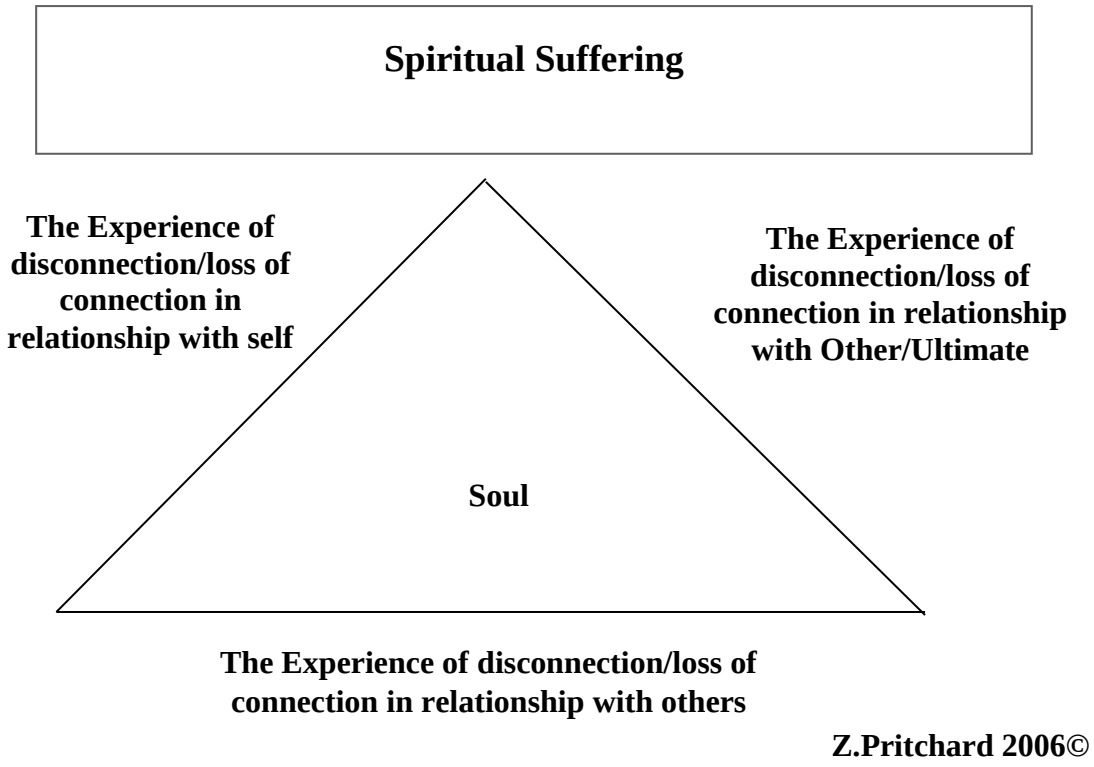

Fig. 3

The following section offers a more detailed analysis of each domain and related dimensions of the model.

Spiritual Orientation

The dimensions of spiritual orientation, as identified above, will now be delineated in the order identified in the Spiritual Orientation Table above: who or what is identified as Ultimate Reality (inclusive of the nature of spiritual identity or soul); significant spiritual and or philosophical beliefs; vocational identity; core values and or beliefs; sense of meaning and purpose; spiritual language; community of belonging; and faith of origin (historical religious grounding).

Other/Ultimate Reality

In contemplative spirituality the unifying essence that integrates all dimensions of human existence is considered to be ultimate Reality or "the Real." A contemplative spirituality conceives the spiritual as that which animates all expressions of being and that manifests itself in the physical, psychological, social, and religious aspects of self. The spiritual is the unifying force that integrates these parts into the whole rather than being simply a part of the whole. It may be likened to the ribbon that threads in and out of each piece of a quilt; it holds the pieces together and is a part of each.

Although the poetic can evoke the experience of the sacred, the very nature of the Real places it beyond the reach and containment of concept and language. Sociologist spirituality researcher Pam McGrath voices this when she notes there is difficulty in "articulating a sufficiently comprehensive and inclusive conceptual understanding of this elusive dimension of life." [451] Religious wisdom has demonstrated across the centuries that there can never be one definitive expression for the experience of the Real. Each culture and faith group can only express the experience of the Real through the particular paradigms, language, and concepts of its culture. Similarly, engagement with Reality (that is, spirituality), can only be conceptualized and articulated from the subjective meaning-making orientation of the individual or community of kind. That being said, the experience of the Real somehow abides within each limited definition of spirituality. The essence of this mystery may be likened to the nature of the hologram:

> A hologram is a special type of storage system that is best explained by an example: if you take a holographic photo, say, of a dog, and cut out one section of it, e.g., the dog's leg, and the enlarge that section to the original size, you will get, not an enlarged leg, but a picture of the whole dog. The hologram provides a

[451]McGrath, "Creating a Language for Spiritual Pain,"637-46.

> concrete illustration of the principle: 'The whole is greater than the sum of the parts,' but there is added a new and intriguing dimension which states: the whole is contained in each of the parts. [452]

If spirituality relates to wholeness (holiness) there cannot, therefore, be such a thing as the spiritual "component," "dimension," or "domain" of the human person; the holy is mysteriously present within all the dimensions of being human while at the same time transcending all dimensions— this understanding of Reality or Other is crucial to a contemplative understanding of spirituality.

A final note relates to the use of language in relation to Other: what is ultimately real for a person may be conveyed in religious and non-religious language, through posture, tone, and even gesture. The use of idiom or metaphor is also noted as some individuals refer to "the Man Upstairs," "Something," "Someone," or "It" as possible references to the transcendence/Other.

Spiritual Identity/Soul

Spiritual identity or soul alludes to the transcendent and depth dimensions of who one truly is: one's personal meaning and/or sense of mission and purpose, spiritual/religious, philosophical, and/or cultural beliefs, vocational work and/or way of life, core values that guide one's personal morality and/or ethical practice, an expression of self that may be associated with in and through a community of belonging. Spiritual identity (soul) animates all the dimensions of being-in-relationship.

[452]Diarmuid Ó Murchú, *Quantum Theology* (New York: Crossroad, 1997), 55.

Spiritual Language

Religious language is not the only medium for expression of spirituality; understandings of transcendence can and often are expressed in everyday language and through symbolism. One clinical example may be afforded of a palliative patient who had a vivid imagination; delighting in fairy tales he often spoke of "happily ever after." In gently exploring what this term meant for him the following creedal statement emerged:

> I believe in happily ever after…I have lived in happily ever after, here, on earth. But, I do not think that I can live happily ever after here anymore…I believe that I will go to another place where I will start again –like being born again, and I will be able to live happily ever after, there…I believe in happily ever after

When it comes to matters of the soul, an imperative for spiritual care of one's patient is to recognize spiritual language as the language of meaning-making.

Community of Belonging

A Community of Belonging refers to an individual's shared identity and participation with a collective. Communities of belonging may include affiliation with a service, leisure, or lifestyle communities, and or religious communities that are meaningful to the individual.

Religious identity refers to a person's naming of self in terms of a religious or communal expression of spirituality, e.g. I am Lutheran. It indicates a sense of belonging to a particular community of belief and practice. However, this is not necessarily an indication of active membership in said community; it may denote a cultural identity e.g. "you don't have to go to church to be as Christian." For some, being religious may mean attending a faith community every now and then, for others it may indicate regular attendance, and for others still, it may include a life of service to that faith community.

An interesting facet is the self-appraisal given by some individuals: "Oh, I wouldn't say we're religious. My son from BC he's the religious one." The individual who made this statement went on to affirm her and the patient's active membership in their local Jewish faith community, their extensive Jewish friendship circle within that community, and a weekly life of community worship in addition to supportive visits by their rabbi. Yet, in her self-understanding, she was not a religious woman. Such a phenomenon cautions against a clinical assumption that one understands what is meant by the phrase, "I'm not religious" or the phrase "I'm spiritual not religious."

The complexity of religious identity is further compounded by the reality that for some regular faith community attendance may or may not mean a person has an inner spiritual life. A landmark study by Allport[453] identifies this phenomenon as "intrinsic" and "extrinsic" expressions of religious spirituality; intrinsic spirituality denotes the person whose religious identity is rooted in an active spiritual life and extrinsic spirituality denotes the individual who participates in religious activities out of a sense of obligation, social status, and other reasons extraneous to an inner spiritual life.

An individual may also self-identify with one religious expression but in his/her operative spirituality adheres to other religious/spiritual/philosophical wisdom, for example the Christian who has integrated beliefs and practices of Buddhism. Furthermore, there are individuals who have a religious identity but have little understanding or a false understanding of their identified religion. Moreover, there are some who adhere to superstitions beliefs and/or engage practices that are not authentic expressions of their religious traditions.

[453]Gordon Allport and Michael Ross, "Personal Religious Orientation and Prejudice," *Journal of Personality & Social Psychology* 5 (1976): 432-443.

Faith of Origin

For many people, religious identity may function by what I am identifying as a "faith of origin." Similar to a family of origin, a faith of origin denotes an individual's formative spirituality or religious "DNA": a world view, morality, and ethics shaped by the beliefs espoused by a particular spiritual or cultural community. While an individual may change and grow in their normal human development, the faith of origin is something deeply embedded and for many individuals appears to surface at crisis points in life.

The faith of origin regularly presents in palliative and end-of-life scenarios when a patient who originally identified as being "not religious" makes requests for rites and rituals belonging to the religious tradition he/she was originally raised in. Sometimes these requests come as a surprise to the individuals themselves. A key spiritual care practice guideline would be to assess a patient's faith of origin along the trajectory of illness should a patient wish to access the services of an original spiritual/cultural community. Even if a patient is not desiring of religious support during the dying journey, his/her faith of origin most often flags required religious protocols upon death, e.g. the patient who identifies as a secular Jew yet desires to be buried as a Jew will need his/her body to be cared for by the health care provider in a manner that is respectful of religious Jewish custom.

An ethical issue that regularly presents at end of life is the request made for rites and/or rituals from the immediate family or family of origin. When this occurs, the clinician needs to ascertain if it is the patient's desire to engage in these practices accommodating for the not irregular occurrence that patients often assent to these requests out of love for their families. The matter, however, becomes more complicated

when the patient is cognitively impaired or unresponsive and so unable to express his/her wishes. On such occasions, the clinician would need to assess if the rite or ritual being asked for is congruent with the patient's explicit and implicit expression of spirituality. This is where an earlier assessment of a patient's spiritual orientation, inclusive of any known faith of origin, would be essential in determining sound ethical practice, (the reader is referred to an earlier paper which identifies the power dynamic of a faith of origin and its impact on the ethics of patient care).[454]

In light of the many and varied interpretations of a religious identity, it is a wise clinical practice guideline for spiritual care of any patient to not assume what a patient means by claiming a religious identity.

In the Dark Night Contemplative Model for Spiritual Assessment in Palliative Care. Figures two and three illustrate spiritual resources (experiences of connection) and spiritual suffering (experiences of loss of connection) in relationship with self, others, and the Other. This following section will offer a further delineation.

Relationship with Self: Spiritual Resource and Spiritual Suffering

Relationship with Self

There are several dimensions of the self: [455] the somatic or physical self, the emotional self, the volitional self or will, and the psychological self that is comprised of the cognitive intellect, imaginative intellect (with the capacity for hope), and the unconscious (that is, aspects of self that remain hidden from one's awareness). Spiritual

[454]Zinia Pritchard, "Ethics in the Practice of Spiritual Care at End of Life," in *Developing Spiritual Care Capacity for Hospice Palliative Care: A Canadian Curricula Resource*, ed. Dan Cooper and Jan Temple-Jones (Edmonton: The Pallium Project, 2006), 81-90.

[455]Thomas Groome, *Sharing Faith : A Comprehensive Approach to Religious Education and Pastoral Ministry : the Way of Shared Praxis* (San Francisco : HarperSanFrancisco, 1991),87.

resources in relationship to oneself denote all *experiences of connection* one might have with any of these dimensions of being, e.g. the experience of connection with one's physical self as an athlete. Conversely, spiritual suffering relates to a *loss of the experience of connection (disconnection)* with oneself, denoting a lost image of self, namely the "who I am" that I perceive myself to be. An inventory of spiritual resources and spiritual suffering in the relationship with self are located in the PP-SAT (Appendix I).

Relationship with others: Spiritual Resources and Spiritual Suffering

Relationship with others relates to all supportive relationships inclusive of relationship with family, the earth, animals, and communities of meaning. Spiritual resources denote experiences *of connection in relationship with others.* In the clinical context, experience of supportive connections relate to a sense of shared faith and hope. Faith may have the character of a religious or spiritual belief but may also be a faith in empirical science and the medical practitioner. At times, faith in the latter can extend beyond the realistic capacity of medicine to deliver, such as the belief in a curative outcome within a palliative setting. A similar belief is at times expressed in the powers of complementary therapies and in sought outcomes of different forms of spiritual practice. Shared hope relates to the possible outcomes of quality of life, length of life, or even cure.

Spiritual resources in relationship to others, therefore, relate to the shared faith and hope that a patient enjoys with another in regards to medical intervention, alternative therapies, and or spiritual outlook or practices. It spiritually connects the patient and the

other through an experience of shared meaning and purpose. The shared dimensions of faith and hope foster a sense of communion among the parties concerned.

Conversely, spiritual suffering in relationship with others is an experience of a loss of shared faith and hope; for example, a once shared hope for extended life is replaced by a patient's hope, instead, for a peaceful death. On those occasions when the patient is unable to express such a shift to the other, perhaps because he/she is keenly aware of the other's inability to let-go of life sustaining interventions, the resulting lack of shared meaning and purpose and experience of loss of connection (disconnection) with the other can lead to expressions of acute spiritual distress inclusive of somatising behaviours. Suffering in this dimension of relating can also entail a lost image of the other, namely how one has perceived the other to be. An inventory of spiritual resources and spiritual suffering in the relationship with others are located in the PP-SAT (Appendix I).

Relationship with Other/Ultimate Reality: Spiritual Resources and Spiritual Suffering

Distinguishing the fact of one's experience of ultimate Reality from the naming of that experience is vital: as a wise contemplative once said, "no one got drunk on the *word* 'wine.'"[456] Across religious traditions Ultimate Reality or the Sacred has been named in different ways, the most common generic term being the word "God." However, even this name can mean different things to different people. For some, it is perhaps the most broad and transcendent term imaginable –liberating and loving. For others it is too small a word and carries with it a punitive sense that cannot be reconciled with the depth experiences of life and love. Furthermore, others would find such a word as quite irrelevant to their world view. In the current climate, language for the Other often makes

[456]Anthony de Mello, *The Song of the Bird* (Garden City, N.Y. : Image Books, 1984),2.

use of the term "the universe" and the identification of "serendipitous" happenings or discoveries closely aligns with the nature of spiritual agency understood within contemplative spirituality as the gift of wisdom (insight) or enlightenment.

Spiritual resources in relationship with Other refer to the *experiences of connection in relationship with what is Ultimate.* In this transpersonal realm of relating, meaning, faith, and hope shape a generative or life–giving perception of what is ultimate for a person. There may be experiences of felt communion, gifts of clarity, insight, or enlightenment. The sense of expansiveness that marks this dimension may also be identified in the patient experience of compassion for others in the midst of personal suffering. Spiritual resources in relationship with Other include the fostering of connection through spiritual practice and creativity, such as prayer (verbal and imaginative), meditation, contemplation, rites/rituals, music, dance, song, art, and acts of service. In this model, "meditation" refers to the spiritual practice that employs "a discursive reasoning process in which words, events, etc., are prayerfully pondered and reflected on with the object of drawing from them some personal meaning or moral."[457] Contemplation, on the other hand, nuances a way of being that "transcends the thinking and reasoning of meditation, as well as the emotions and 'feelings' of the affective faculties."[458] In contemplation, one experiences a non-anxious, restful, and loving awareness of others and Other.

Spiritual suffering in relationship with Other refers to the *experiences of disconnection in relationship with what is Ultimate.* It most often relates to the lost image

[457]Thelma Hall, *Too deep for Words: Rediscovering Lectio Divina* (New York : Paulist Press, 1988), 9.

[458] Ibid.

of the Other—a loss of how one has perceived Other to be. For patients who believe in God, this dimension of suffering engages what is known theologically as the problem of theodicy; biblical scholar Daniel Harrington offers the following definition:

> Derived from the Greek words for "God" (*theos*) and "justice" (*dike*), theodicy refers to the attempt to hold together these three propositions: God is all powerful; God is just; and people suffer. To put it another way, how can an omnipotent and just God allow suffering (especially innocent suffering)? [459]

One's faith in what is ultimate, whether it is conceived as God or life's meaning, has been shaken. The question "why?" and its variants are the most common forms of the quandary that present in spiritual suffering and may be understood as questions of impasse: matters that cannot be intellectually resolved. The lack of meaning can result in a sense of disorientation or feeling lost, abandoned, isolated, or fearful of the Unknown. It is often at these times that an individual can experience spiritual changes: (i) powerlessness or inability to focus in spiritual or creative practices with an accompanying lack of gratification; (ii) a lack of desire to even engage such practices; and (iii) a lack of satisfaction in anything or anyone.

The paradox that lies at the heart of the Dark Night Model for Spiritual Assessment is that integration or wholeness is born out of suffering. The spiritual agency of Other is the fuel that fires the transformative processes of both loss and surrender: (i) the loss of personal gratification in relationship to others/Other may be companioned by surrendering the need for such gratification *(attachment to ego/will)* and a choice to relate to the situation or others without agenda or expectations *(spiritual posture of love)*; (ii) the loss of control, (being in the know), may be companioned by surrendering the need to

[459]Daniel Harrington, *Why do we suffer? : A Scriptural Approach to the Human Condition* (Franklin, WI : Sheed & Ward, 2000) 2.

rely upon the rational mind to make sense of things *(attachment to intellect)* and the choice to step into the darkness of the Unknown *(spiritual posture of faith)*; (iii) the loss of certitude and security may be companioned by surrendering the need for what has been known *(attachment to memory)*, and the choice to entrust self to that which is not fully understood *(spiritual posture of hope)*. A listing of spiritual resources and spiritual suffering in the relationship with Other, spiritual experiences, and changes in spiritual practice are identified in the PP-SAT (Appendix I).

Part II: Anthony's Story: A Palliative Patient Case Study

The reader is now invited to read *Anthony's Story.* Application of the Dark Night Model for Spiritual Assessment will follow.

Medical Summary

Anthony was diagnosed with adenocarcinoma of the colon with metastatic disease. He was admitted to the Tertiary Palliative Care Unit because of poor pain control. Upon admission, his Mini-Mental Score (MMSE) was recorded as being 22/30 (with an expected normal 24);[460] his Edmonton Staging System for Cancer Pain (ESS) was uncertain for psychological suffering within the pain expression. [461] His CAGE score was o/4.[462] Anthony was successfully rotated from hydromorphone to methadone. However, during the course of the admission his Edmonton Symptom Assessment Scale (ESAS) indicated total suffering and his use of break through opioid analgesics for non-cancer pain continued to increase. [463] Psychological suffering appeared evident in his pain expression and he appeared to be somatizing. Towards the last half of his hospital stay

[460] The Mini-Mental Sate Exam is a screening tool used in the palliative care context for assessing delirium/confusion which can have an acute onset, (a matter of days or even hours). The highest score possible is 30. However, when factoring in the variables of age and schooling, this patient would be expected to score 24 if cognitively intact. The patient, though alert, was cognitively impaired upon admission.

[461] The ESS looks at the presence or absence of poor prognostic factors. The presence of one or more such factors would make the task of pain management more challenging.

[462] The CAGE is a screening tool for use of alcohol as a coping mechanism. If a patient scores 2/4 or more this suggests that the patient may cope chemically. Anthony's score did not indicate dependency.

[463] The ESAS is a subjective tool that allows the patient to self-score pain and symptoms from a scale of 0-10, 0 being 'no' experience of the pain/ symptom' and 10 being the 'greatest' experience of the pain/symptom. Anthony's scores had been tabulated as follows: pain 10; tiredness 9; nausea 8; depression 8;anxiety 8;drowsiness 8;appetite 0; feeling of well-being 8; shortness of breath 9.

Anthony's existential distress appeared to resolve and he appeared comfortable until his eventual death on the unit 90 days from the time of admission.

1st Spiritual Care Encounter

In the initial visit initiated by the spiritual caregiver, Anthony described himself as being "spiritual not religious." He had lived by the personal creed "do unto others what you would have them do unto you." Upon enquiry he disclosed that he had been raised in the Roman Catholic faith tradition and had been an active member of his faith community serving as a Knights of Columbus. The spiritual caregiver noted that Anthony's religious code was recorded as "RC" and so advised him of its significance: this would open access to receive the support of the Roman Catholic hospital ministry through pastoral visits and sacramental/ritual supports as well potential visits from his past faith community. He was asked if he desired this. Anthony stated that he did not, and so with his consent the spiritual care giver had the religious code changed to "declined to state." Anthony felt respected by this intervention. Anthony was being supported by his ex-wife, Joanne, a practicing Roman Catholic. The couple had had only one child, Eden, who had died by drowning at the age of three. Anthony had been a long distance truck driver for 30 years and presented as a self-contained man. He had a number of friends in the trucking industry and was valued by his co-workers as always being able to "lend a hand when needed."

2nd Spiritual Care Encounter

Upon the second visit, at the spiritual caregiver's invitation, Anthony elaborated upon the significance of "being able to do unto others what you would have them do unto you." Anthony believed that his ultimate purpose in life was to always treat people well and to do them good. Anthony valued active "doing" as a measure of his care and of his worth. His story omitted any expressions of care received by others. He dismissed any need on his part with the words, "Oh, I'm okay." Anthony went on to mention that a number of trucking friends had dropped by to see him and that he felt at a disadvantage in not being able to do something for them; he agreed with the spiritual caregiver's summary statement that he was a "giver and not a taker." Over time, Anthony's sense of self, rooted in the experience of self-sufficiency and the ability to always do for others, diminished and with this came feelings of isolation.

3rd Spiritual Care Encounter

On the third spiritual care visit Anthony began to talk about his son, Eden. He had been thinking a lot of Eden lately. The spiritual caregiver indicated interest that prompted Anthony to talk about Eden. He began to share who Eden was, how he and his wife Joanne had planned for his birth and the life they shared as a young family as well as his own meaning as a father, someone who would "always be there" for his child. His eyes sparkled as he shared his hopes and dreams. And then, a silence descended. In a mute voice Anthony began to tell the story of Eden's drowning. His back had been turned a minute; he was tending to his wife's request to examine the barbecue for a gas leak. Six friends were around and no-one saw that Eden had wandered away from the older children until they began to shout frantically for help. He remembered running blindly to the water, an inner combustion propelling him at lightning speed, but the lake was eerily

silent, no "Daddy! Help!" He dove in and searched for his son coming up for air only when his lungs forced him to. On the fifth or sixth surfacing he heard his name called; the rescue team had arrived and a small crowd gathered at the shore forming a circle. He struggled to shore. The crowd parted as he strode up to the body of his son, their heavy silence hung like a drawn curtain. All he could hear were the soul wrenching sobs of his wife as she rocked her baby back and forth and a strangled guttural sound, his own, "I wasn't there." Anthony began to cry and his hands shook. The spiritual caregiver compassionately received Anthony's suffering: entering into and remaining with him in his agony, maintaining a reverential silence, shedding her own tears and lending her composure.

After a lengthy silence, Anthony looked up and asked, "Will my boy ever forgive me?" "Maybe this cancer will make up for it." When asked to clarify what he meant by this, Anthony expressed his struggle in faith: "I had always experienced God being there for me and my family as long as I lived my life by treating others as I would have them treat me. I must have done something wrong for God to leave us like that." When he was asked what he thought he did wrong, "I don't know" was his response.
Anthony agreed with the following summary of his faith perspective: by not being there for his son he felt that he had abandoned Eden. Anthony understood this to be a sin (offence) both against his son and against God who had entrusted Eden's life to him. He thus perceived the cancer as the suffering he deserved as reparation for the sin of having abandoned his child. Anthony did not seem to derive peace from this meaning-making of his terminal diagnosis and resisted efforts to review his understanding of his cancer as a punishment. Yet, he was open to spiritual counsel that normalized his experience of the Dark Night of the Soul: the belief that he had displeased God, his inability to pray as he used to, the loss of desire for spiritual things as these bought him no consolation and an experience of dryness in life where, in spite of his "doing for others," nothing seemed to satisfy.

Practitioner's Experience of Impasse
The spiritual caregiver was at an impasse; she did not know how to alleviate Anthony's suffering. In this shared place of powerlessness, not knowing the way forward, her soul lived the question "How do I help him?" One day, in a blank moment, she had a sudden epiphany —"Anthony, like me, lives in the intellect; what he needs is beauty!" Although she was unsure of what this intervention would look like, she trusted that the way ahead would unfold.

4th Spiritual Care Encounter
In a subsequent visit, Anthony agreed to the offer of prayer. The spiritual caregiver opened with a moment of silence. In the stillness she then moved in to a sung lament – the beautiful and haunting melody of the Cry from the Cross. It voiced for Anthony, in an unexpected way, his own inner anguish and despair: *O God, my God, Where have you gone from me?"* Anthony's exclamation, "Ahh!!!" brought on a loud deluge of anguished tears – a dam had broken. The spiritual care giver looked up only once and could not return her eyes to his face – the moment was too sacred. She remained by his side until the tears had been spent. After a period of shared silence she slowly raised her eyes. Anthony had a look of wonder on his face and a peace emanated from him. "The Father

watched his son die too." As he spoke a stillness filled the room; the presence of the Sacred was almost tangible.

Anthony's unexpressed lament resided deep within his body; he felt abandoned by the God he knew who would always protect from harm just as God the Son felt abandoned by the Father –the Father *who was there* and who had to watch his Son's suffering. Jesus' lament was a contemplative experience that gave Anthony both a sense of union with God and insight into his own suffering; he now understood that the Father's lack of intervention in saving his Son from physical death did not mean he had abandoned him. Similarly, Eden's death was not because Anthony had abandoned him. Anthony no longer rationalized his cancer as being a punishment from God; his use of break through medication for non-cancer pain stopped.

5th Spiritual Care Encounter

In the next spiritual care visit, Anthony shared his growing realization that he had emotionally abandoned his wife since the death of Eden. He realized that his inability to be vulnerable in love and his need to be self-sufficient had cost him the mutuality needed in a marriage. Anthony could now see where he had sinned against Joanne; he was open to articulating his feelings to her in a letter and asking her for forgiveness. He also expressed his sorrow to God in prayer, asking God for forgiveness. Anthony was asked if he would like to celebrate the sacrament of reconciliation and he agreed that that would be a good idea. A referral was made to the on-call RC priest.

6th Spiritual Care Encounter

In follow up, the spiritual caregiver asked Anthony how the visit had gone with the on-call priest. Anthony shared that it was a good experience. His eyes lit up when he mentioned that his ex-wife had come to speak with him after receiving his letter. They had had a frank and tearful discussion and had reconciled. It was soon after this that Father John had arrived and had creatively led a communal rite of penance that befitted the situation. The couple had shared Eucharist together. Anthony agreed to having his religious code changed back to RC so that he might continue to be supported by his faith community.

7th Spiritual Care Encounter

Anthony and Joanne made up for lost time. Their union in spirit and love fired them into seeking out a number of ways to prolong Anthony's life including the option for antibiotics when Anthony suffered repeated infections. However, over the course of a few weeks Anthony steadily declined. During the course of a spiritual care visit, Anthony shared that he had had a vision of Eden running to him and that before he had been able to say, "I'm sorry son" Eden had flung his arms around him and asked, "daddy, when are you coming home?" His son was missing him. These experiences of reconnection in love both with Eden and with Joanne left Anthony torn. He did not want to physically abandon Joanne. He wanted to continue to enjoy their renewed sense of intimacy. But he yearned to be reunited with Eden. Anthony was reassured by the spiritual caregiver's normalizing of the pull to both leave and to remain as paradox. Anthony grew quieter as time went by.

He shared with the spiritual caregiver an increasing inability and lack of desire to engage verbal prayer but was not distressed and seemed quite comfortable to "simply be."

8th Spiritual Care Encounter

Although Anthony was inclined more toward solitude and no longer attached to the need to live at all cost, he still struggled to keep going out of his love for Joanne. Unfortunately, she was simply not ready to let him go. The spiritual care giver visited with Joanne, and in the course of their time together, she came to recognize that she was securing her own needs in making Anthony opt for aggressive treatment; Joanne did not want to lose the shared intimacy that had been denied her for so long and was attached to this desire which functioned as an anxiety for her. It was this personal need rather than a love of Anthony for his sake that guided her treatment goals.

Joanne made the decision to surrender her own will and granted Anthony permission to leave. In this unconditional expression of love, she reassured him that this was not abandonment but a freely willed decision, that she was not sure what her future would be like without him but that she stepped out in faith believing that God would show her the way and that her hope was in him for her future. The experience of mutuality in this tender exchange gifted Joanne and Anthony with an even deeper intimacy.

Joanne asked Anthony if he would like Fr. John to come and anoint him and he did. The spiritual caregiver made the referral accordingly. Later that day Anthony and she were blessed with a deep peace in the celebration of the sacrament of the sick. The spiritual caregiver was asked to be a part of this ritual and she offered a prayer of thanksgiving for the journey of reconciliation and the promise of union with Eden in life after death.

Anthony died in peace.

Part III: Application of the Dark Night Model for Contemplative Spiritual Assessment

The facility of the Dark Night spiritual assessment model is now illustrated through case study application of its tool format, the PP-SAT. The latter offers an interpretive guide for assessment that is intended for completion subsequent to (not during) a patient visit. It may also serve as a guide for recording any presenting Dark Night elements in a patient's life in both narrative-based assessments in consultations or progress notes.

The Dark Night Contemplative Spiritual Assessment of Anthony's Case is presented in two places: Table 1: *Multi-domain Application of the Dark Night Model* follows below and Table 2: *Domain Specific Application of the Dark Night Model* is located in Appendix J. Each table identifies the following: (i) the assessment domains; (ii) the

dimensions that characterize each respective domain; and (iii) narrative indicators illustrating the application.

Table 1 illustrates how each spiritual care encounter may be assessed by all applicable domains; this appendix highlights the multidimensional nature of the model, for example in the first patient encounter it identifies the following four domains: spiritual orientation, spiritual resources in relationship with self, spiritual resources in relationship with others, and spiritual suffering in relationship with other.

Table 2 organizes the material to highlight how each assessment domain presents throughout the case study, for example, in which encounter one is to identify the domain of spiritual orientation.

TABLE 2. MULTI-DOMAIN APPLICATION OF THE DARK NIGHT MODEL/PP-SAT[464]

1st SPIRITUAL CARE ENCOUNTER

PATIENT ENCOUNTER	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL ORIENTATION	□Faith of Origin: spiritual identity connected with religious tradition but not membership in religious community □ Vocational identity □ Core values/beliefs	Pt. use to be active member of a RC faith community Pt. expressed his spiritual identity through service as a Knight of Columbus 'do unto others what you would have them do unto you.'
SPIRITUAL RESOURCES IN RELATIONSHIP WITH SELF	□ Experience of connection with the volitional self/ the ability to still 'do'	Pt.'s sense of and understanding of self appears to be connected with his ability to be of service to others: past service as Knights of Columbus and valued by his co-workers as 'always able to lend a hand when needed.' Pt. presents as a self-contained man.
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHERS	□ Supportive relationships: □ spouse □ friends	Supportive relationships in ex-spouse Joanne and trucking friends.
SPIRITUAL SUFFERING IN RELATIONSHIP WITH OTHERS	□ A loss of pt. sense of connection with others	Loss of child Eden who had died from drowning at age three. Desire to not access Roman Catholic faith services

[464] © Zinia Pritchard 2009. Revised 2013.

2nd SPIRITUAL CARE ENCOUNTER

DOMAIN	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL ORIENTATION	□ Sense of meaning and purpose/mission: □ Core values/beliefs:	Pt. believes that his ultimate purpose in life is always to treat people well and do them good. Pt. values active doing as a measure of his care and his worth.
SPIRITUAL SUFFERING IN RELATIONSHIP WITH SELF	□ Experience of loss of connection with volitional self	Pt. feeling disadvantaged at not being able to do something for those who visit Pt. duality: perceives self as a 'giver' and not a 'taker'; does not acknowledge personal needs; a strong sense of self-sufficiency.

3rd SPIRITUAL CARE ENCOUNTER

DOMAIN	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL ORIENTATION	□ Vocational identity □ Sense of meaning and purpose/mission	…his own meaning as a father, someone who would "always be there" for his child.
SPIRITUAL SUFFERING IN RELATIONSHIP WITH OTHERS	□ A loss of pt. sense of connection with others □ Experience of lack of forgiveness/reconciliation with others	'Will my boy ever forgive me?' Anthony agreed with the following summary of his faith perspective: by not being there for his son he felt that he had abandoned Eden. Anthony understood this to be a sin (offence) both …his son
SPIRITUAL SUFFERING	□ A loss of image/perception of	'I had always experienced God being there for me and

IN RELATIONSHIP WITH OTHER	'God,' Life, what is ultimate for self □ A loss of a sense of connection with 'God,' Life, what is ultimate for self □ Feeling abandoned, alone or isolated □ A sense of guilt □ Impasse □ Powerlessness/inability to focus in prayer, meditation or other spiritual or creative practice □ No consolation/gratification derived from usual spiritual/creative practices □ Lack of desire to engage spiritual/creative practice □ Lack of satisfaction in anything/anyone	my family as long as I lived my life by treating others as I would have them treat me.' 'I must have done something wrong for God to leave us like that.' 'Maybe this cancer will make up for it?' He thus perceived the cancer as the suffering he deserved as reparation for the sin of having abandoned his child. Pt. does not seem to derive peace from this meaning-making of his terminal diagnosis and resisted efforts to review his understanding. Inability to pray as he used to Loss of desire for spiritual things Dryness in life: in spite of 'doing for others,' nothing seemed to satisfy.
SPIRITUAL SUFFERING IN RELATIONSHIP WITH SELF	□ Loss of sense of self and who one understands oneself to be □ Experience of loss of connection with the imaginative self	Loss of Anthony's sense of fatherhood imagined as one who would 'always be there' for his child.

4th SPIRITUAL CARE ENCOUNTER

DOMAIN	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL SUFFERING IN RELATIONSHIP WITH OTHER	□ Loss of connection with self, others, Other consciously expressed □ Loss of connection with self, others, Other expressed through somatizing behaviors	Anthony's unexpressed lament resided deep within his body; he felt abandoned by the God he knew who would always protect from harm.
SPIRITUAL RESOURCE IN RELATIONSHIP WITH OTHER	□ Experiences of insight/enlightenment/wisdom	Jesus' lament was a contemplative experience that gave Anthony both a sense of union with God and insight into his own suffering; he now understood that the Father's lack of intervention in saving his Son from physical death did not mean he had abandoned him. Similarly, Eden's death was not because Anthony had abandoned him. Anthony no longer rationalized his cancer as being a punishment from God; his use of break through medication for non-cancer pain stopped.

5th SPIRITUAL CARE ENCOUNTER

DOMAIN	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHER	□ Experiences of insight/enlightenment/wisdom	Anthony shared his growing realization that he had emotionally abandoned his wife since the death of Eden. He realized that his inability to be vulnerable in love and his need to be self-sufficient had cost him the mutuality needed in a marriage. He could now see

	□ Engagement with spiritual/creative practices and service: ritual □ Experience of forgiveness/reconciliation with Other	where he had sinned against his wife. He also expressed his sorrow to God in prayer, asking God for forgiveness.
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHERS	□Experiences of reconciliation/forgiveness of others	Anthony was open to articulating his feelings to [his ex-wife] in a letter and asking her for her forgiveness.
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHER	□ Engagement with spiritual/creative practices and service: ritual	Celebration of the Sacrament of Reconciliation

6th SPIRITUAL CARE ENCOUNTER

DOMAIN	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHERS	□ Experiences of reconciliation/forgiveness with others □ Experience moments of spiritual connection (with self, others or Other) □ A sense of who one most truly is (true self)	His eyes lit up when he mentioned that his ex-wife had come to speak with him after receiving his letter. They had had a frank and tearful discussion and had reconciled. Anthony agreed to having his religious code changed back to RC so that he might continue to be supported by his faith community
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHER	□ Engagement with spiritual/creative practices and service: ritual □ Experience of forgiveness/reconciliation with Other	Father John had arrived and had creatively led a communal rite of penance that befitted the situation.

7th SPIRITUAL CARE ENCOUNTER

DOMAIN	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHERS	□ Experience of shared faith in medical intervention □ Experience of shared hope in outcomes of medical intervention □ Experiences of reconciliation/forgiveness	Anthony and Joanne made up for lost time. Their union in spirit and love fired them into seeking out a number of ways to prolong Anthony's life including the option for antibiotics when Anthony suffered repeated infections. Anthony shared that he had had a vision of Eden running to him and before Anthony had been able to say, 'I'm sorry son' Eden had flung his arms around him and asked, 'daddy, when are you coming home?' His son was missing him.
SPIRITUAL SUFFERING IN RELATIONSHIP WITH OTHER	□ Paradox: holding the tension of two seemingly opposed truths, e.g. the desire to both hold on to life and the desire to 'let go.'	These experiences of reconnection in love both with Eden and with Joanne left Anthony torn. He did not want to physically abandon Joanne. He wanted to continue to enjoy their renewed sense of intimacy. But, he yearned to be reunited with Eden.
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHER	□ Experience a non-anxious, restful, and loving awareness of self/others/Other	Anthony grew quieter as time went by. He shared with the spiritual caregiver an increasing inability and lack of desire to engage verbal prayer but was not distressed and seemed quite comfortable to 'simply be.'

8th SPIRITUAL CARE ENCOUNTER

DOMAIN	DIMENSIONS	NARRATIVE INDICATORS
SPIRITUAL SUFFERING IN RELATIONSHIP WITH OTHERS	□ Experience of unshared faith in medical intervention □ Experience of unshared hope in outcomes of medical intervention	Although Anthony was inclined more toward solitude and no longer attached to the need to live at all cost, he still struggled to keep going out of his love for Joanne. Unfortunately, she was simply not ready to let him go. [She wanted the aggressive treatment to continue].
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHER	Experience moments of spiritual connection □ A sense of union with and/or compassion for others □ A sense of communion with Other □ Engagement with spiritual/creative practices and service: ritual	Later that day Anthony and [Joanne] were blessed with a deep peace in the celebration of the sacrament of the sick.
SPIRITUAL RESOURCES IN RELATIONSHIP WITH SELF	□ Spiritual Coping: surrendering the need for personal gratification in experiences of relating *(attachment to ego/will)* and choosing to relate to the situation/others without agenda/expectations *(spiritual posture of love)* □ Spiritual Coping: surrendering the need to rely upon the rational mind to make sense of things	Joanne came to recognize that she was securing her own needs in making Anthony opt for aggressive treatment: she did not want to lose the shared intimacy that had been denied her for so long...It was this personal need rather than a love of Anthony for his sake that guided her treatment goals. Joanne made the decision to surrender her own will and granted Anthony permission to leave. In this

	(attachment to intellect) and stepping into the darkness of the Unknown *(spiritual posture of faith)* □ Spiritual Coping: surrendering the need for the assurance of meaning *(attachment to what is known/memory)* and choosing to entrust self to that which is not fully understand *(spiritual posture of hope)*	unconditional expression of love, she reassured him that this was not abandonment but a freely willed decision [Joanne] was not sure what her future would be like without him but that she stepped out in faith believing that God would show her the way and that her hope was in him for her future.
SPIRITUAL RESOURCES IN RELATIONSHIP WITH OTHERS	□ Experience moments of spiritual connection (with self, others or Other) □ A sense of union with and or compassion for others	The experience of mutuality in this tender exchange gifted Joanne and Anthony with an even deeper intimacy.

Discussion and Implications

The development of the Dark Night Model for Spiritual Assessment in Palliative Care identifies the role and relevance of a practical theology in its capacity to respond to an expressed clinical need. The clinical utility and interdisciplinary nature of a practical theology also suggests its potential benefit for practice-based spirituality research, curriculum development, and mentorship within the health sciences. The model's development also identifies the collaborative type of leadership that may be offered by a practice-based theologian.

Although the Dark Night paradigm is particularly suited for end-of-life contexts learners have invariably identified its conceptual applicability, comprehensiveness, and patient-centeredness to extend its utility to other clinical contexts, notably, the chronic illness setting.

As an inter-disciplinary enterprise, the model has been identified to also hold potential for future collaborative endeavors: (i) the Dark Night paradigm may be explored for its implementation within different cultural and religious patient contexts; (ii) questions could be formulated to facilitate practitioner exploration of the various contemplative dimensions; (iii) development of physician and nursing case studies can further elucidate the model's application to interdisciplinary professional practice settings; and (iv) reflection upon the contemplative spaces and images of the Dark Night within a clinician's personal and professional life can demonstrate how one's spiritual awareness can inform spiritual assessment.

The Dark Night Model for Spiritual Assessment also highlights the fact that, as with other health care assessments, spiritual care assessments require knowledge, mentorship, and practice to promote clinical competence and confidence. The current study, which may be perceived as a contribution to a knowledge competency for spiritual assessment, invites delineation of other required core competencies. A future paper will endeavor to review the spiritual care competencies of self-awareness, attitudinal postures (disposition and skills), and behaviours necessary for a palliative spiritual assessment.[465]

Conclusion

Spiritual assessment is a clearly identified clinical competency within palliative care. This study has offered a practical theological response in the development and demonstrated application of a Dark Night Model for spiritual assessment in palliative care. It offers clinicians an educational opportunity to enhance their knowledge

[465]Zinia Pritchard, "The Contemplative Practitioner: A Dark Night Model for Spiritual Care of the Dying" (D.Min. diss., article, Saint Stephens College, 2014).

competency for spiritual assessment. Furthermore, it invites consideration of other core competencies required in spiritual care of patients at end-of-life.

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CHAPTER SIX

THE CONTEMPLATIVE PRACTITIONER: A DARK NIGHT MODEL FOR SPIRITUAL CARE OF THE DYING

Introduction to the Dark Night

The Dark Night of the Soul (referenced more accurately as "Dark Night" and also referred to by the abbreviation "the Night") is a spiritual process where the seed of life is buried within the soil of suffering. The paradoxical character of the Dark Night is captured well by Deborah Barrett's allusion to the phrase "to bear suffering" which can mean both the burden of pain and the birthing of new life when in labour.[466] A phrase originally coined by the priest-monk John of the Cross, the Dark Night is a contemplative or mystical spirituality that may be understood as a metaphor for the entire spiritual journey. [467] *A Dark Night Lexicon* (Appendix A) offers the reader an orientation to the sacred anatomy of the Night.

Context of Medical Education

In 1996, the Royal College of Physicians and Surgeons of Canada implemented competency-based medical education through their adoption of the *CanMEDS Physician Competency Framework.* Aimed at improved patient-centered care, *CanMEDS* delineates the knowledge, skills, and professional attitudes required of specialist physicians through seven-roles: medical expert, communicator, collaborator, manager, health advocate,

[466]Deborah Barrett, "Suffering and the Process of Transformation," *Journal of Pastoral* Care 53, no. 4 (1999):461-472.

[467]John of the Cross, *The Ascent of Mount Carmel*, in *The Collected Works of St. John of the Cross,* rev.ed.trans.Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), 101-349.

scholar, and professional. In their central role of medical expert, competencies enable physicians "to collect and interpret information, make appropriate clinical decisions, and carry out diagnostic and therapeutic interventions." [468] The ability to "to perform a complete and appropriate assessment of a patient" is a key medical competency.[469] Palliative medical education builds upon this by adding the further specialist requirement: "[t]o perform and communicate a spiritual history; to identify spiritual issues common in palliative patients and their families."[470]

Mindful of the palliative imperative to attend to the spiritual dimension of health and building upon the *CanMEDS* framework, this study contributes contemplative spiritual care competencies. For patient-centered spiritual assessment and care, this conceptual framework specifies knowledge as *self-awareness* (self-knowledge) and skills and attitudes as *attitudinal postures* by which is intended those dispositions and capacities for being-in-relationship with self, others, and Other.[471] It further adds the competency domain of *observable behaviours.*

The following pages will delineate the core contemplative spiritual care competencies; provide a complete overview of competencies in the *Table of Spiritual Assessment/Care Competencies for the Medical Professional*; and illustrate application of core competencies through a palliative case study entitled "Danielle's Story."

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[468]Royal College of Physicians and Surgeons of Canada, "CanMEDS 2005 Framework" (n.d.), http://www.royalcollege.ca/portal/page/portal/rc/canmeds/framework (accessed December 11th 2012).

[469]Ibid.

[470]Palliative Medicine Residents and Clinical Fellows, One Year Enhanced Program of Added Competence in Palliative Medicine, University of Alberta: objective 1.2.16 (medical expert).

[471]Who or what one considers Ultimate Reality.

Knowledge as Self Awareness

A clinician's heightened sensibility to personal spirituality contributes significantly to a patient-centered assessment: by attending closely to the hills and plains of one's own spiritual life, the clinician is better able to identify the contours of the patient's spiritual life and is better equipped for the task of suspending his/her beliefs and assumptions in the process of listening to the patient. Self-awareness is acknowledged as a core principle of spiritual health care.[472] [473] [474] It is also identified as an advanced spiritual and religious care competency in specialist palliative care by the Marie Curie Cancer Care organization.[475]

Assessment of the Dark Night in one's patient is greatly fostered by the clinician's willingness and ability to have first traced the contours of the Night that may shape one's own inner landscape. To do so enables the clinician to draw upon self-awareness to inform his/her assessment and care of palliative patients. Indeed, a willingness and ability to compassionately tend one's own personal suffering can promote one's capacity to empathically tend the suffering of one's patient. *Clinician's Self- Assessment* (Appendix

[472]Government of Manitoba, *Health and the Human Spirit: Shaping the Direction of Spiritual Health Care in Manitoba: Spiritual Health Care Strategic Plan* (Winnipeg: Manitoba: Manitoba Health Living, Seniors and Consumer Affairs, 2012), http://www.gov.mb.ca/healthyliving/mh/hhs.html (accessed 2013).

[473]Sarah Beckman , Sanna Boxley-Harges, Cheryl Bruick-Sorge, and Becky Salmon, "Five Strategies That Heighten Nurses' Awareness of Spirituality to Impact Client Care," *Holistic Nursing Practice* 21, no. 3(2007):135-9.

[474]Canadian Association for Spiritual Care/Association canadienne de soins spirituels, "Competencies for Spiritual Care and Counselling Specialist" in *Profession: Spiritual Care Competencies* (May 2011), http://www.spiritualcare.ca/page.asp?ID=87&s=1&searchwords=competencies.pdf.May 2011, (accessed August 05, 2013).

[475] Marie Curie Cancer Care, "Spiritual and Religious Care Competencies for Specialist Palliative Care" (n.d.), http://www.mariecurie.org.uk/Documents/HEALTHCARE-PROFESSIONALS/spritual-religious-care-competencies.pdf., (accessed September 7, 2011).

B) offers opportunity for Clinician self-assessment in the Night. An example of how self-awareness and clinical assessment are inter-related within the contemplative spiritual care model is offered in the table below:

Table.1 Self-Awareness and Clinical Assessment

Spiritual Assessment of a Dark Night Process	**Self-Awareness in Dark Night**	**Contemplative Spiritual Care**
Ability to identify a patient's question of impasse or unknown: e.g. "What will happen to me?" "How can I leave?" "Why?"	Recognition that one is confronted with unknowing in the face of a patient's deep existential distress and possible limitations to palliate pain and symptoms. A possible loss of whom one imagines one ought to be as a palliator of suffering.	Adoption of the spiritual virtues of faith, hope and love in patient care: choosing to move into the unknown with one's patient (faith), to entrust oneself to what is Unknown (hope), and to have the courage to care without expected outcomes, even the relief of suffering (love).

Contemplative Attitudinal Postures for Dark Night Spiritual Assessment

The adoption of spiritual practice as a means of providing spiritual care has been identified by both theistic [476] and non-theistic practitioners.[477] A particularly contemplative practice in the provision of care is to be found in the *Contemplative End-of-life Care* course taught through Naropa University; this embraces the Buddhist path of contemplative wisdom through Sogyal Rinpoche's *The Tibetan Book of Living and*

[476]"If he is to dispose others for the action of God in their lives, the director himself must have experience in the spiritual life." St. John of the Cross. http://carmelitesofeldridge.org/juan25.html (accessed September 7, 2011).

[477]"Through learning how to inspire oneself with a daily meditation practice, a sense of confidence and deep love naturally grows. Then, by integrating meditation practice with caregiving work, we can create an environment in which our patients can die in a state of peace and even inspiration." http://www.naropa.edu/extend/contemplativecare/certificate.cfm, (accessed September 7, 2011).

Dying.[478] Contemplative attitudinal postures, which are inter-related, are marked by *kenotic practice*, a fundamental openness or willingness to both act and receive in the relationship with self, others, and Other. The active dimension of kenosis may be understood as a spiritual practice or discipline and the passive dimension that which is pure gift or given:

> "Is there anything I can do to make myself Enlightened?"
> "As little as you can do to make the sun rise in the morning."
> "Then of what use are the spiritual exercises you prescribe?"
> "To make sure you are not asleep when the sun begins to rise." [479]

Noteworthy is the fact that contemplative care postures are parallel to those adopted by patients in their own Dark Night journey, a significant indication of the non-pathological nature of the Night.[480]

Core Attitudinal Posture of Kenosis

The central contemplative practice of kenosis, a non-attachment to beliefs, concepts, images, and desired outcomes in one's manner of relating, results in a self-emptying and interior silence that promotes receptivity in the process of listening:

> Nan-in, a Japanese master during the Meiji era (1868-1912), received a university professor who came to inquire about Zen. Nan-in served tea. He poured his visitor's cup full, and then kept on pouring. The professor watched the overflow until he no longer could restrain himself. "It is overfull. No more will go in!" "Like this cup," Nan-in said, "you are full of your own opinions and speculations. How can I show you Zen unless you first empty your cup?"[481]

[478]Naropa University, "Contemplative End-of-Life Care Certificate Program" (n.d.), http://www.naropa.edu/extend/contemplativecare/certificate.cfm (accessed September 7, 2011).

[479]Anthony deMello, *One Minute Wisdom* (New York: Doubleday, 1986), 11.

[480] Zinia Pritchard, *The Contemplative Spiritual Journey of the Dying: A Retrospective Phenomenological Study* (Edmonton, AB.: Saint Stephen's College, 2010), 1-27.

The intentional emptying of self, carves out within the clinician an open, hospitable space to welcome the patient's story. The active dimension of kenosis is a spiritual discipline, that is, both a posture and an inner ability/skill to attend to one's whole self: to thoughts, feelings, and body sensations and to then consciously place aside what may distract from receptivity of the other/Ultimate Reality: [482]

> [Kenosis is]...to empty ourselves…of those convictions and prejudices, hopes and distractions, which usually accompany us and can short-circuit the reflective process. [It means] suspending interpretation and judgment until we have thoroughly heard.[483]

Personal thoughts influence how one perceives Reality and can prevent the receiving of another's truth. The importance of detaching from one's own limited understandings in order to fully receive another's meaning is highlighted in the African *Legend of the Sky Maiden*. In the story, a beautiful young woman whose home is the sky comes to earth and marries a tribesman bringing with her a large box that she asks the man not to look into. One day, however, in a moment of boredom her spouse does this very thing; he looks into the box only to find there is nothing in it. The story continues:

> When the woman came back, she saw her husband looking strangely at her and said, 'You looked in the box, didn't you? I can't live with you anymore.' 'Why?' the man asked. 'What's so terrible about my peeking into an empty box?' 'I'm not leaving you because you opened the box. I thought you probably would. I'm leaving you because you said it was empty. It wasn't empty; it was full of sky. It contained the light and the air and the smells of my home in the sky. When I went home for the last time, I filled that box with everything that was most precious to me to remind me of where I came from. How can I be your wife if what is most precious to me is emptiness to you?'[484]

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[481]"101 Zen Stories" (n.d.), http://en.wikipedia.org/wiki/101_Zen_Stories(accessed July 27, 2010).

[482]Ibid.

[483]James Whitehead and Evelyn Eaton Whitehead, *Method in Ministry: Theological reflection and Christian Ministry,* rev.ed (Kansas City: Sheed & Ward, 1995), 73.

[484]Harold Kushner, *Who Needs God* (New York: Summit Books, 1989), 11-12

To intentionally remove blinkers and embrace a wide-angle lens of vision allows the clinician to offer the patient a broader canvas upon which the patient may paint the picture of who he/she is. Through kenosis the clinician comes to see a patient as he/she really is and not what the clinician may think, imagine, or desire a patient to be:

> "Don't look for God," the Master said.
> Just look-and all will be revealed."
> "But how is one to look?"
> "Each time you look at anything,
> See only what is there and nothing else."
>
> The disciples were bewildered, so the
> Master made it simpler: "For instance: When
> You look at the moon, see the moon and
> Nothing else."
>
> "What else could one see except the moon
> when one looks at the moon?"
>
> "A hungry person could see a ball of
> cheese. A lover, the face of his beloved." [485]

Kenosis employs the spiritual disposition of seeker on quest [486] — coming to know of the other/Other through unknowing (a noted Dark Night counsel). [487] The type of knowledge received in unknowing is of a holistic nature; through kenosis the clinician is fully present in the here and now and engages the patient as a whole person: one's senses, imagination, memory, and intellect are placed at the service of the other.

Kenotic openness affords a clinician a privileged glimpse into the soul of the patient –the "who" that the patient most deeply is. Insight into a patient's fundamental core,

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[485]Anthony deMello, *One Minute Wisdom* (New York: Doubleday, 1986), 8.

[486]Patricia Killen O'Connell and John De Beer, *The Art of Theological Reflection* (New York: Crossroad, 1994), 11-18.

[487]A.1.13.11

his/her values, beliefs, and intrinsic dignity, touches the clinician's own soul; a deep respect or reverence opens up within oneself and marks the quality of relating with one's patient. It denotes a shift away from relating to the patient as an "It," a collection of symptoms that needs to be managed and controlled, and toward relating to the patient as "Thou." [488]

Kenosis is akin to the practice of empathy: "entering into the patient's problematic situation, grasping her viewpoint and its accompanying emotions... It's a serving function, performed with genuine but disciplined compassion." [489] The desire to be known, to be understood, lies at the heart of emotional intimacy. Kenotic listening as a dynamic of seeking to know another can alleviate the experience of existential isolation; moreover, it holds the potential for shifting a patient's experience of "unbearable suffering" to "bearable suffering."[490]

A kenotic openness to the other/Other is a spiritual discipline requiring the desire and ability to entrust oneself to the process, to surrender one's own agenda, and to be receptive to the unknown. The practice of kenosis is the fulcrum upon which the spiritual attitudinal postures of faith, hope, and love pivot.

By the contemplative posture of faith, the clinician surrenders reliance on his/her intellect to resolve that which cannot be understood nor resolved through the power of the

[488]Martin Buber, *I and Thou*. trans. with an introduction by Walter Arnold Kaufmann (New York: Scribner, 1970), 53-62.

[489]Donald Peel, *The Ministry of Listening: Team Visiting in Hospital and Home* (Toronto, Ont: Anglican Book Centre, 1980), 41.

[490]Arne Rehnsfeldt and Katie Eriksson, "The Progression of Suffering Implies Alleviated Suffering," *Scandinavian Journal of Caring Sciences* 18, no. 3 (2004): 264-272.

mind. Instead, one chooses to move into the Unknown with one's patient seeking the gift of insight/wisdom into a patient's suffering.

By the contemplative posture of hope, the clinician chooses to not let the knowns of the patient or the disease guide clinical perception in the face of spiritual suffering. In so doing, the clinician opens to seeing a patient as if for the first time with the possible gift of receiving new insight or awareness into the patient's dilemma. The contemplative posture of hope is a choice to relate to what is unknown by freely entrusting/surrendering oneself to this unknown; a counter-intuitive and counter-cultural practice to the science of medicine and yet very much at the heart of the art of medicine.

By the contemplative posture of love the clinician chooses to surrender a way of caring for a patient that is dependent upon a particular outcome/resolution: without the satisfaction or gratification of having helped, resolved, changed, fixed or made a difference. Through this practice the clinician communicates a way of being in relationship with his/her patient that nuances unconditional regard and value for the patient as he or she is.

Knowledge as self-awareness and the attitudinal posture of *kenosis* form the key competencies for a contemplative spiritual assessment. The following table will provide a detailed summary of spiritual care competencies. Although developed with the medical professional in mind, these competencies may be applied by any member of the interdisciplinary team.

TABLE OF SPIRITUAL ASSESSMENT/CARE COMPETENCIES FOR THE MEDICAL PROFESSIONAL

Role of Medical Expert

- CanMEDs Key competency 3: Perform a complete and appropriate assessment of a patient[491]
  - Palliative: To perform and communicate a spiritual history; to identify spiritual issues common in palliative patients and their families.[492]

KNOWLEDGE AS SELF-AWARENESS	ATTITUDINAL POSTURES (disposition and skills: capacity/abilities)	BEHAVIOUR Concrete observable actions that demonstrate skill
Awareness of personal spirituality and attending beliefs	Willingness and ability to suspend one's own beliefs in the listening process Openness and ability to invite, receive, and facilitate patient expression of belief and personal spirituality	Impartiality in seeking to understand and support a patient's spiritual world view
Awareness that spirituality is often expressed in everyday language	Receptivity to a patient's language of meaning	Comprehending a patient's spirituality through everyday language of meaning
Awareness of one's limitations and personal biases in favour/against religious language and concepts	Willingness and ability to explore the meaning of a patient's use of religious language and concepts	Asking patient open-ended questions to ascertain patient's particular meaning
Awareness of Dark Night processes within one's own personal/professional life	Willingness and ability to identify personal, inter-personal, and transpersonal experiences of connection, disconnection and transformation in periods of personal struggle *(Clinician's Self-Assessment PP-SAT)*	Identification of Dark Night features in patient-centered care
Realization that spiritual care is engaged once spiritual assessment begins	Openness and ability to engage contemplative spiritual care postures	Implementing contemplative spiritual care behaviours
Awareness of one's personal suffering	Willingness and ability to empathetically receive one's personal story of suffering	Empathetically receiving patient's illness story

[491]Royal College of Physicians and Surgeons of Canada, "CanMEDS 2005 Framework" (n.d.), http://www.royalcollege.ca/portal/page/portal/rc/canmeds/framework (accessed December 11th 2012).

[492]Objective 1.2.16 (medical expert), Palliative Medicine Residents and Clinical Fellows, one year Enhanced Program of Added Competence in Palliative Medicine Objectives, University of Alberta.

Awareness of the expression of one's own sorrowing of soul (lament)	Willingness and ability to engage lament within one's own personal and professional life	Empathetically receiving and facilitating patient lament
Valuing the presence of silence and stillness within one's personal life	Willingness and ability to cultivate clinical presence through silence and stillness	Silent and still attending to one's patient
Recognizing and valuing one's whole self as an oracle of wisdom	Willingness and ability to listen with one's whole self: intellect, imagination, body, and emotion	Engaging one's whole self in attending to patient whole self
Recognizing and valuing paradox/ambiguity at the heart of depth experiences	Willingness and ability to identify and tolerate the ambiguity of paradox in one's own life – to hold the tension of two seemingly conflicting truths	Normalizing and supporting the patient's lived experience of paradox
Awareness and engagement with impasse within one's personal life	Willingness and ability to identify and engage personal questions of impasse	Tolerating unknowing in the face of unanswerable questions – resisting the need to supply an answer.
Awareness of one's experience of limited control in alleviating suffering	Willingness and ability to surrender the need for control: • to let-go one's reliance upon the intellect to be able to fix, manage, or resolve • to compassionately tolerate one's powerlessness and unknowing • to cultivate the spiritual virtue of faith – moving forward into the unknown receptive to what may be made known	Understanding, compassion, and courage in companioning patient experience of impotence/loss of control Courage to journey into the unknown with one's patient.
Awareness of one's experience of insecurity when in the Unknown of suffering	Willingness and ability to surrender the need to be in the know: • to let-go the security that comes from what is known • to compassionately tolerate one's anxiety and/or sense of disorientation • to cultivate the spiritual virtue of hope – choosing to relate to the unknown by entrusting oneself to it	Understanding, compassion, and hope in companioning patient experience of fear, anxiety, and loss of meaning Comfortable with not knowing all the answers and receptive to fresh insights Being in the present moment: upon each patient encounter receiving patient and his/her story "as if for the first time."

Awareness of one's experience of dissatisfaction when unable to relieve suffering	Willingness and ability to surrender the need for personal gratification: • to let-go one's expectation of particular outcomes/resolutions • to compassionately tolerate the experience of emptiness • to cultivate the spiritual virtue of love – choosing to care without the expectation of relieving suffering	Understanding, compassion, and unconditional regard in companioning patient experience of diminishment Caring without the satisfaction or gratification of having helped, resolved, changed, fixed, or made a difference
Awareness of transcendent experiences and insights	• Willingness to acknowledge, marvel, and give gratitude for the gifts of spiritual experience(s) and insight(s)	Engaging a patient's sense of wonder, awe, and gratitude for the gifts of spiritual experience(s) and insight(s)

The Practice of Contemplative Spiritual Care: A Case Study

The following case study drawn from the writer's personal practice seeks to illustrate contemplative spiritual care competencies in care of a palliative patient identified by the name "Danielle" (pseudonym) and her spouse "Joe" (pseudonym). It first narrates the salient spiritual care interactions between the patient and spouse through a verbatim method that records both the words and the thoughts of the spiritual care practitioner. The characters in the piece are denoted by the following initials: P (patient), S (spouse), and C (chaplain). A spiritual care analysis of the verbatim is subsequently offered.

Danielle's Story

The physician, at his wits end, refers a patient to me whom he believes to be somatizing. I make my way to the patient's room in "fear and trembling" [493] as I do not know how I may be able to help her, if at all. The patient is known to me from prior spiritual care visits; she is a married woman in her thirties, a mother of two children, and

[493]Philippians 2:12 RSV

has a Catholic Christian expression of spirituality. I say a prayer to the Spirit before knocking on her door.

Patient Visit

C1: Hello Danielle.

P1: (She looks at me, eyes wide with panic. Her breathing is rapid, she has the aid of oxygen; the conversation is to the point).

C2: Danielle, I don't know how I'm going to help you but I know that sometimes if we go into our fear – there is a light in the darkness.

P2: (She nods her head)

C3: Okay… I'm going to ask you questions and you can simply answer whatever comes into your mind

P3: (She agrees).

C4: Before we start, I think it a good idea if we pray to the Spirit to guide us, (patient is okay with this and a brief prayer follows. I am aware of the risk of faith—a sense of self abandonment. I begin to ask rapid questions focusing on the immediacy of the patient's experience. The patient's responses encompass the following):

P4: I'm afraid to go to sleep…I may not wake up…I may die.

C5: (We continue to talk but it is as if this conversation recedes into the background. I become aware of an image arising out the immediacy of my embodied sensation). Danielle, as you are talking, an image of the crossroads has arisen for me: it is as if *all* your energy is being pulled in the direction of letting go and yet as if *all* your energy is being pulled in the other direction to remain.

P5: Yes, I'm at the Crossroads! I'm at the Crossroads! (Her eyes are wide with comprehension). Can you tell my husband for me?

C6: Of course, (thinking it odd that she would wish me to do this for her. Her spouse and she were childhood sweethearts and enjoyed a strong marriage with good communication skills).

Spouse Visit

C1: (I met with Danielle's spouse Joseph in my office one evening. I was aware of my own psychic tiredness that day. I shared with him what had happened with Danielle and that she was "at the Crossroads").

S1: What do I need to be for her? I have been strong, like a rock…she wanted this from me. What do I do?

C2: (I remember talking but not knowing the way until, mercifully, this inspiration came to me): be for her whatever she needs you to be for her.

S2: (he repeated), be for her whatever she needs me to be for her.

Upon returning to the unit a few days later I found that the Danielle was close to death; her physician and the nursing staff were surprised that she had declined so rapidly. It was as if she had let go. I entered her room and all was peaceful inside. Joseph was seated by her bed. Danielle was non-responsive.

Visit with Spouse and Patient

S1: Hello Zinia. (Joseph appeared peaceful). He then began to share with me the continuation of the process begun during the pastoral encounters:

She asked me, "Did Zinia speak with you?" I told her yes, that you did. She asked me, "what did she tell you?" I told her that you said she was "at the Crossroads" and she agreed that she was. Then I told her, "I can be for you, Danielle, whatever you need me to be for you." And she looked at me and asked, "Can you let me go, please?"

C1: (I went over to Danielle's bedside, bent low to speak into her ear), Hello Danielle, it's Zinia here. I know you can't talk but I just wanted you to know I am with Joseph and that I am here, (silence). Danielle, I know you wanted prayer and so I will say a short prayer with you "…and so we turn to you Lord for your blessing upon Danielle's children, that you would protect them and care for them and grant Joseph your strength." A tear rolled down Danielle's cheek and I knew it was the prayer of her heart.

Danielle died about 3 hours later that day.

Case Analysis

The following analysis reviews the engagement with spirituality at end-of-life through three presenting themes (i) the experience of clinical impasse, (ii) moving toward transcendence, and (iii) the gifts of transcendent experience with attending insight. As a means of highlighting the spiritual care competencies at work, the respective verbatim sections will exam the following two questions: What did the clinician do? Why did the clinician do this?

Theme One: The Clinician's Experience of Impasse

In the verbatim introduction both the physician and spiritual care-giver experience a clinical impasse in their attempts to relieve the suffering of a somatizing[494] patient as

[494]"Somatization implies a tendency to experience and communicate psychological distress in the form of somatic symptoms and to seek medical help for them. So defined, it is neither a disorder nor a diagnostic category but a generic term for a set of experiential, cognitive, and behavioral characteristics of patients who complain of physical symptoms in the absence of relevant medical findings... Somatization may be transient or persistent, and may or may not be associated with a diagnosable medical or psychiatric disorder. The most common concurrence of somatization is with affective and anxiety disorders, and, to a lesser degree, the somatoform disorders… Pain, fatigue, dizziness, and dyspnea are the [most common] *sic* symptoms. Etiology of somatization is multifactorial and so should be its management."(Lipowski 1990,

depicted in the case study introduction. What did the clinicians do in the face of such unmitigated suffering? The spiritual care-giver doubts she can help and the physician could do nothing more: the activities of diagnosing and prescribing had ceased to have effect. The suspension of knowing what to do pushed him firmly into *being,* meaning it pressed him into the disconcerting and uncomfortable space of his own existential predicament: the inability to alleviate suffering. Such impotency challenges the professional self "that secures its identity in accomplishments...the self that is often defined by what one does." [495] As noted by Fitzgerald, in the experience of impasse "[t]he principles of 'first order change' – reason, logic, analysis, planning – do not work."[496] The clinician's self-image as the one who ought to know and be able to remedy is clearly challenged and is identified within the passive Dark Night of Spirit as a form of spiritual suffering. The accompanying sense of impotence, also a feature of spiritual suffering (Passive Dark Night of Sense), can paradoxically birth the wisdom of recognizing the illusion of self-sufficiency.[497]

Why did the clinicians do this?

The clinician's necessary movement from *doing* to *being* is actually a characteristic of contemplative spirituality: "contemplation is a strange new land, where everything

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13-21).In Danielle's case the intensity of her shortness of breath decreased when someone was with her and increased when she was alone. Danielle was clearly in some kind of existential distress.

[495]James Finley, *Merton's Palace of Nowhere: A Search for God Through Awareness of the True Self* (Notre Dame: Ave Maria Press, 1978), 35.

[496]Constance Fitzgerald, "Impasse and the Dark Night in John of the Cross," in *Women's Spirituality Resources for Christian Development*, 2d ed., ed. Joann Wolski Conn (New York: Paulist Press, 1986), 413.

[497]D.N. 1. 12.2

natural to us seems to be turned upside down – where we learn …a new way of being (not to *do*, but simply to *be*)." [498] It invites an understanding of one's true clinical identity as rooted in more than what one does. Both physician and spiritual care-giver did nothing because they had come to the awareness that their clinical knowledge base was insufficient to meet the patient's needs: the physician is "at his wit's end" and the spiritual care-giver admitted not knowing how or even if she could help the patient. The minds of both clinicians "while *full* on one level of a lifetime of knowledge, [were] in total darkness on another, the level of meaning."[499]

The experience of being emptied of understanding and being placed in intellectual obscurity is a movement of soul recognized as the passive Dark Night of Spirit; being in the dark in matters of health renders a clinician particularly vulnerable: "we are affected by darkness…where we are most deeply involved and committed, and in what we love and care for most."[500] Hope for relieving the patient's suffering could not, therefore, be built out of the possession of clinical knowledge.[501] Something *more* was being called for from the clinician, something beyond application of treatments, techniques, and counsel.

Theme Two: Faith, Hope, Love: Moving Toward Transcendence

The spiritual-care clinician's movement toward transcendence is captured in patient encounter C1-C4. What did the clinician do in this part of the patient encounter? She admitted her lack of knowledge: "I don't know how I'm going to help you." By sharing

[498]Thelma Hall, *Too deep for words: rediscovering Lectio Divina* (Paulist Press, 1988), 49.

[499]Constance Fitzgerald, "The Transformative Influence of Wisdom in John of the Cross," in *Women's Spirituality,* 2d ed., ed. Joann Wolski Conn (New York: Paulist Press, 1986), 445.

[500]Fitzgerald, "Impasse and Dark Night," 415.

[501]Fitzgerald, "The Transformative Influence of Wisdom," 446.

her vulnerability with the patient the care-giver moved away from the position of assurance [502] as "the expert" and entered into the unknown with the patient:

> The word "care" finds its roots in the Gothic "kara" which means lament. The basic meaning of care is: to grieve, to experience sorrow, to cry out with...we tend to look at caring as an attitude of the strong toward the weak...And, in fact, we feel quite uncomfortable with an invitation to enter into someone's pain before doing something about it.... [A]re we ready to really experience our powerlessness ... and say: "I do not understand. I do not know what to do but I am here with you." Are we willing to not run away from the pain? [503]

The courage to share the chaos of suffering and bear one's own existential pain as a clinician, rather than to move away from, deny, or suppress it, is *not* a relinquishing of the role of the helping professional. On the contrary, it is the heart of compassionate care.

The clinician's statement, "[I]f we go into our fear" was an act of faith: both she and the patient are venturing together into the unknown, namely, the mystery of what is ailing Danielle: "it is faith that moves us into the Mystery which is unimaginable, incomprehensible and uncontrollable." [504] The clinician also recognized her own poverty to help another without assistance and so appealed to Transcendence: "… pray to the Spirit to guide us." The awareness of needing help reflects a posture of humility or truth: an acceptance of the limits of one's intellect, a tolerant compassion for one's own powerlessness in unknowing, and an openness to receive what may be given in service to the patient's need.

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[502]Patricia O'Connell Killen and John De Beer, *The Art of Theological Reflection* (New York: Crossroad, 1994), 9-13.

[503]Henri Nouwen, *Out of Solitude; Three Meditations on the Christian Life* (Notre Dame, IN: Ave Maria, 1974), 33-34.

[504]Fitzgerald,"The Transformative Influence of Wisdom,"446.

Instead of trying to intellectually grasp the mystery, the clinician decided to relate by entrusting herself to it: "I am aware of the risk of faith—a sense of self abandonment." Fitzgerald identifies the inherent trust within the movement of faith as one of hope which "forfeiting the struggle to press meaning out of loss, becomes a free, trustful commitment to the impossible, which cannot be built out of what one possesses.[505]

The clinician's statement, "I know that sometimes if we go into our fear – there is a light in the darkness," further demonstrates her relinquishing of the need for control, a seemingly counterintuitive entrusting of herself to what she cannot fully understand. As noted by Krisher such a deliberate, free act of the will "does not come without resistance ….We experience a loss of our ego-self, the self that we possess when we freely choose to place our complete trust in the Other."[506] This soulful movement of dying to self and entrusting oneself is the act of spiritual surrender, a core attitudinal posture in spiritual care of patients. As in all matters of genuine love, the giving of oneself is implicitly grounded in trust and comes with no guarantees. It takes risk and bears the quality of hope, "like taking a breath in and then jumping out of a plane in the firm hope (never certainty) that the parachute will open and carry you safely down."[507]

The clinician's ability to let-go the security that comes from being in the know, cultivates the conditions for contemplative spiritual care: the ability to be fully present to oneself and the patient in the moment, open, and receptive to what may be revealed. Through the use of the word "...sometimes" the clinician also demonstrated a lack of

[505]Ibid.

[506]James Krisher, *Spiritual Surrender: Yielding Yourself to a Loving God* (Mystic, CT: Twenty-Third, 1997).

[507]Ibid.

attachment to outcomes for both the patient and herself: "Our abandonment to [Other] must be to the point of complete detachment from all desire to give [patients] any particular directive or insight as well as from any desire for immediate and tangible solutions to difficulties…" [508] This posture communicates that genuine care for one's patient ought not to be dependent upon the relief of patient suffering—at its core, the therapeutic relationship has unconditional regard.

Why did the clinician do this?

Spiritual pain demands something far more from the clinician than the intellect. As Rolheiser has elucidated, a purely rational response to spiritual phenomenon is only a partial relating as one would be willing to engage only to the degree that one is able to take hold of, manage, "remain in control and secure in the face of it."[509] By extension, trying to understand the mystery of spiritual pain by application of conceptual clinical knowledge mediates the patient's world to us only in part. If clinicians are willing to receive insight into the greater reality of such pain, they need to be able to surrender reliance upon their intellects and be willing to embrace their own vulnerability in the face of the unknown.

The clinician's care for patients need not be bound to an anxious desire to secure relief of pain expression.[510] The quality of such care results in a free and compassionate

[508]Francis Kelly Nemeck and Marie Theresa Coombs, *The Way of Spiritual Direction.* (Collegeville Minn.: Liturgical Press, 1993), 86.

[509]Ronald Rolheiser, *The Shattered Lantern: Rediscovering a Felt Presence of God* (New York: Crossroad, 1995), 93.

[510]A.3.20:2 "…attachment is an anxiety that, like a bond, ties the Spirit down to the earth and allows it no enlargement of heart."

tending of one's patient. As noted by Fitzgerald, care of this kind has more the character of unconditional love unencumbered by any expectation that "prevents us from forcing the [patient] into the constraints of our needs." [511] To care in this way requires a willingness and ability to surrender the need for personal gratification, namely to care without the satisfaction of having helped, resolved, changed, made a difference or fixed.

Only limited insight into the patient's pain expression is provided by the security of what the clinician already knows from past experience about this type of illness, this kind of pain, and this patient history. Johnston[512] highlights the fact that basing perception upon what is past is a step removed from the immediacy of the present moment and its potential for new insight. Dark Night counsel also advises that in order to come into the present moment and to deeper awareness the clinician needs to relinquish what he/she knows from past experience:

> To come to the knowledge of all
> Desire the knowledge of nothing.
> To come to the knowledge you know not
> You must go by a way in which you know not. [513]

The clinician whose perception is no longer guided by expectations, now no longer *looks for something* but instead *simply looks*—receptive to fresh insights.[514]

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[511]Fitzgerald, "The Transformative Influence of Wisdom, 446.

[512]William Johnston, *Mystical Theology: The Science of Love* (London: HarperCollins, 1995), 143.

[513]A.1.13.11.

[514]Adapted from Anthony deMello, *One Minute Wisdom* (New York: Doubleday, 1986), 8.

Theme Three: Experiencing Transcendence and the Gift of Insight within Transcendence

Patient encounter C5-P5 and spousal encounter C2-P2 capture the dynamic of spiritual agency within the impasse of patient suffering. Danielle was unable to consciously access what distressed her. While she was able to articulate that she was afraid to die, in hindsight we see that death was not the cause of her anxiety. Instead, her anxiety was tied to her desire for something, namely, for her spouse to give her permission to leave. Her attachment to this desire bound her and gagged her both literarily and physically – she was short of breath.

What Danielle experienced was a felt disconnection or separation from her spouse. As we later witness, the implicate reality [515] is that these spouses share an essential unity. However, at this point in the story the one in whom Danielle had found her peace and support, with whom she had felt so close, now feels so very far away— a paradox eloquently captured by Fitzgerald: "the loved one, the very focus of our desire, has become the cause of [her] agony."[516]

What did the clinician do?

In listening to Danielle, the clinician engaged the kenotic practice of emptying her mind. The stilling and silencing of the rational intellect—"it is as if this conversation recedes into the background"—created space to be attentive to her embodied wisdom: "I become aware of an image arising out the immediacy of my embodied sensation."

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[515]David Bohn cited in Diarmuid Ó Murchú, *Quantum Theology* (New York : Crossroad Pub., 1997), 57.

[516]Constance Fitzgerald, "The Transformative Influence of Wisdom,"446

Why did the clinician do this?

The practice of active kenosis disposed the clinician to be fully attentive to the present moment, wakeful and watchful, able to receive the birthing of an image that captured "the heart of the matter"[517]—Danielle was at the crossroads. As noted by Finley, being emptied of self-sufficiency disposes a person to spiritually receive: "…it is in the deepest darkness that we most fully possess God on earth, because it is then that our minds are most truly liberated." [518]

This paradoxical image of the crossroads was able to hold, express, and reconcile the patient's conflicting energy—the desire to both remain with her spouse and the readiness to leave him. It was a surprising, sacred gift that proved to be the hidden key that unlocked the door to Danielle's distressing impasse. Fitzgerald identifies this gift as the result of a spiritual agency independent of human effort: "genuine change occurs through a 'second order response.' The quality of paradox is at the heart of 'second order change.' It implies the unexpected, the alternative, and the new vision, is not given on demand but is beyond conscious, rational control." [519] While the clinician disposed herself to receive the gift of the image with its imparting wisdom, both this and the ensuing counsel to the patient's husband "to be for her whatever she needs you to be for her" were ultimate or Transcendent experiences. The gift of revealed insight within such sacred encounters is alluded to in the givenness of the phrase, "…this inspiration came to me" and the

[517]Patricia O'Connell Killen and John De Beer, *The Art of Theological Reflection* (New York: Crossroad, 1994), 88.

[518]Thomas Merton, *New Seeds of Contemplation* (Abbey of Gethsemani: A New Directions Book, 1961), 135.

[519]Constance Fitzgerald, "Impasse," 413.

descriptor “mercifully” points to the character of wisdom as a knowledge bestowed through love, a particularly spiritual agency.

Implications and Discussion

The exchange between lovers at life’s end offers vital glimpses into the nature of contemplative spiritual care: Then I told her, “I can be for you, Danielle, whatever you need me to be for you.” And she looked at me and asked, “Can you let me go, please?” A matter that rarely is spoken of in academic writing but which is the very lifeblood of end of life care is love; a particular kind of love—suffering-love. As the tender and difficult exchange between husband and wife illustrates, love becomes visible and takes up residence in the palliative space not merely as guest but as host: the drama of emotional intimacy between patient, spouse, and care-giver “lives, moves, and has its being”[520] within the deep safety of this holding space.

Freedom stands at the heart of genuine love: the spouse’s words, “I can be for you, Danielle, whatever you need me to be for you” offers his beloved the spaciousness to choose to stay with him or to leave him. The unconditional nature and costly honestly of genuine love is regularly witnessed at end of life; guided by a pure heart, true love eschews the need to be loved and is motivated by the desire only to love.

“Can you let me go, please?” The closeness of these two spouses illumines the authentic bond between lovers; a mutual holding each of the other that necessitates the question of letting-go. To relinquish one’s hold and set another free is a painful dying to

[520]Acts 17:28

self. So much in matters of love is enacted; however, at end of life there exists the need for words to be spoken—Danielle needed Joseph's permission to leave him.

Contemplative spiritual care nuances a clinician's *way of being* and honours the compassionate dimension of authentic care; caring clinicians are empathetic to the suffering of their patients. In navigating the vulnerability terrain between relationships, spiritual care places a finger upon a subtle dynamic engendered by patient trust: both the clinician's influence to impact patient choice, and the possible struggle with ego in letting go of perceived necessary interventions in order to be patient-centered.

Attending to the spiritual is a deeply relational endeavor; embracing the humility of self-awareness the care of soul calls upon the clinician to be receptive to that which can only be given in and through the Other. Contemplative spiritual care requires a clinician's spiritual practice: knowledge as self-awareness, augmented by contemplative attitudinal dispositions, engenders the flow of concrete observable actions supportive of spiritual health. The competencies for spiritual care nuance a person-centered[521] approach to care engaging the personal perspectives of patients but also the practitioner's personhood as the primary therapeutic tool. This relating between persons is a spiritual characteristic of palliative care—a profession known for the practice of compassion.

Conclusion

A narrative summary of contemplative spiritual care may be illustrated through the contemplative way of being of a Middle Eastern hospice patient:

[521]Canadian Partnership Against Cancer, "Person-Centred Perspective Advisory Group" (n.d.), http://www.partnershipagainstcancer.ca/about/who-we-are/advisory-structure/person-centred-perspective-advisory-group/ (accessed February 12th 2014).

> He would lift up his face to the sun, his arms would come up as if in worship and he would smile – a desert flower in bloom…He would go through the effort of prying open a door so that he might stand beside it and let the wind's soft coolness caress his face…He would take me down to the animal ward and point out the velvety-smooth of a rabbit's fur and stand a while gazing up and into the bird's cage. It would be a slow walk. A stop and stand and gaze at this and that journey. It was life.[522]

Contemplative care is the experience of receiving and being "at one with" another: pulled into the depth palate of the senses, the clinician holistically engages the patient and fosters empathy and communion. Unencumbered by striving and meaning-making, unattached from agendas, expectations, judgements, and outcomes, the clinician no longer looks for something but rather simply looks.[523] Being suspended in the present moment there is neither past to remember nor future to imagine but simply a "now" that holds the clinician's full attention. An inner silence and stillness sets the pace. A contemplative way of being is fully awakened to the grandeur that charges life in the seeming ordinary,[524] where the clinician has eyes to see and ears to hear the spiritual within a patient-centered encounter.

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[522]Zinia Pritchard, "A Contemplative Way of Being: A Vignette of a Hospice Patient."

[523]Anthony deMello, *One Minute Wisdom* (New York: Doubleday, 1986). 8.

[524]Gerard Manley Hopkins, "God's Grandeur," in *Gerard Manley Hopkins: Selection of his Poems*, ed. W.H. Gardner, The Penguin Poets (Middlesex, England: Penguin Books, 1963), 27.

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CONCLUSION

In this concluding chapter, I offer an assessment of the strengths and limitations of this study, together with an overview of the main findings, recommendations, and a general conclusion.

A unique contribution of this doctoral work which has functioned as both a weakness and strength is the necessity of my personal formation in the Dark Night. The weakness relates to the length of time it took to me to progress sufficiently in the spiritual life to be adequate to the task:

> Apoptotic theology …is primarily an experiential process, a process of entering into the infinite mystery that is God, so that gradually one is transformed by grace and this grace moves through the intense experience of darkness into the vision of the incomprehensible God. Apophatic theology involves interpretation and criticism, conceptualization and theological argument. But all of these are descriptive of a process in which one is engaged, a process in which one must be engaged in order to grasp its interpretation in any depth.[525]

I could not write about what I had not yet lived, and it was in the living that I came to understand. I could not assist others in their spiritual journeys before I had first trodden my own spiritual path in the wilderness and been changed by it. This being said, the strength of this cultivation in the Night lies in that it firmly grounds the work of spiritual care within the spiritual life of the practitioner. It is this life with the Beloved that provides the integrating thread that unites all the pieces of this spiritual study into a whole. What follows is a brief overview of my transformational process in the Night.

As noted by theologian Sandra Schneiders, for St. John of the Cross the coherence of life resided in one's memory: all of one's past life experiences yield guiding wisdom for

[525]Michael Buckley, "Atheism and Contemplation," *Theological Studies Baltimore* 40 (1979): 690.

comprehension of the new—a means by which to reorient oneself in disorienting times.[526] But what happens when this framework of the knowns in one's life can make no sense of a current predicament? St. John identifies a Dark Night journey of personal, profound unraveling that ultimately gives way to the emergence of one's deepest and truest self—this was the essence of my own cultivation in the Dark Night of the Soul for the work of palliative care and this project-dissertation.

St. John describes the Dark Night of the Senses using the allegory of the child who first enjoys the nurture of its mother's breast only to be rudely awakened by the shock of weaning.[527] In my original call to pastoral care and leadership, I had enjoyed a religious experience of spirituality with its familiar moorings of religious language and a world view that paid deference to those theologically and pastorally trained as the guardians and leaders of spirituality. I perceived the Church, with its storehouse of spiritual wisdom, as central in matters of spirituality. My sense of call to care of the dying as clinician, educator, and researcher was deeply grounded in my love for God and in my religious identity as a member of the mystical body of Christ, the Church. I had no idea that my spiritual transformation would be through the loss or deprivation of that which I deeply loved.[528] I needed to undergo a threefold painful purification: to be weaned from the familiar but constricted paradigm of perceiving evidence of the Spirit through an

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[526]Sandra Schneiders, *Finding the Treasure: locating Catholic Religious Life in a New Ecclesial and CulturalCcontext* (New York : Paulist Press, 2000), 188.

[527]DN 1.1.2

[528]Constance Fitzgerald, "Impasse and the Dark Night in John of the Cross," in *Women's Spirituality Resources for Christian Development*, 2d ed., ed. Joann Wolski Conn (New York: Paulist Press, 1986), 414-415.

exclusively religious world view, from religious language as the only expression of spirituality, and from the perception of the Church's unequivocal authority in spiritual matters.

These losses culminated for me in an experience of profound dryness and emptiness in my ministry experience. They also functioned as the means of purifying my motivation, that is, my love for God in the patient encounter—I came to realize that my care, instead of being in service of God, was attached to the gratification or satisfaction I received from a religious expression of spirituality. The motivation for my patient visits needed to be purified—I needed to care as Christ would without condition of any kind but purely for the sake of caring. I also needed to have my ears opened to receive what was genuinely spiritual yet not garbed in the language of religion. The letting-go of theological language both in the patient setting and within the wider context of interdisciplinary collaboration was a painful asceticism.

St. John describes the activity of the divine in the purification of the Dark Night of the Spirit through the allegory of fire, burning and slowly transforming a log of wood. [529] Within the context of inter-disciplinary relating, though I deeply desired connection I found myself holding back—I was afraid of the loss of myself or as I later discovered not myself but my ego.[530] The death of ego and the emergence of the true self is the central spiritually transformative process of the Night. The contemplative saying that "one must lose one's life in order to find it"[531] is a reference to this very real struggle for a larger life.

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[529]DN 2.10.1

[530]John of the Cross, *Dark Night of the* Soul, trans. with an introduction by Mirabai Starr (New York, NY: Riverhead Books, 2002).

[531]Matthew 16:25 (paraphrase) NRSV

Living a "life to the full"[532] requires entrusting ourselves to it, a desire strong enough to choose to die to the known self (ego) and in that dying discover one's true self in mergence with the other/Other, a self that somehow, in spite of our fears, remains distinct.[533]

A personal journal entry perhaps best captures the movements of my soul during this period of purification:

> I did not enjoy patient visits as so much was unknown and unfamiliar for me. I underwent each visit engaging my vulnerability, believing that by stepping into the Unknown of the patient encounter I was somehow going out into Him. I kept returning to the Unknown, to Him. I was empty, I did not go for the enjoyment, I went in search of Him. This is what pulled me back time and again. It was hard work to not have the satisfaction I craved. Sometimes, something was there, I was consoled. But, for the most part, I did not enjoy it and did not want to go—it was done with significant effort. I felt guilty for not having delight. The effort of going out to meet Him, the Unknown, was so much self-denial and also swallowing of my fears as I let go my desire for the known and control each time I entered a patient's room. I love Him. In my inner most self I moved, without conscious knowing, out of myself, died to self, to go out to Him in the darkness of unknowing.

The depth of my longing for union with the Beloved motivated my each and every loss of self—only love can make sense of a costly movement toward that which is longed for and yet feared.

A significant contribution of this work is that it offers a non-pathological perspective on spiritual suffering—normalizing expressions of spiritual or existential pain and also challenging a tendency within health care to pathologize depression. Dark Night spirituality, by its very nature, challenges the duality embedded within a medical culture that perceives ways of coping as either "negative" or "positive"—spiritual health as

[532]John 10:10 (paraphrase) NRSV

[533]Anthony De Mello, *One Minute Wisdom* (New York: Doubleday, 1985), 31.

prescribed by the Night can hold the tension of both the presence and absence of existential distress.

The presence of the Night challenges diagnosis of patient distress based on behaviour alone. Diagnosis requires a clinician to be open to assessing the meaning of a seeming depressive symptom as well—to invite and understand a patient's belief and engagement with spiritual agency. Furthermore, as patients themselves may not be aware of the presence and significance of the Night, the onus is on the clinician to assess such suffering. But more than training is required—diagnosis of the Night is not primarily guided by theoretical understanding but by an experiential knowledge of having traced Dark Night processes within one's life. Hence, spiritual formation is a necessary part of the educational process. A recommendation that flows from this study is the pursuit of post-doctoral research that would clinically empower physicians: What Dark Night processes do palliative practitioners engage in spiritual assessment and contemplative spiritual care of palliative patients? Such a study would allow a soul space for spiritual formation, education, and training in spiritual care of the dying. It would promote the following spiritual care competencies within the practice of palliative care: the ability to recognize Dark Night processes within one's personal and professional life (growth in self-awareness); the ability to identify Dark Night spiritual processes at work in patients (growth in knowledge and professional practice); and the identification and fostering of contemplative Dark Night spiritual care postures in care of palliative patients (change in behavior). Furthermore, it would counter a limitation of this project-dissertation in allowing interdisciplinary health providers to articulate the presence of the Night and how to engage Dark Night processes in care of patients through the particular wisdom and language of their own profession.

Further strengths of this project-dissertation are that it demonstrates both relevance and utility in its application of a theological perspective to the clinical setting. A particular significant contribution both to the field of palliative care and to the general public is that it personally engages readers as they re-call their own experiences with end-of-life scenarios—particularly the witnessing of surrender (letting-go) that is so characteristic of the Night.

Another significant contribution of this work lies in the notion of lament as a valid and normative expression of spiritual suffering. The ability to receive lament rather than trying to answer it or remedy it invites a behaviour modification in a clinician's management of spiritual suffering.

Another strength of this Dark Night study is that it challenges strictly theistic diagnostic measures of spiritual suffering. Its proposed palliative spiritual assessment tool invites measurement of spiritual distress occurring in the other relational domains of being such as the spiritual pain associated with the loss of the image of self.

A particularly significant contribution of this work is its response to the need for a language for spirituality in health. The plurality of spiritual perceptions within health care has prompted both the need to develop a common lexicon for spirituality [534] [535] and a specific language for spiritual pain.[536] [537] The dimensions of the Night translated into

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[534]Balfour M. Mount, William Lawlor, and Eric J. Cassell for McGill Programs in Integrated Whole Person Care Working Group, "Spirituality and Health: Developing a Shared Vocabulary," *Annals- Royal College of Physicians and Surgeons of Canada* 35 (2002): 303-307.

[535]Marjory M. Byrne, "Spirituality in Palliative Care: What Language Do We Need? Learning from Pastoral Care," *International Journal of Palliative Nursing* 13, no. 3 (2007): 118-24.

[536]Pam McGrath, "Spiritual Pain: a Comparison of Findings from Survivors and Hospice Patients," *The American Journal of Hospice & Palliative Care* 20, no. 1(2003):23-33.

[537]Caterina Mako, Kathleen Galek, and Shannon R. Poppito, "Spiritual Pain Among Patients with Advanced Cancer in Palliative Care," *Journal of Palliative Medicine* 9, no. 5 (2006): 1106-1113.

clinical constructs and augmented by a guiding lexicon offer health care professionals one coherent framework and language for spiritual well-being and pain.[538]

A positive outgrowth of this project-dissertation and further evidence of its relevance and utility for interdisciplinary practice is the COF-PHLI, a palliative spiritual history unique in its inclusion of the faith of origin. The tool's current trial as part of a solutions oriented, community based research project in the Greater Trail and Castlegar region, British Columbia,[539] has afforded the writer the opportunity of mentoring an interdisciplinary palliative practitioner in the practice of spiritual care. This in turn has highlighted a necessary qualification of this study: *being* the tool of care rather than applying a tool in care places emphasis on practitioner commitment to personal spirituality—not all clinicians may be willing to consciously engage their spiritual life even for a patient-centered focus of care.

Several recommendations for further study flow out of the contributions made by this project-dissertation. The poignancy of lament within the palliative setting and its differentiation from self-pity deserve further exploration. If lament may be perceived as an agent for ameliorating pain, the relationship between lament and somatization is also worthy of investigation.

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[538]This refers to author's development of *The Dark Night Spiritual Assessment Tool (DN-SAT): A Dark Night Model for Spiritual Assessment.*

[539]Barbara Pesut et al., "Program Assessment Framework for a Rural Palliative Supportive Service," *Palliative Care: Research and Treatment* 7 (2013): 14.

The interdisciplinary field of thanatology has an identified need for further research in anticipatory grief, the type of grief that is normally expressed at end of life.[540] This dissertation and the research that grounds it reframe the experience of end of life loss, suffering, and growth as essentially spiritual. It additionally offers the insight that while human agency is at work, the primary agent of change in grief is the transcendent Other. In light of this, the Dark Night recommends itself as a spiritual theory of anticipatory grief worthy of further study.[541]

A controversial field that would benefit from Dark Night perspectives is the ethics of sedation for psycho-existential distress. Such distress bears remarkable similarity to the nature of spiritual suffering. Although there is no formal universal definition of "psycho-existential distress" within current health care discourse, it is fair to say that the phenomenon referred to relates to non-neuro-physiological suffering which may or may not accompany neuro-physiological pain. Some ethicists have referred to this as "soul pain" or "agent-narrative suffering." [542] Characteristics of psycho-existential distress have been described in a number of ways including hopelessness, alienation, and the sense of being a burden. Considering that this distress may be understood as manifestations of the Dark Night challenges the ethics of medically managing such pain.

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[540]Paul T.P. Wong, "Transformation of grief through meaning: meaning-centered counseling for bereavement," in *Existential and Spiritual Issues in Death Attitudes*, eds. Adrian Tomer, Eliason Grafton, and Paul T. P. Wong (New York: Lawrence Erlbaum Associates, 2008),381.

[541]Zinia Pritchard, "A Critical Application of Grief Theories to a Patient's Lived Spiritual Experience At End-of-Life: A Research Study" (paper written for Thanatology course, Saint Stephen's College, Edmonton, Alberta, May 24, 2010), 1-31.

[542]James J.Walter, "Terminal Sedation: A Catholic Perspective," *Update* 18, no. 2 (2002): 7.

Differentiation between the Dark Night and demoralization syndrome[543] would also be worthy of investigation. Some of the characteristic features of this syndrome, existential distress, helplessness, and aloneness find resonance with the Dark Night facets of distress, impotence, and abandonment. This investigation would augment the taxonomy of distress in the existing literature. [544]

A unique contribution of this project-dissertation is the insight it offers into sacred research methodology: having illustrated how Dark Night postures offer a pathway for contemplative spiritual care of the dying it proposes application of these same postures in the art of contemplative research. The distinguishing features of a Dark Night methodology may be more apparent when compared with the phenomenological "darkness method" of Max van Manen.[545] The explicit integration of the spiritual life of the researcher within the research process does not appear to be a norm in research methodology and so would appear to present a new initiative.

This study is also of public significance: with the rising number of baby boomers retiring and navigating their parents' end-of-life journeys as well as their own ultimate endings, the wisdom of dying as Dark Night moves palliative care to the foreground. The study also commends itself for music and the arts. The wordless movements of ballet may gracefully embody the silence of the Night; the muteness of pain; the subtle, elusive hints of insight; and the fluidity of "effortless effort" that comes as transformative gift. The voice of a violin may soulfully articulate the cry of lament. Lyrics of a song can speak to

[543]David Kisaane et al., "Demoralization syndrome—a relevant psychiatric diagnosis for Palliative Care," *Journal of Palliative Care* 17:1 (2001): 12-21.

[544]Nathan Cherny, "Taxonomy of Distress: Including Spiritual Suffering and Demoralization," *Journal of Supportive Oncology* 8. No.1 (2010): 13-14.

[545]Max Van Manen, *Writing in the Dark: Phenomenological Studies in Interpretive Inquiry* (London, Ont: Althouse Press, 2002), 250.

love's impasse, evocative art in word and image may hold love's paradox, and the full bodied, deep and wide space of the operatic voice has capacity to proclaim the agony and ecstasy of love's consummation. All these expressive arts may be drawn upon in the creation of therapeutic tools such as DVDs and soul journals that can offer spiritual guidance to patients and their families at end of life.

As a service to the Church's mission of evangelization, this project-dissertation offers some challenging perspectives: one of the changes that I have experienced in moving out of the ecclesial world of pastoral leadership and into the world of health care is an awareness of how others may perceive the *lingua franca* of religious life. Until my ears were opened to hear the impact of religious language in my work place, I believe that my ability to both see the Spirit at work in health care and my desire to communicate religious wisdom within a pluralistic environment suffered from the limits of a somewhat insular world view. [546]

My dual identity as a palliative practitioner and theologian has taught me that even the use of the word "God" or perhaps particularly the use of the word "God" needs to be explicitly addressed when speaking of all matters spiritual. Otherwise, one runs the risk of alienating hearers and impeding their possible acknowledgement of spiritual agency within life and practice. In communicating the sacred wisdom of the Church, sensitivity to the impact of religious language is imperative. This kind of sensitivity in proclamation of sacred wisdom speaks to inculturation as the most appropriate means of respectfully engaging with the world as a Church in mission:

> Inculturation is certainly an exercise in prophetic dialogue. It needs, first of all, to be profoundly dialogical, because a context is not always easily readable on the

[546] "And no one puts new wine into old wineskins; otherwise, the wine will burst the skins, and the wine is lost, and so are the skins; but one puts new wine into fresh wineskins." Mark 2:21-23 NRSV

> surface. Years of listening, years of learning from a culture's traditions, the hard work of conversing with both grassroots people and academic studies - these are all essential for both insiders and outsiders in any pastoral situation.[547]

The essential task and strength of this work of practical theology has been one of communication: the translation and mediation between the language worlds of the Church's theology of the Dark Night and the pluralistic expression of spirituality within the wisdom of palliative medicine.

Another insight for consideration is the question of the Church's authority and legitimacy in spiritual matters. The experience of engaging this study and my sojourn through the Night has fully awakened me to the following reality: the Church no longer speaks from a central place of authority within society—it does not hold that power any more. She is only one voice competing among many others. To a large extent the pendulum has swung the opposite direction in that the Church and Christendom in general in Canada now speak from the margins, suffering from silent discrimination. In particular, the Church as institution meets the resistance that appears to be prevalent in North America to all things institutional.

What is the place then of the Church in this post-modern society? I suggest that she re-imagine herself as a strand of the web of life rather than the spider on the web—a somewhat humbling image for the Church.[548] However, I contend that it is a more authentic self-conceptualization: it offers a perception of Reality that shows the essential inter-connectedness and inter-dependence of the Church with the rest of life. This, in turn, would suggest that in relating with others the Church needs to be mutual, to be able

[547]Stephen Bevans and Roger Schroeder, *Constants in Context: A Theology of Mission for Today* (Maryknoll, N.Y. : Orbis Books, 2004), 388.

[548]An apophatic image given as I underwent purification through the passive Dark Night of Spirit.

to both give and receive in matters relating to spirit and truth. This conception of the Church indicates the Church's need of the world for her "self-actualization" as so aptly indicated by Karl Rahner.[549]

Conclusion

The dying space is a contemplative space. Spiritual care of the dying and education of palliative practitioners clearly place emphasis on the meaning of individual spiritual experience rather than shared creeds. The yearning for spiritual connection or communion within the dying space is reflective of a broader movement of Spirit within the culture of health care. Questions of meaning and depth have flooded the market place and have become a driving force within health research. A culture is now awakened to spirituality and in large measure is pursuing this without consultation with the traditional guardians of spirituality, namely religion. Indeed, some question the vitality of spirituality within institutional religion; to be spiritual has, for some, become the opposite of being religious. More often than not people have awoken to the reality that they are spiritual creatures and that this essential identity is not necessarily dependent upon a religious affiliation. In health care discourse this present day reality is expressed through a dichotomous reframing of faith as "spirituality *and* religion." Bridging this divide has been the missionary thrust at the heart of this work of practical theology.

The Dark Nigh of the Soul: A Sacred Anatomy of Dying highlights and substantiates the unique and vital role of a practical theologian within the context of health care

[549]Karl Rahner, *Theological investigations,* trans. with an introduction by Cornelius Ernst (Baltimore : Helicon Press, 1961-1969), 102.

practice, research, and education. The facility for cross-cultural communication of theology is vital in an age where spiritual care is a shared, interdisciplinary endeavour. [550] The reality of an emergent spiritual leadership that is health based and not clerically based necessitates the work to which this study has been committed—the empowerment of palliative practitioners in assessment and care of transformative spiritual suffering in patients.

[550]Christina Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Health Care* (West Conshohocken, PA: Templeton, 2010).

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APPENDICES

APPENDIX A: **A DARK NIGHT LEXICON**

Apophatic: The Dark Night is an apophatic contemplative spirituality referred to as the *via negativa* or negative way. The apophatic may, perhaps, be better understood in contrast to the kataphatic *via positiva* or positive way. The kataphatic emphasizes what is *known* of ultimate Reality. However, concepts and images inspired by the senses are finite constructs and necessarily fail to fully grasp what is essentially Infinite, e.g. statements *about* God are only statements—they are not God.

In the Dark Night the soul comes to know Reality without such mediation. Infinity makes itself *directly* known through the spiritual virtue of faith. Like a child held within the dark and protective cavern of the womb, the individual's spiritual essence embraces unconscious processes. Hence, one's spirituality may be marked by ways of knowing that surpass the intellect and ways of being that suggest passivity and receptivity as authentic dimensions of the spiritual life. The unknowable, hidden and unmediated essence of infinite Reality is the apophatic spirituality of the Dark Night.

Night: Metaphor for the process of spiritual purification. Like nightfall the encountering of life impasses can plunge one into the darkness of night: the way ahead is obscured and the future is unknown. Disoriented on the level of intellect, this loss of bearings leads to feelings of being "at sea" or lost. One cannot proceed forward without the aid of a light or a guide of some kind.

Dark: Metaphor for the unknown, what is obscure and uncertain, relating to the unconscious dimension of the spiritual life that is beyond the senses, intellect, and imagination.

Soul: One's original identity or true inner self, [551] the indwelling of the Other, and [552] one's eternal essence. As such the soul may not be

[551]James Finley, *Merton's Palace of Nowhere: A Search for God Through Awareness of the True Self* (Notre Dame, Ind: Ave Maria Press, 1978), 17.

[552]John of the Cross, *The Spiritual Canticle*, in *The Collected Works of St. John of the Cross,* rev.ed., trans.Kieran Kavanaugh and Otilo Rodriguez with an introduction by Kieran Kavanaugh (Washington, D.C.: Institute of Carmelite Studies Publications, 1991), Stanza 1 no.6-7

understood as a "thing": "[it] is not a part of our being, like a motor in a car. It is our entire substantial reality itself, in its highest and most personal and most existential level..."[553]

Beloved: Name for the Other/ ultimate Reality which is both transcendent (beyond) and abides within (immanent) existence.

Passive Dark Night: An aspect of spiritual agency**;** the dimension of the spiritual life that appears to be more the work of the Beloved/Other.[554]

Active Dark Night: An aspect of human agency: the dimension of the spiritual life that feels to be one's own agency.[555]

Purification: The process of transformative-suffering.

Contemplation: Envisaged as the direct inflow of the Other/Beloved into human existence, pulling the soul toward union/being-at-one-with the Other, self and others.

Also the spiritual agency of purification likened to a fire that purges or burns away all that is contrary to what is ultimately Real and that is conducted without one "doing anything or understanding how this happens.[556]"

Passive Kenosis: The suffering experience of being hollowed out or emptied.

Active Kenosis: The choice to self-empty, surrender or letting go of attachments that impede successfully navigating the unknowns in life.

Purgation/Mortification:

Spiritual Suffering involving the disintegration along intrapersonal, interpersonal and transpersonal dimensions.[557] [558]

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[553]Thomas Merton, *The Inner Experience: Notes on Contemplation*, with an introduction by William Shannon (San Francisco: HarperSanFrancisco, 2003), 6-7.

[554]May, *Dark Night*, 77.

[555]Ibid.

[556]DN 2.5.1.

[557]Constance Fitzgerald, *The Meaning and Recognition of the Dark Night Experience*, lecture by Constance Fitzgerald, Alba House Cassettes (audiocassette), 1991.

All the phases of the Night are inter-related: the deconstruction and integration occurring within one dimension may be more deeply at work within another.[559]

Privation/Deprivation:

The losses suffered in the Night; sense of being lost and feeling abandoned; loss of whom one imagined oneself, others and Other to be.

Lament: Verbal or mute response to the experience of loss.

Dark Night of Sense:

Passive Dark Night of Sense: purification of motivation through deprivation of pleasure.

Active Dark Night of Sense: faithfulness, selfless motivation, and perseverance despite lack of satisfaction in one's spiritual and moral life.[560]

Purification of Awareness: One will see self, others and Other as they really are and not through the lens of one's own needs and desires.[561] One's care for another will no longer be motivated by gratification or attachment to a desire for the other to meet one's own needs.

Dark Night of Spirit:

Passive Dark Night of Spirit: purification of intellect, memory, and will through the disabling (deprivation) of the intellect.

Active Dark Night Spirit: one surrenders the desire to make sense of things chiefly through one's own effort (faith); chooses to entrust self to that which one does not fully understand (hope); and cares for another/Other without the condition that one's own needs be met (love).

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[558]Sandra Marie Schneiders, *Finding the Treasure: Locating Catholic Religious Life in a New Ecclesial and Cultural Context* (New York: Paulist Press, 2000),156.

[559]Schneiders, *Finding the Treasure*, 160,184.

[560]Ronald Rolheiser, *The Shattered Lantern: Rediscovering a Felt Presence of God* (New York: Crossroad), 1995, 88-91.

[561]Ibid., 87-88.

Purification of partial ways of understanding, relating, and loving Reality: when we understand and relate to something *only* in so far as we can intellectually grasp it, and *only* in so far as we ca*n po*ssess it, and *only* in so far as we can remain in c*ontr*ol and secure in th*e fa*ce of it, we w*ill* be relating only partially to th*at r*eality.[562]

Three Spirits of the Night:[563]

The three spirits of the Night have transformative purposes: the purification of the false self and the emergence of the true self. They highlight ego-centred desires that function as attachments: desires for something or someone that the individual believes must be satisfied and upon which the individual is dependent for personal happiness.[564] When these desires are not satisfied the person suffers emotional turmoil and becomes focused on satisfying these ego needs.[565] The individual's failed attempts at self-satisfaction eventually give way to a wilful surrender and an inflow of peace.

Spirit of Fornication: One's need to satisfy the desire for pleasure, affection, and esteem.[566]

The ardent attempt to find the personal gratification now lost in the relationship to life, to the Other, and oneself. "To be more interested in getting a gratifying experience from [who or what we engage] than in the love that had prompted the [engagement] in the first place."[567]

Transformative purpose: To cultivate an individual's love, care or service of the other/Other for his/her own sake.

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[562]Ibid., 93.

[563]DN 14:1-3

[564]Anthony de Mello, *Rediscovering Life: Awaken to Reality* (New York: Image Books, 2012), 32-42.

[565]Thomas Keating, *Invitation to Love: The Way of Christian Contemplation* (New York: Continuum Publishing Group, 1992), 75-76.

[566]Keating, *Invitation to Love*, 75.

[567]May, *The Dark Night*, 144-145.

Spirit of Blasphemy: One's need to satisfy the desire for control.[568]

> An impassioned expression of frustration or anger at the Other in the face of one's own impotence, "In the night of sense we cannot control anything. All our plans, including plans for self-improvement, come to nothing. This eventually causes intense frustration that may express itself in angry thoughts bordering on blasphemy. One would like to grab God by the throat and choke him."[569]
>
> Anger against the Other may also be deflected onto related parties, e.g. ministers, chaplains, and faith communities or be objectified as anger against one's faith. Such indirect expressions of anger may reflect a perception that one's feelings against the Other are unseemly or irreverent.
>
> Transformative purpose: to foster an individual's willful submission to the Other.

Spirit of Confusion/dizziness: One's need to satisfy the desire for certitude: [570]

> The spirit of dizziness spotlights the need for certitude that is rooted in our security program. In this trial, we do not feel certitude about anything. The spiritual journey is a call into the unknown...The only way to get there is to consent not to know. The desire or demand for certitude is an obstacle to launching full sail on the ocean of trust.[571]
>
> Transformative purpose: to engender an individual's entrusting/surrender of self to the Other.

Transition between Passive Nights:

> Experience of contemplation: being-at-one-with the Other/others with attending gift of insight, enlightenment, wisdom or awakening.

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[568]Keating, *Invitation to Love*, 75.

[569]Ibid.

[570]Ibid.

[571]Ibid.

APPENDIX B

CLINICIAN'S DARK NIGHT SELF-ASSESSMENT TOOL[572]

INTRODUCTION	➢ Recall a significant period of personal suffering. Re-tell or journal the experience. Do not add editorial notes or interpretive analysis of your experience. Identify your thoughts, words, and behaviour. Note any physical sensations, feelings or emotions, and mood. ➢ Review the characteristics that were present in your experience by checking off the appropriate boxes below. ➢ Note that the word "God" is only one way in which to name that which is sacred or ultimate. Engage your own language of meaning for transcendence. ➢ Note that "spiritual practice" may relate to any practice that promotes the spiritual life, this may include creative and re-creative practices such as painting, singing and playing a musical instrument.
CHANGE IN SPIRITUAL PRACTICE	□ Powerlessness/inability to focus in prayer, meditation or other spiritual or creative practice □ No consolation/gratification derived from usual spiritual/creative practices □ Lack of desire to engage spiritual/creative practice □ Lack of satisfaction in anything/anyone

[572]Adaptation of Pritchard Palliative Spiritual Assessment Tool (PP-SAT).

SPIRITUAL SUFFERING	□ Loss of self-image: who I am and how I am in the world □ Loss of self: sense of being diminished or emptied □ Loss of my image/perception of others □ Loss of a sense of connection with others □ Loss of my image/perception of "God," Life, what is sacred for me □ Loss of a sense of connection with "God," Life, what is sacred for me □ Feeling that my religious or non-religious beliefs have been shaken or lost □ Impasse: asking questions that could not be intellectually resolved/figured out □ Lack of meaning/striving to make sense of things □ Feeling of being lost or disoriented by lack of meaning □ Feeling abandoned, alone or isolated □ Fear of the Unknown □ Sense of guilt
SPIRITUAL COPING	□ Remaining faithful in spite of a lack of consolation in spiritual/creative practice □ Surrendered the desire to make sense of things chiefly through my own effort (attachment to intellect) and stepped into the darkness of the Unknown (faith) □ Surrendered the need for meaning (attachment to memory) and choose to entrust myself to that which I did not fully understand (hope)

	□ Surrendered the need for control/secured outcomes (attachment to the will) and chose to care without condition (love)
SPIRITUAL EXPERIENCE	□ Experienced moments of spiritual connection (with self, others or Other) □ A sense of who I most truly am (true self) □ A sense of union with and or compassion for others □ A sense of communion with Other □ Experienced moments of insight/wisdom/enlightenment □ Experienced tension of paradox, e.g. the experience of diminishment and the experience of fulfillment. □ Experienced a non-anxious, restful and loving awareness of self/others/Other

APPENDIX C

Symptoms of Major Depressive Disorder

CORE SYMPTOMS	SOMATIC SYMPTOMS	OTHER SYMPTOMS
Depressed mood most of the day nearly every day: • resentful, irritable, angry, or complaining mood or behaviour[573] • demanding or clinging dependency; pessimistic attitude; brooding about past or current unpleasant events • feels sad or empty or appears tearful[574]	Poor appetite/weight loss or increased appetite/ weight gain[575]	Feelings of self-reproach, or excessive or inappropriate guilt (either may be delusional)[576] Preoccupation with feelings of inadequacy/worthlessness[577]
Loss of interest or pleasure in all or almost all activities most of the day nearly every day (anhedonia) [578]	Sleep difficulty or sleeping too much nearly every day[579]	Complaints or evidence of diminished ability to think or concentrate, such as slowed thinking, or indecisiveness nearly every day.[580]
	Observable psychomotor agitation or retardation nearly every day[581]	Recurrent thoughts of death or suicide, or any suicidal behaviour[582]
	Loss of energy, fatiguability, or tiredness nearly every day[583]	Loss of Meaning and Hope[584]

[573]DSM-IV-TR, 349.

[574]Ibid., 356.

[575]Ibid.

[576]Ibid., 350.

[577]DSM-IV-TR, 356.

[578]Ibid.

[579]Ibid

[580]Widiger, "ICD-10 Symptoms," *DSM-IV Sourcebook,* 165.

[581]Ibid

[582]Widiger, "ICD-10 Symptoms," *DSM-IV Sourcebook,* 165.

[583]Ibid

APPENDIX D

Three Signs of the Dark Night of the Senses

Passive Dimension (P) [585] and Active Dimension (A) [586]
1st Set of Signs • P1: Lack of satisfaction and consolation in all dimensions of life; emptiness.[587] • P2: Dryness; distaste/lack of appetite for one's usual spiritual, creative or re-creative practices[588] • A1: Realization that one cannot meditate, imagine or take pleasure from one's usual spiritual, creative or re-creative practices. [589] *2nd Set of Signs* • P3: Guilt and solicitous concern that one is not serving God/living a spiritual life: a sense that one is "off track" because of an awareness of distaste for spiritual things[590] • P4: Dissatisfaction with things in general and yet concerned about God/spiritual life[591] • A3: Realization that one lacks the desire to meditate on anything.[592] *3rd Set of Signs* • P5: Powerlessness due to fruitless endeavour to meditate or imagine. [593] • A1: Pleasure in solitude [594] • A4: Waiting with loving attentiveness upon the Other without meditation, thinking, doing, without particular understanding, simply at rest with inward peace.[595]

[584]Blazer, "Religious and Spiritual Issues," 11.

[585]DN.1.9.2-8.

[586]A.2.13:2-4.

[587]DN.1.9.2.

[588]DN.1.9.4.

[589]A.2.13.2.

[590]DN.1.9.3.

[591]Ibid.

[592]A.2.13.3.

[593]DN.1.9.8

[594]A.2.13.4

APPENDIX E

Joe: A Palliative Patient Narrative

Joe was a 63 year old retired policeman suffering from cancer of the oesophagus. Upon our initial meeting he almost immediately informed me that he was a Christian. Joe then began to share his story of conversion to the Lutheran faith, his wife's faith tradition, and described his supportive relationship with his pastor "David" who was "good at explaining things about God."

Joe then asked if I could help him in knowing about God, "I need to know as much as I can before I meet Him," he said. I remembered the urgency in his voice and the insight that came to me at the time, "I don't know if it's knowledge *about* God that you need as much as knowledge *of* God." I recall coming away from this encounter with a sense of "something" in the shadows of Joe's story. I saw it only obscurely but it was there and I wondered what it was about. I returned later that day with biblical texts that encouraged an experiential encounter with God.

In my subsequent visit with Joe I asked if he had had a chance to read the passages I had left him. He had, he said, but "I need to know more." Joe began to speak about his fear of meeting God and again I became aware of this shadowy figure in our conversation. I asked Joe about his family of origin and his experiences of childhood and he shared with me that his parents were very hard to please. Joe became still and then began to tell the story of his childhood abuse. I remained with him, receptive to every twist and turn of his agonizing tale. It was in this narrative that all was revealed: by word or action Joe's parents had repeatedly reinforced that what he did was not good enough -

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[595]Ibid.

the shadowy figure was Joe's false self, a self that believed that *he* was not good enough. His mistaken personal identity was the driving force behind Joe's anxious "need to know more "leading him to perceive the accumulation of spiritual belief as a means of making him good enough. This insight reaffirmed my assessment that Joe was in need of an experience *of* God.

I spoke about how our image of God can be shaped by these early encounters but that the image of God was not God. "That makes sense." Joe responded, "but, I don't know." (I experienced a little irritation. It always seemed that rational explanations never quite evoked the transformation people needed). In an effort to tap into an image of encounter with the Divine that might help Joe I asked him, "is there any area of your life where you experience simply being accepted for who you are?" He became very quiet. I waited. He gave me a piercing look and then, as if making the decision to trust me, he shared, "my brother Masons." I had not known he was a Mason. "Really? What does it mean for you to be a Mason, Joe ?"

He proceeded to speak, at first haltingly, and then with growing passion about the experiences of community, ritual and service he experienced as a member of the Masonic lodge. He became fully alive and it appeared almost as if a light was shining from within him. I received his outpouring as an in pouring into my own spirit and my heart was warmed by a deep sense of connection and communion. "You have a deep love for them, don't you?" Joe looked taken aback but then said, "love…yes, I guess I hadn't thought of it as that. But, yes, I guess that's the word." Tears began to form at the corners of his eyes. And then his voice broke, "I'm not alone." And he began to cry.

Joe had been living with a deep sense of alienation. Although his mind was able to accept that his image of God was false, and that God's love was not dependent upon

the condition of his being "good enough," he still felt separated from God. It was not until his heart was awakened to the experience of Love that resided within him for his Masonic brothers that he was able to recognize the fact that he had never been apart from God.

At the end of our visit I extended Joe my hand and instinctively he shared with me the secret Masonic handshake. The air was still in the room as we shared a moment of stunned silence. "I don't think you were supposed to do that were you?" I whispered in awe. "No, I don't think I was," he responded. The gift of Joe's true self was probably the most sacred gift I have ever been given.

The following days saw a reduction in Joe's use of opioid medication for break through pain. Joe remained on the unit until his symptoms were adequately managed and he enjoyed several weeks at home before being admitted to hospice where he experienced a peaceful death.

APPENDIX F

The Dark Night and Primary Depression: Differential Diagnosis

SIMILARITIES	DIFFERENCES THAT PRESENT IN THE DARK NIGHT
Loss of interest or pleasure/satisfaction in usual activities	Not self-absorbed: compassion and ability to continue to love, care, and serve others.
Functioning is impacted in relation to spiritual practice	Functioning unimpaired in work, social and or familial life.
Feelings of helplessness (powerlessness)	In spite of sense of powerlessness and absence of meaning there is no expressed request for deliverance or recovery. No suicidal ideation or behaviour.
Impoverishment of thoughts	No psychomotor retardation.
Lack of Motivation (to meditate/reflect).	The individual is still motivated to exercise agency in life despite of lack of gratification. Service is guided more by ethical/moral integrity than by felt gains. Personal agency has the quality of unconditional love: what is given is not attached to desired outcomes.
Self-reproach or guilt (perceived lack of faith)	No dysphoria or brooding.
Emptiness	In time, there is an active choice to self-empty (detach/let-go) the need for satisfaction, comprehension, security and control through spiritual coping mechanisms of faith, hope and love.
Loss of Hope but not hopelessness	Loss of hope in the sense of being unable to construct or imagine a future. Hope gives way to trust/ entrusting of self to the unknown.
Loss of Meaning	Loss of intellectual capacity to make meaning. Intellect gives way to faith: moving into the unknown without the security of comprehension. Meaning is granted through contemplative union and has the quality of insight/enlightenment.

Sadness, disappointment, possible tearfulness, crying.	No pessimism; a sense of rightness about what is happening.
	A sense of humour is retained within the Night.
	No loss of energy or physical symptoms such as disturbances in eating and sleeping or weight gain or loss.

APPENDIX G.

Anthony's Story: A Palliative Patient Narrative

Medical Summary

Anthony was diagnosed with adenocarcinoma of the colon with metastatic disease. He was admitted to the Tertiary Palliative Care Unit because of poor pain control. Upon admission, his Mini-Mental Score (MMSE) was recorded as being 22/30 (with an expected normal 24);[596] his Edmonton Staging System for Cancer Pain (ESS) was uncertain for psychological suffering within the pain expression. [597] His CAGE score was o/4.[598] Anthony was successfully rotated from hydromorphone to methadone. However, during the course of the admission his Edmonton Symptom Assessment Scale (ESAS) indicated total suffering and his use of break through opioid analgesics for non-cancer pain continued to increase. [599] Psychological suffering appeared evident in his pain expression and he appeared to be somatizing. Towards the last half of his hospital stay Anthony's existential distress appeared to resolve and he appeared comfortable until his eventual death on the unit 90 days from the time of admission.

1st Spiritual Care Encounter

In the initial visit initiated by the spiritual caregiver, Anthony described himself as being "spiritual not religious." He had lived by the personal creed "do unto others what you would have them do unto you." Upon enquiry he disclosed that he had been raised in the Roman Catholic faith tradition and had been an active member of his faith community serving as a Knights of Columbus. The spiritual caregiver noted that Anthony's religious code was recorded as "RC" and so advised him of its significance: this would open access to receive the support of the Roman Catholic hospital ministry through pastoral visits and sacramental/ritual supports as well potential visits from his past faith community. He was asked if he desired this. Anthony stated that he did not, and so with his consent the spiritual care giver had the religious code changed to "declined to state." Anthony felt respected by this intervention. Anthony was being supported by his ex-wife, Joanne, a practicing Roman Catholic. The couple had had only one child, Eden, who had died by drowning at the age of three. Anthony had been a long distance truck driver for 30 years and presented as a self-contained man. He had a number of friends in the trucking industry and was valued by his co-workers as always being able to "lend a hand when needed."

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[596] The Mini-Mental Sate Exam is a screening tool used in the palliative care context for assessing delirium/confusion which can have an acute onset, (a matter of days or even hours). The highest score possible is 30. However, when factoring in the variables of age and schooling, this patient would be expected to score 24 if cognitively intact. The patient, though alert, was cognitively impaired upon admission.

[597] The ESS looks at the presence or absence of poor prognostic factors. The presence of one or more such factors would make the task of pain management more challenging.

[598] The CAGE is a screening tool for use of alcohol as a coping mechanism. If a patient scores 2/4 or more this suggests that the patient may cope chemically. Anthony's score did not indicate dependency.

[599] The ESAS is a subjective tool that allows the patient to self score pain and symptoms from a scale of 0-10, 0 being 'no' experience of the pain/ symptom' and 10 being the 'greatest' experience of the pain/symptom. Anthony's scores had been tabulated as follows: pain 10; tiredness 9; nausea 8; depression 8;anxiety 8;drowsiness 8;appetite 0; feeling of well-being 8; shortness of breath 9.

2nd Spiritual Care Encounter

Upon the second visit, at the spiritual caregiver's invitation, Anthony elaborated upon the significance of "being able to do unto others what you would have them do unto you." Anthony believed that his ultimate purpose in life was to always treat people well and to do them good. Anthony valued active "doing" as a measure of his care and of his worth. His story omitted any expressions of care received by others. He dismissed any need on his part with the words, "Oh, I'm okay." Anthony went on to mention that a number of trucking friends had dropped by to see him and that he felt at a disadvantage in not being able to do something for them; he agreed with the spiritual caregiver's summary statement that he was a "giver and not a taker." Over time, Anthony's sense of self, rooted in the experience of self-sufficiency and the ability to always do for others, diminished and with this came feelings of isolation.

3rd Spiritual Care Encounter

On the third spiritual care visit Anthony began to talk about his son, Eden. He had been thinking a lot of Eden lately. The spiritual caregiver indicated interest that prompted Anthony to talk about Eden. He began to share who Eden was, how he and his wife Joanne had planned for his birth and the life they shared as a young family as well as his own meaning as a father, someone who would "always be there" for his child. His eyes sparkled as he shared his hopes and dreams. And then, a silence descended. In a mute voice Anthony began to tell the story of Eden's drowning. His back had been turned a minute; he was tending to his wife's request to examine the barbecue for a gas leak. Six friends were around and no-one saw that Eden had wandered away from the older children until they began to shout frantically for help. He remembered running blindly to the water, an inner combustion propelling him at lightning speed, but the lake was eerily silent, no "Daddy! Help!" He dove in and searched for his son coming up for air only when his lungs forced him to. On the fifth or sixth surfacing he heard his name called; the rescue team had arrived and a small crowd gathered at the shore forming a circle. He struggled to shore. The crowd parted as he strode up to the body of his son, their heavy silence hung like a drawn curtain. All he could hear were the soul wrenching sobs of his wife as she rocked her baby back and forth and a strangled guttural sound, his own, "I wasn't there." Anthony began to cry and his hands shook. The spiritual caregiver compassionately received Anthony's suffering: entering into and remaining with him in his agony, maintaining a reverential silence, shedding her own tears and lending her composure.

After a lengthy silence, Anthony looked up and asked, "Will my boy ever forgive me?" "Maybe this cancer will make up for it." When asked to clarify what he meant by this, Anthony expressed his struggle in faith: "I had always experienced God being there for me and my family as long as I lived my life by treating others as I would have them treat me. I must have done something wrong for God to leave us like that." When he was asked what he thought he did wrong, "I don't know" was his response.

Anthony agreed with the following summary of his faith perspective: by not being there for his son he felt that he had abandoned Eden. Anthony understood this to be a sin (offence) both against his son and against God who had entrusted Eden's life to him. He thus perceived the cancer as the suffering he deserved as reparation for the sin of having abandoned his child. Anthony did not seem to derive peace from this meaning-making of

his terminal diagnosis and resisted efforts to review his understanding of his cancer as a punishment. Yet, he was open to spiritual counsel that normalized his experience of the Dark Night of the Soul: the belief that he had displeased God, his inability to pray as he used to, the loss of desire for spiritual things as these bought him no consolation and an experience of dryness in life where, in spite of his "doing for others," nothing seemed to satisfy.

Practitioner's Experience of Impasse

The spiritual caregiver was at an impasse; she did not know how to alleviate Anthony's suffering. In this shared place of powerlessness, not knowing the way forward, her soul lived the question "How do I help him?" One day, in a blank moment, she had a sudden epiphany —"Anthony, like me, lives in the intellect; what he needs is beauty!" Although she was unsure of what this intervention would look like, she trusted that the way ahead would unfold.

4th Spiritual Care Encounter

In a subsequent visit, Anthony agreed to the offer of prayer. The spiritual caregiver opened with a moment of silence. In the stillness she then moved in to a sung lament – the beautiful and haunting melody of the Cry from the Cross. It voiced for Anthony, in an unexpected way, his own inner anguish and despair: *O God, my God, Where have you gone from me?"* Anthony's exclamation, "Ahh!!!" brought on a loud deluge of anguished tears – a dam had broken. The spiritual care giver looked up only once and could not return her eyes to his face – the moment was too sacred. She remained by his side until the tears had been spent. After a period of shared silence she slowly raised her eyes. Anthony had a look of wonder on his face and a peace emanated from him. "The Father watched his son die too." As he spoke a stillness filled the room; the presence of the Sacred was almost tangible.

Anthony's unexpressed lament resided deep within his body; he felt abandoned by the God he knew who would always protect from harm just as God the Son felt abandoned by the Father –the Father *who was there* and who had to watch his Son's suffering. Jesus' lament was a contemplative experience that gave Anthony both a sense of union with God and insight into his own suffering; he now understood that the Father's lack of intervention in saving his Son from physical death did not mean he had abandoned him. Similarly, Eden's death was not because Anthony had abandoned him. Anthony no longer rationalized his cancer as being a punishment from God; his use of break through medication for non-cancer pain stopped.

5th Spiritual Care Encounter

In the next spiritual care visit, Anthony shared his growing realization that he had emotionally abandoned his wife since the death of Eden. He realized that his inability to be vulnerable in love and his need to be self-sufficient had cost him the mutuality needed in a marriage. Anthony could now see where he had sinned against Joanne; he was open to articulating his feelings to her in a letter and asking her for forgiveness. He also expressed his sorrow to God in prayer, asking God for forgiveness. Anthony was asked if he would like to celebrate the sacrament of reconciliation and he agreed that that would be a good idea. A referral was made to the on-call RC priest.

6th Spiritual Care Encounter

In follow up, the spiritual caregiver asked Anthony how the visit had gone with the on-call priest. Anthony shared that it was a good experience. His eyes lit up when he mentioned that his ex-wife had come to speak with him after receiving his letter. They had had a frank and tearful discussion and had reconciled. It was soon after this that Father John had arrived and had creatively led a communal rite of penance that befitted the situation. The couple had shared Eucharist together. Anthony agreed to having his religious code changed back to RC so that he might continue to be supported by his faith community.

7th *Spiritual Care Encounter*

Anthony and Joanne made up for lost time. Their union in spirit and love fired them into seeking out a number of ways to prolong Anthony's life including the option for antibiotics when Anthony suffered repeated infections. However, over the course of a few weeks Anthony steadily declined. During the course of a spiritual care visit, Anthony shared that he had had a vision of Eden running to him and that before he had been able to say, "I'm sorry son" Eden had flung his arms around him and asked, "daddy, when are you coming home?" His son was missing him. These experiences of reconnection in love both with Eden and with Joanne left Anthony torn. He did not want to physically abandon Joanne. He wanted to continue to enjoy their renewed sense of intimacy. But he yearned to be reunited with Eden. Anthony was reassured by the spiritual caregiver's normalizing of the pull to both leave and to remain as paradox. Anthony grew quieter as time went by. He shared with the spiritual caregiver an increasing inability and lack of desire to engage verbal prayer but was not distressed and seemed quite comfortable to "simply be."

8th Spiritual Care Encounter

Although Anthony was inclined more toward solitude and no longer attached to the need to live at all cost, he still struggled to keep going out of his love for Joanne. Unfortunately, she was simply not ready to let him go. The spiritual care giver visited with Joanne, and in the course of their time together, she came to recognize that she was securing her own needs in making Anthony opt for aggressive treatment; Joanne did not want to lose the shared intimacy that had been denied her for so long and was attached to this desire which functioned as an anxiety for her. It was this personal need rather than a love of Anthony for his sake that guided her treatment goals.

Joanne made the decision to surrender her own will and granted Anthony permission to leave. In this unconditional expression of love, she reassured him that this was not abandonment but a freely willed decision, that she was not sure what her future would be like without him but that she stepped out in faith believing that God would show her the way and that her hope was in him for her future. The experience of mutuality in this tender exchange gifted Joanne and Anthony with an even deeper intimacy.

Joanne asked Anthony if he would like Fr. John to come and anoint him and he did. The spiritual caregiver made the referral accordingly. Later that day Anthony and she were blessed with a deep peace in the celebration of the sacrament of the sick. The spiritual caregiver was asked to be a part of this ritual and she offered a prayer of thanksgiving for the journey of reconciliation and the promise of union with Eden in life after death.

Anthony died in peace.

APPENDIX H

REGIONAL PALLIATIVE CARE PROGRAM
POSTGRADUATE MEDICAL EDUCATION

FAMILY MEDICINE RESIDENTS' EVALUATION OF EDUCATIONAL SESSION: "SPIRITUAL CARE IN PALLIATIVE CARE" 2003-2008

A QUANTITATIVE AND QUALITATIVE REPORT

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INTRODUCTION

Patient-centered medicine is a shared focus for both palliative and family medicine. The Regional Palliative Care Program (RPCP), Edmonton, Alberta has demonstrated leadership and vision in holistic care by choosing to provide family medicine residents rotating through the Tertiary Palliative Care Unit (TPCU) with an introduction to spiritual care of patients at end of life through a one and half hour educational session, "Spiritual Care in Palliative Care" facilitated by TPCU CAPPE Specialist in Pastoral Care (chaplain). Learning was further augmented by ongoing exposure to the chaplain as an integral member of the TPCU interdisciplinary palliative care team. This evaluation provides a quantitative and qualitative analysis of the respondents' evaluation of their exposure to spiritual care and invites consideration for including spiritual care education within the medical curriculum.

SAMPLE

A total of 143 evaluations were received from session participants between January 2003-February 11th 2008. In this same period 205 Family Medicine Residents rotated through the TPCU. An additional 66 non-family medicine residents also rotated through the unit and would have been invited to attend the educational sessions. At the time, the evaluation forms did not provide for a means of identifying different respondents. However, it may be estimated that if forms were completed by family medicine residents alone that 70% rate of return would be indicated and that if completed forms were inclusive of other groups that the rate of return would be 52.5%. Either estimate indicates a significant sample size.

QUANTITATIVE DATA ANALYSIS

There were five quantitative questions posed that measured responses using a likert scale where a measurement of agreement ranged from 0 "not at all" to 10 "highest possible." Results were graphically presented through the use of pie-charts[600] and repeatedly illustrated a majority of strong agreement with the evaluation questions posed:

1. **My exposure to spiritual care on this rotation has impacted my awareness of the spiritual dimension to palliative care medicine**: The highest score of '8' represented 27.9% of the total responses. The combination of scores '7'-'10' demonstrated that three quarters (75%) of respondents were significantly impacted in their awareness of the spiritual dimension of palliative care medicine.

2. **My exposure to spiritual care on this rotation has impacted my approach to the medical care of my patient:** The highest score of '8' represented 27.4% of the total responses. The combination of scores '7'-'10' demonstrated that two thirds (66.7%) of respondents were significantly impacted in their approach to the medical care of their patients.

[600]Not included in this appendix

3. **My exposure to spiritual care on this rotation has caused me to reflect upon my own spiritual values, beliefs, and issues:** Again, the highest score was that of '8' which represented 19.7% of the total responses. The combination of scores '7'-'10' demonstrated that just under two thirds (64.2%) of respondents were significantly able to engage in self-reflection upon their own spiritual values, beliefs and issues.

4. **I would recommend education in spiritual care to be an integrative part of the rotation:** The highest score of '8' represented 26.7% of the total responses. The combination of scores '7'-'10' demonstrated that just over three quarters (77.1%) of respondents felt strongly that spiritual care ought to integral to a rotation in palliative care.

5. **The palliative chaplain mentor has facilitated learning in the area of spiritual care:** The highest score of '8' represented 24.8% of the total responses. The combination of scores '7'-'10' demonstrated that just under three quarters (72.1%) of respondents felt that the educator effectively facilitated learning in this dimension of care.

QUALITATIVE DATA ANALYSIS

An additional two qualitative questions were posed; question 6 identified the respondents' key learning points and question 7 invited the respondents' to name how the learning process could have better met their needs.

Question 6 generated 82 responses, of these 3 data items were discarded as their content indicated a longer exposure to spiritual care within palliative care and probably were responses received from palliative medicine residents/clinical fellows. Qualitative analysis of the data identified four key areas of physicians' learning: the spiritual care professional (34.2%), physician capacity for spiritual care (31.7%), spirituality (20.7%) and the relationship between spirituality, health and pain expression (19.5%).

1. **The Spiritual Care Professional**: 9.8% physicians demonstrated insight into the nature of professional spiritual care "…spiritual care within healthcare/in hospital is inclusive and holistic." 9.8% highlighted understanding into the role of spiritual care professionals "…what they do and how they do what they do." 3.7% commented on the impact of a palliative chaplain and 4.9% that spiritual care is an integral part of patient care. A further 4.9% physicians shared their appreciation for spiritual care insights shared in patient assessments, "…in interdisciplinary team meeting, seeing how spiritual care affects every aspect of palliative patient's care – including the medical aspect." And 9.8% highlighted education in spiritual care as a function and initiative of the spiritual care professional, "…being exposed to an area that gets no attention in our medicine training."

2. **Physician Capacity for Spiritual Care:** the following key areas of learning were identified: 13.4% physicians noted an increased capacity for the work of spiritual care, "…importance of listening to patients and validating their experience," "…being able to practice kenosis [meditative discipline]," "...supportive therapy, how to support patients in an emotional crisis." 9.8% highlighted an increased self-awareness, "…recognition of my own feelings surrounding palliative care and death," inclusive of an ability to refer to the specialist, "…the indications for requesting a spiritual care consult." 8.5% were able to establish a correlation between increased self-awareness and the ability to spiritually care effectively for their patients, "…being more cognizant of the impact of my own beliefs on the interaction with patients," "… I understand that my spiritual interests can be different than the patient believes and I have to listen and respect their beliefs," "…identifying what is important to my own spirituality and my own important relationships and beliefs so that I have a base to help others," "…I realize that there are certain things that I do not feel comfortable discussing and that I need to improve on these skills in the future."

3. **Spirituality:** 12.2% of physicians valued the definition, role, process and scope of spirituality, "…understanding definitions of patient spiritual experiences," "…the concept of spiritual well-being as part of physical and emotional health," "…learning the spiritual process of my patient." A further 3.7% identified learning about different approaches to death and dying across cultures/religions as particularly helpful and 4.9% responses identified spirituality as a patient need, particularly at end of life, "…importance of spirituality for patients when facing death and dying."

4. **Relationship between spiritual issues and medical management:** 9.8% identified spiritual issues and 9.8% realized that there was an inter-relationship between spiritual issues and medical management: "…understanding firsthand how spiritual distress increases pain,""…became more aware of impact of spiritual values and beliefs on coping mechanisms of palliative care patients," "…how a patient's spirituality can impact his/her medical condition and response to medical management especially around the time of death."

Question 7 generated 54 responses, of these 4 data items were discarded as their content indicated a longer exposure to spiritual care within palliative care. Qualitative analysis of the data resulted in the following six emerging themes: 40% indicated the need for clinical mentoring, 16% the *need for* spiritual care education, 14% the need for further spiritual care education, while 8% argued *against the need for* spiritual care education, 8% identified limits to education in spiritual care and 4% indicated appropriate placement of session within the context of the rotation.

1. **Need for Clinical Mentoring:** 40% of respondents identified a clear need for clinical mentoring, 34% through observation of patient-spiritual care interaction/assessment, "…watching chaplain do an initial assessment," "…being present during a spiritual care consult," "…tagging along for an interview/patient discussion would be interesting and helpful." Also 4% indicated the possibility of

case reviews as a help, "…maybe going over individual patients I am caring for with the chaplain."

2. **Need for Spiritual Care Education:** 16% respondents affirmed the need for spiritual care education: 6% identified the need for spiritual care as part of medical education; 4% identified educational need met through spiritual care chart notes and reading materials; 2% identified the need for active listening and self-reflection; 2% identified the need to know how to access community based spiritual care resources; 2% identified the need to know how to take a spiritual history and to respond to patient comments; 2% understanding how spiritual care functions at end of life and 2% affirmed the importance of spiritual care.

3. **Need for Further Spiritual Care Education:** 14% of respondents identified a clear need for additional sessions in spiritual care/longer rotation, "having more hours of discussion about spiritual care," "…perhaps two meetings, one early and one late in the rotation." 4% of these respondents expressed a desire for more concentrated focus on clinical case discussions, "…15 minutes per morning before we start seeing our patients." 2% requested a better understanding of the role of the chaplain and 2% more additional educational handouts specifically on the religious expression of spiritual needs of patients.

4. **Spiritual Care Education Not a Need:** 2% of respondents insightfully noted that receptivity to spiritual care would vary among residents; a following 6% challenged the need for spiritual care education within the medical curriculum: 2% believed that spiritual care education ought to be optional; 2% posited that while spiritual care of palliative patients is very relevant and important [presumably by the specialist in spiritual care] that education for physicians to build capacity for spiritual care-giving is inappropriate. And a further 2% differentiated between intellectual knowing *about* spiritual care which is valuable knowledge but argued that one's own training *for* spiritual care as a physician is not needed unless it is of interest to the physician.

5. **Limits to Education in Spiritual Care:** 8% of respondents identified some of the limitations of the spiritual care education: 2% noted a lack of comfort with religious language and the spiritual nature of spiritual care-giving; 2% that the theoretical constructs presented may be dismissed as the educator's personal belief system only; 2% noted that the education provided is only one approach to spirituality in palliative care and 2% commented that time for spiritual care of patients by family physicians is very limited.

6. **Timing of Sessions:** 4% of respondents identified the need for orientation to spiritual care to be placed earlier in the rotation, "…contact with the Chaplain should be earlier in the rotation, not on the last afternoon." In practice, the nature of this request was much higher and in response to this need the session in spiritual care was moved to the first week of the rotation.

Limits to Study

The study is limited by the fact that the teaching modality of the educator changed over time. Initially, teaching fostered physician self-awareness but such work demanded an ability to personally engage one self. Although most physicians *did* choose to engage in this kind of learning modality not all were able or willing to do so. As a result of this and other factors, the teaching modality transitioned into a more didactic session. In addition, the regular educator was away for a period of over 3 months 2005 and the teaching content of the interim chaplain educator is not known. The analysis of the evaluations received does not account for these shifts in pedagogy and the possible impact on responses received.

Discussion

As a whole, respondents convey an awareness and appreciation for the integral nature of spiritual care in palliative care. However, if medical curriculum is determined by learners then medical educators would do well to note the conflicting evidence regarding education in spiritual care: 16% of respondents indicated that it ought to be a requirement (with a further 14% desiring further spiritual care education) yet 14% indicated that it be optional and dependent upon physician preference. This disparity may be accounted for in the difference between knowing *about* spiritual issues, which is a matter of the intellect, and the actual *work of* spiritual care that is a holistic endeavour that requires a physician's self-awareness and capacity to integrate that self-awareness with patient care.

The qualitative data hints at a possible underlying resistance to physician education in spiritual care: the discomfort with religious expression of spirituality, "…not being a religious or spiritual individual, I was uncomfortable with all the references to God." The counter-cultural nature of spirituality, "…medicine is still very distant and sterile to the patient." The perception that the clinical specialist in spiritual care is a community religious leader or "pastor" that provides care for only Christian faith groups, "….understanding that the chaplain not just ministering to Christian religions." And finally the false assumption that spiritual care is exclusively religious with the attending bias that it is, therefore, closed, "…spiritual care within healthcare/in hospital is inclusive and holistic."

Future Directions in Education and Research

This being said, the analysis certainly demonstrates a gap in knowledge within current medical education of family medicine residents, a fact also noted in the qualitative feedback, "… was never exposed to these approaches prior to this rotation, "…being exposed to an area that gets no attention in our medicine training."

A possible direction for the future may be to attend to the wisdom of one respondent who states, "...this is an important aspect of our learning and should be kept in the curriculum, but it is important to realize that some residents will be more receptive to it than others."

Following upon respondents' comments, the writer's experience in end-of-life medical education as a spiritual care educator, and discussion with a CAPPE certified educator, the following areas are suggested as a starting place for discussion with physician

educators in the development of a spiritual care component within the medical curriculum:

Didactical:

- A foundational understanding of the relationship between spirituality and religion.
- The role of the spiritual care professional.
- Introducing a conceptual model for spirituality in clinical care.
- An introduction to how spirituality can impact well-being and suffering
- Identifying spiritual issues in end-of-life care and how these can impact medical management.
- Introduction to spiritual care specialist spiritual assessments
- Introduction to physician spiritual assessment tools.
- The difference between taking a spiritual history and spiritual care of a patient.
- Information regarding cultural and religious beliefs and practices and how they present at end of life.

Clinical Mentoring:

- Accompanying physicians in their visits with patients, assessing their psychosocial interactions from a spiritual care perspective and modeling appropriate spiritual care interventions.
- Providing physicians with opportunities to increase self-awareness and begin to develop a personal capacity for spiritual assessment and care of their patients.
- Case Reviews that examine spiritual issues, inclusive of ethical issues that normatively present at end of life.
- Identification of points of referral to spiritual care specialists and community religious/spiritual care providers.

Research

- How spiritual issues at end-of-life can impact medical management.
- The relationship between physician self-awareness, spiritual assessment and care at end of life.

CONCLUSION

This report has provided both quantitative and qualitative evidence for the serious consideration of spiritual care education as a provision within the medical curriculum. This innovation embraces a vision of "leadership in partnership" between medical educators and spiritual care educators. It is the hope of the writer that this will provide an important first step in providing physicians with a consistent and integrated understanding of the spiritual dimension and care of patients at end of life.

APPENDIX I

PP-SAT: A DARK NIGHT MODEL
FOR SPIRITUAL ASSESSMENT IN PALLIATIVE CARE

REFERERRAL SOURCE: □ Pt □ Family □ Nursing □ MD □ ID Team □ Palliative Chaplain
□ S/C Chaplain Following □ Other _____

REFERRAL REASON: □ Pt. distress/need □ Family distress/need □ Pp score/ somatization
□ Actively dying □ Palliative Sedation □ Other _____

SPIRITUAL ORIENTATION:
□ Spiritual identity connected with religious tradition but not membership in religious community (faith of origin)
□ Spiritual identity connected with religious tradition and membership in religious community.
□ Identity of Community _____
□ Need for Religious Code Change Yes: ___ From:_____ To: _____ Date: _____
□ Spiritual identity connected with influences from other spiritual traditions: No ____ Yes: _____

SPIRITUAL LANGUAGE: RELIGIOUS/NON-RELIGIOUS LANGUAGE OF MEANING
□ Core values/beliefs: _____
□ Sense of meaning and purpose/mission _____
□ Who/What is Ultimate Reality/Sacred? _____

SPIRITUAL PRACTICE
□ Unable to focus in prayer, meditation or other spiritual or creative practice
□ Spiritual/creative practice brings no consolation/comfort.
□ Lacks the desire to engage spiritual/creative practice.
□ Lack of satisfaction in anything/anyone.
□ Would like spiritual companionship, guidance and support

RELIGIOUS RESOURCES
□ Would like to connect/reconnect with my religious/cultural community
□ Would like to receive specific religious or cultural procedures, rituals or ceremonies_____

SPIRITUAL SUFFERING: LAMENTING THE EXPERIENCE OF LOSS
□ Loss of image of one's self
□ Loss of sense of self/being diminished or emptied
□ Loss of one's image/perception of others
□ Loss of a sense of connection with others
□ Loss of one's image/perception of God/Life
□ Loss of a sense of connection with what is sacred e.g. God or ultimate meaning

□ Feeling that faith has been shaken/a loss of faith
□ Lack of Meaning/striving to make sense of things
□ Feeling lost/disoriented by lack of meaning
□ Feeling abandoned/alone/isolated
□ Afraid of the Unknown
□ Sense of guilt
□ Would like spiritual companionship, guidance and support.

SPIRITUAL SEEKING
□ Seeking forgives/reconciliation/peace
□ Seeking meaning
□ Seeking _____
□ Would like spiritual companionship, guidance and support

SPIRITUAL EXPERIENCE
□ Experienced moments of spiritual connection (with self, others or Other)
□ Sense of authentic/true self
□ Sense of union with others □ Sense of compassion for others
□ Sense of communion with Other
□ Experienced moments of insight/wisdom _____
□ Experiencing Impasse: asking questions that cannot resolved through the intellect
□ Experiencing the tension of paradox, e.g. the desire to live/stay and the desire to die/go
□ Non-anxious, restful and loving awareness of self/others/ Other
□ Lack of attachment to the need for meaning
□ Would welcome spiritual companionship, guidance and support

SPIRITUAL COPING: LETTING-GO ATTACHMENT TO INTELLECT, MEMORY & WILL
□ Remaining faithful in spite of lack of consolation in spiritual/creative practice
□ Faith: letting-go the need to understand through the intellect and choosing to step into the darkness of the Unknown receptive to the gift of insight/wisdom
□ Hope: letting-go of past security in what was known and choosing to relate to the Unknown by freely entrusting oneself to it
□ Love: letting-go of loving self, other, Other with expectation of outcomes and choosing to love without condition

SPIRITUAL CARE
□ Initial Assessment/Consult: Initials: _____ Date _____
□ Spiritual Care Presence
□ Spiritual companionship, guidance and support
□ Empathic receptivity to and facilitation of lament
□ EOL Rites & Rituals Assessment: Initial: ___ Date _____
□ Ethics Discernment of Request for EOL Rite/Ritual:
□ Nature of Rite/Ritual Requested _____
□ Source of Request: □ Patient □ Family □ Other
□ Patient Consent: □ Yes □ No
□ Not able to determine, e.g. on palliative sedation

□ Request congruent with patient spirituality □ Incongruent
□ Provision of Ritual □ Decline of Ritual
□ Assessment of spiritual needs of referral source and provision of spiritual care
□ EOL Religious/Cultural Death Protocol: Initial: _____ Date _____
□ EOL Prayer/Ritual by Chaplain
□ EOL Prayer/Ritual by Community S/C:
□ Sacrament of the Sick: Date ____
□ Aboriginal Sacred Ceremony: Date _____
□ Other: _____: Date _____
□ Other Religious Specific Rites/Ritual, e.g. Baptism _____
□ Special Ceremonies: □ Wedding □ Couple Blessing □ Other Ritual _____

REFERRALS:
□ Community Spiritual Care: Referral Reason:_____ Date: _____
□ MD: Referral Reason: _____ Date: _____
□ SW: Referral Reason: _____ Date: _____
□ MT: Referral Reason: _____ Date: _____ __
□ Psych: Referral Reason: _____ Date: _____
□ Palliative Chaplain: Referral Reason _____ _____Date: _____
□ On-Call Chaplain: Referral Reason _____ _____ _____ Date: _____
□ Other: _____ Referral Reason: _____ Date: _____

APPENDIX J

DOMAIN SPECIFIC APPLICATION OF THE DARK NIGHT MODEL/PP-SAT

DOMAIN: SPIRITUAL ORIENTATION

PATIENT ENCOUNTER	DIMENSION	NARRATIVE INDICATORS
1st	□Faith of Origin: spiritual identity connected with religious tradition but not membership in religious community □ Vocational identity □ Core values/beliefs	○ Pt. use to be active member of a RC faith community ○ Pt. expressed his spiritual identity through service as a Knight of Columbus ○ 'do unto others what you would have them do unto you.'
2nd	□ Sense of meaning and purpose/mission: □ Core values/beliefs:	○ Pt. believes that his ultimate purpose in life is always to treat people well and do them good. ○ Pt. values active doing as a measure of his care and his worth.
3rd	□ Vocational identity □ Sense of meaning and purpose/mission	○ …his own meaning as a father, someone who would "always be there" for his child.

DOMAIN: RESOURCES IN RELATIONSHIP WITH SELF

ENCOUNTER	DIMENSION	NARRATIVE INDICATORS
1st	□ Experience of connection with the volitional self/ the ability to still 'do'	○ Pt.'s sense of and understanding of self appears to be connected with his ability to be of service to others: past service as Knights of Columbus and valued by his co-workers as 'always able to lend a hand when needed.' ○ Pt. presents as a self-contained man.

8th	□ Spiritual Coping: surrendering the need for personal gratification in experiences of relating *(attachment to ego/will)* and choosing to relate to the situation/others without agenda/expectations *(spiritual posture of love)*	○ Joanne came to recognize that she was securing her own needs in making Anthony opt for aggressive treatment: she did not want to lose the shared intimacy that had been denied her for so long...It was this personal need rather than a love of Anthony for his sake that guided her treatment goals.
	□ Spiritual Coping: surrendering the need to rely upon the rational mind to make sense of things *(attachment to intellect)* and stepping into the darkness of the Unknown *(spiritual posture of faith)*	○ Joanne made the decision to surrender her own will and granted Anthony permission to leave. In this unconditional expression of love, she reassured him that this was not abandonment but a freely willed decision
	□ Spiritual Coping: surrendering the need for the assurance of meaning *(attachment to what is known/memory)* and choosing to entrust self to that which is not fully understand *(spiritual posture of hope)*	○ [Joanne] was not sure what her future would be like without him but that she stepped out in faith believing that God would show her the way and that her hope was in him for her future.

DOMAIN: RESOURCES IN RELATIONSHIP WITH OTHERS

ENCOUNTER	DIMENSION	NARRATIVE INDICATORS
1st	□ Supportive relationships: □ spouse □ friends	○ Supportive relationships in ex-spouse Joanne and trucking friends.
5th	□ Experiences of reconciliation/forgiveness of others	○ Anthony was open to articulating his feelings to [his ex-wife] in a letter and asking her for her forgiveness.
6th	□ Experiences of reconciliation/forgiveness with others	○ His eyes lit up when he mentioned that his ex-wife had come to speak with him after receiving his letter.

	□ Experience moments of spiritual connection (with self, others or Other) □ A sense of who one most truly is (true self)	They had had a frank and tearful discussion and had reconciled. ○ Anthony agreed to having his religious code changed back to RC so that he might continue to be supported by his faith community
7th	□ Experience of shared faith in medical intervention □ Experience of shared hope in outcomes of medical intervention □ Experiences of reconciliation/forgiveness	○ Anthony and Joanne made up for lost time. Their union in spirit and love fired them into seeking out a number of ways to prolong Anthony's life including the option for antibiotics when Anthony suffered repeated infections. ○ Anthony shared that he had had a vision of Eden running to him and before Anthony had been able to say, 'I'm sorry son' Eden had flung his arms around him and asked, 'daddy, when are you coming home?' His son was missing him.
8th	□ Experience moments of spiritual connection (with self, others or Other) □ A sense of union with and or compassion for others	○ The experience of mutuality in this tender exchange gifted Joanne and Anthony with an even deeper intimacy.

DOMAIN: RESOURCES IN RELATIONSHIP WITH OTHER

ENCOUNTER	DIMENSION	NARRATIVE INDICATORS
4th	□ Experiences of insight/enlightenment/wisdom	○ Jesus' lament was a contemplative experience that gave Anthony both a sense of union with God and insight into his own suffering; he now

		understood that the Father's lack of intervention in saving his Son from physical death did not mean he had abandoned him. Similarly, Eden's death was not because Anthony had abandoned him. Anthony no longer rationalized his cancer as being a punishment from God; his use of break through medication for non-cancer pain stopped.
5th	□ Experiences of insight/enlightenment/wisdom □ Engagement with spiritual/creative practices and service: ritual □ Experience of forgiveness/reconciliation with Other	○ Anthony shared his growing realization that he had emotionally abandoned his wife since the death of Eden. He realized that his inability to be vulnerable in love and his need to be self-sufficient had cost him the mutuality needed in a marriage. He could now see where he had sinned against his wife. ○ He also expressed his sorrow to God in prayer, asking God for forgiveness.
5th	□ Engagement with spiritual/creative practices and service: ritual	○ Celebration of the Sacrament of Reconciliation
6th	□ Engagement with spiritual/creative practices and service: ritual □ Experience of forgiveness/reconciliation with Other	○ Father John had arrived and had creatively led a communal rite of penance that befitted the situation.

7th	□ Experience a non-anxious, restful, and loving awareness of self/others/Other	○ Anthony grew quieter as time went by. He shared with the spiritual caregiver an increasing inability and lack of desire to engage verbal prayer but was not distressed and seemed quite comfortable to 'simply be.'
8th	Experience moments of spiritual connection □ A sense of union with and/or compassion for others □ A sense of communion with Other □ Engagement with spiritual/creative practices and service: ritual	○ Later that day Anthony and [Joanne] were blessed with a deep peace in the celebration of the sacrament of the sick.

DOMAIN: SUFFERING IN RELATIONSHIP WITH SELF

ENCOUNTER	DIMENSION	NARRATIVE INDICATORS
2nd	□ Experience of loss of connection with volitional self	○ Pt. feeling disadvantaged at not being able to do something for those who visit ○ Pt. duality: perceives self as a 'giver' and not a 'taker'; does not acknowledge personal needs; a strong sense of self-sufficiency.
3rd	□ Loss of sense of self and who one understands oneself to be □ Experience of loss of connection with the imaginative self	○ Loss of Anthony's sense of fatherhood imagined as one who would 'always be there' for his child.

DOMAIN: SUFFERING IN RELATIONSHIP WITH OTHERS

ENCOUNTER	DIMENSION	NARRATIVE INDICATORS
1st	□ A loss of pt. sense of connection with others	○ Loss of child Eden who had died from drowning at age three. ○ Desire to not access Roman Catholic faith services
3rd	□ A loss of pt. sense of connection with others	○ 'Will my boy ever forgive me?'

	□ Experience of lack of forgiveness/reconciliation with others	○ Anthony agreed with the following summary of his faith perspective: by not being there for his son he felt that he had abandoned Eden. ○ Anthony understood this to be a sin (offence) both …his son
8th	□ Experience of unshared faith in medical intervention □ Experience of unshared hope in outcomes of medical intervention	○ Although Anthony was inclined more toward solitude and no longer attached to the need to live at all cost, he still struggled to keep going out of his love for Joanne. Unfortunately, she was simply not ready to let him go. [She wanted the aggressive treatment to continue].

DOMAIN: SUFFERING IN RELATIONSHIP WITH OTHER

ENCOUNTER	DIMENSION	NARRATIVE INDICATORS
3rd	□ A loss of image/perception of 'God,' Life, what is ultimate for self	○ 'I had always experienced God being there for me and my family as long as I lived my life by treating others as I would have them treat me.'
	□ A loss of a sense of connection with 'God,' Life, what is ultimate for self	○ 'I must have done something wrong for God to leave us like that.' ○ 'Maybe this cancer will make up for it?'
	□ Feeling abandoned, alone or isolated	○ He thus perceived the cancer as the suffering he deserved as reparation for the sin of having abandoned his child.
	□ A sense of guilt	
	□ Impasse	○ Pt. does not seem to derive peace from this meaning-making of his terminal

	□ Powerlessness/inability to focus in prayer, meditation or other spiritual or creative practice □ No consolation/gratification derived from usual spiritual/creative practices □ Lack of desire to engage spiritual/creative practice □ Lack of satisfaction in anything/anyone	diagnosis and resisted efforts to review his understanding. ○ Inability to pray as he used to ○ Loss of desire for spiritual things ○ Dryness in life: in spite of 'doing for others,' nothing seemed to satisfy.
4th	□ Loss of connection with self, others, Other consciously expressed □ Loss of connection with self, others, Other expressed through somatizing behaviors	○ Anthony's unexpressed lament resided deep within his body; he felt abandoned by the God he knew who would always protect from harm.
7th	□ Paradox: holding the tension of two seemingly opposed truths, e.g. the desire to both hold on to life and the desire to 'let go.'	○ These experiences of reconnection in love both with Eden and with Joanne left Anthony torn. He did not want to physically abandon Joanne. He wanted to continue to enjoy their renewed sense of intimacy. But, he yearned to be reunited with Eden.