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Spirituality, meaning, and transcendence

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ABSTRACT

End-of-life care provides an opportunity to help a patient find meaning in the experience of dying. This is a challenge because the experience of dying can rob a patient of meaning. The first step is to look at death as being a process of life rather than an event. This is brought about by welding the broken pieces of the mind–body connection. Medicine cannot always fix broken pieces, but spiritual welding always puts us back together again. Compassionate end-of-life care helps a patient connect spirituality with the search for meaning and transcendence.

KEYWORDS: Holistic, Meaning, Person-making, Spiritual, Transcendence

ASSUMPTIONS

Maslow's "Hierarchy of Needs" (Huitt, 2004) establishes a useful distinction between two groupings of human needs, namely, "deficiency" and "growth" needs. The first grouping includes taking care of physiological needs such as hunger, thirst, bodily comforts, and safety/security needs (being out of danger). The article assumes that these needs are being met and moves on to focus on the patient's higher needs. Unlike Maslow's classification, however, the article approaches "growth" needs (belonging and love, esteem needs, need to know and understand, self-actualization, transcendence) as the effect of spirituality on a person-making process. The movement from spirituality to the arms of that process takes place through the discovery of meaning. Thus, the search for meaning functions as a means to an end rather than as an end in itself.

This assumes that pain management is already in place. The Edmonton Symptom Assessment System or ESAS (Bruera et al., 1991) determines a cancer patient's quality of life by measuring nine symptoms common in cancer patients, namely, pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well-being, and shortness of breath. The severity at the time of assessment of each symptom is rated from 0 to 10 on a numerical scale, where 10 is the worst possible severity and 0 means that the symptom is absent. The patient circles the most appropriate number on the scale. The patient's assessment of symptoms can be downloaded onto the arms of the person-making process into the categories of an inner self, a social self, and an environmental self. This way of viewing things provides a valuable map, not only to monitor a patient's degree of comfort, but to ensure that everything possible is done to express someone's best interest.

The article centers on the patient's need to find meaning in death and how meaning fits into these categories. Dying is a personal process and the way those cups are filled varies from person to person. This article makes standard assumptions about hospice care, but in a world where values are relative to culture they can be stated anew. I assume that the patient is competent and has informed consent, that futile treatment is not an issue, and that aid in dying is not provided. The article assumes that the patient's family, friends, and associates are supportive, and that the availability of scarce medical resources is not an issue. In brief, the focus is on the side of life not death, on healing rather than curing, on providing death with dignity in a loving and compassionate environment free from pain and suffering.

ILLNESS AND DISEASE AS LOSS OF UNITY

A metaphysical principle affirms that unity is a sign of perfection. Following this principle, unity

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and good health go hand in hand, whereas division or disunity is associated with disease and illness. At the risk of oversimplifying things, disease refers to a division within a biological organism, whereas illness refers to a division within the mind–body connection. This distinction introduces us to the contrast between healing and curing. When medicine focuses on the biological organism, the goal is to cure disease, but when medicine focuses on the whole person, the goal is to heal as well as to cure. Thus, medicine strives to cure and heal the individual, though there are times when a diseased condition is progressive and irreversible. At those times, the focus shifts to palliative nursing and end of life care.

THE LOSS OF MEANING

I have been teaching courses on death and dying since 1973 and each year I routinely sentence my class to death, not because I dislike students, but to discuss the unnerving character of personal death. I do this at the beginning of the term to introduce two basic ways of confronting personal death, namely, some view the death experience as a source of inspiration, whereas others see it as a source of despair. The class is given a 12-h notice of death and is invited to share personal feelings about death, namely, students are asked to (1) write an ideal obituary, (2) report on how the last precious hours of life are spent, and (3) provide details on the manner of death. These exercises provide a good indication of their basic approach to personal death, whether death is a stranger or an integral part of life. Students' responses to the condemnation are reported in Bryson (1995). We usually have mixed feelings about the possibility of our very own dying. Some students see death as a paradox that appears simultaneously as a source of inspiration and despair, timely and untimely, personal and impersonal. Upon closer analysis, the arms of the paradox settle on two different views of death—the one where death appears as an internal process of life, the other where it is thought to arise as an event. The view of death as event appears to lie outside our control and is therefore judged to be to be a meaningless event. The students that view death as event tend to write an obituary in the third person, as if the death were happening to someone else. They choose to spend their last 12 h of life partying, making love, and getting high. The chosen manner of death is equally exotic. That type of response is a denial of death. However, students that view death as an immanent life process tend to take a more reasoned approach to the exercises. It strikes me that they manage to find meaning in personal death, even when it comes at such an early age. I illustrate the difference between death as process and death as event by drawing on selected works of Martin Heidegger and Jean Paul Sartre, respectively. Heidegger appears to echo a thought expressed earlier by Ivan Illyich in Tolstoy's *The Death of Ivan Illyich* where Ivan faces his own death. His shriek lasts 3 days, but delivers precious insight into the meaning of life.

I think that Kubler-Ross' early writings and stage-based approach to death and dying (1969) captures the view of death as event, but that her later work (1975) captures the view of death as process of life. The characterization of the dying trajectory as a movement from denial, anger, bargaining, depression, to acceptance and death as such explains why it can be difficult to find meaning in a death experience. Students that view death as event find it difficult to find meaning in the face of death. Under that circumstance, death can present as a failure of medicine or technological error (denial), staff's incompetence (anger), an unjust punishment from God (bargaining), or simply being at the wrong place at the wrong time (depression). However, a shift to the view of death as process allows the possibility of having what Balfour Mount (2003) calls an "Existential Moment." The realization of personal finitude can function as a powerful source of inspiration. When that happens, we move out of a spiritual thrust toward a search for meaning and the realization of belonging to something bigger than ourselves. The distinction between being human and being a person provides a useful way to map that transition. Although everyone is human, we are not equally personal. Persons arise at the output of relationships taking place at the levels of an internal self, other persons, and the environment. I tested that model in workshops on a treatment plan for clients of vocational centers and special care residential units (Bryson, 2003) and find it a simple way to conduct a spiritual audit of the locus of meaning in the life of a person.

ROLE OF THE SPIRITUAL

Viktor Frankl's (1984) war time experiences in Auschwitz and other Nazi concentration camps provides a good illustration of the efficiency of connecting spirituality with the search for meaning. As a prisoner in Germany's concentration camps he saw the spiritual nature of relationships. The love he felt for his wife carried him through impossible times of suffering. Those who survived the death camps were not necessarily the physically strong—as many of them simply gave up and died—but the

ones who believed in the loving dimension of life. They had a will to live that would not be crushed. The love we have for each other generates hope, the fundamental stuff of life.

WHAT IS SPIRITUALITY?

Spirituality generates love. The word spiritual comes from the Hebrew *ruah* or the Greek *pneuma* or the Latin word *spiritus*, meaning breath. Breath is associated with life; so literally, spirituality is "breath of life." From an existential point of view, the spiritual is what moves us outside ourselves to find the meaning of life. However, the spiritual continues to exist in us when life seems to lose meaning, though in times of crisis, spiritual energies need to be redirected toward life. George Drazenovich (2004) finds that Christian spirituality is existential; it manifests as loving action for others. Spirituality is a much broader term than religion. The term religion is from the Latin word *religare* meaning "to bind fast." Religion is but one of many connectors that can be welded to the spiritual drive within psyche. Geri Miller (2003) reports that the 2705 member Association for Spiritual, Ethical, and Religious Values in Counselling uses the following description of spirituality:

> Spirit may be defined as the animating life force, represented by such images as breath, wind, vigor, and courage. Spirituality is the drawing out and infusion of spirit in one's life. It is experienced as an active and passive process. Spirituality is also defined as a capacity and tendency that is innate and unique to all persons. The spiritual tendency moves the individual towards knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one's capacity for creativity, growth, and the development of a value system. Spirituality encompasses a variety of phenomena, including experiences, beliefs, and practices. Spirituality is approached from a variety of perspectives, including psychospiritual, religious and transpersonal. While spirituality is usually expressed through culture, it both precedes and transcends culture. (p. 6)

Miller's point is echoed in Elizabeth J. Taylor's (2002) research on how spirituality is defined by the nursing profession. Nursing spirituality expresses the following views of spirituality, namely, spirituality as (1) a life principle, (2) God (or Higher Power) within us, (3) an innate force, (4) a vertical/horizontal tendency, (5) a search for meaning. Taylor's list of spiritual characteristics includes reference to self, others, nature, and God/Life Force/Absolute/Transcendent. Although each of these descriptors provides insight into the nature of spirituality, no single definition prevails. The Association of American Medical Colleges (1999) offers this broad definition of spirituality:

> Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another. (pp. 25–26)

My study of the nursing descriptions of spirituality reveal the inclusion of five central themes: (1) spirituality is an innate tendency toward meaning, (2) the spiritual finds expression in the temporal, (3) though spirituality is animated by the transcendent, (4) spirituality moves us toward the attainment of unity, truth, and goodness (compassion), and (5) spirituality is expressed in four areas of activity taking place (i) at the level of self, (ii) other persons, (iii) the natural environment, and (iv) the unseen order. The push/pull of spirituality as tendency is ascribed to God, or Higher Power, though it can also be driven by evil. In light of this, it seems possible to suggest that *spirituality is "an innate tendency toward God or a Higher Power*." Spirituality arises out of a relationship between our tendency to seek meaning and the transcendent (God or Higher Power). The existence of a transcendent presence in the relationship conveys a sense of belonging to something greater than oneself. It allows us to move outside ourselves in times of crisis. This explains why Maslow's hierarchy of needs culminates in a search for the transcendent.

The caregiver's willingness to promote the patient's quest for transcendence promotes holistic healing (the integration of mind and body).

HOW SPIRITUALITY WORKS

The challenge is to spark the desire for union with the transcendent when life has lost its meaning. Death education can assist us by teaching that death is an integral part of life. Thus when it comes, we are less likely to experience it as meaningless. If I can offer a rough paraphrase of Heidegger's thought on death to make the point, it is as if we are born "full of death" and die when we run out

of it. The literature on palliative care suggests that the denial of death is a mistaken way of conserving meaning when meaning is lost. That opinion, it seems, is at home in a representation of death as event. The evidence of this, it seems to me, exists when dying patients conduct an inventory of their life because they cannot imagine why this loss is happening to them; some patients worry about being at fault for dying. Others see it as punishment from God. On the other hand, the shift to a view of death as process is essential to holistic healing. The challenge facing palliative nursing is that the concerns of the dying are driven by their cultural attitudes, values, and beliefs. The nurse seeks to understand and accept the patient's reality. Some patients raise questions about the afterlife, whereas others are more concerned with the fate of loved ones in their absence. Some patients (and families) remain in denial and guilt. Added to this burden are the realities of progressive and irreversible health condition, the humbling experience of being totally dependent on others, the indignity of being unable to go to the bathroom alone or bathe. The challenge facing caregivers is to redirect spiritual energies toward the discovery of loving meaning in that wasteland.

Reverend Neil McKenna, Chaplain at the Cape Breton Regional Hospital, is a regular guest lecturer in my Spirituality and Health course for nursing students at University College of Cape Breton (UCCB). He suggests that nurses can begin by learning about compassion. This is the glue that holds us together. However, we must begin with an inventory of our own spirituality. We cannot do for others what we cannot do for ourselves. To accomplish this goal, McKenna invites the class to examine six basic areas of spirituality, namely, (1) what gives meaning in my life? (2) What beliefs and values are most important in guiding my life? (3) What does religion mean to me? (4) What does spirituality mean to me? (5) How would a serious, life-threatening illness change the way I find meaning, values, or beliefs in life? (6) What spiritual resources do I bring to my work as a nurse or counsellor? (E.g., what connections have I made between spirituality and my life experiences of suffering, grief, losses, and such?) These questions provide insight into our own spiritual journey so that we can be more effective advocates for a patient's spiritual needs. They help us to transform the view of death as an external event of life into the acceptance of death as an immanent process of life. Once we see death as an opportunity for personal growth, we can share that insight with others. In my classes, that objective is reinforced through Journaling. Students keep a daily log in which they record their observations of the connection between the material presented in class and their own spiritual development. At the end of term, they submit a reflective paper on this material (Out of respect for privacy, I do not see the actual Journal entries). In the beginning, my students' clinical training presents a challenge to acting subjectively. However, the process of facing our own spirituality leads to subjective growth and the ability to identify with a patient's search for meaning and transcendence.

The patient that is suffering needs to find meaning in that suffering before healing takes place. In other words, the patient must want to move ahead. The nurse can assist the patient to find meaning by being compassionate. The nurse does not experience the patient's pain as such. Rather, compassion is the ability to suffer with someone, to help them find meaning when a source of meaning is gone. We do this by being in touch with our own pain and then through resonance we identify (compassion) with the patient-in-pain. A bond is established between us.

Compassion is at opposite ends of the mind–body split because it views the other as an extension of self. Matthew Fox (1979) recognizes the transcendental nature of love: "In loving others I am loving myself and indeed involved in my own best and biggest and fullest self-interest. It is my pleasure to be involved in the relief of the pain of others, a pain which is also my pain and is also God's pain" (p. 33).

To be one with others is to share hope with them. David Macginley, Chaplain, haematology and oncology, Q. E. 11 Hospital, Halifax, NS, is also a regular visitor in my spirituality course. He reminds us that one of the most important gifts nurses bring to a patient is the ability to be real. The nurse brings compassion, joy, hope, and the promise of quality life to the patient, but does so from the point of view of the patient's reality. Being real mirrors the patient's search for meaning. To be real is to walk the walk before talking the talk. Compassionate care moves patients toward the discovery of the transcendent within themselves, in their own life experiences. The need to discover transcendence in life can be likened to an instinct, though subject to the scrutiny of reason. Reason examines the push/pull of the attraction while the will gives the command to use whatever resource is required to attain that good as understood by the intellect. However, the tendency toward transcendence can be temporarily silenced by irreversible disease. Disease does not necessarily generate illness, but it does so whenever the meaning of life is lost. Spirituality can also go sour by giving to something

material the primacy that belongs to the quest for transcendence. For instance, obsessive preoccupation with material things can be a block to making spiritual connections.

An important characteristic of spirituality is that the search for meaning takes place through relationships. The traditional view of the person as human being is an abstraction that limits the search for the expression of spirituality. I do not equate being a person with being a thinking thing. I have had more success with the view that we are the output of relationships. *Rather than think of a person as an entity that has relationships, I reverse the process and think of persons as the output of relationships*. Although we are born human, we are not equally personal. We become personal as a result of associations taking place at three fundamental levels. So, the proposed healing model expresses spirituality through relationships. First, we are the output of relationships taking place at the level of an interior life. Second, we are the output of relationships taking place with other persons (and possibly pets). Third, we are the result of relationships taking place at the level of the natural environment. The search for spirituality, meaning, and transcendence takes place in each of those three associations. We cannot be whole in the absence of one or more associations. Illness is a division in the mind–body relationship that takes place because of a rupture in the associations that characterize us. In brief, we can trace apathy or despair to a loss of meaning in those associations. To mend the associations is to create fresh meaning that, in turn, generates a better sense of self. This is the sense of spiritual welding. Spirituality pushes us to create meaning, but spirituality can also be pulled by the (artificial) introduction of fresh experiences.

There is no self or "I" in the absence of one or more of the associations that constitute persons. We are the output of associations, some freely entered into, others thrust upon us since before birth. Although we do not choose our parents, place of origin, or early childhood acquaintances, we can make changes in some of these associations as we mature. The push-pull of spirituality is strongest when a patient faces death.

All of the definitions of spirituality I found in the literature include reference to relationship with God or a Higher Power, though they place the presence of that Power in a fourth category beyond the three associations detailed here. But I have some philosophical problems with creating a separate (fourth) category for the God experience. First of all, human reason makes use of the principle of sufficient reason to make sense of things. But that principle is limited to the natural environment. We cannot apply it to the unseen order because that realm lies beyond logic. Second, we experience the transcendent in the experiences of this world. This might sound like a truism, but it affirms the belief that mature spirituality is well grounded.

Spirituality generates the search for meaning. Meaning exists in the associations of the person-making processes. Those processes lead us toward transcendence. (1) The inner self refers to associations taking place at the level of psyche, such as states of consciousness, and affective states, including religious beliefs. We align ourselves with these states, not only to feel good about ourselves, but also to empower or disempower others and nature. (2) The social self refers to other persons. We do not say like Descartes "I think, therefore, I am" but rather "others exist, therefore, I am." How I feel about myself translates into how I feel about other persons. The patient that expresses anger toward the nurse is expressing a loss of meaning. The unity that characterizes a healthy social self is broken by disease and illness. The patient feels inadequate because of the social isolation that can take place in the course of disease. One suggestion for the social self spills over into the environmental self, namely, the relaxation of regulations and the ability to fine tune a patient's hospital environment to fit his or her own remembered associations. The more the hospital environment resembles the patient's familiar space, the greater the ease of inducing holistic healing. For instance, each hospital room can have a cork board space next to the patient's bed where pictures of the family, significant others, including pets can be posted. In addition, external support systems are an integral part of the social self. They provide an opportunity for patient/client to share feelings with a group of like-minded individuals. The indignities expressed by the ALS support network at Sue Rodriguez' search for assisted suicide is a case in point (Supreme Court of Canada, Court File Number 23476). They were angered because they were not offered the opportunity to connect with her. I think that a meeting would have benefited everyone. Support groups can function as extended family, even in cyberspace. For example, individuals suffering from COPD can be housebound because of oxygen-related needs. They rely heavily on cyberspace to meet and greet where virtual reality becomes the only reality. I am impressed by the strong bonds that can exist in the virtual community. (3) The third arm of the person-making process is the natural environment (including the hospital room as discussed above). Again, no dualism exists between the environment and us. We are not outside that environment looking at nature, but we are that very environmental being

looking at itself. The geography of place plays a critical role in healing. In sum, the palliative care nurse asks the patient to identify broken associations in the three cups that define who we are. Spiritual welding is the process of reigniting the search for meaning and transcendence by rewiring these associations.

The next observation to make about spirituality is that as tendency it can take a turn for the dark side of life, especially if left unattended or not rewired. The spiritual tendency toward the sacred is not silenced though it can be put on a bad diet of negative social and environmental connectors, especially for an at-risk patient (one without connectors). Even brain chemistry can turn on a patient, as happens in a terminal illness. The dark side of relationships seeks disunity, death, or escape from life. This arises out of inferior welding. The spiritual thirst for transcendence can be passively filled with denial and despair. Thus, we have a responsibility toward vulnerable patients to ensure that we do not disempower them through our own negativities. The push/pull of spirituality can be filled with evil as well as good. We gradually develop moral habits toward good and evil. The term *evil* is taken to refer to whatever promotes disunity (disharmony, dualism, division) in the life of a person. Evil creates division or imbalance. Thus I align myself with disunity when I choose to disempower others, pollute the natural environment, or divide my inner self though acts of self-hate, addiction, and despair. Addiction is a misguided way of coping with negative relationships. It is animated by relationships that promote disunity and lack of compassion. The existential fact of human freedom provides an opportunity for personal growth, but it can also be used to bring on division and death. Freedom comes with awesome costs. The spiritual tendency toward transcendence generates a profound restlessness within us to pursue good and avoid evil. The act of doing good or evil helps us find meaning in life, though one generates an upward movement toward transcendence, whereas the other generates a downward spiral toward division and destruction. The movement toward transcendence generates a sense of peace, unity, truth, and happiness. The movement toward disunity generates decadence and despair.

We find ourselves by helping others. One of the essentials of good palliative nursing is to ensure that spirituality does not go sour. The spiritual tendency toward good and evil appears to be inscribed in our hearts. We become whole as we allow this powerful force within us to emerge, not only to empower ourselves, but others, and the environment. The presence of God or a Higher Power in each of these relationships creates the sense of belonging to something bigger than oneself. This is the stuff of healing and a good death.

SPIRITUAL WELDING

The main play is spiritual welding. The role of caregiver is to identify places where a patient is broken (divided) and the search for meaning is frustrated. Spiritual welding is about putting us back together again. The nurse/counselor listens to a patient/client story to discover the locus of broken relationships and to determine what technique can be used for reconnection with the spiritual tendency. Religion is one of the tools that connect with spirituality. The healing effects that prayer, sacred writings, religious rituals, and symbols have on the faithful are well known. But religion is only one of the many ways of becoming whole. Other techniques that can be useful in spiritual welding include art, dance, exercise, Journaling, meditation, music, play, and therapeutic touch, to name a few. Healing is about finding places in associations where the search for unity is interrupted and welding them in place. Storytelling is a useful method for uncovering an individual's lived experiences. The nurse/counselor uses the narrative to understand what technique(s) are best suited to the patient/client's needs and wants. The environment where client and counselor meet must be inviting (safe space). It must introduce right-brain insight to left-brain logic and address the whole person. Music provides an instance of healing. For example, it can reduce the nausea and vomiting associated with chemotherapy (Mozart effect). Art also has a healing effect on relationships, though the choice of art is individualistic. Dance, play, nature—each technique has effects that can rival the power of religion and prayer. In the last days of life, the dance and play take place only in memory, but as Frankl already knows, that vision of love transforms a painful experience into a source of inspiration.

SPIRITUAL ASSESSMENT

Healing techniques vary depending on material (relationships), type of break, and welder. There is no shortage of spiritual assessment scales to register the search for meaning. The main difference between what is presented here and what exists in the literature is the focus on relationships and the inclusion of the transcendent on the arms of the person-making process. The questionnaire below marks only one glimpse of a changing landscape. Careful spiritual assessment is the gateway to holistic intervention. Two stages mark the process of a successful intervention. First, as palliative nurses

become more familiar with their own spirituality, they will be more attuned to the spirituality of others, as argued earlier. Second, there is a need to find a practical way to collate data about the patient's quest for meaning.

To this end, the nurse encourages the use of narrative. In storytelling, the individual talks about his or her search for meaning. If this is not possible, then, the caregiver strives to learn as much as possible about a patient's personal history through others. The spiritual tendency toward wholeness is experienced in push-pull fashion as a patient (directly or indirectly) rehearses past successes and failures in reaching harmony with the deepest part of self, other persons, and the environment. The narrative form provides the attentive listener with an insight into ways of caring, ways of assisting in the reconnection process. The goal is to capture the patient's world without interpretive bias.

Christina Puchalski (2002) has found that forgiveness is at the heart of healing. It results in greater peace of mind, healing of old emotional wounds, and better relationships; "A lifestyle characterized by forgiveness is often thought to be also characterized by love, empathy, humility and gratitude" (p. 5). All of these virtues enable a person to experience greater meaning in the relationships that characterize life.

The following questions are posted on the arms of the person-making process as a simple but effective roadmap to the development of these virtues. The wording of the questions can be fine-tuned to meet the particulars of a case, though the view that we are the output of relationships remains unaffected. The intent of holistic healing is to scope these relationships for loss of meaning so that the movement toward wholeness (spiritual welding) can begin anew. Here, then, is the proposed questionnaire into the geography of meaning and places of transcendence:

Questions Concerning the Inner Self

What gives my life meaning?
What values and beliefs are most important in my life?
How do I feel about myself (at peace, or anxious)?
How does my illness change the way I find meaning in life?
Do I feel connected to God (Higher Power)?
How do I cope with my illness?
Anything else in this category?

Questions Concerning the Social Self

What relationships are most important to me?
Do I have the support of my church community?
Is my family supporting me in my illness?
Are my friends supporting me in my illness?
Do I harbor resentments toward anyone?
Do I have a pet?
Do I have the support of my work environment?
Do I belong to a support group (Church community, 12-Step, other)?
Anything else in this category?

Questions Concerning the Environmental Self

What do I miss most about my home (house, apartment, room, and neighborhood)?
How is my hospital room (bed, furniture, color scheme, pictures)?
Do I miss nature (find meaning in nature)?
What sorts of meaning do I find in nature (God, Higher Power, peace)?
What do I miss most about nature (hills, ocean, grass, smells, wind, rain)?
Anything else in this category?

CONCLUSION

The ability to find meaning in suffering is critical to healing because it directs us toward a power greater than self. This is accomplished by discovering and filling places of emptiness on the arms of a person-making process. The questionnaire acts as a navigation system pointing to places of significant meaning.

The spiritual dimension of dying moves us beyond pain management to focus on holistic healing. Spirituality reminds me of a popular commercial about a watch that "takes a beating but keeps on ticking." Spirituality is like that as it "keeps on ticking" even in times of terminal illness when the meaning of life can take an unexpected turn. On occasion, spirituality is put on a bad diet when the loss of meaning is not filled by anything positive (transcendent). A patient's movement toward disunity (depression, anger, loneliness, despair, and such) suggests that spirituality has gone sour. The challenge facing palliative care nursing is to put spirituality back on track. This is accomplished by knowing a patient's person-making profile and doing spiritual welding—knowing what piece fits where and why. For instance, the nurse can become a compassionate friend to a patient who is afraid of dying alone. Once this bond is in place, the nurse can then organize substitute social connectors for that patient—chaplain, family (if any), friends, support group, volunteer workers. The same goes for environmental connectors, as the imaginative caregiver strives to identify and fill the environmental

void caused by a terminal illness. I remember reading about a case (in a GWish Newsletter) where nurses took a patient outside in the rain (bed and all) just a few days before she died. The patient expressed an urgent desire to feel the rain on her face one more time before dying. Everyone got wet, but the smile on her face, and her connection with a transcendent life force, made it all worthwhile. Now that's good welding!

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