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Finding peace in clinical settings: A narrative review of concept and practice

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ABSTRACT

The purpose of this review was to investigate and review the concept of "peace" and the role it plays in the spiritual well-being and care of people with a chronic or terminal illness. Our objectives were, first, to examine the importance of peace in palliative care as a measure of acceptance and in chronic illness settings as a predictor of improved survival. Second, we explored the dimensions of peace and their relationships with spiritual well-being. We further examined how the constructs of peace are assessed both within valid spiritual well-being measures and as individual items related solely to peace. Finally, we examined therapies aimed at promoting peace and emotional well-being in palliative and chronic illness settings. Despite much being written about different constructs of peace and the positive effects of being at peace during times of illness, the effects of therapies on the feeling of peace are not well-studied.

KEYWORDS: Peace, Spiritual well-being, Palliative care, Chronic illness, Emotional well-being

INTRODUCTION

> We can never obtain peace in the outer world until we make peace with ourselves.
>
> — the 14th Dalai Lama

"Peace" is an evolving concept applicable to many facets of life, including health, healthcare, culture, politics, and technology (Zucker et al., 2014). However, there are presently no identified biomarkers that have been shown to quantify peace or reliable psychometric measures that solely evaluate the construct of peace. In healthcare, the construct of "peace" has been explored in people with serious and terminal illness using measures evaluating a spectrum of factors associated with spiritual well-being. A growing body of evidence demonstrates positive associations among peace, spiritual well-being, and health outcomes (Salsman et al., 2015; Selman et al., 2013). Conversely, there is evidence which suggests that neglect of patients' spiritual needs is associated with reduced quality of life and decreased satisfaction with care, especially at the end of life (Astrow et al., 2007; Heyland et al., 2010). The cognitive aspects of spirituality are defined as the search for meaning and purpose in life and are associated with relationships to transcendence (Steinhauser et al., 2006). Spirituality is related to but also distinct from religious beliefs, which are associated more with a particular faith tradition and adherence to religious practices (see Kreitzer et al., 2009). Indeed, Puchalski and colleagues (2014) suggested that spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.

Peace is associated with a positive end-of-life experience. Palliative care staff aim to provide comfort and care for those with terminal illnesses and their families, so that patients are free to die peacefully

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in a setting of their own choosing while receiving medical, nursing, psychosocial, and spiritual care (Chochinov, 2006; Kristjanson & Aoun, 2004). In their study "Are You at Peace?" Steinhauser and colleagues (2006) found that being at peace was associated with both religious and secular notions of being at peace with God as well as with a sense of tranquility. They further found that peace was related to patients' view of good clinical care and a chance to say goodbye. Thus, they suggested that the resolution of biomedical, psychosocial, and spiritual issues within healthcare is often preceded by an experience of peacefulness.

PEACE AND ADVANCED ILLNESS

Peace and Palliative Care

Philippe Ariès was one of the first to question the notion of a peaceful death. He suggested that in the Middle Ages people accepted death as a part of life and that they "met death with resignation and the hope of a long and peaceful sleep before a collective judgment" (Ariès, 1974). However, in further analyzing the work of Ariès (1976), Elias (2001) argued that in earlier times people had fewer options for relieving "torment and pain." He also pointed out that fear of death rose sharply in the 14th century and is still prevalent today. This fear can be managed somewhat by the presence of people at the bedside, thus reducing the possibility of a less peaceful death. Certainly, death anxiety is a relevant area of study today (MacLeod et al., 2016).

Self-reported peace has been shown to be a valid measure of emotional adjustment to terminal illness and to be strongly associated with a "good death" (Steinhauser et al., 2000; Ray et al., 2006). Steinhauser and colleagues (2006) suggested that asking a patient about peace is an efficient and nonthreatening way for healthcare workers to initiate discussions about spirituality. Importantly, patients receiving palliative care who experience "peacefulness" are not necessarily in better health than those who are not "at peace," but they are more accepting of their limitations and their situations (Best et al., 2014). Hence, while patients do not expect clinicians to be counselors, they do want to be well-informed at the end of life about knowing what to expect. Best and coworkers (2014) colleagues suggested that, if doctors provide clear and honest information, patients are more likely to gain a sense of spiritual well-being and acceptance of death.

Several studies have proposed strategies allowing patients to die peacefully, free from avoidable distress and suffering. For example, Singer and colleagues (1999) identified five elements of care related to dying peacefully. These domains included receiving adequate pain and symptom relief, avoidance of inappropriate prolongation of the dying process, patients achieving a sense of control, relieving the burden of loved ones, and strengthening relationships with loved ones. Similarly, Ruland and Moore (1998) proposed a theory for a peaceful end of life where outcome indicators for nursing care were based on concepts of: (1) not being in pain; (2) the experience of comfort (e.g., control of nausea, thirst); (3) the experience of dignity/respect; (4) being at peace (e.g., hope, meaningfulness, not dying alone); and (5) closeness to significant others who care.

Stewart and colleagues (1998) suggested that evaluating quality of life in terminally ill patients would in turn improve quality of care. In their examination of physical comfort, psychological, social, and spiritual well-being, they found that peace with life or God is strongly associated with positive emotional and spiritual well-being and enhanced quality of life. Additionally, some studies also highlighted relationships between peacefulness and awareness of being terminally ill. For example, Ray and coworkers (2006) found that patients who recognized and understood their prognosis were better able to achieve a state of peacefulness.

Peace and Chronic Illness

Peace has also been examined in chronic illness as a predictor of mortality. Ironson and colleagues (2002) found that spiritual factors independently predict long-term survival, with "a sense of peace" showing the strongest effect in people with AIDS. Studies have also shown that spiritual factors, especially those mediated by social support, predict survival over several years in people with end-stage renal disease (Spinale et al., 2008; Kimmel et al., 2003). More recently, in a prospective sample of chronic heart failure patients, spiritual peace with adherence to a healthy lifestyle was found to be a stronger predictor of mortality than such physical health indicators as functional status and comorbidity (Park et al., 2016). Although the authors showed these factors to be associated with increased mortality, they found no relationship between religiousness and mortality. Their results echo previous findings where, though religiousness was shown to reduce the risk of mortality in healthy samples, it did not do so in people suffering from serious disease. Furthermore, Büssing and coworkers (2013*a*) found that Chinese patients suffering from a chronic disease (e.g., cancer, chronic pain, hypertension, diabetes, and liver disease) had the highest needs for inner peace and stronger needs with respect to active giving (connectedness and meaning) compared to religious needs. However, it

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is not known whether people suffering from a serious illness can also find a sense of inner peace through religious experience.

Dimensions of Peace

Most definitions describing peace are broad and focused on the absence of such negative circumstances as hatred and conflict, and the presence of such positive conditions as harmony and contentment (Zucker et al., 2014). In their development of the Serenity Scale, Roberts and Aspy (1993) demonstrated that peacefulness for some is associated with a religious belief of "being at peace with God," while it is associated with a secular sense of tranquility for others. Serenity has also been defined as a spiritual state that decreases stress and promotes a state of inner peace (Roberts & Cunningham, 1990; Boyd-Wilson et al., 2004). Other constructs underlying the term "peace" have been defined as a sense of calm, hope/optimism, tolerance of others, personal safety, an absence of violence, and a sense of social connectedness (Sandy & Perkins, 2008). "Peace" is also associated with such other factors as meaning, well-being, a worthwhile life, happiness, an inner haven, and balance (Selman et al., 2013; Lee et al., 2013; Kreitzer et al., 2009; Peterman et al., 2014). Although correlations do exist between these dimensions, there are differences within each construct. For example, investigations of the constructs of "peace" and "meaning" from the Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale (FACIT–Sp) show that scores on the peace subscale correlate with mental health, while the meaning subscale correlates with physical health (Canada et al., 2008; Murphy et al., 2010). Murphy and colleagues (2010) also suggested that meaning and peace are better characterized as two different factors, with "meaning" reflecting a cognitive dimension and "peace" representing an affective dimension. Selman and colleagues (2013) examined the constructs of "peace" and "worthwhile life" (using the Palliative Outcome Scale) and found only moderate correlations between the constructs ($r = 0.35$). Nevertheless, their interview data showed considerable overlap where subjects viewed items similarly concerning perceptions of life, the world, and relationships with others. However, concerning palliative care, they found that only "peace" was related to both preparation for death and having one's affairs in order.

Büssing and colleagues (2010) examined the construct of "inner peace" in their development of the Spiritual Needs Questionnaire. They described inner peace as a "wish to dwell in places of quietness and peace, plunge into the beauty of nature, finding inner peace with others about fears and worries and devotion by others." Tan and colleagues (2012) defined several categories of inner peace using grounded theory, those being physical, psychological, social, and spiritual peace. Their patients also described methods to increase inner peace using such techniques as self-awareness and practicing positive thought and emotion. Encouragingly, Liu and colleagues (2015) showed that mindfulness training increases the level of inner peace in healthy individuals compared with waitlist controls. However, while the authors only investigated immediate effects, this was the first study that provided evidence that mindfulness training can improve inner peace. The authors employed such physical techniques as yoga, walking, and sitting meditation, which may not be appropriate for patients receiving palliative care. Nevertheless, these findings are important as they potentially provide a guide to develop approaches to help patients find peace in spite of their illness.

Relationships between levels of spiritual well-being and quality of life, especially for those coping with chronic or terminal disease, have led clinicians to agree on the importance of both assessing and addressing spiritual issues in healthcare settings. Thus, over the past 15 years, several outcome measures have been developed to assess various dimensions of spiritual well-being, including those related to peace. However, a recent systematic review showed that, though many outcome measures exist, few are specifically designed to measure current spiritual state. Additionally, the same review found that there were no measures for assessing levels of spiritual distress. There is one proposed spiritual distress assessment tool that appears to be a clinically acceptable instrument for assessing spiritual distress in hospitalized elderly persons (the Spiritual Distress Assessment Tool; see Monod et al., 2010). Measuring current levels of spiritual distress may be more clinically relevant than assessing levels of general spiritual well-being when no timepoint is specified. However, an absence of well-being does not necessarily correspond to spiritual distress. We briefly review a sample of widely used measures that integrate items related to peace within a set of other spiritual constructs or as items or a set of items related solely to the concept of peace.

The Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale (FACIT–Sp)

The FACIT–Sp is considered one of the best measures for assessing the current spiritual state of patients (Monod et al., 2011). Developed in the 1990s, the FACIT–Sp is a self-report tool that employs a 5-point Likert-type scale that measures levels of

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quality of life related to spiritual well-being (4 = very much, 3 = quite a bit, 2 = somewhat, 1 a little bit, 0 = not at all). This 12-item questionnaire is divided into three subdomains, those being peace, meaning, and faith (Bredle et al., 2011). The meaning and peace subscales measure "a sense of meaning, peace, and purpose in life," whereas the "faith" subscale measures several features of the association between illness and a person's faith and spiritual beliefs (Peterman et al., 2002). The FACIT–Sp is well-validated in cancer and HIV/AIDS settings (Peterman et al., 2002), and, more recently, in patients with chronic pain conditions (Büssing et al., 2013*a*; 2013*b*; McCabe et al., 2017). In their investigation of multidimensionality of spiritual well-being with quality of life in oncology, Whitford and Olver (2012) found that "peace" was the strongest predictor of quality of life, functional and emotional well-being, coping with hopelessness, and fighting spirit compared to both meaning and faith. Importantly, the recall period for all items in the FACIT–Sp is seven days, which allows for the potential to more accurately determine the need for and type of spiritual intervention.

The Integrated Palliative Outcome Scale (IPOS)

The POS is a 12-item measure designed to evaluate physical symptoms and psychological, emotional, and spiritual needs, with the aim of providing practical support for people severely affected by such diseases as cancer, respiratory, heart, renal and liver failure, and neurological disorders (Collins et al., 2015). The more recent Integrated POS (IPOS) extends to information on mood, family anxieties, and overall feelings of peace (Collins et al., 2015). The IPOS also employs a 5-point Likert-type scale that offers varying verbal descriptors depending on the construct of the item. Like the FACIT–Sp, the IPOS explores current well-being, but for only the previous three days. The POS has also been shown to detect significant clinical improvement during palliative care, at a time when patients are expected to deteriorate, suggesting that there is room for change in the management of people diagnosed with advanced diseases, especially concerning psychological and spiritual well-being (Costantini et al., 2016).

Quality of Life at the End or Life Instrument (QUAL-E)

The QUAL–E is a 20-item tool that measures quality of life at the end of life (Steinhauser et al., 2004). It contains four domains that examine: (1) the impact of symptoms, (2) relationships with healthcare providers, (3) preparation for the end of life, and (4) life completion. The QUAL–E is designed as both a self-report instrument and a structured interview, depending on the wishes of the patient (Wilkinson et al., 2014). Several studies have shown that the QUAL–E is reliable and valid and easy to administer to patients (Steinhauser et al., 2004) and their families (Steinhauser et al., 2014). Additionally, Wilkinson and colleagues (2014) further recommended the QUAL–E as a valuable tool in clinical research settings. In this measure, peace is assessed with the item "I feel at peace." Steinhauser and colleagues (2006) showed that this item has moderate to strong correlations with emotional, spiritual, and social subscales.

The Spiritual Needs Questionnaire (SpNQ)

The SpNQ is a 27-item self-report measure designed to assess the spiritual needs of people with such chronic conditions as chronic pain (fibromyalgia) and cancer (Büssing et al., 2010). As opposed to the common use of a 5-point Likert-type scale, the authors applied a binary agreement scale (yes/no) accompanied by a 3-point strength-of-agreement scale (somewhat, strong, and very strong). The measure aims to evaluate how patients cope with illness in both secular and religious populations. It contains four major constructs: religion, inner peace, existential (reflection/meaning), and active giving. Inner peace was found to be only weakly associated to satisfaction with treatment efficacy but was significantly affected by anxiety, especially in cancer patients (Büssing et al., 2010). Similar findings were noted in people with fibromyalgia, where inner peace correlated significantly with reduced mental health, specifically anxiety and the intention to escape from illness.

The Daily Spiritual Experience Scale (DSES)

The DSES is a 16-item self-report measure that assesses a person's perception of the transcendent (God, the divine) in daily life (Underwood & Teresi, 2002). Items assess a person's internal experience, feelings, and connectedness (with respect to daily life) rather than specific beliefs or behaviours related to particular faiths. The instrument utilizes a 6-point Likert-type scale that measures the number of times a person feels or experiences connectedness with God and others, ranging from "many times a day" to "never." Recent studies have shown that the DSES is a reliable, valid, and cross-culturally sensitive scale that measures religiosity while also correlating well with good health and psychological well-being (Einolf, 2013). It is therefore effective in measuring spiritual factors in people who are not necessarily religious.

The Brief Serenity Scale

The Brief Serenity Scale is a 22-item self-report measure that evaluates three secular factors distinct from religious orientation: acceptance, inner haven, and trust (Kreitzer et al., 2009). Acceptance items measure a person's capacity to accept outcomes they are unable to control and an ability to forgive themselves and others. The authors suggested that acceptance reflects inner harmony notwithstanding life events. Items related to inner haven contain descriptors that relate to such inner resources as self, comfort, strength, calm, quiet, and peace (Kreitzer et al., 2009). The factor of trust relates to a person's trust of events that are beyond their control. This scale has been shown to have high levels of reliability as well as construct and predictive validity. However, though the scale has demonstrated good psychometric properties in an initial development study in transplant patients, we found no studies that administered the Brief Serenity Scale in other clinical populations.

Summary

Many spiritual well-being measures exist. Indeed, Monod and colleagues (2011) identified 35 in their systematic review of the instruments used in clinical settings. However, only a handful of spiritual well-being questionnaires contain items specifically related to peace. In her studies of the importance of peace in palliative care settings, Steinhauser and coworkers have shown that, regardless of religious affinity, wishing for a positive end-of-life experience is strongly associated with "coming to peace" or "being at peace" (see, e.g., Steinhauser et al., 2000).

Therapies Aimed at Promoting Peace in Chronic Illness Settings

Spiritual well-being and posttraumatic growth have been shown to improve with the use of such mindfulness-based therapies as meditation and relaxation as well as other more physical therapies like art and music. Patients suffering from chronic illness or advanced disease often experience physical and psychological problems and spiritual distress. Although these factors are debilitating for many, some people in the advanced stage of disease derive positive features from their experience. For many, this experience can initiate an internal search for meaning and purpose in life, for awareness and inner peace, a process referred to as posttraumatic growth (Cordova et al., 2007). Indeed, a number of therapeutic studies have reported positive changes in terms of spirituality, relationships with others, satisfaction with life, and sense of personal strength (Cordova et al., 2007; Predeger, 1996), much of which has been shown to also be associated with socioeconomic status, optimism (Moore et al., 2011), marital status, employment, and education (Garland et al., 2007).

Meditation

Meditation focuses on increasing mental awareness and clarity of mind (concentrative meditation) or focuses attention on the thoughts, emotions, and sensations that pass through one's mind from moment to moment (mindfulness meditation) (Mayden, 2012). Most of the data come from oncological settings, especially breast cancer, where the intervention was aimed at reducing stress. The data show that, although anxiety and depression scores significantly decrease and that quality of life improves, no significant associations exist between meditation and changes in all areas of spiritual well-being (by FACIT–Sp scores) (Nidich et al., 2009; Ando et al., 2009). In their systematic review, Lamanque and Daneault (2006) similarly found that meditation can have a significant impact on the parameters of mood and anxiety, but not spiritual well-being.

Relaxation

Little data exist concerning the exclusive use of relaxation techniques other than meditation to enhance spiritual well-being in people with chronic illness. Although such techniques as deep breathing and muscle relaxation have been shown to decrease levels of depression, anxiety, and pain intensity (Holland et al., 1991; Decker et al., 1992; Leon-Pizarro et al., 2007), we found few studies that examine the association between single relaxation techniques and spiritual well-being in people with advanced disease. One randomized study of Iranian women with breast cancer found that weekly sessions of guided relaxation and meditation (compared to standard medical care) significantly improved levels of spiritual well-being and quality of life (Jafari et al., 2013). Using the FACIT–Sp, the authors found not only that there were significant increases in meaning, peace, and faith in the intervention group, but also that peace and meaning correlated with quality of life and emotional, physical, and social functioning. Relaxation has also been investigated in combination with other therapies. In a study using a combination of relaxation and acupuncture, Chang and colleagues (2007) found that patients with HIV/AIDS who received acupuncture while listening to relaxation tapes showed significant improvements in spiritual peace as well as mental, emotional, and physical health compared to those receiving acupuncture alone.

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Cognitive Behavioral Therapy (CBT)

Although CBT approaches have been shown to be effective for decreasing symptom severity (e.g., pain, fatigue and sleep disturbance) and mood disturbances (anxiety and depression) in people with chronic medical illnesses (Kwekkeboom et al., 2010; Sherwood et al., 2005; Pearce et al., 2015), less is known about the effects of CBT on spiritual well-being in these groups. Ando and colleagues (2011) found that CBT can enable cancer patients to evaluate their good and bad illness experiences with greater balance, thus increasing their purpose to live, which (according to FACIT–Sp scores) resulted in improved peace of mind. Thus, given the variety of CBT approaches and the ease of their administration, further research efforts in different populations are warranted. As the preliminary research suggests, teaching symptom-based problem solving, emotional expression, distraction, and psychological education to people in advanced stages of illness can significantly improve many aspects of spiritual well-being.

Music Therapy

Music therapy is recognized as a reliable and valid therapy for people suffering with chronic illness. Some studies have shown that it can decrease the anxiety associated with chemotherapy and breast biopsies (Sabo & Michael, 1996) while promoting relaxation and feelings of peace for both cancer and chronic cardiac patients (Hanser & Mandel, 2005; Magill, 2006). Hanser and colleagues (2006) also found that music therapy has an immediate impact on relaxation, comfort, happiness, and heart rate in women with metastatic breast cancer. Unfortunately, they were not able to observe the effect of music therapy over time due to their high attrition rates. In a smaller study, Wlodarczyk (2007) examined the effect of music therapy on spiritual well-being on an inpatient hospice unit. Her results showed that scores on the Spiritual Well-Being Scale increased when music chosen by the patients was played for them. However, although the Spiritual Well-Being Scale is useful in gathering information about levels of spirituality on any given day, no constructs related to spirituality are described in the measure except for "purpose in life." It is thus uncertain if such other constructs as meaning, peace, connectedness, and faith are affected and to what extent. In addition, as with the study conducted by Hanser and colleagues (2006), high attrition rates significantly affected outcomes. Overall, music has been found to facilitate such interpersonal processes as interaction and verbalization. Thus, both patients and families can engage in music therapy, which can include live song, music imagery, music lessons, or relaxation to music (O'Callaghan, 2006).

Art Therapy

Art therapy has been shown to reduce pain while also increasing a sense of well-being (Stuckey & Nobel, 2010). Forzoni and colleagues (2010) showed that art therapy can be helpful in patients undergoing chemotherapy for expression of emotions, relaxation, and the search for meaning. However, while the authors stated that art therapy helps patients to search for meaning, it is unclear if patients actually found meaning or if the meaning related to improved spiritual well-being. Gabriel and coworkers (2001) tested the use of art therapy in patients undergoing bone marrow transplants. Using thematic analysis, they found that art therapy can be particularly helpful in patients who need to resolve difficult family relationships and in those who find themselves in a life-threatening situation and wish to explore their vulnerability and spirituality. Similarly, in a randomized study investigating the effect of creative arts in women diagnosed with stage I and II breast cancer, Puig and colleagues (2006) found that, though psychological well-being and emotional states improved, art therapy was not effective in terms of changing levels of spirituality.

SUMMARY

During the previous decade, the amount of available data concerning the effects of therapy in people with chronic and terminal illness has increased significantly. Study findings suggest that, while therapy was shown to provide effective alternatives for pain management, chemotherapy-related symptoms, and emotional well-being, the effects on spiritual well-being or peacefulness remain largely unknown. Although several studies have employed spiritual well-being measures, only the FACIT–Sp has been used across mind–body therapies. The findings with more mindfulness-based therapies (e.g., meditation, relaxation, CBT) are positive with respect to improvements in spiritual well-being, including the constructs of peace and meaning in life. However, the results are less convincing regarding the effects of art and music therapy with respect to spiritual well-being. This is mostly due to study design, especially the choice of outcome measures and clinical setting. These findings suggest that the effect of therapy on spiritual well-being, especially the feeling of peacefulness, has not been well-studied. Thus, despite much being written about many aspects of peace and peacefulness, we still do not have a clear and agreed-upon understanding of what "being at peace" really means.

Perhaps the answer lies in the words of Ralph Waldo Emerson: "Nothing can bring you peace but yourself."

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