

4 A Middle-Range Theory of Spiritual Well-Being in Illness

For everything there is a season, and a time for every matter under heaven: a time to be born and a time to die; a time to plant and a time to pluck up what is planted.

ECCLESIASTES 3:1

Nursing theorists, as the author of the Book of Ecclesiastes, recognize that in their world of caring for the sick there is indeed “a time to be born and a time to die”; a time for planting and a time to harvest what has been planted. They know that in their patients’ lives there is “a time for every matter under heaven.” Thus, the early “grand theorists” of nursing developed conceptual schemas that attempted to address, in some way, all of a patient’s possible “seasons” of life.

More recently, however, nurse metatheorists, also sensitive to the varied and unique seasons of patients’ lives, have encouraged the development of theories of the middle range. That is, those theories that address specific health- and illness-related phenomena of concern to practicing nurses.

To respond to the call for such theories, a middle-range theory of *spiritual well-being in illness* was developed based on the author’s many years of clinical nursing research with persons experiencing chronic and life-threatening illnesses.*

A BRIEF HISTORY OF THEORY DEVELOPMENT IN NURSING

During the decades of the 1970s and 1980s, especially, both academicians and practicing nurses began to incorporate theories of nursing into their research and practice. The majority of these early nursing models fell into the

*Major sections of this chapter have been taken from Chapter 5, “Conceptual Models of Parish Nursing Practice: A Middle-Range Theory of Spiritual Well-Being in Illness” in *Parish Nursing: Healthcare Ministry Within the Church*, 2003, Jones and Bartlett Publishers. Used with permission of the publisher.

category of “grand theories” of nursing, or those conceptual frameworks that attempted to present a way of describing and understanding the overall discipline of professional nursing practice. Each model contained some exploration of the concepts: person, health, nursing, and environment. There were a number of nursing theory conferences organized to analyze and discuss the logical adequacy and practicality of these theories for use in research and practice. The meetings often included presentations by key nursing theorists of the day, such as Dorothea Orem, Callista Roy, Martha Rogers, and Betty Neuman. Some of the most frequently cited conceptual frameworks were Orem’s self-care model for nursing, the Roy adaptation model, the Neuman systems model, and Rogers’ model of unitary person. Despite focus on the work of the theorists of the late 20th century, as contemporaries of that era, most nurse metatheorists, however, acknowledged and still acknowledge Florence Nightingale as the first nursing theorist; this accolade is based on Nightingale’s exploration and understanding of the need for a framework for nursing practice as described in her 1859 book *Notes on Nursing*.

While some nurse researchers have attempted to use grand theories of nursing to undergird their studies, the breadth of these models makes such efforts difficult. Usually, the grand theory is dissected by an investigator, a portion of the model being employed to provide the framework for research. While the grand theories of nursing provide valuable parameters to delineate and explain the practice of professional nursing, metatheorists have called for and continue to advocate the development of middle-range nursing theories, or those theories that strive to explain more discrete phenomena of interest to practicing nurses.

Distinct from the grand theories of nursing, which attempt to incorporate myriad concepts representing a broad range of phenomena within the discipline, a number of middle-range theories have begun to emerge in the professional literature. Some of these include frameworks dealing with such issues as pain control, chronic sorrow, end of life, uncertainty of the illness experience, and skill acquisition. The concept of “middle-range theory” was introduced in the sociological literature by Robert Merton in 1957 (p. 9); midrange theories were viewed as bodies of knowledge that would encompass a more limited number of variables than grand theories and could be empirically tested. Middle-range nursing theories cluster “around a concept of interest” (Chinn & Kramer, 1995, p. 40), such as those identified previously. They are also described as “theories that focus on specific nursing phenomena that reflect clinical practice” (Meleis, 1997, p. 18); “not covering the full range of phenomena that are of concern within the discipline” (Chinn & Jacobs, 1987, p. 205); sharing “some of the conceptual economy of

grand theories but also [providing] the specificity needed for usefulness in research and practice” (Walker & Avant, 1995, p. 11); and “made up of a limited number of concepts and propositions that are written at a relatively concrete . . . level” (Fawcett, 1992, p. 5). As middle-range theories address a specific phenomenon, their goal is thus to “describe, explain or predict phenomena” (Fawcett, 1992, p. 5). In sum, middle-range theories fall somewhere between the more abstract or grand theories/conceptual models and circumscribed practice theories.

A MIDDLE-RANGE THEORY OF SPIRITUAL WELL-BEING IN ILLNESS

A middle-range theory of spiritual well-being in illness can be useful in orienting the practice of any nurse carrying out holistic health care, which includes attention to the needs of body, mind, and spirit. Such a theoretical orientation is especially important for nurses caring for those experiencing long-term chronic illness, life-threatening and terminal illness, as well as any illness or injury that affects an individual’s personal and/or professional life goals. In such cases, patients frequently struggle mightily to find some reason that can help them find meaning in the illness or disability. Regardless of religious affiliation or its lack, individuals coping with life-altering conditions generally strive to make some sense of the state in which they find themselves. Or, this seeming impossible, most patients try to achieve a sense of acceptance, and even peace, in the midst of their suffering.

A middle-range theory of spiritual well-being in illness can help both nurse practitioners and nurse researchers working with seriously ill persons to assess and evaluate their patients’ spiritual needs and, if warranted, to institute appropriate spiritual care interventions.

DEVELOPMENT OF THE THEORY OF SPIRITUAL WELL-BEING IN ILLNESS

The nursing literature suggests that “middle-range theories generally emerge from combining research and practice, and building on the work of others” (McEwen, 2002, p. 207). The latter point is validated by nurse theorists who assert that middle-range theories may be derived or deduced from grand theories or conceptual frameworks (Ruland & Moore, 1998, p. 170) or from established clinical guidelines (Good, 1998, p. 120). The midrange nursing theory of spiritual well-being in illness was derived from earlier conceptualizations in the area of spiritual well-being and also from the nursing model conceived by Joyce Travelbee, in which a central focus of the framework is the concept of finding meaning in an illness experience.

The core component of the nursing theory of spiritual well-being in illness is the concept of finding *spiritual* meaning in the experience of illness. While Travelbee (1971) indeed introduced the importance of spiritual concerns—"the spiritual values a person holds will determine to a great extent his [sic] perception of illness" (p. 16)—she never explicitly described the concept of "spiritual well-being" in her model. Rather, Travelbee developed an interactional framework based on "human-to-human," nurse-patient relationships, viewing the nurse's role as assisting "the ill patient to experience hope as a means of coping with illness and suffering" (Chinn & Kramer, 1995, p. 176); illness was envisioned as a "spiritual, emotional and physical" experience that might be defined both "subjectively and objectively" (Chinn & Jacobs, 1987, p. 188).

For Travelbee, one's definitions of illness and suffering depended very much on "the symbolic meaning attached to these concepts by the individual" (Thibodeau, 1983, p. 90); she further postulated that "a person's attitude toward suffering ultimately determines how effectively he [sic] copes with illness" (Meleis, 1997, p. 361). Finally, Joyce Travelbee (1971) taught that "the professional nurse practitioner must be prepared to assist individuals and families not just to cope with illness and suffering but to find meaning in these experiences" (p. 13). "This is the difficult task of professional nursing," she admitted, (but) "it must not be evaded" (p. 13).

Joyce Travelbee, a psychiatric nurse practitioner and educator, died at age 47 just as she was beginning doctoral study; thus, we do not know how she might have expanded her beginning conceptual model for nursing practice. Travelbee has been described as a deeply spiritual woman, whose human-to-human vision of nursing practice was importantly influenced by her early educational experience at Charity Hospital in New Orleans, by the work of the great psychotherapist Viktor Frankl, and by the writings of nurse theorist Ida Orlando. Although Joyce Travelbee did not live to further explain and validate her interaction model, her groundbreaking work on the concept of a sick person finding meaning in the experiences of illness and suffering provides a solid and scholarly basis for the development of a midrange-level theory exploring and describing the spiritual meaning of illness and suffering: a nursing theory of spiritual well-being in illness.

As noted, the middle-range theory of spiritual well-being in illness was also inductively derived and concretized through a number of nursing studies exploring the importance of spiritual well-being in coping with chronic illness and disability. Overwhelmingly positive associations, both quantitatively and qualitatively, were found between spiritual well-being and quality of life. That is, those persons who reported a higher degree of

Development of the Theory of Spiritual Well-Being in Illness 89

personal faith, spiritual contentment, and religious practice were much more positive about and satisfied with other aspects of their lives and had greater hope for the future, despite sometimes painful and debilitating illnesses. Several case examples are those of Mr. Jones, a 62-year-old Methodist parishioner who was suffering from leukemia; Mrs. Manley, an 82-year-old Lutheran parishioner with a multiplicity of disease conditions, including osteoporosis, congestive heart failure, and diabetes; and 75-year-old Mrs. McDermott, a Roman Catholic parishioner who was disabled with rheumatoid arthritis, among other diagnoses. In completing the Spiritual Assessment Scale (chapter 3), which measures spiritual well-being, all three scored very positively on the items measuring faith, religious practice, and spiritual contentment or lack of spiritual distress. Similarly, all three study participants were most positive in their responses related to quality of life: hope for the future, for example, being positive about life, being able to get through difficulties, and feeling loved; and life satisfaction, for example, agreeing that they are “just as happy as when younger” (O’Brien, 2001). In looking back, they agreed they were “fairly well satisfied” with their lives (O’Brien, 2001).

Philosophy and Key Concepts

Every theory must have a philosophical basis undergirding the concepts and relationships articulated in the framework. The middle-range theory of spiritual well-being in illness is grounded in the belief that the human person, as well as being possessed of a physical and psychosocial nature, is also a spiritual being capable of transcending and/or accepting such experiences as pain and suffering in the light of his or her higher nature. Over and over, clinical nurses have witnessed ill or disabled patients rise above constraining physical or psychosocial deficits to live extraordinarily positive and productive lives. This ability to accept, and in some cases even embrace, illness and suffering is primarily a function of the patients’ personal spiritual resources. It is for the purpose of identifying, supporting, and strengthening the influence of these spiritual resources, in relation to sickness or disability, that the nursing theory of spiritual well-being in illness has been developed.

The key concept of the middle-range theory of spiritual well-being in illness is, of course, that of spiritual well-being itself. In the conceptual model (Figure 4.1), an ill individual is presented as having the ability to find spiritual meaning in the experience of illness, which can ultimately lead to an outcome of spiritual well-being for the sick person. The capacity to find spiritual

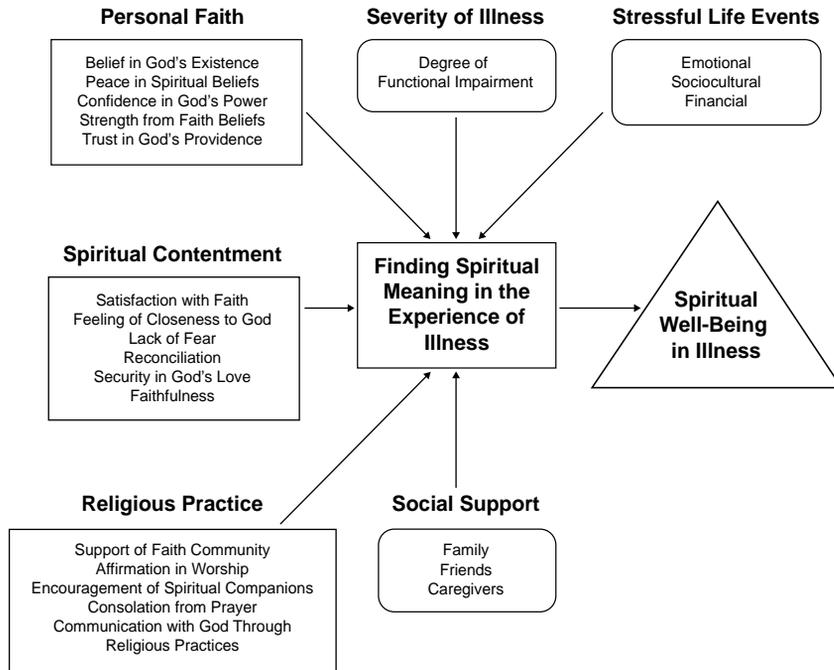


Figure 4.1 A Conceptual Model of Spiritual Well-Being in Illness

meaning in an occasion of illness or suffering is influenced by a number of factors. First and foremost, an individual's perception of the spiritual meaning of an illness experience is influenced by personal spiritual and religious attitudes and behaviors. These attitudes and behaviors include variables related to *personal faith*: belief in God, peace in spiritual and religious beliefs, confidence in God's power, strength received from personal faith beliefs, and trust in God's providence; *spiritual contentment*: satisfaction with faith, feeling of closeness to God, lack of fear, reconciliation, security in God's love, and faithfulness; and *religious practice*: support of a faith community, affirmation in worship, encouragement of spiritual companions, consolation from prayer, and communication with God through religious practices.

The impact of these spiritual and religious attitudes and behaviors on one's finding spiritual meaning in illness may also be mediated by such potentially intervening variables as *severity of illness*: degree of functional impairment; *social support*: support of family, friends, and/or caregivers; and current *stressful life events*: emotional, sociocultural, and/or financial.

The first step in developing a middle-range theory is to conduct an analysis of the core concepts in the model. Nurse metatheorists Walker and

Avant (1995) identify a series of “steps” to be included in a “concept analysis,” which include (among others) determining the “aims of the analysis,” identifying “uses of the concept,” and “defin[ing] empirical referents” (p. 39). The aim of exploring the concept of spiritual well-being is to identify and describe its meaning in terms of contemporary usage, especially in relation to experiences of illness and suffering. The usage and empirical referents of the concept have been examined from the extant literature as well as nursing practice and nursing research. The concept of spiritual well-being was explored in both the nursing and sociological literature in the process of developing the earlier referenced Spiritual Assessment Scale (SAS) (see chapter 3).

Based on prior nursing practice and nursing research, I envision the concept of spiritual well-being as consisting of two dimensions: that of spirituality or one’s personal relationship with God or the Transcendent; and religiosity or religiousness, reflecting an individual’s practice of his or her faith beliefs (this dimension of spiritual well-being may or may not involve participation in an organized religious tradition). Thus, empirical referents of spiritual well-being are conceptualized in terms of *personal faith* and *spiritual contentment* (spirituality) and *religious practice* (religiosity or religiousness).

The definitions of the three empirical referents of spiritual well-being are also included in chapter 3.

Theory Synthesis

Theory synthesis is defined as “a strategy aimed at constructing theory, an interrelated system of ideas, from empirical evidence” (Walker & Avant, 1995, p. 155). In theory synthesis “a theorist pulls together available information about a phenomenon. Concepts and statements are organized into a network or whole, a synthesized theory” (Walker & Avant, 1995, p. 155). In the preceding discussion, a diagrammatic model of the theory of spiritual well-being in illness is presented (Figure 4.1) to identify the relationships between key concepts and potentially mediating variables relevant to the framework. A sick or disabled individual’s ability to find spiritual meaning in an experience of illness or suffering is perceived as being influenced by his or her spiritual and religious attitudes, beliefs, and practices, including those reflecting the concepts of *personal faith*, *spiritual contentment*, and *religious practice*.

An ill person’s personal faith—not only whether or not he or she believes in the existence of God, but also his or her trust in the power and the goodness of God’s care, sense of peacefulness about these beliefs, and courage

and strength derived from them—is critical to whether the individual will be able to identify and/or accept an illness experience as having a spiritual dimension. If one believes in God, yet does not truly trust in or feel at peace in accepting His loving providence, an illness experience may be considered an unwarranted and unfair burden at best, or a punishment for some perceived past indiscretion at worst. In terms of the concept of *spiritual contentment*, an ill person may indeed *believe* in God's existence, His power, His care for all of humankind, and yet not personally feel close to the Lord; his or her faith may be based on a relationship that incorporates fear of God's judgment rather than security in His love. In such a situation, again, it may be very difficult for the individual to perceive an experience of illness or suffering as anything more than a possible retaliation or punishment for past sins.

While *religious practice*, in the formal sense of attending church services, may not be necessary for one to find a spiritual meaning in illness or disability, coping with illness can be greatly facilitated if a sick person has the support of such devotions as prayer or spiritual reading. The encouragement of a faith community with whom one may occasionally share worship or whose members pray for sick parishioners during communal worship services and/or the guidance of a pastor or spiritual companion can also be very comforting spiritual supports in times of illness and suffering.

A practicing nurse can provide important nursing intervention in helping an ill patient who may be struggling with a number of spiritual issues. Very often, as will be seen in the many empirical examples presented throughout this book, nurses facilitate either the enhancement of, or in some cases the return to, religious practices that may have waned or even been abandoned by a patient during the onset of an illness experience.

Also, as demonstrated in the diagrammatic model presented in Figure 4.1, there are a number of potentially confounding variables that may interfere with a sick person's ability to achieve a sense of spiritual well-being in his or her illness. A nurse may have the opportunity to intervene in relation to a number of these factors hindering the ability to find meaning in the illness experience. For example, a nurse may be able to serve as a referral agent assisting sick persons in finding some relief for a functional impairment. For instance, if an ill individual is hard of hearing, the nurse may recommend audiology testing if this has not been done and/or may assist the individual in obtaining a hearing aid if necessary.

A nurse may also serve as a "bridge" facilitating communication with family and friends if these relationships have become strained due to illness or disability. Finally, through the various roles of educator, referral agent, counselor, and patient advocate, the nurse may have the opportunity to

guide, advise, teach, or support an ill patient in regard to a variety of emotional, sociocultural, and even financial concerns that may interfere with the individual achieving a sense of spiritual well-being in the illness experience.

Hypotheses Derived from the Theory

Based on the middle-range theory of spiritual well-being in illness, as described, several hypotheses might be derived related to the association between spiritual well-being and quality of life for those dealing with illness and/or disability. First, it can be proposed that there will be a significant relationship between the degree of a sick person's personal faith and his or her perceived quality of life in an illness experience. Second, there will be a significant relationship between the activity of a sick person's religious practice and his or her perceived quality of life in an illness experience. Third, there will be a significant relationship between the degree of a sick person's feeling of spiritual contentment and his or her perceived quality of life in an illness experience. An overall hypothesis might be stated as follows: there will be a significant relationship between spiritual well-being (personal faith, spiritual contentment, and religious practice) and quality of life among sick persons experiencing illness or disability, controlling for the variables of severity of illness, social support, and stressful life events.

Empirical Testing

As presented in chapter 11, testing of the preceding relationships has already begun. Empirical findings support both the subhypotheses and the overall hypothesis, correlating spiritual well-being (as a total concept and in its subcomponents: personal faith, spiritual contentment, and religious practice) with quality of life. The research was conducted among chronically ill adults at the end of life experiencing myriad illness conditions; study participants belonged to a variety of religious traditions and faith communities. It is anticipated that future nursing studies might be carried out with other patient populations experiencing both similar and different illness conditions and disabilities. Such research would greatly assist in validating the importance of the nursing role of spiritual caregiving; positive findings would strengthen and potentially expand the spiritual care role of the nurse while also supporting the health care dimension of the nursing ministry.

It is suggested that, as in the studies presented in this book, nursing research to test the middle-range theory of spiritual well-being in illness

employ methodological triangulation; that is, the collecting of both quantitative and qualitative data to explore the relationship of spiritual well-being to coping with illness and disability. While the quantitative data would provide a strong statistical basis for the relationship, the qualitative data elicited in focused conversational interviews with ill persons could provide the detailed narrative examples from which guidelines for the nurse's role of integrator of faith and health could be further expanded and clarified.

REFERENCES

- Chinn, P. L., & Jacobs, M. K. (1987). *Theory and nursing: A systematic approach* (2nd ed.). St. Louis, MO: C. V. Mosby.
- Chinn, P. L., & Kramer, M. K. (1995). *Theory and nursing: A systematic approach* (4th ed.). St. Louis, MO: C. V. Mosby.
- Fawcett, J. (1992). *The relationship of theory and research* (3rd ed.). Philadelphia: F. A. Davis.
- Good, M. (1998). A middle-range theory of acute pain management: Use in research. *Nursing Outlook*, 46(3), 120–124.
- McEwen, M. (2002). Middle-range nursing theories. In M. McEwen & E. M. Wills (Eds.), *Theoretical basis for nursing* (pp. 202–225). Philadelphia: Lippincott, Williams & Wilkins.
- Meleis, A. I. (1997). *Theoretical nursing: Development and progress* (3rd ed.). Philadelphia: Lippincott.
- O'Brien, M. E. (2001). *Spiritual well-being in chronic illness*. Unpublished study report, Catholic University of America, Washington, DC.
- O'Brien, M. E. (2003). *Parish nursing: Healthcare ministry within the church*. Sudbury, MA: Jones and Bartlett.
- Ruland, C. M., & Moore, S. M. (1998). Theory construction based on standards of care: A proposed theory of the peaceful end of life. *Nursing Outlook*, 46(4), 169–175.
- Thibodeau, J. A. (1983). *Nursing models: Analysis and evaluation*. Monterey, CA: Wadsworth Health Sciences Division.
- Travelbee, J. (1971). *Interpersonal aspects of nursing*. Philadelphia: F. A. Davis.
- Walker, L. O., & Avant, K. C. (1995). *Strategies for theory construction in nursing* (3rd ed.). Norwalk, CT: Appleton & Lange.