

# Permission for departing: spiritual nursing care in human finitude

*Permissão de partida: um cuidado espiritual de enfermagem na finitude humana*

*Permiso para partir: un cuidado espiritual de enfermería en la finitud humana*

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## ABSTRACT

**Objectives:** To reflect on teaching experience in the application of the spiritual nursing care called permission for departing. **Methods:** It is a methodological reflection and description of a subtle technology for spiritual nursing care called permission for departing. **Results:** the permission for departing is a spiritual care that allows for an intentional therapeutic relationship of trust and safety among the professional, patients, and the family, enabling the expression of feelings, beliefs, and religious or spiritual rites that help in death and dying situations. **Final Considerations:** a concept structured by words and attitudes reinforcing what is positive was coined, aiming at a consciousness state of peace and the promotion of dignity in the death and dying process, as well as for time for the patients, their families and the team to experience contemplation and parting.

**Descriptors:** Spirituality; Nursing; Nursing Care; Hospice Care; Hospice and Palliative Care Nursing.

## RESUMO

**Objetivos:** refletir sobre a experiência docente na aplicação do cuidado espiritual de enfermagem denominado permissão de partida. **Métodos:** trata-se de uma reflexão e descrição metodológica de uma tecnologia leve de cuidado espiritual de enfermagem denominada permissão de partida. **Resultados:** a permissão de partida é um cuidado espiritual que facilita uma relação terapêutica intencional de confiança e segurança entre o profissional, o paciente e a família, propiciando a expressão de sentimentos, crenças e rituais religiosos ou espirituais que auxiliam na situação de morte e morrer. **Considerações Finais:** cunhou-se um conceito estruturado por palavras e atitudes que reforçam o positivo, buscando um estado de consciência de paz e a promoção da dignidade no processo de morte e morrer, bem como um tempo para que o paciente, a família e a equipe possam vivenciar recolhimento e despedida.

**Descritores:** Espiritualidade; Enfermagem; Cuidados de Enfermagem; Cuidados Paliativos na Terminalidade da Vida; Enfermagem de Cuidados Paliativos na Terminalidade da Vida.

## RESUMEN

**Objetivos:** reflexionar sobre la experiencia docente en la práctica del cuidado espiritual de enfermería llamado permiso para partir. **Métodos:** se trata de reflexión y descripción metodológica de una tecnología sutil de cuidado espiritual de enfermería llamada permiso para partir. **Resultados:** el permiso para partir es un cuidado espiritual que proporciona una relación terapéutica intencional de confianza y seguridad entre el profesional, el paciente y la familia, además propicia la expresión de sentimientos, de creencias y de rituales religiosos o espirituales que auxilian en la situación de muerte y del morir. **Consideraciones Finales:** se ha acuñado un concepto estructurado con palabras y actitudes que refuerzan lo positivo, que busca un estado de conciencia de paz y la promoción de la dignidad en el proceso de muerte y del morir, así como un tiempo para que el paciente, la familia y el personal puedan experimentar la recogida y la despedida.

**Descritores:** Espiritualidad; Enfermería; Atención de Enfermería; Cuidados Paliativos al Final de la Vida; Enfermería de Cuidados Paliativos al Final de la Vida.

## INTRODUCTION

Life and finitude are inseparably intertwined as parts of human journey and, since immemorial times, these questions remain as the source of reflection. Since primitive peoples to the current society, no civilization has left the complexity of the human spiritual dimension beyond the physical body unscathed<sup>(1)</sup>. Therefore, death, set as a certainty, may trigger physical and spiritual suffering in face of human unpreparedness to deal with this reality. Such difficulty, seen and outlined in the social context, is reflected in professional relations and in their respective working processes, endorsing, for example, in the health area, one of the plausible justifications for professional stiffening regarding spiritual care in health.

Facing the cultural and social scenario that affects the professional unpreparedness to embrace people in death and dying processes, it was created, in January 2017, an extension project of the Universidade Federal da Fronteira Sul (UFFS), Chapecó campus, in partnership with the West Regional Hospital (HRO - *Hospital Regional do Oeste*), aiming to sensitize the triad patient-family-professional, involved in this health situation, and to promote relief of psychic pains related to the end of life, favoring a dignified and bearable condition for living and dying, besides strengthening and relieving the pain of the ones who stay, family members and significant people for the patient.

Teaching experience with this triad in the death and dying process was the background to create and develop the spiritual nursing care called permission for departing (PD). This care is justified in face of the resistance and anguish experienced by the nursing professional when handling the patients and their families in the process of death and dying, which was pointed out by literature<sup>(2)</sup> and empirically observed by the authors in their professional daily lives, implicating on a – certainly not the only one – relevant and applicable strategy for spiritual care.

Therefore, it is essential to reflect on the death and dying process so that health professionals have theoretical-methodological subsidy to handle the finitude of life during the care process and, thus, produce better practices in health care.

## OBJECTIVES

To reflect on teaching experience in the application of the spiritual nursing care called permission for departing.

### **The development of the spiritual care: permission for departing**

Permission for departing (PD) is a spiritual care that enables an intentional therapeutic contact based on trust and safety among the professional, patients, and the family, easing a free and secure expression of feelings, beliefs, and religious or spiritual rites that may be carried out in death and dying situations. PD is set as a spiritual care, since it is a subtle technology, that is, it is a relationship technology, which produces bonds, mediates patient sheltering, besides systematically operating through interpersonal bonds, environment handling, and the conduction of structured phrases that will be explained throughout this study. In this sense, it is expected for PD to enable the therapeutic

condition needed for expressing pain, anguish, expectations, and fears experienced by the patients and their family members, making it easier to overcome resistance and blame in order to re-significate the patients' dying process, as well as the others' lives, when they are gone.

The applicability of this spiritual care technology has revealed itself as promising to effectively reduce the patients and family members' spiritual suffering in face of the finitude of life, and to sensitize health professionals regarding spiritual suffering and the need for care in this dimension of health care, conceived under a widened thinking of assistance to the integrality of being. In fact, the objective of this technology is assured as the nursing professionals are instrumentalized for the PD and dedicate themselves to elaborate psychically their own beliefs and feeling regarding death, life, and the professional-patient relationship, so to abstain themselves of personal judgements and tendencies on the scenario established.

Therefore, the criteria for developing the PD are: respecting the patients and family's religious or spiritual beliefs when applying this care; guaranteeing the participants' full religious freedom; safeguarding confidential information that may be confided by the patient or family member to the professional (with the exception of information protected by ethical codes, which should be notified to specific entities); the participant's informed consent; and the emotional support for the patients and family members before, during, and after the procedure.

Methodologically, PD requires a previous contact for the family and the patients' information and consent, when the patient is conscious, once they are the object of care. This initial condition is determining for the result of the practice and it demands communication skills and the professional's empathic behavior to identify the field for applying the care.

Some questions are essential for developing the care: is a death and dying situation clinically established? Are the patients and family members informed on that phenomenon? Do the patients and/or family members need PD to ease the unattachment and/or to reduce any perceived level of spiritual suffering and/or to develop a clarification on this condition of proximity to death? Does the patient understand and accept the proposed spiritual care? Do the family members understand and accept the proposed spiritual care? Are the family members willing to offer PD to the patients?

Initially, it is recommended to enable a quiet and private environment, which can protect privacy, the respect and caring dialogue essential for this care, and which provides the professional conditions to carry out and explain PD for these people. Depending on the place's characteristics (health institution, household, or other), the patients or family members' personal objects recalling their beliefs and cultural symbols may be used, as well as instrumental music and other resources, which can catalyze the process of concentration and affective and spiritual connection among present people.

It is essential for the environment where the PD will occur to not refer to any specific religious belief, so that it may embrace the beliefs and rites valued by the family concerned. Likewise, it is essential for the professionals developing the care to take on a respectful attitude, refraining from any expression of their own beliefs and religion. It is important to remember that not all

people practice a religion or believe in God or any other divinity. Thus, religious or spiritual tendency by the professional may impose barriers to interpersonal communication, detracting PD from its character.

Preferably, but not necessarily, holding hands with the family and side by side with the patient, being conscious or not, the following steps are taken: 1) affirming with the family the importance of the patient as a human being worthy of respect (all repeat: "We are grateful for his/her existence"); 2) it is reaffirmed that the feeling that united them will not wither with time and distance (all repeat: "We want him/her good"); 3) forgiving committed failures is proposed (all repeat: "We forgive you and hope you forgive us"); 4) happy moments are shared and recovered (all repeat: "We won't forget it), and the gratitude for the presence, for companionship, and dedication in the journey (all repeat: "Thank you very much"); 5) each family member may express something that may have marked the existence along with the one departing, always reinforcing positive feelings; 6) family members caringly say: "We are here and everything is alright! You can leave in peace! We will stay together! We will look after each other!"; and 7) the professional or one of the family members reads or makes a speech, prayer or message, which is meaningful for the beliefs of the family and of the one who is departing. Present people may use symbols that nurture and express their beliefs. Such care may be performed more than once with the same patient and family members, since they express their will and disposition to do so.

Prayers have been studied in health area as a spiritual activity promoting well-being that affects the health state, reducing anxiety, stabilizing blood pressure and respiratory rate in people with chronic diseases, as well as maximizing their adherence to the treatment, constituting a simple, feasible and costless technique, as a supporting therapy<sup>(3)</sup>. In this sense, prayers are a tool for spiritual nursing care, currently supported by scientific evidences, which can help in the PD process, as long as it is contextualized. In singular situations in which the patient does not recognize as legitimate a system of belief or prayers, it is possible to work PD based on words to which this individual confers existential meaning, which can be investigated with the patient or with significant people present during hospitalization. It is, thus, important not to impose to patients and their family member any type of belief or faith.

It is highlighted that the care must be previously informed and explained to the participants, who must consent to every step. When they desire to develop this care, but express reservations regarding some of the items comprising PD, the professional can adapt it to the circumstance.

The duration and the appropriate time to carry out PD vary and depend on a previous wide evaluation of the professional intending to develop it. In this evaluation, it is necessary to explore, along with the patient and family members, the feelings involved in the relation, with the intend of safeguarding the integrity of everyone involved and to avoid damages caused by iatrogenic or partial communication, as well as the imposition of beliefs and actions by the professional. In summary, it is indispensable for the decision for the care to be shared and not taken unilaterally by the professional.

### **Theoretical references of the three essential elements constituting the permission for departing: gratitude, love, and forgiveness**

Death, since the beginning, is considered a mystery that raises numerous questions involving who we are, where we came from, and where do we go to. In face of finitude, human beings experience the urgency of life and the conflicts inherent to it, sometimes making it harder for health assistance to be performed. Despite recognizing its existence, we glimpse our own finitude when seeing a patient in a death and dying situation question the meaning of life itself, since it is known that the man is the only live being that is conscious of its own finitude<sup>(4)</sup>.

Psychology has, during the last 60 years, studied human suffering deeply, specially during the 20<sup>th</sup> century<sup>(5)</sup>. In parallel, studies on well-being were developed and, after the 2000s, psychological researches with constructs opposing to suffering, such as gratitude, love, forgiveness, among others, were intensified, thus conceiving a new approach, defined by Seligman and collaborators as Positive Psychology<sup>(6)</sup>. The interest of Positive Psychology consists on developing strategies through which human beings may optimize good life conditions. In this sense, aggravation prevention and health promotion mechanisms are strengthened.

Based on these initiatives, concepts related to what the authors call "strengths and virtues" were developed<sup>(7)</sup>. For the authors, strengths are positive characteristics expressed by thoughts, feelings, and attitudes. They correspond to ways or manners to achieve personal virtues, they can be developed by any human being and, by practicing it, the being becomes virtuous. The authors have described 24 forces. The present study uses the concepts of virtues and forces: gratitude, love, and forgiveness, inherent to Positive Psychology, to support the PD spiritual care.

From these authors' point of view, gratitude is a force that indicates the attention given to good live events. By associating it to other forces, human beings can develop the virtue of transcendence and transmute it to a higher consciousness level, forming bonds to the universe, something bigger and meaningful. Under this view, love is a force that values close and intimate relationships, leading to the development of the humanity virtue, which involves care in interpersonal relationships. Forgiveness is a force that recalls the temperance virtue, that is, moderation and balance in the process of living.

Besides the theoretical references from Positive Psychology, there are other current notions on gratitude, love, and forgiveness, which contribute to structuring PD. Gratitude involves a feeling of debts or the recognition due to a benefit performed, based on an empathic attitude by the one thanking it and valuing the presence of the other one, in this case, the patient in a death and dying situation<sup>(8)</sup>. It is also considered an intimate energy, with the possibility of helping in healing negative patterns in thought, guaranteeing positive mental states, making the professionals more attentive and determined, as well as the patients feeling loved and cared for, since they are respected in their singularity, promoting emotional well-being.

Love is a feeling portrayed as an admirable cord that implies on responsibility, empathy, and compassion<sup>(9)</sup>. In PD, love, expressed by the sentence "We want him/her well!", is uttered in order to

bring up to consciousness the connection between the significant people present and the one out of therapeutic possibilities, with the intention of breaking with resistance to the farewell and of allowing for a true interpersonal contact, comforting all.

For that, health professional that are willing to care for others in finitude, in a careful way, will be able to truly comfort and support the patients and their family members. Forgiveness, a socio-cognitive and interpersonal skill, knows no bounds and is constituted as a moral attitude in which the person considers abdicating from the right to resent, judge, and have negative behaviors. Lastly, it is highlighted the function of linguistic compounds "We won't forget you!"; "We are here and everything is alright! You can leave in peace! We will stay together! We will look after each other!"; which are interwoven in the PD's essential elements. "We won't forget you" intends to comfort the one about to leave this existence. It is a measure that reinforces their legacy and personal marks, suggesting their presence will be eternalized. ""We are here and everything is alright! You can leave in peace! We will stay together! We will look after each other!" intends to relieve the patients from their responsibility to the others, verbally reinforcing that this is the moment for their spiritual preparation, to experience unattachment and deliverance. All sentences are connected to one another and were empirically developed based on systematic observation of the demands of patients and family members experiencing the process of death and dying.

It is also important to reinforce the interface between the references from Positive Psychology, which intends to lead to good psychosocial functioning and to resilience<sup>(5)</sup>, and the therapeutic character of PD, which, by using the forces of gratitude, love, and forgiveness, subsidizes the development of personal virtues that will help in facing adversities and overcoming grief.

### Permission for departing: challenges for nursing

the first experiences with this care technology can be challenging, just as other multiple care techniques, however, the repetition of this procedure should result on more confidence by the professional and the achievement of results. However, resistance to PD is foreseen, as a subtle care technology to be used in the daily exercise of nursing, due to multiple factors, such as the possible conflict between this technology and the professional's belief system, the impact of biomedical heritage on nursing, which is paradigmatic and worships hard and soft-hard technology in detriment of spiritual care, the inexistence of scientific evidences on the results of PD or even that institutional or professional resistance to what is new, so commonly observed. Still, it is highlighted the need to overcome biomedical orthodoxy in order to include the spiritual dimension on care. It is about daring to use other care forms in the death and dying process, which will enrich the relationship among professional-patient-family in the development of widened and integrative health practices.

PD, as a care technology, challenges the physical limits of care and it has been widening a professional network concerned in taking care of the patient and family's spiritual dimension, in different care scenarios, such as households, hospitals, primary health care, in multiple death/dying conditions. For PD to be safely performed, the professional will need to believe in the spiritual dimension as field of nursing for the development of integral care, given the relevance of spirituality for the work in health, as a force capable to help individuals, families, and communities to overcome difficulties in life. Given that, the importance of taking care of spirituality is highlighted, once spiritual care is key for a personal shift in the process of living, growing old, and dying<sup>(10)</sup>.

PD is restricted to the concept that has been structured by the Universidade Federal da Fronteira Sul, operated as described in this study and not implying, under no circumstances, on any attempt of convincing patients and family members regarding the interruption of means guaranteeing the maintenance of life. This care technology is, thus, not related to any kind of life abbreviation modality, as well as it is independent of any therapeutic approach and/or technological resources instituted by the health service or by the family with the patient, not being a substitute for any traditional medical therapy.

### FINAL CONSIDERATIONS

Reducing fear and suffering related to human finitude allows us to glimpse, for a brief moment, transcendence, to help packing for departing and to go through, with family and patients, all pending matter that need to be solved. By building a bridge towards the new, a concept structured by words and attitudes reinforcing what is positive was coined, aiming at a peaceful consciousness state and promoting dignity in the death and dying process, as well as granting time for the patient, family and team to experience contemplation and farewells.

The structured PD concept intends to "free" the patient to depart, to deliver themselves lovingly, without fear of suffering, to death. For the family, spiritual care strengthens the hope for better days and the maintenance of the strength to move on. For the team, the understanding that spirituality and science are allied, intertwined in care, and may design a widened assistance to human beings in the death and dying process.

This work is relevant as it instrumentalizes the nursing team for spiritual care in death and dying situations of any nature, regardless of area of action. By using technologies valuing the patients and their family's spiritual dimension, nursing expands its territory and reach, as well as the scientific context, even though it cannot translate into numbers and algorithms all human dimensions, which keeps it distance from reaching the being's truth and essence. Once it is a technology under development, other studies are suggested to demonstrate and assess the results of PD under different perspectives.

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