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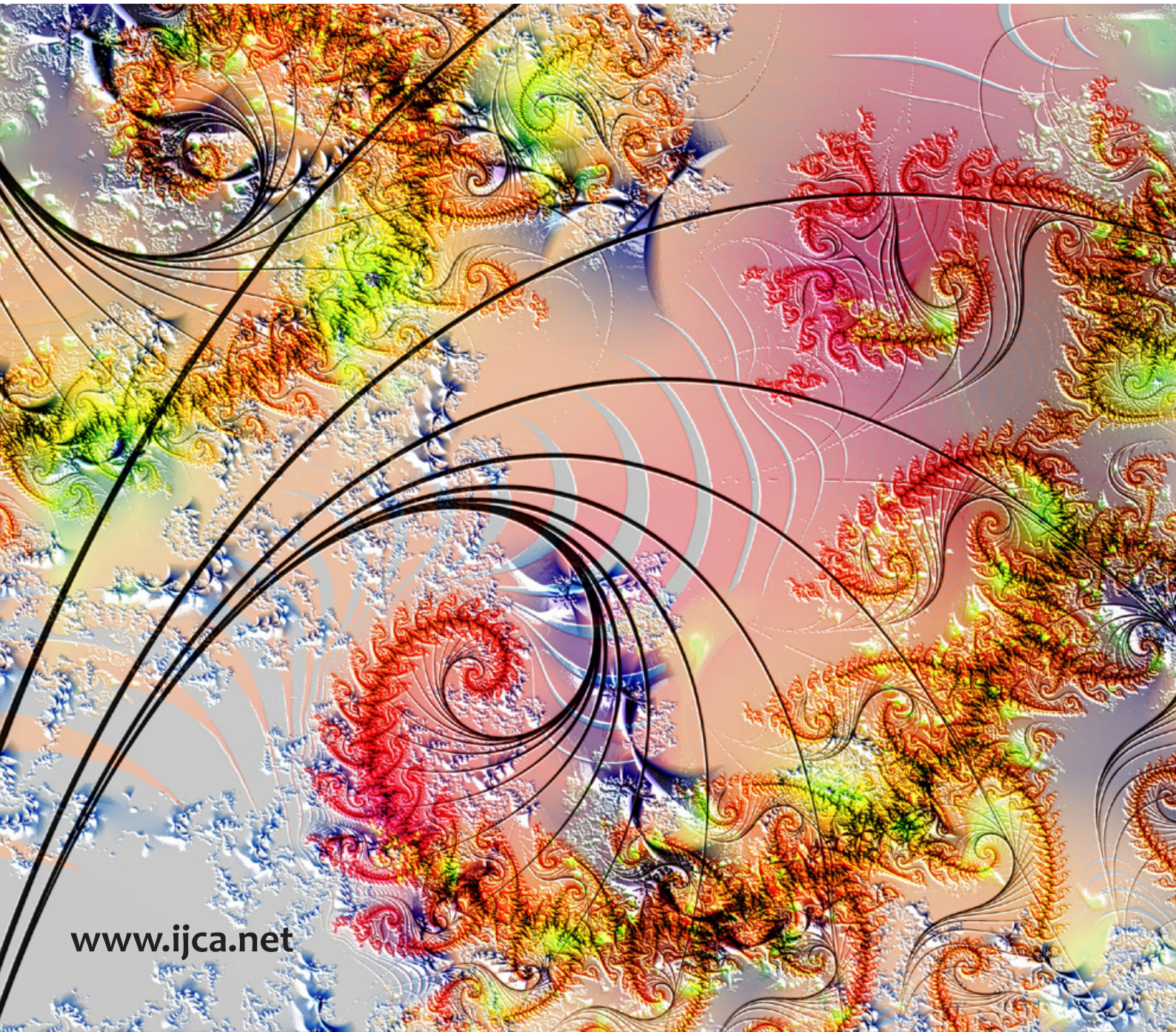

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Editorial

In this issue we feature a range of papers informed by the theme of *symptom management in clinical care* — by practitioners working in a diverse range of therapeutic and palliative care environments.

The word 'symptom' is derived from the ancient Greek *symptoma,* meaning "a happening, accident or disease", and which itself originated from the stem *sympiptein,* meaning "to befall, happen; coincide, fall together" — from *syn,* "together" and *piptein,* "to fall". Reflecting on the word's etymology, we are reminded that a symptom is something that has *befallen* the individual — and that there is an essential separation between the two. Accordingly, we need to stay focused as holistic clinical practitioners on the fundamental needs of the patient as well as the requirements to effectively address the symptoms that afflict them.

In keeping, the contributors to this issue reflect the dual capacity for clinical aromatherapy to address the deepest needs of the individual as well as effectively manage symptoms in their greatest hour of need.

Carol Rose addresses the potential of aromatherapy to ease the spiritual distress of patients with cancer, while Felicity Warner shares her groundbreaking approach to palliative care. Rodney Schwan, too, discusses a profoundly compassionate way of caring aromatically for the totality of the individual based on Maslow's hierarchy of needs.

At the same time, Jackie Stringer and Melanie Kovac demonstrate the remarkable antimicrobial, antifungal and anti-inflammatory activities of essential oils through sharing their exemplary clinical research.

What these practitioners have in common is an informed awareness of the diverse ways in which essential oils can benefit the individual as well as ease their suffering – whether of a physical, emotional and/or spiritual nature. Their professional endeavours in applying evidence-based knowledge to clinical practice is an irreplaceable commitment to the future of our therapy.

With gratitude,
Gabriel Mojay

Spiritual distress in patients with cancer: The potential of aromatherapy

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Spirituality is integral to human beings and has been identified as an important determinant of quality of life (Cohen et al, 1996) and crucial to a patient's ability to cope with illness (Alcorn et al, 2010). Existential questions are triggered more often in patients with cancer than any other chronic illness and if left unaddressed, result in spiritual distress (Puchalski, 2012). However, many patients report their spiritual needs are unmet by healthcare professionals who often find spiritual aspects of care confusing (Austen et al, 2016).

Qualitative studies identified that patients consider spiritual care as relational, advocating for compassionate healthcare professionals (Edwards et al, 2010). Aromatherapy offers significant potential as an integrative therapy in spiritual care, primarily through the patient-therapist relationship. Talking openly provides valuable patient support; a vital part of spiritual expression (Edwards et al, 2010). However, the effects of aromatherapy in spiritual care have not been fully evaluated. This calls for further clinical investigation which requires us, as aromatherapists, to possess a comprehensive understanding of spirituality, its distinct difference from religion, together with an appreciation of the complexities of spiritual distress and how this can be addressed. This paper explores these issues and considers future research initiatives.

Introduction

Spirituality forms a vital dimension of our being and is defined as *"that which allows a person to experience transcendant meaning in life. This is often expressed as a relationship with God, but it can be about nature, art, music, family, or community – whatever beliefs and values give a person a sense of meaning and purpose in life"* (Puchalski and Romer, 2000).

There is a common misunderstanding that spiritu--ality and religion are synonymous. Chochinov and Cann (2005) explored these differences, summarising that *"within the religious realm, spirituality aligns itself to a personal God whereas within the secular realm, it invokes a search for significance and meaning"*.

Spirituality and religion are distinctly different but at the same time complementary. As such, spirituality can find its expression through religion as a particular set of beliefs, or it can be experienced through broader contexts of relationships and life experience making it personal and unique to the individual.

The relationship between spirituality and illness

In recent years, an increasing number of studies have investigated the relationship between spirituality and illness, particularly in the area of cancer and the end of stage of life (Balboni et al, 2009; Delgado-Guay et al, 2011; Epstein-Peterson et al, 2015; Austen et al, 2016). A diagnosis of cancer is life-changing, impacting the individual physically,

socially, emotionally and spiritually. Deep existential questions of meaning and purpose can be triggered, more often in patients with cancer than with any other chronic illness (Cohen et al, 1996).

A strong sense of spirituality has been identified as crucial to a patient's ability to cope with illness (Alcorn et al, 2010) and is associated with an improved quality of life (Balboni et al, 2007). Patients consider their spirituality a source of positivity, hope and gratitude (Delgado-Guay et al, 2011), providing strength and comfort in times of adjustment, or in prioritising what holds meaning and importance in their lives (Puchalski, 2012).

Clearly, spiritual and religious beliefs are important to patients with cancer, influencing their coping strategies and quality of life. Whilst spirituality can be a source of strength for patients, it can also be a source of distress.

Spiritual distress

Defined by the Hospice and Palliative Care Nurses Association as *"a disruption to one's beliefs of value system, a shaking of one's basic beliefs"*, spiritual distress can adversely impact a patient's quality of life. Puchalski (2012) states that spiritual distress can occur at any point within the cancer trajectory, particularly around initial diagnosis or with recurrence of disease. Elevation in spiritual distress has also been identified at the end of active treatments (Norris et al, 2011), but is most prevalent at the end-stage-of-life (Puchalski, 2012).

Manifestations of spiritual distress

Spiritual distress does not manifest as a set of pre-determined symptoms, rather a variety of expressions of distress which are unique to each patient. For some patients, it may influence how they experience and express the physical symptoms of their disease, particularly pain. For others, spiritual distress may cause greater concern than their physical symptoms. In a review of qualitative research, Edwards et al (2010) identified fear, insecurity and nervousness as predominant manifestations of spiritual distress. Associated increases in anxiety, depression, panic attacks, uncertainty and fear of the unknown were also reported. Spiritual suffering can be expressed through questioning the meaning of life, anger with God, or viewing illness as a punishment for life choices (Richardson, 2014). Additionally, feelings of guilt, shame or an inability to trust oneself, other people or God/higher being, can result in a lack of inner peace (Speck, 2011).

The concept of 'total pain'

Richardson (2014) advises that in situations where a patient is not responding adequately to recognised interventions of symptom management, consideration must be placed with what else could be contributing to their distress. To assist healthcare professionals, Dame Cicely Saunders, founder of the modern-day Hospice movement, proposed the concept of 'total pain', which comprises physical, social, emotional and spiritual components of distress (see Figure 1). Each patient will present with a unique combination of components which are specific to their situation.

For several decades, this concept of total pain has been well received within the palliative care community. However, a large scale study of patients with advanced cancer, found the majority report their spiritual needs were unmet by healthcare professionals and spiritual issues were not discussed as freely as they desired (Balboni et al, 2009). Subsequent studies in the advanced disease

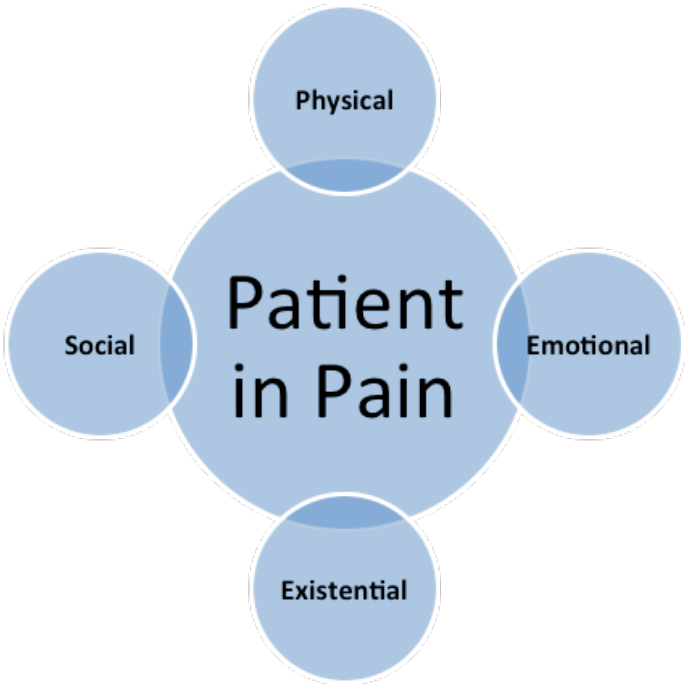

Figure 1. Total Pain concept (Cicely Saunders, 1964)

setting report similar findings (Epstein-Peterson et al, 2015; Austen et al, 2016). This raises the crucial question of whether the concept of spirituality by which healthcare professionals practice actually corresponds to what spirituality means to the patient.

The patient's perspective

A striking theme of the qualitative research is that the terms 'spiritual' and 'spirituality' do not generally form part of a patient's vocabulary. Edwards et al (2010), highlight that fulfilling 'relationships' are considered crucial to a patient's inner peace and spiritual wholeness. Included, are relationships with self, family, friends, nature and music together with God or a higher being. Additionally, this extends to healthcare and other allied professionals involved in the patients care. Central to these professional relationships, patients advocate kindness, compassion, sensitivity and respect, where the emphasis is on a patient-centred approach (Edwards et al, 2010).

Many patients share that having a healthcare professional who is open to spiritual discussion enables them to explore the challenges they face when confronted with their own mortality (Richardson, 2014). However, whilst most healthcare professionals recognise the importance of spiritual care, few feel equipped to address this with their patients. Lack of training, skills and confidence in spiritual matters are identified as sources of concern (Epstein-Peterson, 2015; Austen et al, 2016). Other prohibitory factors include limited time, insufficient privacy and diminished continuity of care (Richardson, 2014; Epstein-Peterson et al, 2015). Clearly, the assessment and delivery of spiritual care remains confusing to most healthcare professionals. As a result, this leads to the risk of inadequate care where the focus is placed on religious needs rather than incorporating the wider aspects of spirituality.

Spiritual care

Spiritual care can take many forms including recognising spiritual distress, inviting conversation about spiritual matters, acknowledging and encouraging an individual's spiritual beliefs, making appropriate referral to spiritual leaders and other support networks. Predominantly, the focus is on being present with the patient, sharing their journey by listening and connecting with them as a human being as well as assisting them to find meaning, hope and strength (Edwards et al, 2010). Some practical guidance is proposed by Rousseau (2000a) which is summarised in Table 1.

Several recommendations have been made for the integration of complementary approaches in the provision of spiritual care, including aromatherapy (Adam and Jewell, 2007; Speck, 2011; Puchalski, 2012). Although the effects of aromatherapy in spiritual care have not been fully evaluated, its potential contribution cannot be under-estimated.

Internationally, the use of aromatherapy within oncology and palliative care settings has increased substantially. This is reflected in the work of Harris (2004), Price & Price (2012), Berger et al (2013), Buckle (2015) and Knapp-Hayes (2015), among others, whose input has aided collaborative care aimed at improving quality of life in patients with advanced illness as well as their families. In terms of spiritual care, the valuable contribution of

Table 1. Practical guidance in alleviating spiritual distress (adapted from Rousseau, 2000a)

- Control physical symptoms
- Provide a supportive presence
- Encourage life-review to assist the patient to recognise purpose, value & meaning
- Explore issues of guilt, remorse, forgiveness & reconciliation
- Encouraging & facilitating religious expression
- Re-framing goals to ones which are short-term and achievable
- Encourage use of meditation, guided imagery, music, reading, poetry and art that focus on healing rather than cure

aromatherapy is reflected in the observations of Dr Hann, a fellow Medical Director at the Centre for Palliative Care Studies in San Diego, who stated, *"When the care team is confronted with tough patients with difficult to manage pain or complex psycho-social issues, we turn to aromatherapy for help"* (Schwan and Ash, 2004).

Much has been written on aromatic interventions for the management of physical, psychological and emotional symptoms associated with cancer and end stage of life (Harris, 2004; Buckle, 2015; Knapp-Hayes, 2015). However, there are other additional factors which may assist an aromatherapist's understanding of the spiritual dimension of care in order to enhance clinical practice. These include:

- Relationships
- Communication
- Spiritual care: when should it begin?
- Spiritual assessment
- Essential oils in spiritual care
- Aromatic applications
- End of life care
- Family and carers

Relationships

Whilst patients want healthcare professionals to be involved in their spiritual care, their preference is for those *"who were able to step beyond rigid professional boundaries"* to facilitate spiritual expression, rather than give spiritual advice or possess knowledge of different religions/faiths (Edwards et al, 2010). Changing the *"rigid professional boundaries"* that exist within healthcare underpins the international work of Dr Robin Youngson (2012), Founder of 'Hearts in Healthcare', who states *"Healthcare's focus on physical disease and bio-medicine is unbalanced. We need to pay much more attention to emotional, psychological and spiritual well-being and the huge importance of healing relationships."*

In aromatherapy, a principle and consistent finding of the qualitative research is the greater emphasis patients place on the patient-therapist relationship (Corner et al, 1995; Kite et al, 1998; Dunwoody et al, 2002; Berger et al, 2013). The benefit of being able to talk openly and freely with the aromatherapist is reflected in their descriptions (see Table 2).

Further observations by Dunwoody et al (2002) identified that patients did not necessarily focus on their illness with the aromatherapist but discussed their everyday concerns and fears. Sharing these innermost troubles is a fundamental aspect of spiritual care. Building such compassionate relationships provides valuable spiritual support which patients report as being the most important aspect of their spiritual expression (Edwards et al, 2010). Clearly, spiritual care for patients is relational and as such, is not an 'intervention' but an expression of the way care is delivered. At its core is communication.

Communication

Patients report a reluctance to share matters of a spiritual nature to busy healthcare professionals (Murray et al, 2004), preferring environments that facilitate opportunities for expression of their anxieties, fears and uncertainties (Edwards et al, 2010). Creating a peaceful environment which enables a patient space to tell their story in an unhurried and uninterrupted way is essential. Effective and sensitive skills of communication,

Table 2. Patient's descriptions of the patient-therapist relationship

"(Being able to) open up and discuss concerns in a way that had previously been difficult in other settings" (Kite et al, 1998).
"Prior to the treatment (aromatherapy) I was so low, so stressed out, I did not want to talk about my problems, but she (the aromatherapist) let me get it all out, my emotional hang-ups and a lot of the time it wasn't even about cancer" (Dunwoody et al, 2002).
"It (aromatherapy) put me in touch with my deeper self" (Berger et al, 2013).

using open-ended questions, appropriate reflection and summary, combined with an ability to listen without exerting 'expert advice', is paramount.

Spiritual discussion often utilises the simple but important intervention of 'life-review'. Sensitive exploration enables a patient to derive meaning and purpose as well as gain a sense of perspective of their life. As Speck (2011) observed, it can be a time where regrets and 'unfinished business' surface which, in order to achieve inner peace, results in a need for closure. Patients will often seek forgiveness, or have a desire to forgive another; for some, it may be to make peace with God.

Laughter, humour and the smiles of others are among the armoury a patient utilises to uplift their spirits (Edwards et al, 2010). Incorporating positive approaches which facilitate hope and an ability to embrace the moment are also important (Speck, 2011). Unfortunately, hope and terminal illness are often considered a paradox. According to Rousseau (2000b), hope plays a vital role in enabling a patient to successfully cope with their illness and thus improve their quality of life. Ways in which hope can be fostered are outlined in Table 3.

Spiritual care: when should it begin?

Speaking from experience as a hospital chaplain, Peter Speck (2011) asserts that existential questions arise at critical points throughout a person's life as well as during illness. This is in line with the revised World Health Organisation approach to palliative care, which recognises that symptoms experienced at the end stage of life have their origins at an earlier time of the disease trajectory (Sepulveda et al, 2002). For aromatherapists, being involved in these early stages enhances development of the patient-therapist relationship to one where patients can derive support and comfort throughout their cancer journey. Additionally, it facilitates the process of 'letting go', by enabling patients to feel supported as they take the necessary 'small steps, with time for adjustment and grief' (Edwards, 2010).

Spiritual assessment

Through sensitive exploration, spiritual assessment has the potential to consider deeper levels of a patient's personal characteristics, their strengths, coping-mechanisms and support networks. This represents a vital opportunity in understanding what is important to each patient and their family as well as identifying significant areas of distress. Such information enables caring professionals to make appropriate referrals for chaplain/pastoral care and to support groups. For aromatherapists, it also provides insightful guidance to essential oil selection, appropriate application and timing of interventions.

For those who prefer a structured framework, Richardson (2014) explores various validated spiritual assessment tools. In reality though, the opportunity for such discussions often present when least expected. Within the peaceful surrounds of an aromatherapy room, where a patient feels unhurried, relaxed and listened to, the opportunity may arise when they may choose to share their existential concerns. Some patients may articulate their spiritual needs easily while others struggle to express these deeply personal aspects. Speck (2011) advocates the use of dialogue which aligns with that of the patient to explore key existential areas, such as those listed in Table 4.

Table 3. Interventions that engender hope (Rousseau, 2000b)

- Adequate control of symptoms
- Fostering and developing interpersonal connectedness and relationships
- Assistance in attaining practical goals
- Exploring spiritual beliefs
- Supporting and identifying personal attributes, such as determination, courage and serenity
- Encouraging light heartedness when appropriate
- Affirming worth by treating the patient as a valued individual
- Recalling uplifting memories with life-review

Table 4. Themes to assist spiritual assessment (Speck, 2011)

Suggested themes	Additional notes of Peter Speck
a) In the course of your life, with all its up and downs, have you developed ways of making sense of the things that have happened to you?	*The answer to questions a & b may highlight the importance of the patients family, philosophy of life, or their belief system, as well something of their mental state. Hence it is not pushing someone down a narrow religious pathway.*
b) When life has been difficult what has helped you cope?"	
c) Would you like to talk to someone about the effect your illness is having on you or your family?	*Again, this does not have to be a religious/faith leader, but when appropriate, such a person should be introduced sensitively to patient and family to avoid the stereotypical image of the prelude to death. If the conversation indicates that 'belief' is important, then staff should enquire what form that takes and whether or not it is religious.*

Aromatherapists are well placed to make valuable contributions to all parts of this assessment process which involves direct liaison with the patient's multi-disciplinary healthcare team to ensure clear lines of communication.

Essential oils for spiritual care

Aromatic oils have been recognised and used within spiritual care for thousands of years. Many underpin a variety of religious rituals and ceremonies, including several which are mentioned in the Bible for their mental, spiritual and psychological healing (Mojay, 1997) and are listed in Table 5. Selecting oils which have such long-standing traditions may bring comfort to many patients but particularly to those who derive strength from their religious beliefs.

Psychological manifestations of spiritual distress

As discussed, key manifestations of spiritual distress are identified as fear, insecurity and nervousness together with increased anxiety, depression, panic attacks and fear of the unknown. Furthermore, patients report that feelings of fear are worse at night when negative thoughts escalate and generate insomnia (Edwards et al, 2010). The treatment of anxiety and insomnia is a central domain of aromatherapy and has been well researched in the cancer population (Corner, 1995; Wilkinson et al, 1999; Louis and Kowalski, 2002; Wilkinson et al, 2007; Imanishi et al, 2009; Chang, 2008; Dyer et al, 2016). Whilst *Lavandula angustifolia* (true lavender) is the most commonly studied essential oil in this area, and often unsurpassed in its treatment of anxiety and insomnia, in a review of the aromatherapy literature, Dobetsberger and Buchbauer (2011) propose other popular anxiolytics. These are listed in Table 6 and jointly reflect the calming effects of ester and alcohol-rich oils on the central nervous system and the uplifting qualities of the monoterpene-rich oils.

In situations where patients are experiencing severe anxiety, fear and panic, the deeply calming properties of *Citrus reticulata* (mandarin), *Cananga odorata* (ylang ylang), *Origanum majorana* (sweet marjoram), *Nardostachys jatamansi* (spikenard) and *Boswellia carterii* (frankincense) are also valuable. Additional to these oils, Knapp-Hayes (2015) recommends *Pinus sylvestris* (scotch pine), *Myrtus communis* (myrtle), *Styrax benzoin* (benzoin), *Santalum spicatum* (sandalwood) and *Citrus aurantium* var. amara (petitgrain). Collectively, this offers a broad range of essential oils from which the patient can make their personal choice.

Table 5. Aromatic oils referenced in the Bible (Mojay, 1997)

Latin name	Common name
Cedrus atlantica	Atlas cedar
Boswellia carterii	frankincense
Hyssopus officinalis	hyssop
Commiphora myrrha	myrrh
Nardostachys jatamansi	spikenard

Physical manifestations of spiritual distress

The control of physical symptoms is integral to the alleviation of spiritual distress (see Table 1) and interventions which foster hope (see Table 2). Essential oils and aromatherapy applications can positively complement orthodox medical approaches. These include symptoms of pain, dyspnoea, fatigue, nausea and vomiting, constipation, anorexia, dry mouth and oral mucositis. It is not within the scope of this paper to discuss the aromatic management of these symptoms and readers are referred to the published works of Harris (2004), Price and Price (2012), Buckle (2015) and Knapp-Hayes (2015).

Patient choice

Empowering patients to choose their own essential oils and how these will be administered is paramount for effective spiritual care. For some patients, religious beliefs and customary rituals may influence their choice of oils and applications. For others, being able to select oils which hold personal meaning may enrich their comfort. Incorporating this patient-centred approach provides patients with a greater sense of control over their illness as well as the opportunity to be more active in their care. This applies across the entire cancer trajectory. Additionally, working together in this way serves to enrich the patient-therapist relationship.

Aromatic applications

Massage

Aromatherapy massage has been consistently popular as a source of physical, psychological and emotional relief in patients with cancer (Corner et al, 1995; Kite et al, 1998; Dunwoody et al, 2002; Fellowes et al, 2004) as well as being a reason for patients seeking complementary therapy (Adams and Jewell, 2007). In a small study examining aromatherapy massage versus cognitive behavioural therapy for emotional distress in this patient group, Serfaty et al (2011) identified spiritual distress in 80% of the patients recruited, with a significant improvement in the way patients felt following aromatherapy massage (p=<0.01). Whilst aromatherapy massage may be beneficial for patients with an elevated performance status, massage of shorter duration or, moderated to hand or foot treatments (Chang, 2008; Kohara et al, 2004) or utilising the 'M' Technique® (Buckle, 2015), may be more comfortable for patients entering the end-stage-of-life.

Table 6. Essential oils with anxiolytic properties (Dobetsberger and Buchbauer, 2011)

Latin name	Common name
Citrus aurantium var. amara	neroli
Anthemis nobilis	Roman chamomile
Citrus sinensis	sweet orange
Citrus bergamia	bergamot
Rosa damascena	rose
Citrus limon	lemon
Santalum spicatum	sandalwood (Australian)
Pelargonium graveolens	geranium
Salvia sclarea	clary sage

Inhalation

Inhaled forms of essential oils are renowned for their direct effect on the limbic system, particularly in aiding quality sleep (Dyer et al, 2016) and alleviating other cancer-related symptoms including, anxiety, fear, depression and nausea (Buckle, 2015). Incorporating aromasticks tailored to individual needs, offers a wide scope of symptom management as well as being an effective means of empowering patients to take more control (Dyer et al, 2016).

Odour and its complex relationship with emotion and memory, triggered by a simple sensory cue, is an area of relevance for the aromatic management of spiritual distress. As discussed, 'life-review' is a key intervention of spiritual care, although some patients may find this process difficult as they struggle to derive meaning and perspective. Integrating aromas which hold significance for a patient has the potential to reconnect them with important memories of their life, enabling them to reflect and communicate more easily. According to Lewis (2015), the aroma does not necessarily need to be an essential oil(s). It can be anything that holds a personal, positive memory; one which induces comfort and inner peace. From personal experience, some examples that patients have requested include; seaweed, fresh soil, oily rags, old-fashioned sweets and specific flowers.

Take home preparations

Preparing blends that patients can continue to use at home can be valuable in extending the deeply relaxing effects achieved during the aromatherapy session. Described by Harris (2004) as 'odour-conditioning', the aromatics used within the session are repeated (both blend and application) over several consecutive sessions to *"fix the conditioned link between the aroma and the desired response"*. Associated details of the session such as music, ambience and symptom control, must also remain consistent to aid positive responses. Incorporating other modalities such as visualisation, hypnosis and guided relaxation can assist this process.

Once odour-conditioning has been established, the essential oils can be prepared for easy application by the patient at home in a variety of forms including, aroma inhaler devices, spritzers, rollerball applicators, aromapatches, creams and gels. Such personalised aromatherapy products are reported by patients and their families as being *"small but important"* measures which bring *"significant comfort"* (Berger et al, 2013). Additionally, planning such aromatic interventions with the patient empowers them to remain in control of their care in both life and its latter stages.

End-of-life care

Towards the end-of-life, spiritual issues may become more prevalent as a patient confronts the nearness of their mortality. At this time, a patient may not be able to sustain deep existential conversations and adjustments to the aromatherapy session will be necessary, such as shorter session times. For some patients, planning their end-of-life care may be something that has been contemplated and considered many times over during the course of their life and illness. Others may rationalise death through their life experiences, whilst others derive hope and comfort from their faith or spiritual beliefs. Some patients though, will struggle in their search for meaning and inner peace. Whichever way a patient presents, aromatherapy has something to offer.

Traditions of anointing with aromatic oils begin to feature more prominently towards the end-of-life, particularly in those with religious affiliations. There may be requests for preparation of specific oils with spiritual significance for the patient, to be used by their spiritual leaders or close family and carers (Harris, 2004). Additionally, personalised blends which are reflective of their aromatherapy sessions may also offer comfort.

As the end-of-life approaches, rollerball applicators, aromapatches and intermittent diffusion may be more appropriate and easier to administer, especially for family members and carers. Application of warm towels soaked in botanical hydrosols to cleanse the body can also be deeply comforting.

Spiritual distress in family and carers

Existential questions are not exclusive to the patient. Family, carers, children and friends closely involved in the care and support of their loved one frequently struggle with their own spiritual issues. Invariably, the focus of attention is predominantly on the patient and spiritual distress in family members and carers often goes undetected. If left unaddressed, this can be detrimental to the individual's future health and well-being (Edwards et al, 2010).

Aromatherapy can be immensely beneficial in assisting the family and carers during all phases of their loved ones illness, including bereavement.

Spiritual and religious differences may exist between the patient and their family and carers which can result in further distress if differing views are imposed. Sensitive communication is paramount here. Aromatherapy has the potential to create a calm, tranquil environment conducive for family members and carers to express their fears, doubts and anxieties which could help prevent spiritual needs becoming spiritual distress.

Conclusion

Spiritual distress represents a significant problem for patients across the entire cancer trajectory (Puchalski, 2012) and remains overlooked by healthcare professionals who often find spiritual aspects of patient care confusing (Austen et al, 2016). A striking theme within the qualitative research is that patients consider spiritual care as relational, advocating for healthcare professionals who are *"able to step beyond rigid professional boundaries"*. This implies a serious reconsideration of current healthcare practice. Speck (2011) calls for integrated care pathways which incorporate the wider issues of spiritual care. This has far-reaching, positive implications for healthcare, as highlighted by Youngson (2012) thus: *"Compassionate healthcare is safer, more effective, satisfies patients, saves time, reduces demand, gives meaning to work and costs less."*

Aromatherapy offers significant potential as an integrative therapy in spiritual care, primarily through the patient-therapist relationship. As holistic practitioners, qualified aromatherapists are uniquely placed to contribute to the spiritual care of patients with cancer, their family and carers. Whilst essential oils and botanical hydrosols are invaluable as complementary interventions to alleviate the manifestations of spiritual distress, their effect has not been fully evaluated. This calls for further clinical investigation, using qualitative research methods to appreciate the complexities of spiritual distress and the subjective nature of aromatherapy interventions. Evaluation across the cancer trajectory is important, not just at the end stage of life. Furthermore, the spiritual needs of family members and carers in relation to the effects of aromatic intervention, also requires sensitive research.

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