18 Problems with Spiritual Distress

The Patient with Spiritual Distress

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Learning Objectives

- Define spiritual distress.
- Identify some life events and physical changes that may precipitate spiritual distress.
- Differentiate between religion and spirituality.
- Identify effective interventions for dealing with an individual experiencing spiritual distress.
- Describe common nurses' reactions to patients' spiritual distress.

Glossary

Chaplain – *Clergyperson who has a formal relationship with a particular healthcare organization.*

Religion – *A system of beliefs, worship, or conduct. Generally refers to formal, institutionalized practices.*

Spiritual distress – *A disturbance in the belief or value system that is a personal source of strength and hope; may be accompanied by an inability to carry out religious practices, possibly creating even more stress because the individual cannot use spirituality to cope with stress.*

Spiritual leaders – *Officers and persons who provide spiritual support, including chaplains, priests, ministers, rabbis, monks, pastors, elders, deacons, mullahs, or hajjis. There is a wide and diverse range of spiritual practitioners with a number of different titles.*

Spirituality or worldview – *Beliefs of individuals permeate all areas of their life and influence attitudes, beliefs, values, and health.*

All people have a spiritual dimension, regardless of whether or not they participate in formal religious practices. Spirituality allows us to transcend the self and connect with people, our surroundings, and powers outside of ourselves. Spirituality can give meaning to life and impact the ability to trust, love, and forgive. People need to find meaning beyond their current suffering. This allows them to make sense of that situation (Kellehear, 2000). Spirituality is uniquely human; it is universal and innate (Taylor, 2006). One of the difficulties with the Western view of spirituality is that a separation is made between the "spiritual" and "physical" realms. Other cultures, as well as alternative medicine are less inclined to have such a rigid delineation between these areas. Religion is different from spirituality, although it is complementary. Religion gives us tradition, ritual, and a specific doctrine. Spiritual distress is an existential crisis in which the beliefs or values around which the person has organized his or her life are threatened. Various events along the health-illness spectrum as well as outside crises could result in an episode of spiritual distress. The events of September 11, 2001, for many, resulted in spiritual distress, because life as it had been known could no longer be counted on to be predictable. This also can be experienced on an individual or family basis as the result of illness or major change in health. Parents' belief system may be shaken when they learn that their child has an incurable illness or will not recover from an accident. For individuals, it can be learning of a life-threatening illness. When people are faced with these situations, you may hear them say, "Life will never be the same" or "How can I go on living?" The very foundation of their life as they know it is threatened. They may no longer feel safe and able to go about their everyday activities. Some may question their belief in God or other higher power.

Spiritual distress may manifest itself in many different ways. Individuals are a complex combination of biological, psychological, sociocultural, and spiritual parts, all interacting and affecting all other aspects of the individual's life. An insult to one's spiritual dimension can affect every other dimension of the individual and influence the patient's experience of illness.

Spiritual distress occurs when a person believes that life no longer has meaning or purpose, or experiences a sense of hopelessness. Like many other entities that can be viewed on a continuum, spiritual distress may be a temporary, transient phenomenon in a response to a specific stressor or it may be a longer reaching event prompting the individual to question or reexamine assumptions and priorities. In a few rare instances, extreme spiritual distress may indicate psychopathology. One aspect of spiritual distress is what Mary Elizabeth O'Brien (2003) terms as spiritual pain. This includes a perception of loss or separation from God; the experience of evil or disillusionment; a sense of failing God–the

recognition of one's own sinfulness or shortcomings and failings; a perception of a lack of reconciliation with God; and a sense of loneliness of spirit. An example of this is a woman, early in the AIDS epidemic, who following childbirth was given a transfusion of HIV-infected blood. The mother developed AIDS. Her religious community was quite conservative and taught that HIV was God's punishment for those who disobeyed God. This patient and her family experienced not only spiritual pain from a sense of separation and judgment from God but also ostracism from her religious community.

In many ways, spiritual distress can follow a similar pattern to the grief response. Grief over small losses may be short-term, and with proper support, recovery will be rapid. Great losses affect the individual more profoundly and can be seen in changes in the person's mood, affect, energy level, interest in life, and somatic condition. In the most extreme pathological grief, in which individuals are not recovering, their ability to carry out activities of daily living is greatly reduced and may sometimes require psychiatric hospitalization. Individuals experiencing similar events such as death of a close family member may respond in a myriad of ways.

Both grief and spiritual distress deal with loss. The major difference is that spiritual distress disrupts the meaning that governs a person's life. There may be a perceived or real deterioration or collapse in his or her relationship with a divine Supreme Being, or with persons who represent the Supreme Being. According to O'Brien, there can be a deep sense of hurt stemming from feelings of loss or separation from God, a sense of personal inadequacy or failure before God and profound loneliness of spirit (2003).

The presence of stressors does not necessarily predict or cause spiritual distress. The Chinese character for crisis, which is a combination of the symbols for danger and opportunity, helps one to understand this. For some individuals, a stressor or crisis, such as a life-threatening illness or tragedy, can ultimately become the source of a tremendously positive experience. Although they readily acknowledge that they would have never chosen such events, they ultimately view them not as traumatic events but as opportunities for growth. In some ways, it parallels a wilderness experience. The arduous physical demands allow an individual to transcend his or her immediate surroundings and experience a sense of empowerment that results in the person being better equipped to handle the challenges of life.

Nurses may feel uncomfortable or experience conflict when providing spiritual support if the patient is religious and the nurse is not or if the patient's expression of spirituality differs from that of the nurse. In addition, nurses may experience conflict with a patient's belief system, as with a Jehovah's Witness patient who refuses a life-saving blood transfusion. These are normal responses to the unknown. How one responds to a patient's spiritual needs depends both on one's education and background. It is important, however, not to evaluate the patient's value system by personal standards. According to Stephenson, Drauker, and Martsolf (2003), some individuals find it easier to describe their spiritual life in terms of relationships and connections and disconnections. Relationships, which were used to describe life stories of persons in hospice, applied equally to others as well as God.

The increased cultural and religious diversity of our society has led to much more diversity of religions in our health-care institutions. Nurses must be open and more sensitive to religious customs that may be foreign to them. Being present for Hindu prayers, respecting the practices of an Islamic patient, and observing death rituals for an Orthodox Jewish patient are all examples of this. Nurses may need to seek out information on appropriate behaviors for religious groups that are foreign to the nurse.

Patients' responses to illness have been found to influence nurses' own spiritual beliefs. In a 1994 study by Taylor, Amenta, and Highfield, oncology nurses ranked their patients as a major source of spiritual nurturing. Nurses, however, may have difficulty providing spiritual care because of lack of skill, time constraints, or fear of being criticized by coworkers. For nurses uncomfortable with religious language and concepts, it may be helpful to approach spiritual distress from a cultural framework. In 1999, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) added a standard on determining spiritual support services for patients on their admission to healthcare institutions. JCAHO current standards (2007) continue to emphasize spiritual care with particular emphasis on spiritual care for dying patients. Hospice care requires incorporation of a spiritual assessment and offering of chaplaincy services as part of the Medicare Hospice Benefit. Nurses who work or have worked in this type of setting have more exposure to working closely with chaplaincy and may be more comfortable with addressing spiritual distress. There are many ways that nurses can assist in spiritual caregiving as part of routine nursing care (Box 18–1).

BOX 18–1
Nursing Activities to Promote Spiritual Caregiving

- Promote spiritual readings
- Advocate for finding a spiritual leader of patient's faith
- Active listening
- Instilling hope
- Clarifying values
- Touch
- Encouraging meditation and prayer
- Supporting religious rituals
- Promoting being with nature
- Advocate for institution to provide spiritual reading material, religious objects (prayer books, Sabbath candles, incense).

Source: Based on information from Taylor, E. J. (2006). Spirituality and spiritual nurture in cancer care. In R. M. Carroll-Johnson, L. M. Gorman, & N. J. Bush (Eds.), *Psychosocial nursing care along the cancer continuum* (2nd ed.) (pp. 117–131). Pittsburgh, PA: Oncology Nursing Press.

ETIOLOGY

Spiritual distress occurs when particular stressors or life events threaten the individual's belief system and affect biological, psychological, sociocultural, and spiritual aspects of life. These stressors may be unique to the individual, or they may be similar to reactions experienced by others after certain shared events such as September 11, 2001. The crisis may have a variety of causes, including loss of a significant person, employment, position, or status; financial reversal; major illness or loss of a body part, or a change in self-image. In some cultures, it may also result from shame. However, what is lost is not as important as the value that the individual ascribes to it.

Cognitive theory looks at the effect of beliefs on feelings, and psychodynamic theory helps one understand the underlying process of spiritual distress. For instance, a great deal of spiritual distress can be experienced, even to the point of affecting physical health, when a person believes that he or she can never be forgiven. A person's belief in the ability to be forgiven may be associated with his or her perception of how others show approval. The individual may accept forgiveness from God or a higher power in the same manner as forgiveness was accepted from parents because the relationship with God or a higher power is often similar to the relationship with one's parents.

Psychological theories look at the various dynamics that can result in spiritual distress. A person with a high degree of inner strength, or ego functioning, may experience less spiritual distress in response to a loss than one who has a lower level of ego functioning. The way in which one normally adapts to crises and changes will also influence the risk of spiritual distress. Persons who are inflexible may have more difficulty accepting major changes. Similarly, individuals who are prone to anxiety may feel overwhelmed in the face of major change and have difficulty dealing with it.

Crisis theory considers not only the normal changes in life and life event stressors but also looks at the impact of disaster or massive crisis on the individual. Faith or a belief system may help a person to cope with a crisis, but if the crisis is of a high magnitude, the person may feel that his or her belief system is challenged or inadequate and may be of little help.

One of the hallmarks of a disaster or massive crisis, such as a devastating hurricane, earthquake, or crash of an airplane, is the enormous sense of an individual's loss of control and extreme feelings of vulnerability. There may be a sense of betrayal, and the events may be expressed as not being "right." The individual may reveal a sense of how things "should" be, his or her expectation of the world. The sense of betrayal and anger may be expressed in spiritual terms such as "How could God let this happen?"

A sense of mastery over one's environment, highly prized in American culture, is threatened when a major crisis occurs. When an individual no longer feels safe in usual activities, a feeling of unease can spread to other areas of life.

RELATED CLINICAL CONCERNS

Although identifiable traumatic events may precipitate spiritual distress, it is important to be aware of physiological conditions that may exacerbate the situation. Illnesses associated with increased sense of vulnerability and the possibility of death (particularly cancer) may lead to heightened spiritual awareness. Similarly, a patient's moving from aggressive treatment to hospice care may be accompanied with a number of spiritual issues as one's mortality can no longer be denied. Pain, suffering, and severe side effects may affect spiritual life. Patients may also have a reduction in the energy they need for their usual means of spiritual coping, such as praying and attending religious services. Advanced, serious illness may stimulate a patient's wish to repair past relationships and seek forgiveness for past wrongdoings. Spiritual beliefs may support or promote these actions.

Although there is no clear relationship between specific disease entities and spiritual distress, a spiritual state can be influenced by biological changes, such as changes in neurotransmitters, endocrine levels, or blood chemistry. Just as there are differences in coping mechanisms, there are differences in the way in which the individual as an organism responds to illness. Even when an event appears to be a precipitant for spiritual distress, biological factors could also be at work. A complete physical assessment and supporting tests can help determine these biologic factors. Also there is interplay between the physical disorder and mental well-being. An individual who has not had mental illness or spiritual distress in the past, may be affected by both physiological changes that impact things such as moods and a general sense of well-being, as well as the emotional impact of dealing with change and loss.

Spirituality and cancer has probably been studied the most. A diagnosis of cancer can contribute to spiritual distress because the person questions the presence of a higher power, seeing the disease as a punishment for past wrongdoings. It can also strengthen faith, provide motivation for increased use of prayer and self-exploration (Taylor, 2006).

LIFE SPAN ISSUES

Children

Because the belief systems of young children are not as developed as those of adults, children may not be able to adequately verbalize their sense of spiritual distress. Instead, they may present with such physical symptoms as weight loss, failure to thrive, and reversal of developmental milestones. Most frequently their stress is in response to loss of a parent or caretaker or a major change affecting a parent or caretaker. The child can sense the distress of the parent. For example, a young child may not fully understand the impact of death, but he or she can sense, and be negatively affected by, the tremendous distress the loss of a child or spouse can cause his or her caretaker. The child often responds by being more clinging or dependent at times of crisis.

Signs of distress in older children may be subtle. Some children experiencing depression may act out in different ways. Behavioral problems may be exacerbated. It is important to pay attention to subtle changes in a child, such as a lack of interest in usual pursuits, withdrawal or isolation, or a decrease in school performance. One of the most traumatic events for children is loss of parents or siblings by death or divorce. Children may mistakenly believe that they personally caused the loss of the parent and may not comprehend other dynamics at work. Children's spiritual or religious beliefs are strongly influenced by those of their parents. More questioning of parental values tends to occur when the child becomes an adolescent.

Adolescents

Adolescents are generally more able to articulate distress, but they may be hesitant to confide in an adult. More aware of the complexities of life and often having a strong personal moral code, they may be traumatized by the failings of an idealized parent. Loss of parents, siblings, classmates, or acquaintances by death, divorce, or relocation can be tremendously stressful events for the adolescent. Youths whose sexual orientation differs from parental or societal expectation may either act out or experience their crisis in secret. Another traumatic event includes sexual exploitation by peers or adults. Even though sexual activity during teen years is rising, it may be exceedingly traumatic for the individual. Teens, especially girls, must deal with the dilemma of pregnancy and the changes it will make in their lives and those of their parents. Teens are also vulnerable to life's tragedies such as the death of a parent, or loss of a peer due to accident or suicide, which can lead to questioning of spiritual beliefs and loss of hope.

Because adolescents are so impressionable and idealistic, they are very vulnerable to the influence of cults and religious conversions. The beginning recognition that life is not as ideal and perfect as they once believed may cause individuals to lose hope and question their former spiritual beliefs. And if they unite with a particular belief system, because of their developmental stage, it would be anticipated that they may see things in absolute terms as "all or nothing" or "black and white". They may be as receptive to ideas that there may be a mixture of good and bad, or positive and negative attributes.

Middle Age

Promoting spirituality in the family and active participation in religious community with possible leadership roles may be important in this stage of life. Multiple responsibilities may affect a person's time and energy to achieve and meet all the expectations.

Older Adults

Later life is a period characterized by extremes. There is tremendous variety in functioning. For some, a significant change in physical or sensory functioning may affect their view of self and their spiritual beliefs. Many individuals experience the

death of a spouse and friends and changes in residence. Some may depend more on their spiritual life as their acquaintances diminish and limitations grow. Spiritual distress in older people often includes questions regarding the afterlife, values, and reflections on the satisfaction and accomplishments of their lives. Forgiveness related to past wrongdoings by themselves or others may become more important.

Religious teachings from childhood may become more important for some in later years as people face changes and losses. However, sometimes attending worship services and participating in religious practices may be more difficult to accomplish because of illness and fatigue or because of changes in mobility or logistics of transportation. It may be that with age they do not have the same level of independence and autonomy that they had during their younger years. The later years can be difficult for those who have not had any particular religious beliefs and have not been affiliated with any religious body.

POSSIBLE NURSES' REACTIONS

- May not feel comfortable or adequately prepared to help patients with spiritual concerns.
- May be influenced by their own background, beliefs, values, and experiences, which may differ from those of the patient.
- May react negatively or judgmentally, or distance themselves from patients whose beliefs, practices, lifestyles, or cultures differ from their own.
- May focus attention on religious content rather than assessing other issues that may be the cause of anxiety.
- May attempt to change or argue with religious content of patient's beliefs.
- May confuse religious with spiritual beliefs.
- May feel powerless when unable to help patients with spiritual concerns. Nurses may distance themselves from patients to cope with their own feelings of inadequacy.
- May not understand the meaning of the loss from the patient's spiritual perspective and may try to reassure the patient in ways that are not effective or meaningful.
- May resent clergy because of their closeness and ability to meet some patients' needs.
- Conversely, out of feelings of fear and inadequacy, may refer patients to the chaplain too quickly rather than attempt to deal with the concerns.
- May reassure patients based on their own knowledge of illnesses and fail to hear the patients' concerns.
- May feel judgmental about individuals expressing spiritual concerns or practices, especially if those concerns are unfamiliar to the nurse.
- May feel anxious when encountering unfamiliar practices.

- May feel so stressed, overworked, or overwhelmed by the physical needs of the patient or their own workload that they do not consider the spiritual dimension.
- May have trouble setting personal limits on the role of the nurse and spiritual beliefs.

ASSESSMENT

Spiritual assessment is required as part of the overall patient assessment by JCAHO. There are a number of models. One model for spiritual assessment is called the HOPE Assessment as discussed in Chapter 3. Spiritual assessment provides the basis for the spiritual plan of care and for communication about the care provided. The purpose of the assessment is to find out how a person finds meaning and purpose in life and identify the concomitant behaviors, emotions, relationships and practices. Fitchett (2002) points out that spiritual assessment is an ongoing process. As the nurse becomes better acquainted with the patient, there is the opportunity to develop a more comprehensive assessment and possibly revise a previous assessment. See Box 18–2 for suggestions on questions to ask in a spiritual assessment.

Behavior and Appearance

- Often has religious items or literature at bedside
- Frequently quotes from the Bible or other spiritual literature
- May display exaggerated religious rituals or behavior such as reading the Bible excessively rather than talking
- May appear withdrawn and preoccupied with own beliefs, unable to focus on conversations and events in immediate environment
- Makes constant reference to religious themes in conversation
- Asks frequent questions such as “Is this God’s will?” or “Why is God letting me suffer?”
- Lethargic; may exhibit a lack of interest in surroundings
- May be overtly or passively suicidal
- Frequently questions others about their spiritual beliefs
- States that spiritual beliefs are no longer comforting
- Behavior changes, such as increased alcohol use or acting out

Mood and Emotions

- Highly anxious
- Denies emotions or concerns

BOX 18–2
Assessing for Spiritual Beliefs

Initial Assessment

1. What is your source of strength and hope and meaning?
2. What is your religious affiliation, and how important is this in your life? Any recent changes?
3. Is there a clergy person available to you while in the hospital?
4. Are there any religious or spiritual practices that are important to you while in the hospital?
5. Are there any religious or spiritual articles that are important to you while in the hospital?
6. Is there any spiritual literature that is important to you while in the hospital? Is there any religious music which is particularly significant to you?

Advanced Assessment

1. Has being sick or in the hospital made any difference in your feelings toward God or in your beliefs?
2. What has bothered you the most about being sick or in the hospital?
3. What helps you the most when you are afraid or in need of special help?
4. What religious or spiritual idea or concept is most important to you?
5. What did your family believe? What was meaningful and important to them?
6. What exposure, if any, did you have to religious or spiritual beliefs as a child? Has that changed? How?
7. Have your religious interests arisen gradually or out of a crisis?
8. Do you have special religious leaders? How do you view them?
9. What would help you maintain your spirituality?
10. Does prayer provide comfort for you? If you pray, about what do you pray? When do you pray?
11. What happens when you pray or meditate?

- Expresses bitterness or anger over perceived abandonment by God or belief that God is causing the suffering
- Appears depressed
- Expresses feelings of helplessness or hopelessness
- Does not derive enjoyment and satisfaction from formerly pleasurable activities

Thoughts, Beliefs, and Perceptions

- Believes that nothing can help
- Exhibits global, all-or-nothing thinking

- Believes that life is overwhelming and that he or she cannot continue living
- Questions long-held beliefs and may doubt his or her faith
- Believes that he or she has committed sins that cannot be forgiven
- Believes they may be separated from God or a higher power
- Is self-absorbed in own belief system
- Views self as guilty and in need of punishment
- Views self as spiritually superior to others
- Believes that a higher power requires suffering and pain and therefore refuses pain control measures
- Views self as having a great mission to accomplish
- Claims to hear voices of God, Moses, or other religious figures
- Holds omnipotent view of self—a specialness that rests in the inability to be forgiven by God or higher power

Relationships and Interactions

- Feels isolated and alone even in the presence of others
- May be so preoccupied that they are unable to interact with others
- Withdraws from others who do not share similar beliefs
- May experience change in relationship with family or friends who are involved with religious beliefs
- May seek out members of similar religious group for support, caregiving

Physical Responses

- Reports increased discomforts
- Change in eating or sleeping patterns
- May have increase of somatic symptoms and medication-seeking behaviors

Pertinent History

- Involved in specific religious groups, cults, or a variety of different religious groups
- History of emotional disorders or emotionally charged previous situations, such as abortion or catastrophic events

COLLABORATIVE MANAGEMENT

Chaplaincy/Clergy

Some health-care agencies have full-time chaplains on staff. Others may have volunteer chaplains or links to clergy in the community. Chaplains provide spiritual counseling and are often knowledgeable about community support resources that may be useful for the patient. Working with the social workers, they can help in making funeral arrangements or locating needed services or volunteers.

Chaplains can help both patients and staff members to find ways to cope with the problem situation. However, not all patients hold clergy in high regard. Some can talk about spiritual concerns more effectively to a nurse. Others may view clergy negatively or with suspicion or fear that they are associated only with bad news, depending on previous life experiences. Also, depending on the situation, the patient may prefer to share concerns with a chaplain other than the one associated with the place where he or she worships.

Clergy are restricted as to what information they can share with nursing staff and others. Like mental health professionals and lawyers, clergy are bound by professional ethics and law regarding what they may reveal of anything told to them in confidence.

Pharmacological

Psychoactive substances can influence mood and consequently the way in which the individual perceives the situation and how well he or she functions in responding to it. This can contribute to spiritual distress. Nurses need to be aware of the many prescription drugs that have such effects, such as beta-blockers, steroids, antihypertensives, immunosuppressants, and chemotherapy. Patient's spiritual or religious beliefs may also influence their acceptance of some medications such as analgesics and psychotropics. Individuals may believe that these medications could block their access to their higher power.

NURSING MANAGEMENT

SPIRITUAL DISTRESS evidenced by questioning beliefs, despair, hopelessness, or inability to practice beliefs related to suffering, illness, or hospitalization.

Patient Outcomes

- Verbalizes "I feel better," "I feel relieved," "I feel at peace," or similar statements
- Demonstrates increased social interaction
- Reports feeling rested and comfortable
- Demonstrates reduced crying or other signs of distress

Interventions

- Empathize with patient's degree of pain or despair.
- Recognize that your own personal values and beliefs may not be effective for others. Be willing to set aside your own beliefs when analyzing the patient's spiritual needs.
- Become familiar with the patient's beliefs and practices.
- Use self-disclosure of own spiritual beliefs *only* to foster patient's therapeutic goals.

- Use questions to determine the role that religion and spirituality play in the patient's life. For example, "The chart says you are Catholic. What religious practices are important to you during your illness?"
- Seek assistance of or referrals to hospital chaplain or other resources when you feel uncomfortable or unable to meet the patient's spiritual needs. Recognize the role that members of the patient's church or temple can play in providing support.
- Involve chaplains in team meetings and patient care conferences to collaborate on treatment plan.
- Promote use of prayer and scripture when appropriate if within patient's belief system (Box 18–3).
- Become familiar with agency policy regarding praying with patients.
- Provide supportive, private environment to meet spiritual needs.
- Be honest with the patient. If you are not comfortable praying, it is appropriate to disclose this, but offer to be present while the patient says a prayer.
- Substitute supportive response for prayer when the setting or timing is inappropriate.

BOX 18–3
Guidelines for Use of Prayer and Religious Literature

1. Prayer combined with therapeutic use of self can be used to meet the patient's spiritual needs and show empathy. A therapeutic relationship must already be established with the patient before engaging in prayer, a more intimate form of communication.
2. Prayer can consist of simply sharing a few brief sentences to express an immediate need or can be taken from a formally written source.
3. The request for prayer and religious literature should be initiated by the patient. If you are not comfortable, discuss with colleagues other alternatives.
4. Ask the patient to define the specific needs for which he or she is requesting prayer.
5. Ask what passages the patient wants to read and how they are significant.
6. Validate expressed feelings such as pain, fear, anxiety, stress, helplessness, or anger at God.
7. Know that prayer can be an affirmation of God's presence and hope for the patient.
8. If reading from religious literature, select passages carefully. Consult with chaplain or other staff if in doubt. Some passages may be misinterpreted, be interpreted literally, or be beyond the level of this patient.

- Work with patient and staff to adapt patient's schedule or activities to incorporate religious rituals whenever possible.
- Allow patient to ventilate thoughts and feelings. Explore what precipitated the feeling of loss. Help patient clarify any underlying feelings of guilt. Help the patient explore and evaluate whether the source is rational or distorted.
- Help patient explore previously held false assumptions and, as indicated, refer to spiritual passages affirming hope, if within the nurse's comfort and knowledge.
- Allow family to participate in religious rituals such as ritual body care after death or baptism of a critically ill child.
- Be open to patient's expression of spiritual concerns. Avoid dismissing practices as inappropriate or pathologic.
- If the patient shares fears, remember that acceptance and listening are more important than having the answers.

SPIRITUAL DISTRESS evidenced by religious delusions or obsessions related to impaired thought process.

Patient Outcomes

- Demonstrates improved reality orientation
- Verbalizes concerns and conflicts
- Verbalizes improved sense of peace and well-being
- Demonstrates appropriate social interactions

Interventions

- Become familiar with the norms of the patient's particular religious group to assess the patient's deviation from standard practice.
- Be aware that delusions may represent areas of personal conflict or concerns. For example, the Messiah complex may reveal that patient has a need to feel special, and dwelling on past sins may show that patient feels badly about self. Focus on feelings the patient is having rather than on content of delusion.
- Use great caution in reinforcing religious beliefs with psychotic patients because this may perpetuate reality distortions. Seek assistance from available mental health resources as well as chaplain or clergy.
- Set limits on time spent talking about obsessions and performing ritualistic behavior with the patient. Make a contract regarding time when you will listen. Be consistent.
- Encourage patient to discuss concerns other than religious issues. Bring patient back to recent specific experiences or events.
- Avoid arguing with the patient about the validity of his or her beliefs. Rather, acknowledge the feelings these beliefs may evoke, such as fear or sadness.

- Recognize that reducing obsessional thoughts or compulsive behavior may result in increased anxiety or possibly even a panic reaction (see Chapter 7, Problems with Anxiety, for interventions). Discuss with the physician the need for evaluation by a mental health professional and appropriate medication.

HOPELESSNESS evidenced by depression, apathy, withdrawal, rejection of spiritual beliefs related to loss, impending death, incurable disease, lack of meaning; spiritual crisis.

Patient Outcomes

- Verbalizes phrases like "I hadn't thought of it that way" or "I feel better"
- Demonstrates increased social interactions
- Able to identify one or more future goals

Interventions

- Encourage patient to share feelings and concerns and talk about what has triggered the sense of hopelessness.
- Maintain a concerned yet positive attitude around patient, but avoid an overly cheerful approach that may inhibit communication.
- Focus on short-term, concrete goals; identify specific things the patient can do now. For instance, focus on the pleasure of visiting with granddaughter today rather than the hope to be playing tennis next year. Make a plan with patient for achievable goals, such as sitting up in chair for 5 minutes longer today than yesterday. Often a patient may feel less hopeless and depressed if progress in one area can be achieved.
- Recognize that pain, fatigue, and other stressors will affect ability to maintain hope. Use interventions to deal with these stressors.
- Seek out chaplain to discuss patient's beliefs to help challenge hopelessness and support a more hopeful view.
- Recognize that, with time to work through a loss or crisis, the patient may be able to focus on the future. Allow the patient time to work through the grieving process.
- Be aware of your own anxiety around patient. Patient could sense your tension and think that his or her issues are unacceptable.

ALTERNATE NURSING DIAGNOSES

Anxiety
Grieving, Dysfunctional
Spiritual Well-Being, Readiness for Enhanced
Thought Processes, Disturbed

WHEN TO CALL FOR HELP

- Patient is suicidal or homicidal.
- Religious practices interfere severely with healthcare regimen.
- Patient becomes psychotic.

WHO TO CALL FOR HELP

- Chaplain
- Patient's personal spiritual leader
- Family members
- Social Worker
- Psychiatric Team

PATIENT AND FAMILY EDUCATION

- Educate patient and family on ways to incorporate religious practices into the treatment plan for the specific illness. For instance, the patient can adapt dietary restrictions and fasting requirements around specific beliefs.
- Educate the family on the importance of patient's spiritual beliefs if the family is not supportive of them.
- Encourage family to not impose their beliefs on the patient if they are different.
- Encourage family to bring in Bibles or religious articles, as appropriate.

CHARTING TIPS

- Document patient's beliefs, especially as they relate to patient's illness.
- Document conflicts between patient and family.
- Document patient's response to visit with clergy.
- Document nursing interventions and patient responses to spiritual interventions such as prayer, scripture reading, or meditation.
- For patient's at the end of life, document any prayers or rituals done in preparation for death, e.g., Sacrament of the Sick.

COMMUNITY-BASED CARE

- Refer to clergy or agency chaplain, as appropriate.
- Encourage attendance at religious or health-related support groups, such as Reach for Recovery.
- Encourage participation in patient's own house of worship as indicated.
- Use members of patient's religious community to assist with home care when appropriate.