A NATIONAL EPIDEMIC

WE ALL KNOW . . .

. . . that U.S. Copyright Law grants to the copyright owner the exclusive right to duplicate copyrighted, printed and recorded materials. Piracy involves the illegal duplication of copyrighted materials.

YOU MAY NOT KNOW . . .

. . . that every time you use or make an illegal copy of any printed material in any form or by any method you may be liable for further litigation.
. . . that your institution's duplication or processing equipment may also be confiscated and destroyed if involved in illegal duplication.
. . . that the penalty for criminal violation is up to five years in prison and/or a $250,000 fine under a tough new law. (Title 17, U.S. Code, Section 506, and Title 18, U.S. Code Section 2319).
. . . that civil or criminal litigation may be costly and embarrassing to any organization or individual. We request you contact us immediately regarding illegal duplication of these copyrighted, printed materials. The National Center of Continuing Education will pay a substantial reward for information leading to the conviction of any individual or institution making any unauthorized duplication of material copyrighted by J.L. Keefer or The National Center of Continuing Education.
# TABLE OF CONTENTS

About The Author .............................................................................................................3
Instructional Objectives .....................................................................................................3
Purpose and Goals ..............................................................................................................3
Introduction .......................................................................................................................3
The Relationship Between Faith and Health .................................................................3
   Sin ..................................................................................................................................4
   Repentance and Forgiveness ......................................................................................4
The Stages Of Faith Development .................................................................................4
   Stage 0 .......................................................................................................................5
   Stage 1 .......................................................................................................................5
   Stage 2 .......................................................................................................................5
   Stage 3 .......................................................................................................................5
   Stage 4 .......................................................................................................................5
   Stage 5 .......................................................................................................................5
   Stage 6 .......................................................................................................................7
Barriers To Spiritual Development .................................................................................7
   Unhealthy Family Systems .......................................................................................7
   Abuse .......................................................................................................................8
   Addictions ...............................................................................................................8
   Unprocessed Pain and Grief .....................................................................................8
   Fear, Anxiety, and Stress .........................................................................................8
Nursing Assessment .........................................................................................................9
   Multicultural Nursing and Diversity .......................................................................9
   Assessing the Spiritual Dimension ........................................................................11
   Assessing Barriers to Spiritual Development ......................................................11
Nursing Intervention .......................................................................................................11
Patient Education ...........................................................................................................14
   Boundary Setting Skills .........................................................................................14
   Addiction ................................................................................................................16
   Unprocessed Pain and Grief ....................................................................................16
   Stress Management ................................................................................................16
   Fear ........................................................................................................................16
References And Suggested Reading ..............................................................................17

Extraordinary efforts have been made by the authors, the editor and the publisher of the National Center of Continuing Education, Inc. courses to ensure dosage recommendations and treatments are precise and agree with the highest standards of practice. However, as a result of accumulating clinical experience and continuing laboratory studies, dosage schedules and/or treatment recommendations are often altered or discontinued. In all cases the advice of a physician should be sought and followed concerning initiating or discontinuing all medications or treatments. The planner(s), author(s) and/or editor(s) of each course have attested to no conflict of interest nor bias on the subject. The National Center of Continuing Education, Inc. does not accept commercial support on any course nor do they endorse any products that may be mentioned in the course. Any off-label use for medications mentioned in a course is identified as such.

No part of this publication may be reproduced stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior written permission of the publisher.
About The Author

Marilyn Hanser, MA, RN graduated from Baylor University School of Nursing in 1976. Upon graduation she joined the US Navy and was stationed at the Naval Regional Medical Center in Oakland, California, where she achieved the rank of LTJG before she was honorably discharged in 1978. For many years she managed her own health education and consulting business specializing in women’s health issues. She was certified in lay counseling by the American Association of Christian Counselors.

Instructional Objectives

At the end of this course the learner will be able to:

1. Name two characteristics unique to each stage of spiritual development
2. Explain the relationship between faith and health
3. List and describe the five barriers to spiritual development
4. List the major cultural issues in multicultural nursing
5. Describe assessment of spiritual dimension
6. Name ten nursing diagnoses related to the spiritual dimension
7. Outline the important aspects of the nursing referral process.
8. Name the specific issues in patient education related to the spiritual dimension

Purpose and Goals

The goal of this course is to educate the healthcare professional on interventions related to the Christian spiritual dimension. This course will also differentiate between psychopathology and spiritual needs, focusing on cultural issues and stages unique to spiritual development.

Introduction

The nursing process recognizes five dimensions to human existence: the physical, emotional, intellectual, social, and spiritual dimensions. Part of assessment of each patient is to specifically analyze each of the dimensions in that patient’s life, make nursing diagnoses based on that assessment, and intervene therapeutically in the situation. The physical dimension is usually assessed by getting a family health history, gathering data from written records, evaluating test results, and gathering information about normal daily routines such as diet, exercise, and substance abuse. It also includes physical examinations, signs, and symptoms. In assessing the emotional dimension, the nurse notes whether the patient’s affect matches the presenting circumstances, what emotional response patterns exist, and how the patient copes with these emotions. The intellectual dimension includes the patient’s perceptions, memory, cognition, communication patterns, and whether one is primarily flexible or rigid in one’s approach to life. To assess the social dimension the nurse observes the client’s self-concept, interpersonal relationships, socialization patterns, pertinent cultural factors, level of independence, and ability to trust others.

The focus of this course, the spiritual dimension, is often overlooked. Some experts suggest this is partly due the nursing field’s strong emphasis on being nonjudgmental. Nurses may steer clear of spiritual issues to avoid conflicts with clients over values and beliefs. Others think nurses avoid this topic because they don’t understand the difference between psychopathology and spiritual needs. Therefore it is important to differentiate between the two. Spirituality, in general, refers to the search for meaning in life and the development of one’s values and belief system. For the Christian, life is given meaning by the one true God who sent His Son to earth to show people how to live and to pay for sins through His excruciating death on the cross. When believers confess this belief and repent their sins, God, who is faithful and just, forgives their sins. As a result Christians live with a sense of joy because they know they are united with their savior for eternity.

Christianity is unique among religions. No other religion worships the God who loved humanity so much that He came to live among them, to understand their pain, to intercede for them, and to die in their place. They don’t have to work for their salvation as most religions teach. They don’t have to find God because He already found them. When Christians truly understand this concept they are set free.

Nurses face deeply spiritual situations in their work. They work with the dying, those living with chronic pain, and those who have suffered physical, emotional, and spiritual abuse. They see people who are frightened as they await the possibility of a life-ending or life-altering diagnosis. They deal with family members who are scared for their loved ones and for themselves as they face life’s changes. Nurses who work in emergency rooms see grizzly things resulting from accidents, suicide attempts, and murder. Since September 11, 2001 Americans have been forced to accept the reality of terrorism and, since nurses are among the first to encounter the victims of terrorist attacks, they play a big role in helping victims and their families learn to cope with their circumstances. If they don’t learn to cope with their situation, they often find themselves living in a state of constant fear and/or chronic anxiety. This takes its toll on the body and the spirit as well.

Christians have a different worldview that helps them understand these traumas. They believe in a loving God who cares about suffering and wants to help us through it. This course is designed to help Christian nurses share their faith in an appropriate, respectful, and life-affirming way so the people they encounter each day have the opportunity to experience God’s love in the way Christians do and, as a result, find their suffering eased.

The Relationship Between Faith and Health

It is important for people to feel a sense of purpose that gives life meaning. People need to believe that their lives make sense. Failure to see purpose in life or to find meaning in life’s experiences contributes to spiritual, psychological and physical distress.

Nurses see people from all stages of life who have difficulty finding meaning in their lives. Middle-aged women say they don’t know who they are now that they can no longer procreate. Often these women don’t want another child, but the fact they no longer have the option signifies the onset of old age. This may trigger self-esteem issues associated with no longer possessing physical beauty as defined by today’s standards. The physical changes that take place in middle age make it clear that we don’t live forever. As a result, many middle-aged men also deal with aging issues.

Western culture, with its strong emphasis on youth and beauty, tends to view old age as a time of decline and loss of status. The alert nurse is in a position to help people with these spiritual issues by actively listening to their concerns, assessing their spiritual needs, and recommending appropriate interventions.

Other stresses on patients may include caring for small children, disciplining teenagers, caring for aging and/or dying parents, adjusting to children leaving home or returning home (often bringing grandchildren with them), insecure employment leading to financial stress, friends and family members who move away, divorce, a sick or dying spouse, and/or a diagnosis of a terminal illness. This is by no means a comprehensive list of stressors facing patients but when the nurse listens actively they will hear some of these concerns and will be alert for others that may surface as well. It is essential for those dealing with these issues to find meaning and purpose in their lives so they can cope effectively with the stressors and reduces the negative effects on their health.
Change of any kind can act as a stressor. For example, a woman who has spent many years caring for her terminally ill spouse may feel some relief when he dies. Keep in mind, however, she has not only lost her life companion but, if her life has revolved around taking care of him, she may also feel she has lost the primary reason for her own existence (See Figure 2). If she is to maintain good health she will need to find new meaning and purpose in life now that he is gone. She will need to find something else around which to organize her life.

This is often an easier task for Christians because they know their lives have meaning and worth simply because they are children of God. However, those who haven’t given faith much thought may struggle with finding meaning and purpose in their lives, especially after a life-altering event. This provides the Christian nurse with the opportunity to listen to patient needs and to gently witness to the healing power of Christ. (This will be covered in greater detail in the section on nursing intervention).

Spiritual, mental and physical health is also determined by the way individuals view God. Belief in a loving and forgiving God sets expectations of support and strength while belief in a vengeful God of wrath sets expectations of punishment. Those who believe primarily in a God of wrath may interpret life’s stresses as punishment from God. Often this leaves them feeling alienated from God and from other people. They may view themselves as unlovable, defective, and/or bad. They may be filled with anxiety, guilt and fear as they contemplate further punishment for their sins.

However, those who understand the Christian doctrine of repentance and forgiveness know their sins are forgiven, God loves and cares for them, and God will help them find meaning in their new circumstances.

Christians believe that God is the Creator of the universe and they are made in His image. However defined, the capacity for creativity and inspiration can add meaning to one’s life. Emotional and spiritual distress can divert the energy needed for creative endeavors into maintaining emotional security. The Christian nurse is in a position to recognize this and to intervene therapeutically to restore the distressed person’s sense of creativity.

**Sin**

Mark R. McMinn, a modern Christian psychologist, says most Christian theology divides sin into two types. The first is personal sin based on choices we make every day - adultery, murder, theft, gossip, and idolatry. A Christian life should be based on honesty, integrity, compassion, and generosity. When Christians fall short of these goals they are aware that they have sinned.

The second type is original sin, which McMinn says is “so much bigger than we think: more pervasive, more complex, more devastating and terrible than we allow ourselves to perceive. It stains our world in ways that cannot possibly be captured with our mental checklists of good and bad behaviors.” He further states that sin is part of a person’s character and has seeped down into the very essence of a person’s being, affecting all of our thoughts, feelings, actions, and relationships. As a result original sin has a huge impact on health.

McMinn illustrates the impact of sin on our health with an example of a client suffering from past sexual abuse. This person is keenly aware of the sinfulness and brokenness of the world (original sin). They also struggles with the sinful choices made to ease the pain of the abuse i.e. drug and alcohol abuse, eating disorders, sexual acting out (personal sin). This person lives daily with the consequences of the perpetrator’s sin as well as with the consequences of his/her own choices in dealing with it. Years of alcohol, drug, and food abuse wreak havoc on the body. Sexual acting out leads to STDs, unwanted pregnancies, abortions, and broken relationships. This scenario of original sin, personal sin, and the consequences of each is played out daily in many peoples lives.

McMinn stresses that sin is not “just unfortunate, but is unimaginably terrible.” It doesn’t just affect people occasionally but “infests” the world, and as a result infects people’s lives constantly in ways they often do not understand.

**Repentance and Forgiveness**

“Repentance” was a large part of the Apostle Paul’s message. The word means to “turn around” and go in a new direction. Repentance is defined by Paul as an intensely emotional and sinful choice to seek forgiveness. This does not mean one forgets that offender. This does not mean one forgets that offender. It is called wrong right by falsely justifying or denying a wrong or hurt occurred.

Nurses may help patients begin the process of repentance by changed their thinking and actions. Patients may also benefit from other methods of gaining repentance. For example, the nurse can help patients find a spiritual mentor to help them through the process. Nurses can also foster repentance in others when it is a reality in their own lives as well; they must act with humility rather than harshness. They must be constantly vigilant not to react with pride or a critical spirit. When nurses understand the nature of true repentance they are better able to help clients receive God’s forgiveness.

Forgiveness is at the center of Christianity. Once a person has accepted God’s forgiveness they are obligated to forgive others; but human forgiveness is different from Godly forgiveness. God knows the heart and humans don’t. Because humans are on an equal footing with each other people can’t be certain about an individual’s motives. Therefore humans must forgive.

Forgiveness between human beings is not to be confused with reconciliation or with letting someone off the hook. Forgiveness is not:
- denying a wrong or hurt occurred
- calling wrong right by falsely justifying or rationalizing the offender’s behavior
- saying it doesn’t matter
- choosing not to hold the offender accountable
- making excuses for the behavior

Instead, forgiveness is a conscious decision to let go of the hurt and pain caused by the offender. This does not mean one forgets that the event happened; it does not mean one never relives the hurt and pain. Human brains are wired to remember things that are considered dangerous so it is unfair to think a human brain should forget. Instead, humans are to let go of any revenge fantasies they might be harboring, any resentment or bitterness that causes them to strike out at the person who hurt us, and any coldness in their attitude which causes their hearts to be hardened against the other person.

When people forgive, they free up a great deal of energy that can be used in more productive ways. People are free to create, love, and enjoy the wonderful gift of life God has given us.

**The Stages Of Faith Development**

to include the spiritual dimension inherent in each stage.

Fowler suggests seven stages of faith (Figure 1), starting with that of the newborn and ending with that of the fully spiritually developed adult (a place very few ever reach). It is Fowler’s contention that movement from one stage to the next is usually precipitated by some form of crisis such as death, divorce, the onset of adolescence, menopause, serious illness, a traumatic experience, etc. Such situations cause people to ask questions about the meaning and purpose of their lives. The search for answers to these questions often precipitates a spiritual crisis, causing the individual to move from one stage of faith development to the next in order to effectively answer the questions and alleviate the distress inherent in the crisis situation. A discussion of Fowler’s seven stages of faith follows.

Stage 0

Stage 0 is described by Fowler as a “pre-stage” which runs from birth to about two years of age. The main psychological task of this period is the development of trust in the world as a basically good place where one’s needs will be met. The strength of trust, autonomy, hope, and courage developed in this stage underlie all that comes in later faith development. Experiences in this stage have a profound influence on the infant’s ability to trust his/her caretakers and may later affect his/her ability to trust God. For example, if an infant is physically abused by caretakers at this stage of development, the infant’s ability to trust in a world where one gets one’s needs met may be seriously compromised. Because Christians depict God as a loving parent worthy of our trust, anything that damages one’s ability to trust his/her caretakers may have equally devastating consequences on one’s ability to let go and completely trust God to meet one’s needs.

Stage 1

Transition to Stage 1 begins with the convergence of thought and language, opening up the use of symbols in speech and ritual play. This stage lasts from about two to six years of age and is characterized by ritual play and storytelling. The imaginative processes underlying fantasy are unstrained by logical thought processes. Awareness of self, death, sex, and of the strong cultural and familial taboos developed around these issues begins in this stage. New images of God are formed from the activities of ritual play, storytelling, and fantasy; often these images are symbolic and archetypal in nature. Bible stories, fairy tales, and dreams are full of these archetypal images. At this stage, if too much emphasis is placed on negative archetypal images such as the “devil” and the “torments of hell”, a narrow and rigid faith may develop.

Stage 2

Transition to Stage 2 begins when the child is ready to clarify for him/herself the distinction between what is real and what only seems to be real. This stage begins about age 6-8 and continues until the beginning of adolescence. The major task of this period is to develop the ability to separate reality from make-believe. Reciprocal fairness and an immanent justice based on reciprocity are overriding concepts. Children in this stage tend to be quite literal and to anthropomorphize (conception of a deity in human form) the characters in their cosmic narratives as a way of finding meaning and coherence in their experiences. A child abused at this stage will decide that he/she must have deserved it because God is fair and would not allow something unfair to happen. An abused child may get stuck at this stage and develop into an over-controlling, perfectionistic, and works-oriented adult.

Stage 3

Stage 3 usually begins just before adolescence and extends until one develops a stage 4 level of thinking anywhere from late adolescence to old age. The transition to Stage 3 occurs when the literalism of Stage 2 begins to break down and conflicts between authoritative narratives must be faced. Stage 3 is characterized by a religious hunger for a God who knows, accepts, and validates the self in a deep manner. God is seen as a divinely personal significant other in one’s life. Those in this stage are aware they have values, can articulate and defend those values, and usually feel quite passionate about them. They have not, however, questioned or evaluated the system to which they adhere because to do so would place them outside their religious group and thus they would risk losing the community which, at this stage of life, defines them. From a faith development perspective, the main danger of this stage is that the individuation process may stop. Interpersonal betrayals (such as molestation by a trusted father figure) can lead to despair and distrust; they may prevent the development of the individual’s personal relationship with God. Without this sense of a personal relationship with God, the individual cannot progress to Stage 4 development.

Stage 4

Factors contributing to Stage 4 transition include contradictions between valued authority sources, changes in policies and procedures once deemed sacred, and encounters with other faith traditions which cause one to question one’s own traditions. This stage often begins in late adolescence as one prepares to leave home and is usually not completed until middle age, although some rare individuals may complete stage 4 tasks in their mid twenties. Many adults will spend the rest of their lives at this stage. It is characterized by dichotomous thinking ("either this is true or that is true" rather than "it is possible that both of these apparently contradictory concepts are true at the same time" which characterizes stage 5). Stage 4 is also characterized by questioning and testing the values one has been taught e.g. symbols and rituals are often seen as empty and meaningless. Ideally the opinions of others are taken into consideration as the individual makes decisions and takes responsibility for those choices. Nevertheless, there must be a critical distancing from the previous value system in order for the individual to emerge with his/her own relationship with God.

This period of questioning can be hard on relationships but a nurse who is aware of what is happening may be able to help everyone involved keep a proper perspective and, thus, reduce the anxiety inherent in this process of individuation. Stage 4 faith development tasks ultimately must be done alone. However, support group settings may help those who are just entering this stage feel more connected. This can be particularly important if there is a history of child abuse occurring at one of the other stages of faith development where the important task of the development of trust has been undermined.

There is a danger for the individual who remains stuck in this stage. He/she may develop a tendency to overintellectualize faith at the expense of feelings and emotions.

Stage 5

Transition to Stage 5 faith development occurs when previously suppressed feelings and emotions begin to emerge. Rituals and symbols re-emerge as an important part of faith expression; they often have a deep emotional component that was missing in the earlier stages because those at Stage 5 have grasped the depth of the reality to which the symbols and rituals refer. Stage 5 faith development is unusual before middle age and reflects a detachment which enables one to let things be as they are rather than trying to control everything to fit one’s idea of how things should be. The emphasis is on the interrelation of God’s creation. Because those at this level have critically evaluated their own faith tradition, they now have confidence in its worth and are able to open themselves up to new ideas without fear. They enjoy ecumenical encounters while simultaneously remaining firmly rooted in their own tradition. There is an opening up to the
<table>
<thead>
<tr>
<th>Stage</th>
<th>Major Development Tasks</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Stages of Faith Development</td>
<td>Development of trust in the world</td>
</tr>
<tr>
<td>1</td>
<td>2-5 years</td>
<td>Language development, use of symbols</td>
</tr>
<tr>
<td>2</td>
<td>6-8 years</td>
<td>Development ability to separate reality from make-believe</td>
</tr>
<tr>
<td>3</td>
<td>early adolescence to stage 4 development</td>
<td>Development of a personal relationship with God</td>
</tr>
<tr>
<td>4</td>
<td>anywhere from late adolescence to middle age</td>
<td>Objectively question one’s own faith traditions leading to the development of individuated faith</td>
</tr>
<tr>
<td>5</td>
<td>Rarely before middle age</td>
<td>Come to terms with one’s unconscious and recognize way it drives behavior</td>
</tr>
<tr>
<td>6</td>
<td>Rarely achieved</td>
<td>Community is the whole world</td>
</tr>
</tbody>
</table>

Figure 1

- Experiences with caretakers profoundly influence relationship with God
- Ritual play and storytelling
- Awareness of self, death, and sex
- Awareness of cultural taboos
- Fairness and reciprocity are important concepts
- Tendency to anthropomorphize
- Hunger for a God who knows and accepts one in a deep manner
- Aware of own values and can articulate and defend them
- Passionate about values
- Dichotomous thinking
- Symbols and rituals seem meaningless
- Re-emergence of rituals and symbols as important
- Awareness of interrelationship of God’s creation
- Enjoyment of ecumenical encounters
- Comfortable with paradox
- Compassion and disregard for self-preservation
- Radically committed to justice, inclusiveness, and unconditional love

- Development of trust in the world
- Language development, use of symbols
- Development ability to separate reality from make-believe
- Development of a personal relationship with God
- Objectively question one’s own faith traditions leading to the development of individuated faith
- Come to terms with one’s unconscious and recognize way it drives behavior
- Community is the whole world
Stage 6

Stage 6 is a level that, according to Fowler, only a handful of people throughout history have achieved and most of those were martyrs. Transition to this stage occurs when the individual is no longer able to live with the division between the untransformed world and their transforming vision of what the world could be. At this stage the welfare of the entire world is the focus. It is marked by compassion and a disregard for self-preservation. Because it is also marked by a disregard for society’s institutions, those at this stage are often viewed as threatening to society as a whole. The simplicity of their beliefs and lifestyle is usually somewhat appealing to the rest of us. Their community is the whole world and they are radically committed to justice, inclusiveness, and unconditional love. Jesus was at Stage 6 faith development when he made the decision to go to the cross for the welfare of the world rather than avoid the pain, humiliation, and death that the cross represented.

It is important to keep in mind that friction often occurs between those at one stage of development and those in the stage immediately preceding or immediately succeeding that stage. For example, there is likely to be tension between those at Stage 4 and those at Stage 3 and Stage 5 development. A major aspect of Stage 4 is the rejection of symbols and rituals as meaningless and empty. Often those at this stage are quite vocal about their beliefs. For someone at Stage 3 (who has no concept yet of what it means to question the basics of one’s faith tradition) these beliefs can seem almost blasphemous. As a result powerful emotions may emerge on both sides as the Stage 4 individual insists on their right to their own beliefs and the Stage 3 individual worries about the salvation of the Stage 4 person who seems to be rejecting the faith.

Conflict between Stage 4 and Stage 5 is slightly different. By Stage 5 the individual has done the questioning of faith tradition concerning rituals and symbols and has found new meaning and purpose in those traditions. Rituals and symbols may again be an important aspect of worship and faith expression. But for those at Stage 4, the Stage 5 individual seems no different from one at Stage 3. Stage 4 often has contempt for those in both Stage 3 and Stage 5 which can result in considerable friction within families and faith communities. Usually the Stage 5 person has some understanding of where the Stage 4 person is coming from because they have already been there and worked through those issues. The ability of the Stage 5 person to understand is often a significant resource for the alert nurse to access when trying to ease tensions within a family.

Because of this inherent conflict between the stages of faith development, it is vital that Christian nurses explore their own faith development and the resulting emotional triggers so they are able to keep those triggers out of any potential counseling situation. In the above example, a Stage 4 nurse might have the tendency to side with the Stage 4 individual against a Stage 3 or Stage 5 family member. Obviously this would be counterproductive and would probably shut down communication around the subject. As a result family members in conflict would probably remain in conflict and the nurse would lose the opportunity to grow in his/her own faith development.

Barriers To Spiritual Development

Many things can impact a person’s life in such a way that spiritual growth is retarded or impeded. Often one remains at the stage of development one was in at the time of the impact. Sometimes one moves more slowly through the stages due to fear and lack of trust. Christians believe that spiritual growth occurs through the pain and suffering that life naturally brings us. Christian nurses need to help their patients face their pain in a way that promotes spiritual growth and healing. This section of the course will discuss some of the major barriers to spiritual growth.

Unhealthy Family Systems

Since many of the barriers to spiritual growth arise out of unhealthy family systems it seems appropriate to begin with a discussion of this topic. Because most unhealthy families have fuzzy or non-existent boundaries, a clear understanding of the concept of boundaries is essential in recognizing unhealthy family systems. According to Christian therapists Dr. Henry Cloud and Dr. John Townsend in their book Boundaries: When to Say Yes and When to Say No, clear boundaries are essential to a healthy and balanced life because they define who one is or is not. They also define areas of responsibility vs. the responsibilities of others. Boundaries impact all aspects of peoples lives. Physical boundaries determine who a person allows to touch them and under what conditions. Mental boundaries allow a person the freedom to think their own thoughts and have their own opinions. Emotional boundaries help deal with a person’s individual emotions and disengage from the harmful emotions of others (especially those who try to manipulate in one way or another). Spiritual boundaries keep one clear on who God is vs. who humans are so one can determine the difference between His will and ours.

The things that fall within one’s boundaries and for which one is responsible include the following:

- Feelings -- Feelings should neither be ignored nor given full reign. Because they come from the heart, feelings can help one ascertain the realities of personal relationships with other people. They tell a person when something is wrong (anger) and when things are going well (feeling close and loving). The key concept here is that an individual’s feelings are an individual’s responsibility. They must be owned and then used to solve the problem to which they point.

- Attitudes and beliefs -- These include the stance one takes toward others, God, the world, work, as well as what one accepts as true. When a person takes responsibility for their own attitudes and beliefs then one can begin to change the unhealthy attitudes instead of blaming others for them. Attitudes and beliefs are learned when one is young and eventually must be questioned if one is to truly take responsibility for them. Families with boundary problems often have distorted views about personal responsibility. They may think holding someone accountable is mean and, as a result, they tend to let people off the hook too easily. They also have a tendency to see others as responsible for their feelings and to blame others when things aren’t going their way. This leads to feelings of inappropriate guilt, especially when children are blamed for the problems of the adults in their lives. As these children grow up they see themselves as responsible for everything and everyone. Undoing the
damage caused by inappropriate guilt can be a lengthy process. Thoughts are to be taken captive to make them obedient to Christ (2 Cor 10:5). People are responsible for all of their thoughts (even the distorted ones) and for their growth in wisdom and the learning of God’s ways. Often this means one has to identify and challenge wrong thoughts placed in their head by other people, usually when they were too young to know better. This requires the humility to be constantly vigilant in determining where one’s own distorted thinking is damaging our relationships.

- Behavior and choices - People are responsible for what they choose to do as well as the consequences resulting from those choices. Many relationship problems stem from confusion on this issue. To be spiritually healthy one must recognize when a person is blaming others for their behaviors and choices and when others are trying to blame them for theirs.

- Values - People are responsible for the things they choose to value and love. They get into spiritual trouble when they choose to love the wrong things (power, wealth, status, fleshly pleasures) and when they value other people’s opinions more than God’s.

- Setting limits individually and with others - One must limit their exposure to people who treat them poorly or who engage in evil. It is not, however, a person’s job to try to change them so they meet personal standards - God will do that in His own perfect timing if it is within His will. A person must also set limits on their own destructive desires and behaviors. This is often difficult because they may not know their true desires. In order to recognize them one must spend time in solitude and in prayer to hear God’s discerning voice speaking. He knows our true desires because He put them there.

- Stewardship of money and other God-given gifts - A person must be willing to leave their comfort zone to obey God’s will for the use of the gifts He has given. God does not ask a person to be unafraid of new things but asks that we trust Him enough to do it anyway.

- Love - People are responsible for both receiving and giving love, despite past hurts and fears (2 Cor 6:11-13). One must learn to take in the love of others and of God just as one must learn to love others the way God loves them.

### Addictions

Addicted individuals all have one thing in common: when their spirit is troubled they turn to an earthly substance or behavior for comfort instead of turning to God. Anything which provides the individual with an escape from whatever is troubling their spirit has the potential to become addictive. Such substances and behaviors may include drugs, alcohol, food, sex, shopping, excessive TV watching, busyness (this addiction is actually an addiction to the adrenaline produced by the stress involved in being overly busy), and Hollywood’s image of the ideal. When one is addicted it becomes impossible to “be still and know that I am God.” Therefore the addict cannot pray or meditate. This has definite spiritual implications.

Some addictions are learned early in life (eating soothes hunger pain and is a pleasurable activity) while others develop later. All have negative life-altering consequences. For example, overeating usually leads to obesity with its associated health problems while excessive shopping may lead to financial bondage. Drug and alcohol abuse may lead to promiscuity, prostitution, and theft to financially support the addiction. Sexual addictions may lead to sexually transmitted diseases and/or the pain of broken relationships.

Addictions are difficult to treat and most professionals in the field recognize a spiritual dimension to the problem. The addictive substance or behavior, in many ways, starts off as a substitute for God and then becomes the bane of one’s existence. This exacerbates any existing trust issues the individual has in their relationship with God.

People are all bombarded daily with Hollywood’s images of ideal beauty. For most, these ideal images are impossible to achieve but that doesn’t keep most from trying. The increase in eating disorders and elective plastic surgery procedures such as “tummy tucks”, breast augmentation, penile implants, and face lifts are proof that many people are not satisfied with the way God created them and are attempting to improve on His “mistakes”.

Christians are not immune to these seductive temptations but, as Christians, recognize these addictions as substitutions for God and, therefore, as violations of the commandment “Thou shalt have no other gods before me.” It is not a Christians place, however, to judge but, instead, to recognize the deep pain behind all addictions. One can then begin the process of developing a trusting relationship with the addict. Once patients see that nurses are not judging them, it is easier to share faith and make appropriate referrals.

### Unprocessed Pain and Grief

Many addictions stem from an inability to process pain and grief, usually because childhood caretakers were uncomfortable with these feelings and shut down their expression. Because it wasn’t “safe” to have such feelings, the addict learned to shut them down with a substance or behavior that provided comfort. Over time that coping mechanism developed into an addiction.

The expression of pain and grief is a healthy response to any loss. Loss is the state in which a valued object, person, body part, or state of mind that was formerly present is no longer there to be seen, felt, heard, or experienced. The loss may be temporary or permanent, real or imagined, physical or symbolic. What matters is how the individual views and responds to the loss; this is usually dictated by past experiences with loss, the value placed on the loss, and the sociocultural environment in which the loss occurs. Losses may include such things as death, divorce, aging, change in social role, change in self-concept, or a change in world-view.

Loss, in a healthy individual, will trigger the grieving process. The person will go through the stages of denial, anger, bargaining, depression, and acceptance in a timely fashion. However, if one has grown up in a family in which the expression of grief was not allowed, one may not allow the natural grieving process to occur. One can then get stuck at any of the stages; the most common stages in which to remain stuck are denial, anger, and depression.

Most religions have ritualized ceremonies to help people deal with loss. For Christians these include funeral rites to cope with death, confirmation rites to affirm the loss of childhood and the moving into a new stage of life, and baptism to signify the death of the old person and the birth of a new person in Christ. When family systems refuse to allow an individual to fully participate in the grieving process associated with these rites, spiritual development may be stunted. Remember that the movement...
from one stage of spiritual development to the next is usually precipitated by a crisis involving a loss of some kind. If the crisis is not resolved in a healthy manner, further spiritual development may not occur. As a result, the individual remains in a toxic state of chronic denial, anger, or depression.

Some causes of grief are often not recognized by either families or by society as a whole. One such loss is the pain many women suffer as a result of abortion. In work as a Director of the Post-Abortion Support Team for a local pregnancy center, this unresolved grief occurs all the time. Women suffer quietly for decades with enormous impact on their lives because society will not let them grieve the loss of their babies. Officially, the baby is referred to as “products of conception” or “just a blob of tissue.” These dehumanizing terms make a post-abortive woman afraid to talk about her grief and loss. How can she be in so much pain over a “blob of tissue?” So she concludes that something is wrong with her for having these feelings. It is strongly urged that all Christian nurses (no matter what their stand is on the legalized abortion debate) recognize that some post-abortive women are in tremendous pain because they believe they have killed their own children. It doesn’t matter what a nurse thinks about it. All that matters is that the patient believes it and no one will not be able to talk her out of such a deeply held spiritual belief. She needs the nurse to accept that she believes it and no one will not be able to talk her out of her belief. The patient there. This is probably easier for the Christian nurse if the patient is a Christian—but remember all spiritual development, whether Christian or not, goes through Fowler’s six stages. Also keep in mind the spirituality of Christians will vary according to their sociocultural background.

All cultures classify people by age and sex and then place expectations on people based on those classifications. In some cultures advanced age is revered while in others it is a time of insecurity, alienation, and high stress. White middle-class America tends to stereotype the aged as unproductive and burdensome while black Americans often view aged women as a source of love, strength, and stability. Most Americans generally consider adolescence to be a time of high stress because there is no clear end to the adolescent period and prolonged education affects social role expectations. Various life-style, occupational, and religious choices are open to today’s adolescent as well. Making these choices can increase stress.

In the Amish culture, however, there are fewer of these stressors on adolescents. Education is finished after the eighth grade and most boys become farmers; most girls marry Amish farmers. In general, Amish adolescents don’t experience the same adolescent stresses as those raised in a city mainline church, even though both groups are Christians.

Stress affects all of us. There is no culture, race, age, gender, socio-economic or educational background that protects humans from stressors. The Holmes-Rahe Social Readjustment Rating Scale (Figure 2) offers a metric scale to specific stressors. Weighing each event, or Life Change Unit (LCU) allows a clinical perspective on the likelihood of an individual developing an illness. Many of the life events listed in the scale can be expected in one’s lifetime.

Many of those who experience tragedy and survived have to deal with the symptoms of post traumatic stress disorder (PTSD) as they relive the horror and try to make sense of their ordeal. Military families now face long deployments to dangerous areas of the world. Those left behind worry about the safety of loved ones overseas while simultaneously taking on the job of single parenting. Those deployed often suffer from long periods of boredom interspersed with moments of sheer terror. Others are affected in subtler ways but all have the task of finding new meaning in their lives given loss of their innocence and their awareness that tragedy could happen again. Many are acutely aware that the next time it could be someone close who is harmed.

How does a Christian respond to the intense faith issues created by traumasituations? First one must recognize that within every crisis there is an opportunity for spiritual growth. While fear, anxiety, and stress are barriers to spiritual development if they are not processed in a healthy manner, they may also be the impetus to move an individual from one stage of faith development to the next if they are handled in a healthy way. The suffering involved is given meaning as it draws one closer to God.

When one is chronically anxious and/or stressed, it is difficult to engage in the spiritual practices designed to calm a person. It is harder to pray, to be still, know that God is God, and to meditate.

Other types of trauma may also contribute to the development of PTSD. Chronic childhood sexual abuse, rape, witnessing a murder, and fearing for one’s life are just a few of the traumas leading to PTSD. The important thing to remember is how PTSD affects its victims. When one is suffering from the symptoms of PTSD, a sense of stillness and peace is almost impossible to find. The sudden triggering of flashbacks and the intense emotions of the experience itself make life a roller coaster ride for a while. If, however, one hangs in there and allows the emotions and flashbacks to run their course, a new sense of peace is found.

The increasing violence within health care facilities may take a toll on the coping mechanisms of even the strongest nurses. Patients and their families may become hostile during the process of caregiving. A recent survey by the ANA found that 17% of nurses had been physically assaulted within the year prior to the survey and that 57% had experienced threats or verbal abuse. This can make going to work a frightening prospect, resulting in chronic anxiety and stress for caregivers.

Nursing Assessment

Multicultural Nursing and Diversity

As the United States becomes increasingly diverse in its cultural backgrounds, it is important the American nurse develop an understanding of these cultures and their dominant religious beliefs as well as how those beliefs affect the individual patient’s spirituality. The nurse must assess where the individual patient is in their spiritual development and try to meet the patient there.
## Holmes-Rahe Social Readjustment Rating Scale

<table>
<thead>
<tr>
<th>Life Event</th>
<th>Mean Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Death of spouse</td>
<td>100</td>
</tr>
<tr>
<td>2. Divorce</td>
<td>73</td>
</tr>
<tr>
<td>3. Marital separation from mate</td>
<td>65</td>
</tr>
<tr>
<td>4. Detention in jail or other institution</td>
<td>63</td>
</tr>
<tr>
<td>5. Death of a close family member</td>
<td>63</td>
</tr>
<tr>
<td>6. Major personal injury or illness</td>
<td>53</td>
</tr>
<tr>
<td>7. Marriage</td>
<td>50</td>
</tr>
<tr>
<td>8. Being fired at work</td>
<td>47</td>
</tr>
<tr>
<td>9. Marital reconciliation with mate</td>
<td>45</td>
</tr>
<tr>
<td>10. Retirement from work</td>
<td>45</td>
</tr>
<tr>
<td>11. Major change in health or behavior of a family member</td>
<td>44</td>
</tr>
<tr>
<td>12. Pregnancy</td>
<td>40</td>
</tr>
<tr>
<td>13. Sexual difficulties</td>
<td>39</td>
</tr>
<tr>
<td>14. Gaining a new family member through birth, adoption, older child moving in</td>
<td>39</td>
</tr>
<tr>
<td>15. Major business readjustment (e.g., merger, reorganization, bankruptcy, etc.)</td>
<td>39</td>
</tr>
<tr>
<td>16. Major change in financial state (e.g., a lot worse or a lot better than usual)</td>
<td>38</td>
</tr>
<tr>
<td>17. Death of a close friend</td>
<td>37</td>
</tr>
<tr>
<td>18. Changing to a different line of work</td>
<td>36</td>
</tr>
<tr>
<td>19. Major change in the number of arguments with spouse (e.g., either a lot more or a lot less than usual regarding child-rearing, personal habits, etc.)</td>
<td>35</td>
</tr>
<tr>
<td>20. Taking out a mortgage or loan for a major purchase (e.g., home, business, etc.)</td>
<td>31</td>
</tr>
<tr>
<td>21. Foreclosure on a mortgage or a loan</td>
<td>30</td>
</tr>
<tr>
<td>22. Major change in responsibilities at work (e.g., promotion, demotion, lateral transfer)</td>
<td>29</td>
</tr>
<tr>
<td>23. Son or daughter leaving home (e.g., marriage, college, etc.)</td>
<td>29</td>
</tr>
<tr>
<td>24. Trouble with in-laws</td>
<td>29</td>
</tr>
<tr>
<td>25. Outstanding personal achievement</td>
<td>28</td>
</tr>
<tr>
<td>26. Spouse beginning or ceasing work outside the home</td>
<td>26</td>
</tr>
<tr>
<td>27. Beginning or ceasing formal schooling</td>
<td>26</td>
</tr>
<tr>
<td>28. Major change in living conditions (e.g., building a new home, remodeling, deterioration of home or neighborhood)</td>
<td>25</td>
</tr>
<tr>
<td>29. Revision of personal habits (dress, manners, associations, etc.)</td>
<td>24</td>
</tr>
<tr>
<td>30. Trouble with the boss</td>
<td>23</td>
</tr>
<tr>
<td>31. Major change in working hours or conditions</td>
<td>20</td>
</tr>
<tr>
<td>32. Change in residence</td>
<td>20</td>
</tr>
<tr>
<td>33. Changing to a new school</td>
<td>20</td>
</tr>
<tr>
<td>34. Major change in usual type and/or amount of recreation</td>
<td>19</td>
</tr>
<tr>
<td>35. Major change in church activities (e.g., a lot more or a lot less than usual)</td>
<td>19</td>
</tr>
<tr>
<td>36. Major change in social activities (e.g., clubs, dancing, movies, visiting, etc.)</td>
<td>18</td>
</tr>
<tr>
<td>37. Taking out a mortgage or loan for a lesser purchase (e.g., for a car, TV, freezer, etc.)</td>
<td>17</td>
</tr>
<tr>
<td>38. Major change in sleeping habits (a lot more or a lot less sleep, or change in part of day when asleep)</td>
<td>16</td>
</tr>
<tr>
<td>39. Major change in number of family get-togethers (e.g., a lot more or a lot less than usual)</td>
<td>15</td>
</tr>
<tr>
<td>40. Major change in eating habits (a lot more or a lot less food intake, or very different meal hours or surroundings)</td>
<td>15</td>
</tr>
<tr>
<td>41. Vacation</td>
<td>13</td>
</tr>
<tr>
<td>42. Christmas</td>
<td>12</td>
</tr>
<tr>
<td>43. Minor violations of law (e.g., traffic tickets, jaywalking, disturbing the peace, etc.)</td>
<td>11</td>
</tr>
<tr>
<td>Totals</td>
<td>1466</td>
</tr>
</tbody>
</table>

From:

---

**Figure 2**
emotions, values direct communication, and is open to psychotherapy as a resource for improving mental and spiritual health. Many of our ethnic cultures, on the other hand, value community and family over the individual, are oriented in the present, don’t value being “on time” for appointments, see psychotherapy as shameful, and are generally wary of the American health care system. The nurse who works with ethnic populations must be aware of these differences and must be willing to respect them. The nurse must also understand that these cultural values impact the individual patient’s spirituality and will become paramount in compliance with health care recommendations.

Assessing the Spiritual Dimension

When assessing the spiritual dimension of a particular patient the following questions may prove useful:

- What gives your life meaning? What is the source of your strength and hope?
- Describe your concept of God.
- How do you feel about health issues as related to your spiritual beliefs?
- How does your illness affect the way you see yourself?
- What methods have you used in the past to cope with difficulty?
- What religious practices are important to you?
- How does your current situation affect your thoughts and feelings about God and how you practice your faith?
- Do you need to forgive or seek forgiveness from anyone?
- Do you have any unfinished business? (if the person is facing death)

Mental Health nurses suggest a few measurement tools for assessing depression, anxiety, stress, somatization, and obsessive-compulsive disorder. These instruments include the Beck Depression Inventory, Profile of Mood States, Symptoms of Stress Inventory, and the Symptoms Distress Checklist. Check with a local mental health agency to learn how to acquire these assessment tools.

Assessing Barriers to Spiritual Development

Assessing family systems for signs of health and dysfunction is part of the nursing process. It is important to determine the following:

- Who makes up the family unit?
- Who is supportive of the patient?
- What is the nature and pattern of interactions within the family?
- How does the family handle conflict and boundary issues?
- What is the level of trust within the family?

"Teaching the proper expression of emotions is one of the best ways to help an addict heal."

- How is the balance between dependence and independence distributed?
- Are there important cultural factors to consider?
- Is there a history of physical, emotional, or sexual abuse?
- Are there family “secrets” or topics that are off-limits?
- How does the family deal with faith issues?
- What does the family believe about illness and death?

Sometimes abuse takes place outside of the family, therefore it is important to determine whether the patient has been abused at school or church, as a child or as an adult. To determine if a history of abuse exists, assess the following:

- Is the patient unusually naive for his/her age?
- Is he/she easily taken advantage of?
- Does the client seem overly self-protective and suspicious?
- Does the client make statements indicating an unwillingness to rely on others for help?
- Does he/she appear to have a strong need to be in control?
- Is the client clingy or whiny?

Assessing the patient’s level of unprocessed grief requires the following:

- Determine somatic distress by asking questions about sleeping patterns, eating patterns, normal activities of daily life. Is the patient experiencing GI disturbances, changes in weight, hyperventilation, insomnia? Is he/she unable to cry over the loss?
- Does he/she have a great deal of anxiety and concern about the unknown?
- Is there a history of difficulty in expressing difficult emotions? Patients who can’t express anger often have trouble working through the grieving process.
- Is the patient experiencing inappropriate guilt over the circumstances surrounding the loss?
- Are persistent symptoms of depression present?
- Has the loss been expressed through religious ritual such as a funeral? What role does religion and spirituality play in the patient’s worldview?

Anxiety responses are rated on a scale of one-to-four. Those at levels one and two are still able to focus and listen so they are teachable. Those at levels three and four, however, are so preoccupied they will not comprehend instructions. Therefore, it is important to assess the patient’s anxiety level before attempting any nursing intervention. The following symptoms are indicative of Stage One anxiety:

- normal muscle tone
- sharpened senses
- stable vital signs
- moderate rate of speech
- response is based in reality

Stage Two anxiety is indicated by:

- elevated muscle tension
- elevated vital signs
- increased perspiration
- gastrointestinal distress
- frequent sighing
- worry

Stage Three anxiety is indicated by:

- further increased perspiration
- rapid, shallow breathing
- chest palpitations
- muscle tension with tremors, pacing, wringing of hands
- increased rate and pitch of speech
- nausea, vomiting, headache
- a sense of feeling unreal, wooden, strange, and powerless

Stage Four is considered panic and is characterized by:

- increase in all physical symptoms
- immobilization or aimless pacing
- unclear communication
- feelings of dread, terror, fear of dying

Once the level of anxiety has been assessed the nurse can decide whether, when, and what type of intervention is necessary.

Nursing Intervention

There are five specific nursing interventions related to the spiritual dimension of life. These interventions help nurses aid patients in the process of dealing with difficult circumstances. These interventions are:

1. prayer
2. use of scripture
3. providing a centered presence
4. active listening
5. referral

Christian prayer is defined as a humble
request to the omniscient and omnipotent God to bring about what he knows is best in a particular situation (Mt 6:25-34). One should ask for specific outcomes but must always acknowledge that our requests are subject to the will of the Lord (Jn 5:14).

Although the exact physiological process by which prayer works has not been determined, prayer has been demonstrated to stimulate healing. Experts think prayer stimulates the relaxation response and enhances the immune system. Nurses in holistic practices (whether Christian or not) concede there is an element of mystery in the use of prayer for healing purposes. Christians attribute this mysterious component to the presence of God and the healing work of Christ in our lives and in the lives of our patients.

An article in the Journal of Christian Nursing stresses the important relationship between the healing of body, mind, and spirit. This is the essence of holistic medicine’s call to view the patient as a whole person. Therefore, the article concludes that nurses who believe in God’s power to heal must pray for their patients. Because most of Jesus’ ministry was a public one, the article further concludes that the Christian nurse must not only pray individually for his/her patients, but must publicly ask the body of Christ (the church) to pray as well. If one is asked by one’s patient to pray together, the Christian nurse is ethically bound to do so.

Christian nurses report that intervention with prayer helps clients cope with anxieties surrounding diagnoses in both themselves and in their loved ones. Prayer is seen as an important tool to deepen the nurse/patient bond (an important element in the healing process). One nurse reports she was told by a semi-comatose cancer patient that he felt an electrical current run through his body while she was praying with him and he knew God was there. Some Christian nurses suggest contacting churches and other religious bodies within the community - such organizations may serve as a support system for patients while they are in the hospital and also once they return home.

An article in the Journal of Christian Nursing provides four steps to follow to determine if a situation calls for you to pray with your patient. These steps are:

1. Ask questions to determine what the particular concerns are. Keep focused on the present by asking open-ended questions such as “What is bothering you the most right now?” Give feedback that whatever he/she is feeling is normal.
2. Ask what usually helps the most when he/she is feeling this way. If the patient doesn’t know then ask whether family, friends, or God have helped before. Try to ascertain whether he/she believes in God.
3. Ask God if it is appropriate to offer prayer in this situation and then ask the patient for permission to pray (the author says she has never been turned down when she has made this offer). Remember this kind of prayer should be affirming rather than confrontational and the issue of salvation should not be addressed. The purpose of this kind of prayer is to reaffirm God’s love, to introduce the patient to God’s love, or to ask for strength in coping with one’s particular situation.
4. Be willing to pray without fear of what to say. Simply tell God what the patient has said about the hurts, fears, and concerns he/she is feeling. The author also suggests introducing the use of scripture into the process by quoting passages that assure one of God’s power and authority over all situations as well as those passages which describe God’s love and mercy. This nurse sees her role as one of bringing Jesus to the patient in the roles of healer, comforter, friend, burden-bearer, and savior. This is especially important if the patient has expressed strong emotions such as fear, anger, extreme anxiety, or overwhelming sadness. These emotions may indicate a person in spiritual distress.

Shared prayer can be one of the most intimate and deepest forms of communication. Anything that has the result of bringing someone closer to God is going to create a bond between those involved in the process. Praying with the patient rather than for the patient has the potential to change both the nurse and the patient. Consequently the nurse’s faith and sense of connection is also deepened by the experience. In this way, the process of shared prayer creates meaning for everyone involved.

The authors stress the importance of active listening in the conversation after shared prayer as well as in the conversation leading up to prayer. The interaction should never end with the prayer itself. Instead, the patient should be encouraged to express feelings and concerns and the nurse should listen actively and respond accordingly.

To ascertain the kind of praying most meaningful for a particular patient, it is helpful to know something about his/her religious background. For example, Roman Catholics often use a rosary to pray. The authors suggest a Catholic nurse who will pray with a rosary may be able to provide the best prayers in this situation. Some people prefer formal prayers while others are more comfortable with spontaneous praying. Different populations and ethnic groups may have their own preferences. When in doubt ask the patient what he/she prefers.

Occasionally a nurse will be asked to pray for something that he/she considers inappropriate e.g. an amputee who asks to have his leg grow back or a menopausal woman who asks to turn back the clock so she can be young again. In these situations prayer would be reduced to a form of magic and God would be nothing more than a big genie in the sky. In such cases, according to the authors, nurses should not pray for what the patient asks because such prayer would only serve to reinforce an inaccurate picture of God as well as to encourage unrealistic expectations. Instead they suggest drawing a picture of God as the Heavenly Father to whom we bring our problems. Encourage the patient to express any feelings about the situation and then pray specifically about those feelings. Stress that God is in ultimate control of the situation. When praying for healing, both the nurse and the patient should remember that, to God, spiritual healing is more important than physical healing. Pray cautiously for physical healing because it is not within God’s plan for all patients. Spiritual healing, however, is part of God’s plan for everyone.

### Nursing Diagnoses

The following are nursing diagnoses related to the spiritual dimension of human existence:
- anxiety
- body image disturbance
- caregiver role strain
- fear
- dysfunctional grieving
- anticipatory grieving
- hopelessness
- powerlessness
- personal identity/self esteem disturbance
- rape-trauma syndrome
- spiritual distress
### Stages of Anxiety

**Stage One Anxiety**
- normal muscle tone
- sharpened senses
- stable vital signs
- moderate rate of speech
- response is based in reality

**Stage Two Anxiety**
- elevated muscle tension
- elevated vital signs
- increased perspiration
- gastrointestinal distress
- frequent sighing
- worry

**Stage Three Anxiety**
- further increased perspiration
- rapid, shallow breathing
- chest palpitations
- muscle tension with tremors, pacing, wringing of hands
- increased rate and pitch of speech
- nausea, vomiting, headache
- a sense of feeling unreal, wooden, strange, and powerless

**Stage Four Anxiety**
- increase in all physical symptoms
- immobilization or aimless pacing
- unclear communication
- feelings of dread, terror, fear of dying

*Figure 3*
Larry Dossey, MD, in his book, *Prayer is Good Medicine*, warns about the danger of negative prayer. He cites examples from different faith traditions in which negative prayer actually caused harm to the recipient of the prayer. One powerful example is the story of a woman who began having regular headaches every morning at exactly 9am. After several days of this, the woman sought guidance from a wise friend who was also a psychiatrist. He suggested perhaps someone was praying negatively about her at that time of day and that she counter the negativity with a flood of love toward whoever was doing this. She did so and her headaches disappeared. The woman later learned that one of her relatives had recently joined a cult and had been praying negatively for her at the same time of day she experienced the headaches. Dossey stresses that although negative prayer can have harmful results on the person being prayed for, love can overcome the negativity, making the person impervious to the harmful effects of the negative prayers. Such knowledge helps people feel a healthy sense of power over those who would do them harm.

Studies of cultures and their relationship to spirituality and religious faith suggests that individuals from developed countries tend to adopt a rationalist attitude and are less comfortable with the idea of prayer and healing in connection to the sacred than indigenous people of other cultures who are more likely to be comfortable with the concept of prayer, demonstrate the use of prayer/meditation, a belief in God, and a general sense of connection to other people as well as to nature.

The trend in attitudes in developed countries, however, seems to be shifting. A CNN survey found that 73% of adults believe that praying for someone that is ill will help heal them, and 50% of patients would like for their doctors to pray with them. Because we are all individuals with various experiences and backgrounds the wise nurse will keep cultural issues in mind as he/she struggles with the question of how and when to pray with patients.

People in crisis often suffer an identity or self-esteem disturbance as they learn to cope with their new circumstances. Those adjusting to permanent physical injuries such as the loss of a limb or severe burns may have body-image disturbances as well. Experts state that those who use times of crisis for deep reflection and appreciation of their inner selves often fare better than those who continue to see things in a superficial way. Meditation, prayer, Christian counseling, and joining a support group may help in this process. People in crisis often take on new interests and develop new dreams during this period of reflection. Those who find meaning and value in their work, hobbies, and relationships with friends, family, and God seem to weather crises better than those with more superficial values. These people see their crises as a normal part of life and as opportunities to grow in faith. Once the crisis is over, they see the spiritual growth that has taken place and usually will say it was worth it.

The American Association of Christian Counselors publishes “The Soul Care Bible” to help believers more confidently know and use God’s Word in dealing with people in difficult circumstances. It provides practical tools, strategies, and direction to help people work through life’s challenges. For more information see www.nelsonbibles.com.

Active listening is the major tool used to develop a therapeutic relationship with our patients. The process is enhanced if a nurse can accept patients where they are, without judgment, while inviting them to cognitively reframe their situations. Nurses must be vigilant about professional boundaries such as confidentiality and must not take the patient’s problems on themselves or risk developing caregiver role strain which can lead to the development of PTSD in the nurse.

Often nurses will need to refer patients to someone else for further evaluation and intervention. Such referrals include pastors, mental health professionals (especially Christian-based therapists), support groups for specific diagnoses, 12-step programs, and physicians. Local newspapers often advertise self-help and support groups available in the area. Nurses should be aware of the resources within their practice community so they make timely and appropriate referrals.

**Patient Education**

While patient education is not an intervention specific to the spiritual dimension, it is a nursing intervention which often affects the spiritual dimension by providing new information to reduce stress, anxiety, and fear. The result is often a change in the way patients see their situations. Education may also provide a sense of control over problems so patients feel more powerful and hopeful about their circumstances.

**Boundary Setting Skills**

Nurses need to use the information in this course to teach boundary setting skills to patients. The first step is to help patients recognize the warning signals that alert them to boundary violations. Anger, frustration, and resentment are the major indicators that one’s boundaries are being violated. If someone can’t feel these emotions when he/she is violated, it is often a sign that they are afraid of the separateness that accompanies standing up for oneself. In this case, the nurse should refer the patient to a Christian therapist for help in learning to recognize these emotions, assessing what they mean, and having the courage to be honest with the violator about their feelings.

Boundary setting is often scary to the patient because it is an unfamiliar behavior and there are always relationship ramifications when one begins to set boundaries. Generally, the violator is not happy about the news and may get angry in return. All of the victim’s fears of abandonment will surface in the face of that anger and he/she may feel inappropriate guilt.
A Christian Model of Health Promotion

This model consists of four behaviorally oriented themes derived from scripture and then examined from the perspective of scientific theory and nursing research. These four themes include:

1. Recognize that you are valued by God. Scripture constantly reminds us of this love. (See Mt 10:29-31 and Lk 12:6-7 and Eph 3:18-19) God wants us to know that despite our flaws He loves and values each one of us - that is why He sent His son to the cross to die in our place. This knowledge is meant to raise our self-esteem so we are better able to cope with life’s challenges. Those with high self-esteem tend to be more self-confident, less anxious, and are more likely to engage in positive health practices.

2. Provide care and support to others. Scripture is full of passages telling us to love and support one another not just in speech but in action as well. We are to be compassionate, patient, and tender. (Lk 6:27 and Eph 4:2 and Eph 4:32). Social sciences refer to this as a “social support system.” Those with a good social support system tend to have higher self-esteem and take better care of themselves.

3. Try trusting God (Ps 37:8-9 and Prov 20:24 and Mt 6:25-34). Scientific research tells us that anxiety and worry are hard on one’s health. They may eventually lead to cardiovascular disease, infections, cancers, and autoimmune disorders. Scripture encourages us to take our worries and concerns to God in prayer and trust Him to meet our needs.

4. Maintain balance and moderation in your life. Scripture tells us there is a time to work and a time to rest (Eccl 3:1-2) and to set aside one day a week for rest (Mk 2:27). Research shows that maintaining balance in eating, sleeping, relaxation, and exercise promotes good health.
and be tempted to back down. It is important for the nurse to understand this reaction, warn the patient so he/she is not blindsided by the reaction, and be supportive as the process moves forward. If the patient hangs in there, the feelings of resentment, anger, frustration, and guilt will gradually disappear and he/she will find himself/herself attracted to people who have good boundaries and respect the boundaries of others.

Addiction

When learning to cope with addiction, patients often become narrowly focused on the problem itself instead of considering what it takes to lead an abundant and healthy life. Jesus said “Whoever drinks the water I give him will never thirst.” (John 4:14) The more help patients are given access to this living water promised by Jesus, the more they will lead fulfilled lives and the less prone they will be to addiction. Christian nurses must teach them the things that feed the soul i.e. the use of prayer and scripture to maintain a healthy relationship with God. Christians cannot fully know God this side of the grave but must experience Him through faith and by letting Him speak to us through nature, poetry, journaling, and other people.

The need for human companionship is wired into each person. Adam needed Eve as a companion even before the “fall.” Jesus needed his disciples to confide in and to share his ministry. Relationships with friends help us lead an abundant life. This need is not a negative reflection on a personal relationship with God but an affirmation that God designed people to need each other.

God also designed people to play. Addictions are a distorted form of play and can be overcome by learning to play as children do. Addicts need to learn how to have fun again. Help them connect with what they did for fun as children and see if new forms of fun are triggered by these memories.

Unprocessed Pain and Grief

Dysfunctional grieving leads to spiritual distress. Nurses should teach patients about the normal grieving process by naming and describing the stages of grief (denial, anger, bargaining, depression, and acceptance). If you suspect a patient is stuck somewhere in the grieving process you should gently help him/her express feelings by actively listening, giving reassurance that such feelings are normal, praying together, and referring for further treatment if necessary. Usually all a patient needs is to express the pain in a safe environment to someone willing to listen. If, however, you uncover childhood issues contributing to the dysfunctional grieving you should refer for further counseling.

Often there are feelings of guilt associated with unprocessed pain and grief. If your patient is feeling guilty you can encourage self-forgiveness by helping the patient to:
- take appropriate responsibility for what was or was not done
- confess the wrongs to God and ask for forgiveness
- make amends where possible (as long as it causes no harm to self or others)
- assess what has been learned from the experience so that it is not repeated

Stress Management

For optimal spiritual health people need to find a balance between being alert and energetic on the one hand and being relaxed and calm on the other. Encourage them to take time for themselves each day, to honor their physical, emotional, and spiritual needs, and to give themselves positive affirmations on a regular basis. Stress management techniques that work for most people include:
- Progressive Relaxation - This technique consists of deliberately over-tensing specific muscle groups because over-tensed muscles often relax to a deeper state of relaxation than they were in prior to the tensing. This tensing is done progressively throughout the body, starting at the feet and working up to the head.
- Hatha Yoga - This is a gentle form of yoga designed to induce relaxation and calm. The Christian practitioner of yoga must take great care that he/she not succumb to the temptations of yoga’s spiritual dogma. Practicing yoga as a Christian does not diminish the physical, mental, and spiritual relaxation that is received from the practice.
- Prayer/meditation (either alone or in a group)
- Visualization/Imagery techniques - These can be done individually or in a group setting with a trained facilitator. In either setting, the patient is encouraged to think about a relaxing event, real or imagined, in order to decrease the respiratory rate, heart rate, and blood pressure. Christians encourage other Christians to focus on God’s unconditional love as shown in Jesus’ enduring and gentle grace.
- Support groups (both self-help types and those facilitated by a professional)
- These groups encourage people to share their needs and desires with their loved ones. Christians recognize that God often speaks to us through the voices of those closest to us.
- Christian-Based Counseling - This helps uncover underlying emotional problems such as low self-esteem, depression, and the fear of aging to name just a few.
- Massage therapy - This treats the build up of tension in the body’s muscles. Because there is such a strong connection between the body, mind, and spirit, spiritual health may improve and psychosomatic ailments decrease through the use of massage therapy.
- Regular exercise and good nutrition. Christians are commanded to take care of our bodies because they believe they are temples of the Holy Spirit. Sometimes anti-depressant and/or anti-anxiety medications may be necessary to help patients deal with the stress in their lives. The best results are usually achieved by a combination of medication, cognitive therapy, and spiritual counseling. In many cases, the need for medication is temporary but for those with chemical imbalances in the brain, long-term medication use may be appropriate. In such cases, the nurse must be alert to any feelings of inferiority the patient might express concerning long-term use of meds e.g. “I think it is a sign of weakness if someone needs to take anti-depressants for the rest of their lives.” Those who feel this way are at risk for discontinuing their meds and perhaps endangering their health as a result. The nurse should explain the concept of chemical imbalances in the brain and help the patient understand that this needn’t be a stigma. People rarely express the belief that needing to take anti-hypertensives shows a character weakness. The use of psychiatric meds is no different and may even be considered a gift from God when used properly. Stress that these drugs often help individuals increase productivity and as a result those with the courage to buck the stigma can actually better serve their Lord.

Fear

Many of the above techniques will work to reduce fear as well but often a frightened patient needs accurate information on the subject in order to put the fear in perspective. Since the anthrax scare in the fall of 2001 many people are concerned about the possibility of bioterrorist attacks. Experts are focusing on four likely agents - anthrax, smallpox, plague, and botulism. All four are highly lethal, easily produced in large quantities, disseminated in aerosol form, odorless, and invisible. Early detection and treatment is important and, yet, many of these diseases mimic the flu making early detection and treatment difficult. Obviously there is real cause for concern so patient fears should not be minimized.

Encourage patients by letting them know that the medical and nursing communities are working hard to learn how to combat these new dangers. Emergency room and ambulance personnel are training for future attacks...
by learning to distinguish the early warning signs of exposure to biological agents from the symptoms of the flu (be suspicious of flu-like symptoms in patients who have been vaccinated against flu). The Mayo Clinic recently developed a test for anthrax. It eliminates the waiting period now needed for agent identification. The results make early detection and treatment more likely. Many states are coordinating emergency response systems so that efficient and effective response is possible in the event of an attack. The Red Cross is actively involved in this process. Systems to recognize a cluster of people with similar symptoms and methods for reporting such findings are being developed to encourage early detection. In the meantime anyone can call the CDC at (770) 488-7100 for Hospital Infections Program or Bioterrorism Emergency Response to report suspected bioterrorist attacks. Experts recommend calling your local police and health department officials as well. Encourage patients to do what they can to protect themselves. Even small things like stocking up on food and water can give a sense of control and eliminate the feelings of powerlessness and hopelessness so common to spiritual distress. Other recommendations to encourage patients include:

- help patients acknowledge and express their feelings
- encourage connections with other people
- encourage self-care by reducing stress, eating healthfully, exercising, and getting enough sleep
- stress the importance of living in the moment rather than worrying and obsessing about the future
- encourage trust in our faithful God where we can feel peaceful despite our circumstances
- refer to a physician for possible medication if symptoms persist
- refer to a licensed therapist if symptoms of PTSD persist
- allow children to fully express their fears (even if they seem exaggerated) and then try to put their fears in perspective with age-appropriate information
- give resources for more information i.e. the Red Cross may be reached at www.redcross.org. Websites applicable to bioterrorism include www.apic.org and www.bt.cdc.gov

For nurses it is imperative that they learn to practice and teach the concept of “boundaries” regarding the flood of information coming from the news media. They must realize that some of it is sensationalized for ratings purposes. Good boundaries help people evaluate for accuracy and assess the true level of threat. Then one reacts out of knowledge and logic instead of reacting to the media’s exaggeration. When one reacts calmly we set an example for patients and are better able to provide them with information that may reduce their fear as well.

Spirituality is just one aspect of the human condition but it plays a vital role in the overall health of an individual. Nurses are in a unique position to affect the spiritual growth and development of their patients because they have contact with them at times of life crises when such growth and development is most likely to occur. Christians understand that, because of sin, there are many barriers to spiritual development. These include such things as the boundary violations that occur in all forms of abuse, unhealthy family communication patterns, unprocessed pain and suffering, unprocessed grief and loss, stress, anxiety, fear, chronic anger, addictions, and traumatic experiences.

Christian nurses must be vigilant in assessing for these factors, make the proper nursing diagnoses, and intervene therapeutically to help our patients use the crises in their lives for their spiritual growth. There are specific nursing interventions that are used in this process. They include the use of scripture, praying with and for our patients, providing a centered and listening presence, and appropriate referral to other professionals such as licensed Christian therapists, physicians, and/or pastors. Nurses can also teach patients about their situations so they can put things in perspective and better understand their options. This helps provide a sense of control which alleviates the feelings of powerlessness and hopelessness so common to those in spiritual distress. If Christian nurses let go and let God work in the circumstances of their patients’ lives they will find their own spirituality growing and developing as well.

The more we grow the more we are able to help the patient who needs our support, love, and our unique understanding of the world. This unique understanding comes from knowing Jesus Christ as Lord and Savior. It is a gift and we are to share it with the world.

References And Suggested Reading
Aswad, JM, “A healing balm.” J Christ Nurs, Jan-Mar 2011, 28(1) p51
Delgado C. Nurses’ spiritual care practices: becoming less religious? J Christ Nurs, Apr-Jun 2015, 32(2) p116-22
Dyess SM. Exploration and Description of Faith-Based Health Resources: Findings Inform Advancing Holistic Health Care [In Process Citation] Holist Nurs Pract, Jul-Aug 2015, 29(4) p216-24
Edlund BJ. Revisiting spirituality in aging, J Gerontol Nurs, Jul 2014, 40(7) p4-5
Fountain ME, Fountain RP. Does attitude play a role in spiritual care? J Christ Nurs Jan-Mar 2015, 32(1) p55
Helming, MB, “Healing through prayer: a qualitative study.” Holist Nurs, Jan-Feb 2011, 25(1) p33-44
Hui, D, de la Cruz, M, Thorney, S, et al., “The frequency and correlates of spiritual distress among patients with advanced cancer admitted to an acute palliative care unit.” Am J Hosp Palliat Care, Jun 2011, 28(4) p264-70
Reimer-Kirkham S. Nursing research on religion and spirituality through a social justice lens. ANS Adv Nurs Sci, Jul-Sep 2014, 37(3) p249-57

© National Center of Continuing Education • www.nursece.com Healing the Spiritual Dimension


Shores, CI. “Spiritual perspectives of nursing students.” *Nurs Educ Perspect*, Jan-Feb 2010, 31(1) p8-11


We Want You To Learn!
Healing
The
Spiritual Dimension
A Christian Perspective