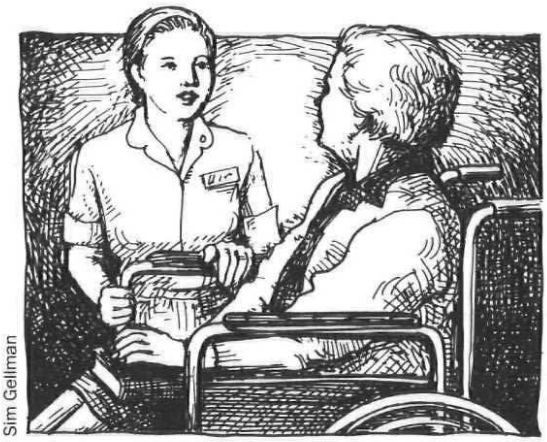
TRENDS & Ideas



Sim Gellman

NURSING

Caring for the Spirit

Nurses are responsible for many facets of patient care, not the least of which is spiritual care. Hospitalization can give rise to a spiritual crisis and search for meaning in which nurses can be a crucial support. However, a definition of the term "spiritual" is difficult to conceive, writes Janet Mayer in *Second Opinion*. Mayer also points out that nurses' training in spiritual care is often minimal and that changes in schools of nursing need to take place. "Spiritual care of patients is seen as fundamental to the nursing task," she observes. However, "understanding of what may be implied by such care is vague, ambiguous, or nonexistent."

Mayer says that if the term "spiritual" is defined too narrowly, "it becomes identical with the religious or the cultural and is thus exclusive or individualistic in its application." Defined too broadly, the term "seems to encompass everything and thus may be too amorphous and vague to be meaningful," she believes.

Many healthcare providers also have difficulty distinguishing between the terms "spiritual" and "religious," explains Mayer. "Religious needs and practices are . . . easier to identify and define than the more vague and elusive concepts associated with definitions of *spiritual*," writes Mayer. "Spiritual care should be seen to pervade care as a whole."

Even if some nurses are familiar with and feel comfortable providing spiritual care, many are unsure about how to put spiritual care into practice. Schools of nursing must take action to change this, asserts Mayer. She says that the concepts of spiritual care must "pervade all lectures and all nursing practice . . . as something of intrinsic value and importance that every nurse may feel confident to give."

For nurses to show such care for patients, Mayer recommends that nurse educators show the same such care for student nurses. Many student nurses are young and have difficulty empathizing with patients. She suggests that their training be based in primary healthcare environments rather than in hospitals. "It is well known that those medical schools that initiate their students by exposure to the community rather than the dissection table produce and attract a different sort of doctor whose approach is less mechanistic," notes Mayer.

Nurses should not be expected to shoulder all the responsibility for patients' spiritual care, however. "All hospital staff have a responsibility for the spiritual care of patients," she asserts. "Where possible, education of medical, paramedical, and nursing students should be coordinated to foster from the beginning mutual respect and awareness."

THE ELDERLY

Abuse Laws Treat Seniors Like Children

Many states' elder-abuse laws tend to hinder attempts to quell abuse because they copy laws intended to protect children. Physicians and social-service professionals in most states must report any sign of elder abuse to state authorities. This "strips the elderly of the confidentiality between doctor and patient–not to mention the ability to make their own decisions," reports Joseph P. Shapiro in a recent issue of *U.S. News & World Report*.

Shapiro says that 40 percent of elderly Americans live on their own. Most are financially secure and capable of taking care of themselves. Unlike children, the elderly are more often victims of financial exploitation rather than physical or sexual abuse, explains Cornell gerontologist Karl Pillemer. In some instances seniors' adult children and other relatives have taken money from them to support drug habits, says Douglas Kaplan, the Yolo County, CA, public guardian.

Child abuse often is related to the care giver's stress. Those who abuse the elderly, on the other hand, are often relatives or acquaintances who have histories of mental illness or alcoholism, according to Rosalie Wolf of the National Committee for the Prevention of Elder Abuse.

But are the laws aimed at protecting the elderly making them more vulnerable to abuse? In 1987 the Associated Press reported that almost anyone could become the guardian of a troubled senior. Because they had no standing in guardianship decisions in some states, many elderly lost the right to vote, drive a car, control their finances, and make other basic decisions. Shapiro notes that the American Bar Association has urged almost every state to "tighten control of guardianship decisions."

State investigators try to ensure that guardians do not abuse their wards. However, states are often unable to fund more than a few investigators. For example, in Pinellas County, FL, the probate court has 1 investigator to oversee 3,000 wards. The American Association for Retired Persons has responded to this need by recruiting volunteers to monitor elders in the care of guardians in Denver, Houston, and Atlanta, notes Shapiro. And Hoftsra University law professor John Regan suggests that states could protect the elderly far more efficiently by funding preventive programs rather than concentrating on investigating abuse reports.

PSYCHOLOGY

For Shame

The place once held by guilt as the perceived root of most of our neuroses is being usurped by a previously unacknowledged emotion: shame. Until recently psychologists had little training in recognizing and treating shame, Robert Karen writes in the *Atlantic Monthly*. But in the past few years the number of books and seminars on shame has increased, as shame theorists embark on what some observers have likened to a crusade.

"Shame is critical not just in treatment but in intergroup relations, ethnic relations, and international relations," says psychologist Gershen Kaufman, author of *The Psychology of Shame*. "If we are to survive on this planet, then we have to come to terms with shame."

Current research has linked shame with aggression, addictions, obsessions, narcissism, depression, and a host of other psychiatric syndromes. Psychologists believe that shame can arise from social changes and child-rearing practices that foster insecurity about one's self-worth, Karen reports. And normal shame becomes pathogenic as the person tries to avoid facing it.

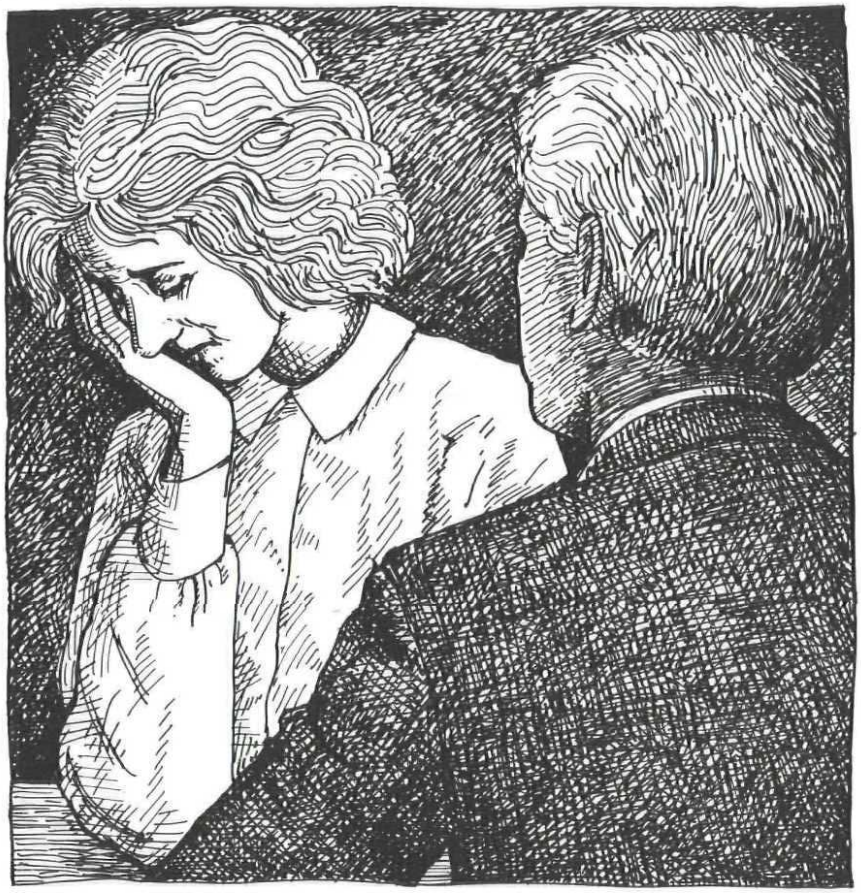
Shame is similar to guilt, but modern theorists are drawing careful distinctions between the two. "If guilt is about behavior that has harmed others, shame is about not being good enough," Karen writes. Shame is not so much about what one has done as about what one is—a pathological sense of defectiveness for which one cannot make amends.

This sort of shame—this wound in the self—can be instilled at a young age when the child lacks parental love that appreciates the child for what he or she is and respects the child's feelings and differences. Rebuking the child, turning away, revealing disgust at the child's actions or appearance, or not allowing the child to express an opposing opinion or preference can all lead the child to feel that he or she has no value or worth.

Shame theorists advocate an entire retooling of the psychiatric profession to account for shame. Broad treatment approaches in favor include developing a greater sensitivity to shame, carefully avoiding anything that might increase the patient's shame, helping the patient see the connection between shame and its effects, and creating a "safe haven where the patient is able to speak the terrible 'truths' he harbors about himself," Karen writes.

A difficulty in achieving this is that shame is a fundamental aspect of the patient-therapist relationship. "So long as you are an adult speaking to another adult to whom you are telling the most intimate things, there is an undercurrent of shame in every session," says psychologist Helen Lewis, a pioneer in shame theory. She claims that shame is generally activated and ignored in treatment and that, instead, analysts should train patients to identify their state of shame.

With the current popularity of both popular and professional books on shame, some therapists fear an overemphasis on shame as the root of all psychopathologies. For example, some see shame as at the heart of all eating disorders or aggressions, while others believe the causality can run the other way. "As people have been trying to give shame its due in recent years, there has been a tendency for the pendulum to swing too far," says psychologist Susan Miller, author of *The Shame Experience*. In time, Karen predicts, accumulating research and experience will "slow the pendulum and allow a more balanced assessment to take hold."



GENETICS

Deadly Inheritance

Some prospective parents may soon learn that their genes, which will not be harmful to their own children, could be deadly to their great-great-grandchildren. Scientists have found that myotonic dystrophy is caused by a gene that grows bigger and more destructive each time it is inherited, reports Gina Kolata in the *New York Times*.

Geneticists had previously dismissed neurologists' reports that myotonic dystrophy became more devastating with each generation, notes David Housman, MD, a Massachusetts Institute of Technology molecular geneticist. Geneticists claimed that neurologists were coming to this conclusion from a biased sample. But the neurologists were correct, concedes Housman. As the gene expands, the disease becomes more severe and the age of onset earlier.

Geneticists have recently found similar patterns with two other genes. The finding "opens up moral, social, and ethical problems that were totally unanticipated," explains Housman.

The discovery is also causing scientists to rethink the prevailing concept "that genes are handed down through generations essentially unchanged," reports Kolata. Scientists must also consider that other mutant genes might eventually cure themselves.