

mutual relationship and their lifestyle. They too experience the pain of turmoil and uncertainty. Nurses must also help the family. By allowing the family to ventilate their repulsion and fear and by showing acceptance of these feelings, the nurse can help the family be more useful to, and accepting of, the patient. Through intensive listening, the nurse provides a sounding board and then redirects the members of the family back to each other so that they can give and receive each other's support. Asserting the normality of untoward feelings also assists with future acceptance, while decreasing guilt and blame.

Resolution

Resolution is the stage of identity change. At first patients may *overidentify* themselves as invalids. They may discriminate against their bodies. Another method patients may use is to detach themselves emotionally from the source of trauma (e.g., a stoma, prosthesis, scar, or paralyzed limb) by naming it and referring to it in a simultaneously alienated and affectionate way. Patients are sensitive to the ways in which health care workers respond to their bodies. A patient may make negative remarks to test the acceptance of the nurse. Chiding or telling the patient that many others share the problem will be less helpful than acknowledging feelings and indicating acceptance by continuing to care for, and talk with, the patient.

As time passes and the patient adapts, the sting of the endured hurt abates, and the patient moves toward an identification as a person who has certain limitations due to illness rather than as a "cripple" or an "invalid." The patient no longer uses a defect as the basis of identity. As the resolution is reached, patients are able to depend on others, if necessary, and should not need to push beyond their endurance or to overcompensate for an inadequacy or limitation. Often, the patient reflects on the crisis as a time of growth or maturation. Such a patient achieves a sense of pride at accomplishing the difficult adaptation and is able to look back realistically on successes and disappointments without discomfort. At this time, the patient may find it useful and gratifying to help others by serving as a role model for people in the stage of restitution who are experiencing their own identity crises.

Unfortunately, the critical care nurse is rarely in a position to observe the successful outcome of resolution. However, it is useful to know the process in order to work with and communicate an attitude of hope, especially when the patient is most self-disparaging.

NURSING INTERVENTIONS

The goal of nursing care during the resolution stage is to help the patient attach a sense of self-esteem to a rectified identity. Nursing intervention centers on helping the patient find the degree of dependence that is needed and can be accepted. The nurse must accept and recognize with the patient that periods of vacillation between independence and dependence will occur. The nurse should encourage a positive emotional response to a new state of modified dependence. Certainly the nurse can support and reinforce the patient's growing sense of pride in rehabilitation. For nurses who have had the experience of successfully working through the process with one person,

the challenge is to stand back and allow the patient to move away from them.

case study ■ GRIEF AND LOSS

Mr. Saunders, age 53, was admitted to the ICU conscious but unresponsive to verbal questioning. According to the accident report, a large truck had swerved out of control on an icy road, killing Mr. Saunders' fiancée and injuring him. He had been hospitalized for observation and treatment of chest wounds and blood loss. Mr. Saunders' leg was amputated above the left knee as a result of an injury incurred in Vietnam 30 years ago.

While trying to reach Mr. Saunders' family, the nurse learned that his mother had died of cancer about 1 year ago and that 3 months later his father, suffering from depression, had killed himself. He had one sister who was flying in to see him.

The primary nursing problems were maintenance of ventilation and vital signs, pain control, and immobility. Mr. Saunders remained uncommunicative, although he was tearful. When he did talk, he expressed hopelessness and said he wanted to die. He asked, "Why me, God? What have I done to deserve this?" The Collaborative Care Guide in Box 2-4 focuses on addressing Mr. Saunders' psychosocial problems. ■

SPIRITUALITY AND HEALING

Caring in nursing includes recognition and support of the spiritual nature of human beings. Spirituality refers to the realm of invisible and intangible factors that influence our thoughts and behaviors. This recognition not only includes religious beliefs, but goes beyond them. When people sense power and influence outside of time and physical existence, they are said to be experiencing the metaphysical aspects of spirituality.

Spirituality includes one's system of beliefs and values.³²⁻³⁴ Intuition and knowledge from unknown sources and origins of unconditional love and belonging typically are viewed as spiritual power. A sense of universal connection, personal empowerment, and reverence for life also pertains to the existence of spirituality. These elements also may be viewed as benefits of spirituality. Spirituality includes the following:

- Religion
- Beliefs and values
- Intuition
- Knowledge from the unknown
- Unconditional love
- A sense of belonging
- A sense of connection with the universe
- Reverence for life
- Personal empowerment

Critical care patients and their families frequently pray for miraculous healing. Miracles of healing, when they are experienced by believers, can be viewed as normal healing