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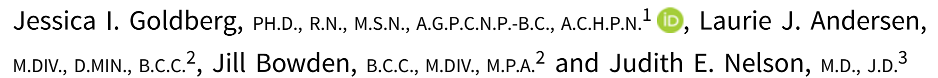
Recognizing spiritual injury in cancer: A case study



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Case Report

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Abstract

Background. Spiritual distress is a common symptom among patients with cancer. Spiritual injury (SI), a type of spiritual distress, occurs when there is a breakdown in the relationship between the individual and their higher power. Patients who experience spiritual injury may have poor health outcomes.
Methods. A case report of a woman with stage IV non-small cell lung cancer who had experienced a SI.
Results. The palliative care team, in collaboration with the palliative care chaplain, was able to recognize that the patient had experienced a SI. They were able to help the patient to process and reflect upon this experience and ultimately treat her suffering.
Significance of results. All palliative care providers should assess their patients' spiritual health and monitor for the existence of SI.

Background

Spirituality is one way that patients can achieve meaning and purpose in their lives and express their connection to others, including to a higher power (Puchalski et al., 2014). When patients undergo a difficult life event, such as a diagnosis of cancer, they may turn to their spiritual beliefs and practices to help process and cope with the experience (Schreiber and Brockopp, 2012). Spirituality is an important domain of palliative care and in order to provide comprehensive whole-person care, all practitioners should assess their patients' spiritual health and monitor for the presence of distress (Ferrell et al., 2018; Riba et al., 2019).

Spiritual distress occurs when there is a loss of meaning and peace in one's life because of one's beliefs (Schultz et al., 2017). Spiritual distress is commonly reported among patients with cancer (Astrow et al., 2018). However, one component of spiritual distress, termed spiritual injury (SI), has not been well described outside of the care of combat veterans. SI is triggered when there is a break in the connection between the individual and the higher power (Davies, 2020). Patients experiencing SI believe that they might have violated religious laws or God's requirements, leading to feelings of abandonment and alienation from the larger system that provided meaning (Berg, 2011). SI can be associated with feelings of anger, shame, guilt, sadness, despair, loss of purpose in life, a desire for punishment (even without the possibility of atonement), and fear of death (Berg, 2011; Carey and Hodgson, 2018).

Although spirituality is a key component of a comprehensive palliative care assessment and spiritual distress is typically addressed, many providers are unaware of the presence and the impact of SI. We describe a patient with cancer who experienced SI and review the therapeutic benefit of recognition and treatment of this important source of distress.

Case description

A 56-year-old woman with a diagnosis of stage IV non-small cell lung cancer was admitted to the hospital with poorly controlled chest wall pain. She underwent imaging and was found to have progression of disease in her chest and spine. The primary oncology team had difficulty managing the patient's pain; she continued to report severe pain but refused the use of opioids and was emotionally withdrawn. The patient's refusal of potentially effective pain medication was distressing to the team. As a result, a palliative care consultation was requested for assistance with complex symptom management.

As part of the palliative care assessment, the patient's values and spiritual practices were explored. The patient self-identified as a charismatic "Born Again" Christian. The charismatic movement emphasizes gifts conferred by the Holy Spirit, such as healing the sick and speaking in tongues (Dein and Cook, 2015). According to her faith tradition, she believed that God would perform a miracle to heal her because she was "newly baptized and has been faithful".

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The patient's world view saw God as all powerful and responsible for all events, both good and bad, as reward or punishment for one's actions.

In close collaboration with the palliative care chaplain, the palliative care team was able to identify that the patient had experienced a profound SI. She had led a good life, faithfully followed the traditions of her church, and could not reconcile this with her feelings of rejection from God, which was expressed by her cancer-related pain and progression of disease. The patient shared thoughts such as "what did I do to make God turn away from me" and "do I deserve this pain". The interdisciplinary palliative care team was able to form a therapeutic relationship with the patient and help her process her emotions and reflect on feelings of guilt and abandonment. The patient's SI influenced her experience of pain and when she was able to consider that her physical pain was not a punishment from God, she was amenable to opioid titration and the comprehensive treatment of her suffering.

Discussion

Spiritual distress is common among patients with cancer and has been described as an important unmet palliative care need in this population (Wang et al., 2018). The recognition and treatment of spiritual distress is important to the health of patients with cancer because it is associated with decreases in physical, emotional, and social well-being (Jim et al., 2015; Astrow et al., 2018). SI, a component of spiritual distress, is not as well understood and its prevalence in this population is unknown. In the veteran population, SI has been shown to be associated with increased incidence of depression, post-traumatic stress disorder, and alcohol abuse (Berg, 2011; Battles et al., 2019). It may be that a patient with cancer and SI is also at greater risk of poor health outcomes.

This case demonstrates the importance of recognizing SI in patients with cancer. Although many patients with cancer would like to discuss their spiritual needs and beliefs, healthcare providers often hesitate to have these conversations (Palmer Kelly et al., 2021). It is recognized that building trust, which is needed for deep sharing, takes skill and focus, and is often the responsibility of the chaplain (Jeuland et al., 2017). National consensus guidelines recognize the role of the chaplain as part of best practice for the interdisciplinary palliative care team (Ferrell et al., 2018; Riba et al., 2019). However, many hospitals still lack access to chaplains (Cadge et al., 2008). Regardless of the availability of a chaplain, all palliative care providers should evaluate their patient's spiritual health as part of a comprehensive assessment.

There are several tools available to guide non-chaplain clinicians in assessing the spiritual health of their patients (Borneman et al., 2010). In the event that the clinician, in consultation with the chaplain or independently, identifies the presence of a SI, the following are suggestions to guide therapeutic conversations (Chang et al., 2015; Carey and Hodgson, 2018).

1. Take time (if possible) to develop a relationship.
   Understand that patients may be reluctant to share their distress during your initial conversation. Not all patients will trust immediately but may develop trust over time.
2. Allow for patient reflection.
   Encourage the patient to share the relevant story when you have time to listen. It can be painful for a patient to be cut short after sharing deeply. Avoid the use of statements that may be received as judgmental or critical and, instead, create a safe space for the patient to share. It may be helpful to use statements such as, "Does this illness have a religious/spiritual meaning for you?", "Has your illness affected your relationship with God/your spirituality?" As patients may have difficulty creating a narrative, you can be helpful in finding connections as they tell their story. Acknowledge the patient's feelings and help them name their emotions.
3. Guide the patient through a review of the experience.
   Help the patient identify themes and search for meaning in experiences related to their personal religious and spiritual beliefs and values. For some patients, it may be beneficial to make connections to religious texts to put their personal experience in context. Most importantly, your role here is to help the patient process their experience of rejection.
4. Know that any provider may help the patient rebuild their belief system without necessarily being a part of that same system. Affirm the patient's fears, hopes, and needs. In some instances, a compassionate medical provider may come to embody an image of God or a higher power that is less judgmental and more forgiving.
5. Encourage the patient to create new rituals. Guide the patient toward other activities or experiences that provide a sense of meaning and purpose. It may be helpful to use statements such as, "What are some ways that you feel connected to something bigger than yourself?"
   Reinforce the process.
   Encourage the patient that this is a process. It may take time, repetition, and support from others on the care team and people in their lives.

Conclusion

A SI can be a profound event in the life of a patient with cancer. It can contribute to significant distress for both the patient and the provider. This component of spiritual healing can be addressed by all interdisciplinary palliative care providers, as much as possible, and reinforced within the team.

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