Spirituality: The neglected dimension of holistic mental health care

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Abstract
Although spirituality and religion are potentially divisive and controversial, we cannot avoid discussing them. Certainly in mental health these topics are viewed with mistrust. However, in recent times strong evidence has been presented to suggest that incorporating spiritual care in treatment plans helps recovery, reduces relapses, and improves quality of life. Mental health patients have consistently identified spiritual needs as an important issue to them and several studies have found that spiritual care positively contributes to symptom relief and general well-being. Therefore, as part of providing holistic care, mental health patients should be offered a spiritual assessment followed by attempts to include their spiritual needs incorporated in care planning. This paper explores spirituality as a neglected dimension in mental health treatment plans. It will also highlight the importance of spiritual assessment, and highlight the benefits of including spirituality in treatment plans as part of holistic care for mental health service users.

Keywords: spirituality, religion, holistic care, mental health

INTRODUCTION

World Health Organisation’s [WHO] (1946) definition of health states that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Swarbrick (2006) explains that although controversial, the definition of health incorporates the spiritual dimension, which in turn, ensures a holistic approach in delivering mental health care. Lippincott Williams and Wilkins (2008) explain that the goal of holistic care is to meet not just the patient’s physical needs but also their mental, social and emotional needs. They argue that holistic care addresses all dimensions of a mental health patient, including physical, emotional, social, and spiritual. Hilbers, Haynes, and Kivikko (2010) state that spirituality or religion is important for many contemporary Australians. For instance, nearly three-quarters of the population profess a religious affiliation, with rural areas and the elderly having a higher proportion. The terms spirituality and religion are often treated interchangeably.

Spirituality is described by Bellamy et al. (2007) as the central way of life which guides people’s conduct and is the essence of individual’s existence that integrates and transcends the physical, emotional, intellectual, volitional and social dimension. Religion on the other hand, is the organized outward expression of that connection and meaning; or simply the external expression of one’s faith (Yuen, Lum, Skibinski, & Pardeck, 2003). As Koenig (2009) puts it, spirituality is considered more personal, while religion is more organised often includes rituals and attendance within a social group. Unsurprisingly, spirituality within health care in general and nursing in particular has rightly attracted a degree of sceptical criticism in some quarters (Mohr et al., 2010). This article is an opinion piece resulting from my experience as a community mental health nurse in Tasmania, working with people experiencing mental health issues and their families. For the purpose of this discussion, mental health will be used interchangeably for both psychiatry and mental health.

Several authors including Koenig (2008), Sullivan (2009), Hodge (2004), and Russinova and Cash (2007) all agree that users of mental health services consistently identify spiritual and religious needs as an important issue in their lives. Spirituality and religiousness have been identified as key in the process of recovery from severe mental disorders such as schizophrenia, through providing meaning and hope in suffering. Similarly, Srilatha and Newhill (2011) argue that a wellness or recovery approach offers a holistic framework in which to view the person as a whole being (physical, spiritual, emotional, environment, social, occupational-leisure, intellectual,
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and environmental dimensions. Research by Mohr, Brandt, Borras, Gilliéron, and Huguelet (2006) and Fallot (2007) found that patients with psychosis viewed religion and spirituality as important and a source of strength. However, most mental health treatment plans seem not to reflect the spiritual dimension in aspects of care.

Nurses are expected to respect the basic human rights and cultural identity needs of patients and their families. The competency standards for the Nurse Practitioner (2006) require nurse practitioners to provide holistic nursing care through initiating therapeutic links with the patient and their community recognising and respecting cultural identity and lifestyle choices (Australian Nursing and Midwifery Council [ANMC], 2006). A cultural assessment yields the information you need to administer high-quality nursing care to members of various cultural populations. The goal of the cultural assessment is to gain awareness and understanding of cultural variations and their effects on the care provided incorporating cultural beliefs and religious practices into all mental health treatment plans and therapeutic interactions (ANMC, 2006; Srilatha & Newhill, 2011).

Mental health clinicians are expected to establish therapeutic links with the client and community that empower and respect lifestyle choices (ANMC, 2006). Interestingly, in the holistic framework of Aboriginal philosophy, it is difficult to separate many things; in particular, health is inextricably tied to wellbeing, and wellbeing for Aboriginal people is, by its very nature, spiritual (Armstrong, 2002; Grieves, 2009). Armstrong (2002) notes the importance of Aboriginal spirituality in dealing with Aboriginal people who have health, substance misuse or mental health issues requiring clinicians working in mental health to work in a holistic way that addresses the need for community development through the healing of mental health (Grieves, 2009). Bassett, Lloyd, and Tse (2008) explain that spiritual care can be a process by which people affected by mental health problems reclaim their lives and rebuild their self-esteem, trust and develop a new sense of meaning and purpose to life. Having a sense of identity and acceptance can significantly contribute to recovery from mental illness through compliance and adherence to treatment plans. These motivational qualities in turn help reduce relapse frequencies and improve social inclusion (Alliston, 2000; Jacobson & Greenley, 2001; Spaniol, 2001).

Research by Rasic, Robinson, Bolton, Bienvenu, and Sareen (2011), Wilding, May, and Muir-Cochrane (2005), and Tooth, Kalyanasundaram, Glover, and Momenzdah (2003) suggest that religious beliefs and spiritual care may reduce suicidality in mental health patients. In their study Rasic et al. (2011) found that religious worship attendance may be an independent protective factor against suicide attempts. Similarly, seeking spiritual comfort was a protective factor against suicidal ideation and spiritual beliefs were able to provide a healthy bond to life (Wilding et al., 2005). If spirituality can be so important that it can convince a person who is contemplating suicide to remain alive, then health professionals really ought to raise the topic of spirituality with their clients, or refer them on to others able to discuss this important area if they are uncomfortable discussing it. Koslander, Barbosa da Silva, and Roxberg (2009) point out that the biomedical model primarily focuses on the human body and human physiological needs and has tended to neglect human psychosocial, existential, and spiritual needs. For the field of biomedicine to take mental health needs seriously, its concept of sickness and mental health, in particular, will need to be supplemented with a humanistic and holistic concept of health and illness (Koslander et al., 2009). D’Souza and George (2006) recommend that clinicians should acknowledge the importance of spirituality and religious beliefs in the lives of their patients and carers.

Clinicians working in mental health (i.e., doctors, nurses, and allied health) should be trained to take a spiritual history as part of a psychiatric assessment. Crisp and Taylor (2009) suggest that to provide meaningful and supportive spiritual care, it is crucial for mental health clinicians to understand the concepts that are at the foundation of spiritual health. Offering users a spiritual assessment is the first step in including the spiritual dimension to treatment planning. Spiritual assessment is the process by which clinicians working in mental health

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can identify a patient's spiritual needs pertaining to mental and physical health (Anandarajah & Hight, 2001). In New Zealand, the Māori philosophy toward health is based on a holistic health and wellness model called ‘te whare tapa wha’ (Māori Health, 2011). The spiritual dimension is represented by ‘te taha wairua’ which refers to spiritual awareness and is recognised as the essential requirement for health and well-being. It is believed that without spiritual awareness an individual can be lacking in well-being and therefore more prone to ill health. Therefore, clinicians working with mental health clients are expected to include the Māori spiritual dimension as part of the treatment plan and offer clients a spiritual assessment (Māori Health, 2011).

Culliford (2007) recommends using some form of spiritual screening or assessment when facilitating appropriate spiritual support in community or inpatient psychiatric facility. Useful screening tools include the Royal Free Interview for Spiritual and Religious Beliefs (King, Speck, & Thomas, 2001); the Spiritual Involvement and Beliefs Scale (Hatch, Burg, Naberhaus, & Hellmich, 1998) or the HOPE questions (Anandarajah & Hight, 2001). The mnemonic HOPE directs the assessor’s attention to four areas of the patient’s life: sources of Hope, meaning, comfort, strength, peace, love and connection. D’Souza and George (2006) argue that knowledge of a patient’s spiritual history should come as naturally as asking patients about their interpersonal relationships, marital history, hobbies and interests. Crisp and Taylor (2009) further challenge nurses working with mental health patients to accept that spiritual caring is their role and responsibility. Dein, Cook, Powell, and Eagger (2010) state that a religiosity gap has been frequently pointed out in empirical studies that most psychiatrists are less religious than their patients and often neglect religious issues in clinical assessments. A holistic perspective understands people with mental health issues not merely as a physical or biological being but also as a person with intentions and ambitions and endorsing values, who lives in a social context and who strives to fulfil his or her life plans or vital goals. Unfortunately, more often in mental health inpatient or community units, a patient’s expressions of spiritual needs have frequently been interpreted as mental illness, such as a psychosis, further shutting away any further discussion about their spiritual needs (Greasley, Chui, & Gartland, 2001; Mental Health Foundation, 2002). Ashcroft, Anthony, and Mancuso (2010) suggest for health professionals to start by simply listening to what the client has to say about spiritual issues. Taking a spiritual history is all that is needed in understanding an individual’s ways of dealing with the distress or coping with their mental illness. Unfortunately, individuals with religious beliefs may be extremely reluctant to engage with psychiatric services that they perceive to be disparaging of their spirituality or religious practices (Dein et al., 2010).

Anandarajah and Hight (2001) point out that understanding one’s own spiritual beliefs, values and biases helps the clinician remain patient-centred and non-judgemental when dealing with the spiritual concerns of mental health patients. Andrews and Boyle (2003) discuss several reasons why nurses fail to provide spiritual care to culturally diverse clients is because they may view religion and spiritual needs as a private matter between the client and their Creator, they may deny the existence of spiritual needs or feel uncomfortable about one’s own religious beliefs, lack knowledge about the religious beliefs or spirituality of others, mistake spiritual needs for psychosocial needs or even believe that the spiritual needs of clients are the responsibility of a family or pastor. Spiritual care can be instrumental in affording patients dignity, which is manifested by showing love for patients and helping them attain inner peace and emotional well-being (Narayanasamy & Owen, 2001). Narayanasamy (2004) describes spirituality as the individual’s guiding principle, which gives meaning and purpose, a belief that relates a person to the world, a link to consciousness. Thus, the goal of spiritual nursing care is to promote the client’s physical, emotional, and spiritual health. The nurse who provides spiritual interventions recognizes that the balance of physical, psychosocial, and spiritual well-being is essential to overall good health. Spiritual care training may have significant benefits for the wellbeing of the nurses who undertake it, as well as the patients they care for (Mohr, 2006; Andrews & Boyle, 2003).
CONCLUSION
It is clear from this discussion that the holistic view of nursing is the focus and heart of nursing practice and the methodical introduction of the concept of spirituality into psychiatry as part of holistic care, may help to avoid some of the prejudice among clinicians working in mental health (Dein et al., 2010). There is increasing recognition that, irrespective of their personal position as regards spirituality, clinicians have a duty to those in their care to take this aspect of their lives seriously. In the context of psychiatry in general, this means no longer dismissing the spiritual content of psychotic communication as merely ‘illness’ (Clarke, 2010; Crisp & Taylor, 2009). However, there are several potential barriers to spiritual care including lack of time, personal, cultural or institutional factors, and educational needs among professionals. Nurses have the potential to influence attitudes and raise awareness of the relevance of this neglected human dimension of spirituality in mental health practice.

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