

Introduction to Spirituality, Religion and Mental Health: A brief evidence resource

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Launch of Acute Guidelines on Spirituality

One of the many interesting aspects of the evolving mental health agenda that Peter Gilbert* notices as he criss-crosses the country is that each and every conference/workshop on Spirituality is massively over-subscribed. NMIHE and the new University of Worcester put on an event in June entitled *Spirituality, Culture and Identity*, and expected a room for 100 participants would be plenty big enough - it wasn't!

Research into the attitudes of all professional groups comes up with the same finding: 'We think matters of spirituality and religion are very important, but how do we go about it?'

To assist with this The NIMHE/CSIP Acute Care Programme commissioned Staffordshire University+ to write guidance for staff in acute mental health settings (community as well as inpatient). This task was undertaken through consultation with relevant groups and the result has been well received, with staff saying the guidelines would be suitable for all mental health circumstances, not just acute.

The Guidelines consist of:

- Evidence base ---access on the website
- Booklet—web and paper copy
- Leaflet—web and paper copy
- Poster [to be used as an example for users, carers and staff to compile their own to meet local circumstances]

A number of regional conferences will commence from December (e.g. Sussex, 3rd December 2008) to launch the Guidelines.

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Spirituality, Religion and Mental Health: A brief evidence resource.

by

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Introduction

This document provides a brief evidence resource for staff engaged in meeting the spiritual and religious needs of people using mental health services. It has been developed from a literature review conducted for the Care Services Improvement Partnership as part of a wider resource project led by Prof. Peter Gilbert supported by Lesley Hayes and Rob Merchant at Staffordshire University.

Information regarding the literature review methodology and the evidence identified is contained in the appendix. The main section is intended to be a brief accessible resource presented for use in four identified areas for practice:

1. Risk Assessment
2. Admission
3. Therapeutic engagement and treatment
4. Discharge management

What is Spirituality?

The meaning of the word 'spirituality' in the context of the health environment has been explored in a number of different texts^{1,2,3}. Here, spirituality is treated as a gateway word enabling access to a range of different ideas and experiences for service users.

Spirituality is not the opposite of religion. Religious beliefs contain strong spiritual dimensions, philosophically and historically. However, spirituality can be used as a description of belief(s) that are not formed from a formal religion and are personal to the individual who holds them. Please refer to the *Facilitating Spirituality* leaflet and *The Guidelines on Spirituality for Staff in Acute Care Services*, which have been developed in conjunction with this brief evidence resource for further information.

The key to understanding a person's spirituality is the ability to:

- (a) listen to the person and engage in dialogue to enable understanding
- (b) be self aware of our own spiritual essence and values

Spiritual and religious care is grounded in the value of the person. It is the authors' view that the heart of spiritual care is person centred, values diversity of belief and practice, and seeks to promote well being.⁴

Risk Assessment

Initial assessment provides a key encounter point in which to place the value of the whole person at the centre of activity. Holistic care is defined as *care that recognises people with mental health problems as whole persons with interrelated psychological, social, physical and spiritual needs*⁵. Engaging in holistic care requires the promotion of the spiritual dimension of the health of human beings as well as the physical, mental and social facets⁶. Research among mental health service users has revealed how important spiritual care and counsel are in assessing and responding to the needs of service users^{7,8}. Spiritual care has been associated with the quality of interpersonal care in terms of the expressions of love and compassion towards patients/service users. However this may be undermined by a changing ethos in nursing, with an increasing focus on the mechanics of nursing rather than personalised care^{9,10,11}.

Caring professionals e.g. nurses often feel uncomfortable or unprepared to discuss spiritual issues^{12,13}. However an initial rapid assessment may simply take the form of the following questions: (1) 'Are you particularly religious or spiritual?' (2) 'What helps you most when things are difficult, when times are hard?'¹⁴ Developing appropriate training to support front line staff will enable them to support spiritual and/or religious needs^{15,16}. Support for training extends beyond acute inpatient care settings into community mental health service provision particularly when set against the backdrop of an increasingly diverse society^{17,18}.

The spiritual understanding of individual service users needs to be included in assessment arrangements, referral and information systems¹⁹. Integrating brief assessment forms at this point enables the person's spiritual or religious beliefs to be recognised in the proceeding response stages and safeguards against spiritual and religious areas of people's lives being ignored or misinterpreted²⁰. Effective assessment, which encompasses spiritual and religious beliefs, enables the recognition of a patient's human rights while in receipt of services and helps enable staff to engage in issues of consent that can inform the care of people with diverse religious backgrounds²¹.

The EMPIRIC study has highlighted the need for UK based research to understand the complexity of spirituality and religion in a UK context; one suggestion from EMPIRIC has been that people experiencing common mental disorders, who are not affiliated to a religious group, may become more 'spiritual' in a search for meaning or relief from symptoms²². Research by Maltby and Day (2002) found a relationship between religiosity and schizotypy traits which is consistent with theory that an intrinsic orientation towards religion is associated with lower levels of schizotypy, while religious experience and an extrinsic orientation towards religion is associated with higher levels of schizotypy²³. This highlights the need to develop assessment tools capable of responding to both spiritual and religious beliefs when assessing patient needs. Perceptions of schizophrenia have been explored across different ethnic communities; the results of a study on this subject

found that ethnicity was an important factor in influencing perceptions of schizophrenia, as were religion, education, gender and contact with people with mental health problems²⁴.

Recognising the specialist needs of ethnically diverse communities is important in the development of services. These specialist needs may include assessing asylum seekers with war zone experiences²⁵. However, experience of conflict is not restricted to asylum seekers alone; research amongst social work mental health practitioners in Northern Ireland has revealed the need to pay greater attention to the past and present effects of violence in a society with complex religious and national identities²⁶. People who have left violent societies, when entering the UK often experience poor housing, unemployment, racism and isolation which combine to impact their health status²⁷. A study of Ethiopian refugees found that while refugees were more likely to seek Western medicine than they did in Ethiopia, they maintained a strong emphasis on externalised factors influencing health e.g. happiness and good social relations²⁸. However the impact of violence upon people from different ethnic backgrounds extends to the UK. Research examining the September 11th terrorist attacks found that amongst British Muslims implicit or indirect discrimination rose by 82.6% and overt discrimination by 76.3%, with 35.6% of respondents likely to have suffered mental health problems as a result. The author of this research concluded that religious affiliation may be a more affective predictor of an experience of prejudice than race or ethnicity²⁹.

Assessment of cultural values, including religious beliefs, is important to provide relevant services to people from diverse communities and will help avoid stereotyping or mislabelling^{30,31,32}. Research into the experience of South Asian men found that these issues were rarely discussed or included in assessment procedures despite these beliefs influencing coping styles³³. Exploration of young refugee Somali women demonstrated the complexity of assessment and service response required to support young women who navigated conflicting and changing cultural and religious positions, while also seeking to conceal distress, which combined to frustrate the ability to access support services³⁴.

A study exploring the impact of post-natal depression amongst Bangladeshi mothers found that primary care services were not always their first point of contact, the mothers instead seeking the support of family, friends and religious leaders in the first instance³⁵, a finding that was repeated in research amongst first generation older Somali migrants³⁶. However, previous research amongst Asian communities found contradicting accounts, with no rejection of mainstream services and a reliance upon GP services for mental health care in the community³⁷.

Research exploring the perception of depression by older White British and Black African-Caribbean people found that most participants regardless of ethnicity (or a prior experience of depression) did not consider depression an illness; ethnicity not depression affected the interpretation of symptoms. In addition, more Black African-Caribbean participants identified the etiology of

depression as having a spiritual nature and therefore considered spiritual help an appropriate response³⁸.

Admission

Entry into the mental health environment requires staff teams who are prepared to receive patients, recognising and acknowledging their needs while also being aware of their own perceptions of the nature of a particular religious system or spiritual outlook.

A review of guidance documents regarding diversity in mental health care carried out by Owen and Khalil (2007) identifies that discriminated groups of people continue to be over represented within mental health services and that frequently their needs are not met³⁹. Recommendations from their review include promoting equality and diversity amongst the workforce, changing organisational cultures and practices to enable fresh initiatives and collaboration, and the development of education and training. The review also recommended the provision of quiet and/or worship spaces within the built environment to enable spiritual and religious expression.

Initial brief screening provides indication if further assessment of spiritual or religious need is necessary. A more detailed spiritual history can establish aspects of the patient's backgrounds, specific problems related to spirituality or religion, available spiritual supports and additional spiritual needs⁴⁰. Tools enabling a more detailed spiritual history include FICA (Faith, Importance, Community, Address), HOPE (sources of Hope, Organised religion, Personal spirituality and Practices, Effects on medical (psychiatric) care⁴¹. (See the *Guidelines* document, which accompanies this resource, for further information).

Front line staff are in a key position to help overcome the prejudices faced by people of different beliefs⁴² and can enable spiritual assessment as a routine part of a taking a patient's psychosocial history⁴³. However, detailed information needs to be made available within the patient's notes that not only includes religious affiliation but also beliefs and practices relevant to the individual⁴⁴. Understanding patients' etiological beliefs and use of language are possible pathways to improved care^{45,46} and could prove valuable in providing for the patients orientation within an acute setting. In 2001, Harriet Gaze observed '...the food is foreign, your religion is not understood and English is not your first language. You might not be able to make a complaint without an interpreter'⁴⁷. Without effective assessment and response in the admission process, which takes into account the religious (and spiritual) needs of patients, services risk failing to provide effective care.

Building a quality environment which supports the religious and spiritual needs of patients requires staff to be able to provide interpersonal care to patients. However the quality of interpersonal care has been questioned. It can be affected by ideas of professional distance from the patient, a desire by staff to protect their own mental health and a failure in training to prepare staff in understanding their own prejudices, beliefs, ability to communicate, and to demonstrate empathy⁴⁸. The Somerset Spirituality Project⁴⁹ has provided

evidence of both the importance of spirituality for some people with severe mental health problems but also the difficulty they experience in having this aspect of their lives taken seriously by professionals^{50,51}.

Some services use generic terms to describe a whole people group in a way that fails to understand individual needs and differences. A study conducted by Greenwood et al. (2000) revealed the term 'Asian' as problematic, as people practice a variety of religious and cultural beliefs which encompass food, washing facilities, and privacy. Respondents in the same study requested more than one type of therapy to include both medical and additional treatment such as psychotherapy or herbalism⁵². The failure to accurately recognise a person's religious affiliation, as well as their ethnicity, may lead to inappropriate provision and alienation from the service seeking to provide support.

The importance of developing an approach to practice of holism and humanism is considered by Woogara (2001) analysing the potential the impact of the European Convention on Human Rights in UK law, observing; '...privacy is a basic human right, and that its respect by health professionals is vital for a patient's physical, mental, emotional and spiritual well-being.' (p.234). Woogara goes further by suggesting that respect for privacy creates an conducive climate for a feeling of physical and mental well being which could contribute to the therapeutic process and recovery.

Therapeutic engagement and treatment

Collaborative practice can reduce the risk of idiosyncratic decision-making when interpreting the mental health of individuals who describe a spiritual experience⁵³. The identification of personal bias on the part of the service professional and reducing error in evaluations may be important in improving patient autonomy and treatment benefit⁵⁴. The effective inclusion of chaplaincy services and multidisciplinary liaison will aid the development of comprehensive assessment and response to patient or client needs⁵⁵. Research carried out at Hollins Park Hospital, Warrington, UK found that 45% of GP's, 33% of Psychiatrists and 76% of nursing staff felt strongly that human beings are made up of spirit as well as body⁵⁶. Other studies have shown that 84% of OT's see spirituality as vital to health and rehabilitation⁵⁷ and that social workers recognise spirituality's importance in a whole person, whole systems approach^{58,59}. Differing perceptions between professions should be recognised as a potential barrier when building collaborative practice.

Multidisciplinary involvement in community settings enables a broad range of participants to be involved in meeting client/patient needs. Reporting on assertive community treatment Ayonrinde et al. (2000) described the process of multi-sectoral collaborative practice reaching beyond the immediate mental health team to encompass voluntary and statutory, housing, befriending, and ethnic and religious agencies that engaged with clients in the community⁶⁰. However, the complexity of such practice development should not be underestimated⁶¹.

Spiritual/religious assessment enables the identification of needs of people from diverse communities. Cultural beliefs influence coping styles and attitudes to treatment. However, these are not always assessed leading to patient perceptions of treatment as authoritarian and disrespectful or a lack of understanding regarding diagnosis and rationale for treatment.⁶² Professionals need to be aware of the interplay that occurs between conflicting cultural expectations, distinctions between psychosocial, spiritual, physical health problems and communication⁶³. A study carried out by Malik (2000) demonstrated the resilience of some South Asian cultural formations which conceptualised mental health in holistic, relational and religious frameworks⁶⁴. An in-depth qualitative interview study with 52 adult females explored the degree to which religious coping strategies were perceived as effective with depressive and schizophrenic symptoms. The research authors reported prayer was perceived as effective amongst Afro-Caribbean Christian and Pakistani Muslim groups, while participants in the same groups also reported community stigma associated with mental illness resulting in a preference for private coping strategies. Across all non-white groups, including Jewish participants, there existed fear of being misunderstood by health professionals⁶⁵.

The failure to communicate with patients can extend to families as services fail to adequately meet people's diverse needs⁶⁶, terminology can prove important as terms such as 'depression' or 'behavioural problems' may be preferable to 'mental illness'.⁶⁷

Spirituality and religion can form components of crisis experienced by the person. Therapeutic responses that do not take into account spiritual aspects of psychosis, presenting spiritual engagement as purely beneficial, risk alienating people for whom spiritual forces are very real in their experiences of psychosis⁶⁸. A small study of 7 participants found that the religious background of the patient affected the content of delusions, but the nature of the delusion was affected by other factors⁶⁹. However research has demonstrated that in some circumstances religious beliefs were only discussed with patients who had psychotic symptoms with a religious content, therefore failing to meet the wider spiritual and religious care needs of other patients⁷⁰. Chadwick (1997) recommended the development of a 'person' orientated rather than a 'symptom' orientated recovery programme in mental health services that recognised the role of spiritual crisis in the patients experience of psychosis⁷¹. The ability of mental health nurses to employ a complex and inter-relating set of criteria when evaluating spiritual-type experiences, combined with a tolerance of ambiguity and an awareness of their own subjectivity, has been observed in a qualitative study with 14 UK mental health nurses⁷².

The Somerset Spirituality project has demonstrated the importance of a response to spiritual need within the therapeutic environment contrasted with the discovery of a lack of provision from psychiatry, religious organisations and secular counselling services and the existence of professional and institutional barriers to improvement⁷³⁷⁴. Further work by Foskett et al. following the Somerset Spirituality Project has traced the implication

promoting good practice and engaging local religious groups and the difficulties encountered⁷⁵. The work of the National Institute for Mental Health in England national spirituality project (2003) highlighted both areas of good practice but also how much still needs to be developed to respond effectively to the spiritual needs of mental health service users⁷⁶.

Discharge management

Discharge planning in relation to the needs of people from diverse communities needs to take into account pre-existing relationships within families and communities from which religious and social support can be provided for the person⁷⁷. Brimblecombe et al.'s 2006 national consultation (also expressed in the Chief Nursing Officer's review of mental health nursing *From Values to Action*⁷⁸) explored implementing holistic practice in mental health nursing and found that mental health nurses needed to understand local resources to support social inclusion e.g. knowing how to access benefits, housing, employment advice.⁷⁹ It is the recommendation of this paper that front line staff such as mental health nurses also receive support to understand local faith community resources as a means of supporting social inclusion on discharge. Work rehabilitation activities undertaken during the process of therapeutic response can engage a variety of partners including voluntary, religious and other agencies,⁸⁰ potentially providing a bridging connectivity when planning discharge. When connecting with faith communities within a locality mental health services may need to be aware of the need for engagement with attitudes towards mental health amongst some religious groups^{81,82}.

A study of white British Christians from a theologically conservative church, conducted by Gray (2001), found that while there was no evidence of judgemental attitudes, and less negative and rejecting attitudes than the general UK population, amongst the single participating congregation there were concerns about dangerousness and unpredictability, finding service users difficult to talk with⁸³. Gray's recommendations include further public education as necessary to alter negative perceptions of people with a mental illness.

Hatfield et al.'s (1996) research amongst 106 people in a British town explored attitudes towards mental health services, found both a lack of knowledge and a heavy reliance upon GP services for mental health care⁸⁴. Recognising the need for primary care services that are effectively able to support people with mental illness in the community appears to be important when supporting people after discharge.

Building on the issue of community engagement Qaisra Khan (2006), reporting on the development of a chaplaincy service development process and the recognition that more mental health services are now community based, observed the importance of enabling mental health service users to make links with places of worship^{85,86,87}. Leavey et al. (2007) have provided a useful study exploring the move of psychiatric care to community contexts and the burden of care this has presented for faith-based organisations. Interviews with 32 clergy (ministers, rabbis and imams) found low confidence in

managing psychiatric problems, combined with anxiety, fear and stereotypes, affecting willingness to formalise their function in the care of people with mental illness within a community setting⁸⁸.

Leighton (2002) provides an interesting exploration of bed blocking in psychiatric rehabilitation units using a sociological model of enquiry combined with empirical research. Leighton argues that the current move towards individualised care within psychiatric nursing is counterproductive for some client groups, where individualised care leads to assumed mainstream social values that conflict with the life values of some service users. Leighton observes that 'these clients may resist normalisation, independence and individualism, preferring instead a more collective, pastoral and spiritual lifestyle'. This for Leighton leads to conflict and rejection of what are considered imposed values/beliefs within a care setting⁸⁹. It would appear that the challenge to discharge management may not simply rest in the bridge between the mental health care environment and community but also within the prevailing culture of mental health care that promotes an individualised service response that fails to recognise collective care.

Summary

In their paper 'Addressing diversity in mental health care' (2007), Sara Owen and Elizabeth Khalil provide a helpful summary of recommendations contained in guidance documents produced in the UK focused on spirituality and mental health from a number of differing organisations. The resulting list, repeating many of the themes found in this brief resource document, is replicated here as a potential resource to enable a reflective analysis of spiritual care provision:

- Incorporate spiritual issues into routine service and practices.
- Share good practice locally and beyond
- Incorporate spiritual understanding of individual service users in assessment arrangement, and referral and information systems
- Review and change service policies
- Review contracts and service specification
- Respect service users' spiritual beliefs
- Recognise all spiritual beliefs, including non-religious philosophies, not just mainstream religious faiths such as Christianity and Judaism
- Provide access to a quiet place to reflect and/or to worship
- Positive steps should be taken to give faith communities access to mental health awareness training, which should include information to help them differentiate between spiritual and delusional beliefs
- Pastoral care should be openly available

S. Owen & E. Khalil (2007) Addressing diversity in mental health care: A review of guidance documents. *International Journal of Nursing Studies*. 44. pp467-478

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