A GROUNDED THEORY STUDY OF THE EXPERIENCE OF SPIRITUALITY

AMONG PERSONS LIVING WITH SCHIZOPHRENIA

by

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ABSTRACT

Spirituality in the discipline of nursing has gained popularity over the past two decades. National and provincial nursing associations and colleges expect nurses to be educated in providing spiritual health assessments and interventions in order to provide holistic nursing care. There is a paucity of research in the nursing literature on the meaning of spirituality from the perspectives of individuals who experience chronic mental illness, specifically schizophrenia. Spirituality remains an elusive construct, challenging psychiatric nurse educators, researchers and practitioners in the development of nursing curricula to guide psychiatric nursing practice. The focus of this research study was to develop a substantive theory about the experience of spirituality among individuals living with schizophrenia using grounded theory methodology in the tradition of Glaser and Strauss (1967). Forty semi-structured interviews and four focus groups were conducted with 20 participants who self-reported to be diagnosed with schizophrenia.

Findings: The substantive theory "spirituality as connection" indicates that spirituality for persons living with schizophrenia involves a dialectical process in which one strives to be connected to one's spiritual self (body-mind-spirit), significant others (family, friends, God / Higher Power, health care professionals), community (others living with a mental illness, others who are well, a faith community, the community in which participants lived), and nature, while at the same time experiencing situations and incidents that promote disconnection from these sub-themes. Strategies used by participants to achieve connection included: taking prescribed atypical anti-psychotic medications, maintaining their health and a healthy lifestyle, use of prayer / meditation, caring for self and others, and engaging in creative activities that added meaning to their life experiences. Among the 17 factors contributing to connection, exemplars are: reconnecting with one's spirit through prayer and meditation, attending drop-in centres for persons living with a mental illness, and walking / hiking in nature. Outcomes include feeling peaceful, love, contentment, being accepted and nurtured by others. Among the 14 factors contributing to disconnection, exemplars are: the effect of the illness on relationships with other people, the stigma of being in a psychiatric ward, being unemployed, and taking typical anti-psychotic medications. Outcomes include feeling powerlessness, isolation, rejection and alienation.

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It is my honor to dedicate my doctoral dissertation to three very significant people whose lives have had a major influential role over my own. To my mother, my eldest sister and eldest brother who left our physical world during the course of my own journey in doctoral studies. Each of you lived each day you had with courage, love and grace despite being challenged with many of life's obstacles. I am proud of each of you as you lived your lives with a fierce sense of determinism, assertiveness, authority, authenticity, humor, and spirituality.

To my mother, Helene Marie Tarko (nee Gautron)
August 28, 1926 - May 28, 1999

You taught your children how to work hard
You modeled the significance of family values every day
As a single parent of six children you led by example for 73 years
Your presence enriched my life and those who you touched
The power of your life continues to influence me daily
Your spirit will always be a part of mine

To my eldest sister, Rosan Janet Francey (nee Tarko)
January 8, 1955 - November 28, 1999

You taught me patience
You modeled a strong caring work ethic
You taught me how to cook and bake from afar
You modeled values of love, justice, loyalty, honesty and respect
Your life was too short for all of us, especially for your children, Kimberly and Ryan
As a widow, you lived every day with courage and died with grace
Your physical presence is deeply missed

To my eldest brother, Ronald Ernest Tarko
July 14, 1956 - July 13, 2001

You taught me how to ride a bicycle, play ball and climb trees
You modeled values of love, justice, loyalty and respect always
You worked hard, played hard and valued others' efforts to do the same
Your life was filled with a variety of people who loved and respected you
You knew your skill at downhill skiing, Black Diamond runs surpassed Larry and I
Your presence will always be with us as we continue our annual ski vacations,
now in your honor - Your physical presence is deeply missed - bro

"I will see you all again - On the Other Side"

CHAPTER ONE

Introduction

The notion of holistic nursing care is described in the literature as including the

totality of the person, encompassing body, mind and spirit (Frisch, Dossey, Guzzetta, &

Quinn, 2000). Over the past two decades holism and holistic care have emerged as central

concepts in nursing. As words, holism and holistic care invoke diverse interpretations as to

meaning, characteristics, and attributes. How nurses provide holistic care and what the

outcomes are for clients constitute fundamental components of the ongoing debate. Within

the notions of holism and holistic care, spirituality and spiritual care are being explicated as

key attributes and are the subjects of much debate. The debate focuses, in part, on what is

meant by spiritual care as an attribute of holistic nursing care (Burkhardt & Nagai Jacobson,

2000; Burkhart & Solari-Twadell, 2001; Cumbie, 2001; Lane, 1987; McSherry & Draper,

1998; Muldoon & King, 1995; Stuart, Deckro, & Mandle, 1989).

One of the primary reasons for the debate is the diversity of definitions and the lack of

consensus in nursing regarding conceptual and operational definitions of spirituality

(Bradshaw, 1997; Cawley, 1997; Dyson, Cobb, & Forman, 1997; Emblen, 1992; Golberg,

1998; Greenstreet, 1999; Kendrick & Robinson, 2000; McSherry, 2000; McSherry & Draper,

1997; Narayanasamy & Owens, 2001; Price, Stevens, & LaBarre, 1995; Sellers & Haag,

1998). A second factor influencing the debate is the lack of clarity of the concept in the

nursing literature as a result of the synonymous use of the terms "spirituality" and "religion"

(Barnum, 1996; Burkhardt, 1989; Burkhart & Solari-Twadell, 2001; Dyson, et al., 1997;

Emblen, 1992). Burkhart and Solari-Twadell sought to differentiate the definitions of

spirituality and religiousness as documented in the nursing literature. The authors report that

the nursing literature has been inconsistent in defining the two terms. In general, the nursing literature on spirituality defines spirituality as being a broader construct than religiousness while the nursing literature on religion defines religiousness as the broader concept with spirituality as a sub-concept (Burkhart & Solari-Twadell, 2001).

According to the American Holistic Nursing Association, nurses are expected to meet the needs of clients in each of the dimensions of body, mind and spirit when providing nursing care to client populations (Burkhardt & Nagai Jacobson, 2000; Frisch et al., 2000). Given the current lack of nursing theory development on spirituality, the need exists to begin to discover the meaning of the experience of spirituality among client groups in order to begin to develop nursing curricula addressing spirituality in nursing, in particular psychiatric-mental health nursing education and practice. A review of the nursing literature on spirituality in psychiatric-mental health nursing revealed a paucity of nursing research (Charters, 1999; Moller, 1999; Peterson & Nelson, 1987) while the nursing literature on spirituality in nursing has served to extend the debate as to what constitutes spirituality and what constitutes the provision of spiritual care.

The nursing literature on spirituality focuses on how spirituality has been addressed in a variety of nursing contexts over the past two decades (Ameling & Povilonis, 2001; Barnum, 1996; Burkhardt, 1989; Cumbie, 2001; Dyson et al., 1997; Emblen, 1992; Lane, 1987; McSherry & Draper, 1997; Muldoon & King, 1995; Stuart et al., 1989). Under the umbrella construct of spirituality, the nursing literature delineates a number of sub-concepts (see Chapter 2). Some of these concepts are derived from the relational quality expressed through interpersonal relationships with other persons and include the "existence of love, faith, hope, trust therein providing meaning to life and a reason for being" (Labun, 1988, p. 315).

While studies, which focus on spirituality in the broader context of nursing, are being conducted with increasing frequency, research about spirituality among individuals living with a mental illness is warranted in order to begin to uncover the meanings these individuals associate with spirituality (Greasley, Chiu, & Gartland, 2001; Piles, 1990; Weaver, Flannelly, Flannelly, Koenig, & Larson, 1998) and how psychiatric-mental health nurse practitioners can begin to meet their spiritual needs. Such inquiry may provide direction for psychiatric-mental health nursing curricula development, evaluation, and change with the specific aims of improving the quality of holistic nursing care (body-mind-spirit) in the context of psychiatric-mental health nursing practice.

Purpose of the Study

The primary purpose of this research study is to develop substantive theory related to the experience of spirituality with individuals living with a mental illness who have been diagnosed with schizophrenia. The rationale for the selection of persons living with schizophrenia as opposed to other types of mental disorders for this study is based on the notion that persons living with schizophrenia constitute the largest group of persons who live with a persistent chronic mental illness (Sadock & Sadock, 2000). This research study sought to have participants who had been diagnosed with schizophrenia describe their own experience of spirituality providing thick and rich descriptive accounts of their lived experience of the phenomenon.

The knowledge generated by this study will contribute to the development of substantive theory on spirituality as experienced by individuals diagnosed with schizophrenia for psychiatric-mental health nursing education and practice. The findings may be used to develop curricula and assist in meeting the teaching/learning needs of psychiatric nursing

students and psychiatric-mental health nurse practitioners' continuing education needs.
Foremost, the findings may contribute to practitioners being better able to meet the spiritual needs of individuals experiencing persistent, chronic mental illness and who are often marginalized by society and the health care system. In addition, the study will examine implications for psychiatric-mental health nursing education, research and practice regarding the substantive area of spirituality among individuals diagnosed with schizophrenia.

<div align="center">Research Aims</div>

Specific aims of the research study include having participants diagnosed with schizophrenia describe: (1) individual experiences of spirituality; (2) how individuals attain, maintain and/or retain their own sense of spirituality; (3) individual perceptions of factors which enhance or impede their ability to experience spirituality; and (4) individual perceptions and experiences of how health care professionals such as psychiatric-mental health nurses can foster or inhibit the individual's spirituality while receiving psychiatric-mental health care. In addition, implications for psychiatric nursing curricula regarding the substantive area of spirituality among individuals diagnosed with schizophrenia are addressed.

<div align="center">Theoretical Framework</div>

The focus of this research study is on delineating a context-grounded description and theoretical explanation of the experience of spirituality among individuals diagnosed with schizophrenia. The research focuses on the experience of spirituality among individuals living with schizophrenia and the meaning derived from these experiences. The methodology for this study is grounded theory methodology in the tradition of Glaser and Strauss (1967) and is rooted philosophically with symbolic interaction theory developed by Mead (1934) to

explore and describe how individuals diagnosed with a mental illness, schizophrenia, experience spirituality. Qualitative methods are most appropriate when asking questions dealing with subjective experiences and perceptions with situational meaning (Burns & Grove, 1997; Morse & Field, 1995; Morse, Swanson, & Kuzel, 2001; Schumacher & McMillan, 1993); therefore the procedures of grounded theory were selected for this study.

Grounded theory methodology was selected in order to develop a substantive theory related to spirituality among individuals living with schizophrenia that may guide psychiatric-mental health nursing curricula development and implementation. This substantive theory has the potential to expand the current understanding of spirituality in nursing and enhance the provision of spiritual nursing care as a component of holistic nursing care in the context of psychiatric-mental health nursing practice.

<div align="center">Problem Statement</div>

The nursing literature does not provide conclusive research evidence about how to provide spiritual care as an aspect of holistic care (body-mind-spirit) among persons living with a mental illness such as schizophrenia (Greasley et al., 2001; Nolan & Crawford, 1997; Piles, 1990; Tuck, Pullen, & Lynn, 1997; Weaver et al., 1998). The experience of a mental illness often precipitates some level of spiritual distress (Sumner, 1998; Townsend, 2000); therefore, the experience of spirituality ought to be investigated among persons diagnosed with schizophrenia if psychiatric-mental health nurses are to provide competent holistic care. This investigation aims to understand better the experience of spirituality among individuals living with schizophrenia and to begin to delineate implications for psychiatric-mental health nursing curricula and practice. Pullen, Tuck, and Mix (1996) claim the discipline of nursing has focused on gaining an understanding, conceptualizing, and theorizing about spirituality,

yet spirituality is commonly overlooked in nursing practice. Pullen et al. (1996) note four "reasons for this oversight: (a) nurses' lack of self-spiritual awareness; (b) fear of imposing personal beliefs on the client; (c) time constraints; and (d) lack of nursing education in spirituality interventions" (p. 87).

Significance of the Problem

A shift in contemporary nursing ideology to re-imagine, articulate and integrate spirituality into psychiatric-mental health nursing curricula and practice is the current problem. There is a need to develop substantive theory to guide psychiatric-mental health nursing curriculum and practice that explicitly addresses the experience of spirituality among persons living with a mental illness. Further research is needed to explore the meaning of spirituality among persons living with various types of mental illnesses in order to explicate spirituality and spiritual care in psychiatric-mental health nursing practice as a component of holistic health assessment and intervention.

The relevance of spirituality to nursing and the need to provide spiritual nursing care is further supported in documents developed by professional and regulatory nursing associations/colleges in Canada and internationally. According to nursing's Professional Code of Ethics (Canadian Nurses Association {CNA}, 1997; College of Registered Psychiatric Nurses of British Columbia {CRPNBC}, 2000), and nursing's standards of practice and competency documents (CRPNBC, 1995a, 1995b; Registered Nurses Association of British Columbia {RNABC}, 1998; Registered Psychiatric Nurses of Canada, {RPNC}, 2001), Registered Psychiatric Nurses (RPNs) and Registered Nurses (RNs) are expected to provide competent holistic nursing care to client populations. Additionally, the Canadian Federation of Mental Health Nurses {CFMHN} (1995) standards of psychiatric and

mental health nursing practice implicitly address spirituality and holistic care in their reference to the nurse's conceptual model of nursing practice. Currently, there is a lack of direction and clarity as to the teaching and learning (knowledge, attitudes, assessment, and intervention skills) associated with the construct, spirituality in nursing education, specifically what it is, how it is defined, what spiritual needs are and how to accommodate patients' spiritual needs in psychiatric nursing curricula and practice (Boutell & Bozett, 1990; Bradshaw, 1997; Carson, Winkelstein, Soeken, & Brunins, 1986; Greenstreet, 1999; McSherry, 2000; McSherry & Draper, 1997; Narayanasamy, 1993).

Frisch (2000) asserts that the American Holistic Nursing Association shares a philosophy which "acknowledges and values the connectedness of body-mind-spirit, the inherent goodness of human beings, the ability of each person to find meaning and purpose in his or her life, and the nurse's role of support to each client so that the client may find comfort, peace, and harmony" (p. 1). A dichotomy exists between the ideal of providing spiritual care in theory and the lack of clarity regarding what nurses should do in clinical practice when addressing their patients' spiritual needs (Carson, 1989; Labun, 1988; Martsolf & Mickley, 1998; McSherry, 2000; McSherry & Draper, 1997; Narayanasamy, 1993; Oldnall, 1995, 1996; Piles, 1990; Shelly & Fish, 1988; Tarko, 1995).

Nurse theorists such as Fulton (1995), Neuman (2002), Newman (1994), Parse (1981, 1995), Roy (1984), Travelbee (1971), and Watson (1985) contend that spirituality is an essential dimension of holistic nursing practice and can contribute to a sense of spiritual well-being for individuals who experience physical or emotional acute, chronic and terminal illnesses. However, few research studies on spiritual care in nursing and even fewer research studies on spiritual care in psychiatric-mental health nursing practice exist. The literature on

nursing education provides little insight into how the construct of spirituality has been integrated into nursing education curricula (Boutell & Bozett, 1990; Bradshaw, 1997; Carson et al., 1986; Greenstreet, 1999; McSherry, 2000; McSherry & Draper, 1997; Narayanasamy, 1993). Given the current state of theory development, further research is needed in relation to the concepts of spirituality, spirituality and nursing education, and spirituality and nursing practice if holistic nursing care is to be provided as delineated in the competency documents and standards of practice documents for clinical nursing competencies for both Registered Psychiatric Nurses (RPNs) and Registered Nurses (RNs).

Such research could facilitate meeting both basic and continuing education needs of psychiatric-mental health practitioners. The following section delineates definitions of terms that guided the discussion of spirituality in the current study.

<div align="center">Definition of Terms</div>

Holistic care - is the care that is focused on the body, mind, and spirit that is woven together, one part affecting and being affected by the other parts (Stoll, 1989).

Religion - is the structured doctrinal/belief system and traditional practices as well as the community which lives out the belief and practice in individual and/or corporate expressions (Dr. Nancy Cocks, Theologian, Personal Communication, November 22, 2000).

Religiosity - is the commitment and response of believers to both the belief system and the practices of a particular group/structured community (Dr. Nancy Cocks, Theologian, Personal Communication, November 22, 2000).

Self-transcendence - is defined as the expansion of one's conceptual boundaries inwardly through introspection activities, outwardly through concerns about others' welfare, and

temporally by integrating perceptions of one's past and future to enhance the present (Reed, 1991a, p. 5).

Spirituality - is defined as: (a) a guiding philosophy, (b) a motivating force, (c) an inherent quality, (d) a hierarchical conscious state that eventually merges with the Absolute, (e) a transcendent interconnected relationship with a higher being, and (f) a transcendent harmonious interpersonal relationship (Morris, 1995).

Spiritual Distress - is defined as "the state in which the individual or group is at risk of experiencing a disturbance in the belief or value system which provides strength, hope, and meaning to life" (Carpenito, 1999, p. 403).

Spiritual Needs - are described as any factors necessary to establish and/or maintain a relationship with God or other higher being (Charters, 1999; Emblen & Halstead, 1993; Hammer, 1990; Hermann, 2001; Stallwood & Stoll, 1975), the need for expressions of feelings/emotions and searching for meaning and purpose (Emblen & Halstead, 1993; Narayanasamy & Owens, 2001; Peterson & Nelson, 1987), the need to give and receive love, the need to give and receive forgiveness, relatedness to others (Carson, 1980; Hermann, 2001; Peterson & Nelson, 1987), the need for hope and creativity (Carson, 1980; Emblen & Halstead, 1993; Peterson & Nelson, 1987), transcendence (Emblen & Halstead, 1993), and the need to experience nature and a positive outlook (Hermann, 2001).

Spiritual Well-Being - is defined as an ability to find meaning and purpose of present and future life events, and an inner harmony manifested by being content with life, regardless of personal failures and illnesses (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwork, 1985a).

Assumptions Related to the Study of the Phenomenon

The very nature of grounded theory methodology requires researchers to use themselves as "tools" throughout the research process. It is imperative that an examination of their biases and assumptions be a part of this process (Paterson, 1994). With this premise stated, it is essential for the researcher to identify explicitly his own perspective on the research topic.

Basic assumptions of this researcher regarding the phenomena of spirituality and persons who experience a mental illness such as schizophrenia include:

1. Spirituality is an individual inner subjective experience that may or may not be associated with traditional religious affiliation.

2. Spirituality is an intrinsic dimension of the human experience.

3. An individual's spirituality is a complex, multidimensional phenomenon.

4. There are an infinite variety of experiences of spirituality because of the uniqueness of each individual.

5. The experiences of spirituality among persons living with a mental illness (schizophrenia) are unique and qualitatively different from descriptions which have been documented based on persons living with a terminal illness or a chronic physical illness.

6. Individuals who are being prescribed antipsychotic medications and are mentally stable are able to verbally articulate their unique experience of spirituality.

7. The essential components of spirituality as lived by individuals diagnosed with a mental illness exist and can be explicated from verbal accounts of the experience of spirituality as shared by the individual diagnosed with schizophrenia.

Limitations

The researcher recognized the following limitations of the study:

1. All participants could be clustered at the higher end of the occupational and social functioning level of persons living with severe and persistent mental illness who live in the community either in semi-independent (psychiatric boarding home) or independent (apartment) housing.

2. Audio taping of the interviews may have been a deterrent to open, honest communication.

3. The essential structure of spirituality as lived by individuals diagnosed with schizophrenia may only be generalized to the participants in this study or used for a similar sample group.

4. Participants interviewed were from one urban geographic area (the lower mainland of British Columbia).

Relevance for Psychiatric-Mental Health Nursing Education

A review of the nursing literature revealed that significant gaps exist as to a conceptual and operational definition of spirituality in the discipline of nursing (Burkhardt, 1989; Dyson et al., 1997; Emblen, 1992; McSherry & Draper, 1998). It is unclear what spirituality is and how the teaching and learning of the construct in nursing education programs can be integrated into curricula (Boutell & Bozett, 1990; Bradshaw, 1997; Carson et al., 1986; Greenstreet, 1999; McSherry, 2000; McSherry & Draper, 1997; Narayanasamy, 1993). Further, uncertainty exists as to how the construct is applied to clinical nursing practice in order to provide competent spiritual care to clients of mental health services (Bradshaw, 1997; Campinha-Bacote, 1995; Carson et al., 1986; Clark, Cross, Deanne, &

Lowry, 1991; Dyson et al., 1997; Golberg, 1998; McSherry & Draper, 1997, 1998; Morris, 1995, 1996; Narayanasamy, 1993; Piles, 1990; Price et al., 1995; Tarko, 1995).

Holistic care (body-mind-spirit) is an ideal which is ascribed to in theory but falls short in the clinical practice environments where professional nurses tend to avoid talking to their clients in psychiatric-mental health nursing settings about issues/concerns related to spirituality (Fulton, 1995; Golberg, 1998; Peterson & Nelson, 1987; Piles, 1990; Soeken, 1989; Stoll, 1989). This literature suggests the primary reasons nursing education has not encompassed spirituality in curricula include: (1) the difficulties which have arisen in conceptualizing the construct, (2) uncertainty as to the nurse's role in this regard, (3) concern one might transmit one's own values/beliefs if one were to teach content regarding spirituality, and (4) the uncertainty about how to provide spiritual care within the context of psychiatric nursing environments.

The goal of this research inquiry is to develop substantive theory and identify implications for psychiatric nursing curricula derived from the research data. Developing substantive theory from this inquiry has the potential to be helpful to nurse educators in guiding the development, change and implementation of psychiatric-mental health nursing curricula in efforts to teach psychiatric nursing students a holistic approach to psychiatric-mental health nursing care.

Historical Context

In British Columbia, psychiatric-mental health nursing care is practiced with diverse client populations in diverse contexts and clinical settings ranging from large psychiatric-mental health hospitals, emergency departments and psychiatric units of community general hospitals, community based psychiatric boarding homes, independent living settings, hotel

rooms on Vancouver's east side to rural and geographically isolated regions throughout the province. Traditionally, the focus of psychiatric-mental health nursing care has been client focused; however, there is currently a shift to family focused care as psychiatric-mental health nurses begin to assume a broader view of the client in their context of practice with advanced education. Psychiatric-mental health nurses with advanced education are being challenged to view individuals, families, groups, aggregates, and community as client-systems in conjunction with trends pertaining to primary health, including health promotion and community based psychiatric-mental health services (Crawford & Tarko, 2002). Fundamental principles of psychiatric-mental health nursing care include: providing competent holistic care to assist an individual, family or community to prevent or cope with the experience of living with a mental illness, to promote optimal levels of functioning and the best quality of life, and to assist the client to find meaning in these experiences.

Schizophrenia is a common, often misunderstood, persistent mental illness and it is estimated that 1% of the population is, has been, or will be affected by the illness (Sadock & Sadock, 2000). Sadock and Sadock posit that in males, the onset of positive symptoms usually occurs between the ages of 17 to 27 years, while the onset is a lengthy plateau in females reported between 17 to 37 years of age. The stigma associated with schizophrenia makes it more tragic because clients and families must bear the stigma as well as the illness that frequently leads to marginalization. Demographically, Sadock and Sadock report schizophrenia is the most expensive of all chronic illnesses due to the individual's inability to be self-supporting and frequent re-admissions to hospital for re-stabilization of symptoms with psychotropic agents. According to the British Columbia Schizophrenia Society {BCSS} (2001), schizophrenia costs Canadians in excess of $2.3 billion dollars in direct health care

costs and additional $2 billion dollars in support costs associated with welfare, family assistance and community support services, for a total estimated $4.3 billion dollars. The BCSS reports persons living with schizophrenia occupy more hospital beds than any other medical illness, that is, persons living with schizophrenia occupy one in twelve hospital beds in Canada.

Psychiatric rehabilitation emphasizes the important role psychiatric-mental health care providers have in assisting to instill and promote hope, purpose and meaning in the lives of their clients. Little research exists in relation to the quality of life and the perception of what gives individuals living with schizophrenia a sense of purpose and meaning in life during periods of exacerbation of symptomatology.

In British Columbia alone, there are over 40,000 individuals diagnosed with schizophrenia. The experience of living with schizophrenia has an impact on families and communities who are often ill prepared for the unanticipated individual and family developmental transitions they experience. Psychiatric-mental health nurses have the potential to intervene with client groups holistically as they encounter challenges navigating a shrinking health care system in search for support and the delivery of psychiatric treatment. There is very little psychiatric-mental health nursing research available in the nursing literature to guide practitioners in providing optimal holistic psychiatric-mental health nursing care to individuals with schizophrenia and in the context of families whose lives have been affected by schizophrenia.

In British Columbia, as in other Canadian provinces, research in psychiatric-mental health nursing has not experienced the same popularity of nursing research or funding as in other areas such as cancer, cardiac, and diabetes care research. The current research will

assist in delineating implications for psychiatric nursing curricula to better meet the spiritual needs of individuals living with schizophrenia in the context of providing holistic psychiatric-mental health nursing care.

<center>Personal Context</center>

I have been involved in the practice of psychiatric-mental health nursing for twenty years. Throughout this time I have struggled with the notion of spiritual care as an aspect of holistic care in the context of psychiatric-mental health nursing environments. This research has resulted from my interest in both the idea of spirituality and the meaning of the experience of spirituality as lived by persons diagnosed with schizophrenia. I am involved in an ongoing journey of spiritual discovery and I am interested in how spirituality can be nurtured and enhanced through the therapeutic process within the context of a psychiatric-mental health nurse-client relationship. As well, although I do not have any personal experience with having a mental illness, I have clinical psychiatric-mental health nursing experience in providing psychiatric-mental health nursing care for persons who are diagnosed with schizophrenia in the context of psychiatric units of general hospitals, major provincial psychiatric hospitals, palliative nursing care and a forensic/ correctional milieu.

I have been involved in the education of psychiatric-mental health nurses for fifteen years. As a classroom instructor and clinical psychiatric nursing instructor, I am cognizant that major gaps exist between nursing theory and psychiatric-mental health nursing practice related to how psychiatric-mental health nurses can begin to address the spiritual dimension of persons living with a mental illness in their clinical practice. As a result of these experiences, I have become increasingly aware of the need for research in relation to the experience of spirituality among persons living with a mental illness such as schizophrenia.

The next chapter will provide a review of the nursing literature in relation to the construct of spirituality from a philosophical, historical, and theoretical perspective.

CHAPTER TWO

Literature Review

This chapter begins with a synopsis of the nature of schizophrenia and reviews the

nursing literature in relation to the construct of spirituality. I explore the construct of

spirituality as a tradition in nursing. From a historical perspective, I examine how the

construct of spirituality in nursing has been influenced by other disciplines and provide a

synopsis of the history of theory development in the discipline of nursing as it relates to the

construct of spirituality. In addition, I examine conceptual models and theories of nursing in

which spirituality is considered a central concept. I will further explicate the construct of

spirituality by reviewing definitions and descriptions of the construct and differentiating it

from religion. A review of the nursing process and spirituality and nursing assessment of

spiritual needs is presented. The chapter concludes with a review of how spirituality has been

addressed in selected nursing research studies, psychiatric-mental health nursing education,

and practice.

The Nature of Schizophrenia

Schizophrenia is believed to affect one in 100 people worldwide and in British

Columbia this translates into approximately 40,000 individuals or 290,000 fellow Canadians

living with this chronic persistent mental illness (BCSS, 2001). Many theories have emerged

as to the causes of schizophrenia, ranging from psychodynamic, behavioral, humanistic-

existentialism, and biological perspectives. The biological perspective appears to receive the

most attention with research being funded for drug trials related to the efficacy of newer

antipsychotic medications and their impact on the control and management of signs and

symptoms associated with schizophrenia.

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition-text

revised [DSM-IV-TR] (American Psychiatric Association, 2000) notes the essential features

of schizophrenia include a mixture of signs and symptoms that have been present for a

significant amount of time, persisting for a minimum of six months in duration. These

symptoms are reported to include positive and negative symptoms and are associated with

marked social and occupational dysfunction. Cancro and Lehmann (as cited in Sadock &

Sadock, 2000) delineated negative and positive symptoms associated with schizophrenia.

According to Cancro and Lehmann, these behaviors include positive symptoms such as

auditory and visual hallucinations, delusions of persecution and grandiosity, alterations in

thought processes such as derailment, tangentiality, incoherence, and circumstantiality.

Negative symptoms associated with schizophrenia are clustered into the following behaviors:

affective flattening (unchanging facial expression, decreased spontaneous movements,

paucity of expressive gestures, affective nonresponsivity), alogia (poverty of speech, poverty

of content of speech, blocking, increased response latency), avolition-apathy (decreased

interest in grooming and personal hygiene, impersistence in relation to work or school),

anhedonia-asociality (decreased recreational interests, sexual interest, relationships with

friends and peer groups), and attention in relation to social inattentiveness (Cancro &

Lehmann).

Treatment modalities associated with schizophrenia have improved significantly over

the past decade with the advent of atypical antipsychotic medications. Buchanan and

Carpenter (as cited in Sadock & Sadock, 2000) note the efficacy of atypical antipsychotic

medicines such as clozapine (clozaril) for treatment-resistant patients has developed new

pharmacological treatments for schizophrenia with regard to reducing the positive and

negative symptomology and relapse associated with schizophrenia. Buchanan and Carpenter report atypical antipsychotic agents such as clozapine (clozaril), risperidone (risperdal), olanzapine (zyprexia), quetiapine (seroquel), and ziprasidone (zeldox) are leading the way into better management by way of diminishing both the positive and negative symptoms and reducing relapse rates for persons with schizophrenia. Other research studies comparing atypical over typical antipsychotic agents report diminished positive and negative symptoms associated with schizophrenia and decreased times of relapse (Foster & Goa, 1998; Galvin, Knezek, Rush, Toprac, & Johnson, 1999; Hamilton, Revicki, Edgell, Genduso, & Tollefson, 1999; Hanson, 1999; Mauskopf, David, Grainger, & Gibson, 1999; Palmer, Revicki, Genduso, Hamilton, & Brown, 1998; Procyshyn & Zerjav, 1998; Reid, 1999; Revicki, 2000; Tunis, Johnstone, Gibson, Loosbrock, & Dulisse, 1999).

The typical antipsychotic agents such as chlorpromazine, loxapine, haloperidol, and thioridazine are considered to evoke significant extrapyramidal side effects [dystonia, akathesia, akinesia, rigidity, and tremors] on patients, reducing positive symptoms with little effect on reducing the negative symptoms associated with schizophrenia (Bezchlibnyk-Butler & Jeffries, 1996; Karch, 2000; Ralph, 1999; Sadock & Sadock, 2000). Treatment modalities associated with the typical agents have a poorer response to relieving negative symptoms of schizophrenia, which further impacts individuals' ability to successfully reintegrate into community living situations. Further discussion of treatment implications of antipsychotic medications are presented in Chapter Five. The next section examines the underpinnings of spirituality as a tradition in the discipline of nursing.

Spirituality - A Tradition in Nursing

Within its religious underpinnings, the profession of nursing sought to serve the ill

and the poor through acts of charity and goodwill and has been framed within religious orders

of earlier times. Barnum (1996) suggests "nursing's relationship with spirituality over the

years has fluctuated; nursing as a discrete profession arose from spirituality, then turned its

back on spirituality, and now is turning back to see what was lost" (p. vii). The application of

theories borrowed from other disciplines and their influences on theory development in

nursing as they relate to spirituality will be addressed. It can be argued that theory

development in nursing during the past four decades has been influenced by other disciplines

and that this has impeded the inclusion of spirituality as an explicit aspect of nursing theories

in recent decades.

Greek mythology notes the ancient goddess of health was Hygeia, the daughter of

Aesculapius, the classical god of medicine and nurses are described in Greek literature. The

conception of modern nursing is said to have begun with the beginning of Christianity

(Donahue, 1985); that is, religion provided the impetus for nursing (Barnum, 1996). Donahue

(1985) asserts "the roots of a movement toward the creation of religious orders of men and

women with primary motivation of nursing the sick began to occur in the late [1000-1500]

Middle Ages" (p. 140). Knights served as nurses during the crusades of the Holy Land and

male military orders referred to as "Hospitalers" and charitable secular orders of women are

noted to have nursed. The Reformation period from 1550-1850 is described as a dark period

of nursing in which nursing conditions changed dramatically with the near disappearance of

male nurses coupled with the prominence of religious orders of women such as the

Deaconesses, Sisters of Charity and Sisters of Mercy. As well, women prisoners and prostitutes were enrolled into nursing service (Donahue, 1985).

Florence Nightingale's era (1820-1910) marked the evolution of modern nursing as noted by her reform of nursing education by way of having nurses assume responsiblility for nursing education in England and North America (Dunahue, 1985). Nightingale (1946) considered nursing a calling to be answered only by women and believed she ought to strive to change the things she perceived as unacceptable in the work called nursing as it was. The prevailing Victorian religious mood of Unitarianism influenced the life of Nightingale. Widerquist (1992) asserts that values underpinning faith for Unitarians from 1810-1888 are captured in the passage "the fatherhood of God; the brotherhood of man; the leadership of Jesus; salvation by character; and the progress of mankind onwards and upwards forever" (p. 50) which are evident in Nightingale's life and in her writings, specifically her belief about salvation by character. Nightingale (1946) declared nursing to be an art and science and differentiated nursing from medicine. She asserted that to nurse is to nourish or look after others carefully to promote growth, development, or other favorable conditions whereas to doctor is to diagnose, treat, and cure disease. The impact that Nightingale had on nursing's perception of spirituality at that time was rooted in religious affiliation and the value of salvation by character where nurses would dedicate their lives to the profession of nursing with strong religious affiliation.

Lindberg, Hunter and Kruszewkski (1994) note that many similarities were evident between medicine and nursing practice at the turn of the 19th century, except for nurses whose profession was influenced by principles associated with religious affiliation. Throughout the 20th century the profession of nursing developed separately from the

profession of medicine as a consequence of the vision and leadership of early pioneers such as Florence Nightingale. The evolution of nursing throughout the 20th century has seen the divergence of theory development between medicine and nursing which has occurred since the death of Florence Nightingale, contributing to an understanding of nursing's development as an art, science and profession.

A significant shift in the discipline of nursing occurred in the United States and Canada when nursing education became situated in the university setting: in the early 1900s baccalaureate preparation arose, followed by master's programs in the late 1950s; the 1960s saw development of doctoral programs in nursing in the USA and in the 1990s such programs began in Canada (Creasia & Parker, 1996; Kerr & MacPhail, 1996). This shift from hospital-trained nurses to university-educated nurses enabled nurses to study the basic sciences and humanities, advocated as nursing foundations. Advanced education in nursing to the graduate level fostered the development of a body of knowledge through research activities within the discipline of nursing (Creasia & Parker, 1996; Kerr & MacPhail, 1996). The next section explores influences from other human science disciplines as they relate to spirituality and theory development in nursing.

Spirituality and Human Science Disciplines

A review of nursing theories and conceptual models of nursing provides insight into the influences related disciplines have had on nursing theory development over the past four decades. It can be argued that related disciplines such as medicine, psychiatry and psychology have contributed to theory development in the discipline of nursing, and equally, have impeded aspects of theory development related to spirituality by the very nature of the focus in their theories.

The discipline of psychology has utilized systems theory to assist in explaining aspects of human behavior and as a lense to view phenomena in the world. For example, systems theory is concerned with changes due to the interplay among all the factors in a situation; interactions between the individual and the environment occur constantly; thus the situation is complex and continually changing (Bertalanffy, 1968). A system is conceptualized as a whole with interrelated parts, in which each of the parts has a function and the system as a totality has a function (Bertalanffy, 1968). Systems can be arranged into hierarchical levels of complexity which include subsystems and suprasystems. Systems theory enables nurses to consider the multitude of influences on the whole person and the impact of change on any part of the whole system. In the discipline of nursing, systems theory has influenced theory development by way of its utility as an approach to assessing and guiding nursing interventions with individuals (Johnson, 1980; King, 1981; Neuman, 2002), groups (King, 1981; Neuman, 2002), families, and communities (Neuman, 2002).

Within the discipline of psychology the theory of general adaptation was developed. A second example of a theory which has influenced theory development in the discipline of nursing is that of general adaptation theory, a theory of adaptation to stress which posits three phases of adjustment to stress (Selye, 1974, 1982) and can be applied to patients who experience psychological, social, and physiological stress (Neuman, 2002; Roy, 1984). General adaptation theory views change as a result of person-environment interaction related to cause and effect. This perspective suggests individuals adjust to alterations in the environment in order to avoid a disruption in their balanced existence. Adaptation theory enables nurses to consider how balance is sustained and the potential effects of disequilibrium on the individual (Neuman, 2002; Roy, 1984).

Also, from the discipline of psychology is the theory of coping which serves as a third example of a theory which has influenced theory development in the discipline of nursing. Theories of coping developed by Lazarus (1981) and Lazarus and Folkman (1984) claim coping is the process that leads to adaptation, a process central to Roy's (1984) Adaptation Model of Nursing and embedded in the Neuman Systems Model of Nursing (2002).

The above are examples of three theories from a related discipline which have influenced the conceptual basis for nurse theorists (Johnson, 1980; King, 1981; Neuman, 2002; Roy, 1984). Systems theory, adaptation theory and stress theory have influenced nursing theory development; however, they have not contributed to the inclusion or development of spirituality in any aspects of conceptual models of nursing (Johnson, 1980; King, 1981; Neuman, 2002; Roy, 1984).

The discipline of nursing is viewed as having a history of recognizing and declaring the significance of religion and spirituality which is antithetical to a legacy of negative attitudes and beliefs toward religion in psychiatry and psychology. Nightingale, the founder of modern nursing, sought to teach others that spirituality was intrinsic to human experience and compatible with scientific inquiry (Macrae, 1995). On the other hand, Sigmund Freud, founder of modern psychiatry in the discipline of medicine, had a strongly held view of religion as being pathological and synonymous with neurosis (Freud, 1952, 1962). A second major figure in modern psychiatry, Albert Ellis, psychologist and founder of the school of psychotherapy known as "Rational Emotive Therapy" asserted that religiosity is in many respects equivalent to irrational thinking and emotional disturbance (Ellis, 1980). The noted Yale psychologist, Seymour Sarason (1993) suggests that any elements of the religious world view may well be regarded as "a reflection of irrationality, of superstition, of immaturity, of a

neurosis" (p. 187). It can be argued that the perspectives on religion by all three of these noted scholars have had an overall negative influence in psychiatry by way of the explict perspective of viewing any talk about religious or spiritual concerns as a disturbance in the individual's cognitive level of functioning, thereby needing psychiatric treatment.

The relationship between psychiatry and psychiatric nursing in regards to the perception of religion and spirituality is not explicated in psychiatric nursing literature. I assume that the perspectives of Freud (1952, 1962), Ellis (1980) and Sarason (1993) continue to provide a negative influence in psychiatry where psychiatrists have played major roles among the interdisciplinary health care team. As psychiatric nurses become more educated and socialized into their professional roles and assume a patient advocacy role for spiritual and religious concerns, negative attitudes and assumptions may be challenged in a constructive way to promote dialogue, discourse and increased awareness as to the role spirituality may have in relation to mental health and wellness of client groups.

The discipline of nursing explicitly recognizes the spiritual aspect of human experience in its clinical diagnosis nomenclature (Carpenito, 1999; Weaver et al., 1998). The notion of "spiritual distress" has been an official nursing diagnosis since 1988, according to a nursing diagnosis taxonomy put forth by the North American Nursing Diagnosis Association [NANDA] (Carpenito, 1999). This movement is a first step in providing clear direction to the profession of nursing and specifically to practicing nurses related to the inclusion of spiritual issues in the context of holistic care in psychiatric nursing settings (Carpenito, 1999; Townsend, 1997).

In contrast, diagnostic criteria for mental disorders and major classifications of disorders in psychiatry and psychology are outlined in the Diagnostic and Statistical Manual

of Mental Disorders (DSM). The DSM has until recently considered religion and spirituality only when illustrating examples of severe forms of psychopathology as located in the "Glossary of Technical Terms". Turner, Lukoff, Barnhouse, and Lu (1995) argue that the removal of the negative illustrations of religion and spirituality in the 1994 edition of the DSM-IV and the inclusion of religious and spiritual problems under Axis Code V will enhance cultural sensitivity regarding religion and spirituality for clinicians and may assist in shifting attention to the paucity of research in the field of psychiatry and psychology in relation to the relationship of spirituality to better mental health. Turner et al. (1995) argue that there is a need for a more culturally sensitive psychiatric classification system that would recognize psychospiritual and psychoreligious problems as "nonpathological". Turner et al. contend that this new proposed diagnostic category would increase the accuracy of diagnostic assessments when religious and spiritual issues are involved and reduce the occurrence of harm from misdiagnosis of psychoreligious and psychospiritual problems.

A review of how the concepts of religion and spirituality are viewed in the DSM-III (American Psychiatric Association, 1980) revealed one statement refering to delusions of religiosity as one type of delusion associated with the clinical Axis I diagnosis criteria for a Schizophrenic Disorder. In the DSM-III R (American Psychiatric Association, 1987) a delusional disorder of a gandiose type is noted to be a "delusional disorder in which the predominant theme of the delusion(s) is one of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person" (p. 203). Similarly, in the DSM-IV (American Psychiatric Association, 1994) a delusional disorder of a grandiose type is seen to have possible "religious content, e.g., the person believes they have a special message from a deity" (p. 297). I assume, based on two decades of psychiatric nursing practice, that when a

psychiatric diagnosis is made, the first intervention when encountering God-talk, or talk about religious or spiritual concerns is to assess and ascertain whether the individual's ideas are related to the psychological pathology (psychosis, delusions of grandeur) associated with the individual's presentation. Health care professionals who do not explore the underlying meaning of talking about religious values and beliefs because of fear of reinforcing delusional ideas may be missing a significant aspect of holistic health assessment and opportunities to tap into a potential resource for health and healing among psychiatric-mental health client groups.

In my experience, it is not uncommon for some individuals admitted to a psychiatric unit in a psychotic state with a previous psychiatric diagnosis of schizophrenia to talk about God, religion or spiritual themes. The individual's mental status may reveal delusions of grandiosity with the perception they believe they are God, the Messiah or a prophet. It is my perception that individuals admitted to a psychiatric unit learn that any talk about religion or spiritual matters is discouraged and sometimes interpreted as irrational thinking or delusional by the medical staff in psychiatric settings. In order to prevent harm that can arise from misdiagnosing a client with spiritual or religious concerns as having a psychiatric condition, mental health professionals need to be able to distinguish between healthy and unhealthy expressions of spirituality and religious beliefs (Campinha-Bacote, 1995).

It can be argued that psychiatry has influenced the practice of psychiatric nursing through the pioneer work of Hildegard Peplau, who is recognized as a pioneer in psychiatric nursing. Peplau's (1952) theory of interpersonal relations was influenced by Abraham Maslow's Theory of Human Motivation, Harry Stack Sullivan's work on personality development and interpersonal relations and Neal Elgar Miller's work on personality theory,

adjustment mechanisms, psychotherapy, and principles of social learning. Peplau (1952) views the person as "an organism that lives in an unstable equilibrium (ie. physiological, psychological, and social fluidity) and life is the process of striving in the direction of stable equilibrium; ie., a fixed pattern that is never reached except in death" (p. 82). Peplau's conceptualization of person does not explicate the dimension of spirituality explicitly. Peplau asserted human beings are irreducible and indivisible which may account for the ommission of a spiritual dimension in viewing persons holistically in her theory.

Peplau (1952) asserts that health "implies forward movement of personality and other ongoing human processes in the direction of creative, constructive, productive, personal and community living" (p. 12). I suggest that implicit in Peplau's definition of health is the idea of a spiritual aspect of living, specifically, the notions of creativity, personal and community living which are implicitly addressed as aspects of relatedness and connectedness to others, as an expression of spirituality. In Peplau's model, the relationship between the nurse and the client is central to working towards resolution of feelings associated with frustration, conflict and anxiety in an effort to meet the client's needs. Peplau's model emphasizes the "therapeutic use of self" and communication strategies to promote the therapeutic nature of the nurse-client relationship. Research studies in nursing suggest the concepts of relatedness and connectedness to others are sub-concepts associated with the broader construct of spirituality (Golberg, 1998; Hunglemann-Kenkel et al., 1985b) and these sub-concepts appear to be the underpinnings of Peplau's Theory of Interpersonal Relations.

Both the work of Sullivan related to interpersonal relations and Maslow's conceptualization of a hierarchy of needs played a significant role and influenced Peplau's theory related to the needs of clients and the therapeutic nature of the nurse-client

relationship. It can be argued, psychiatry and the perceived view on religion as being synonymous with neurosis (Freud, 1952) did not have a positive influence related to the inclusion of spirituality as conceptualized in Peplau's theory of nursing.

Within any conceptual model of nursing, Fawcett (2000) asserts that four meta-paradigms central to the discipline of nursing include: (1) the person who receives nursing care (patient or client); (2) the environment (society); (3) nursing (goals, roles, functions); and (4) health. Fawcett notes there are seven conceptual models of nursing which address all four meta-paradigms; these include nursing models by Johnson, King, Levine, Neuman, Orem, Rogers and Roy. The models vary in the amount of emphasis placed on each of the four meta-paradigms as well as in the theories that explain the concepts and the interrelationships among the concepts. The construct of spirituality as conceptualized explicitly in models of nursing remains in the formative stages of development as part of the Neuman (2002) systems model and is implicitly addressed by Rogers (1970) and Roy (1984). These three key conceptual models of nursing and their relationship to spirituality are explored in the following section.

Conceptual Models of Nursing and Spirituality

A review of the literature related to nursing practice models reveals a noticeable absence of spirituality as a significant construct (Martsolf & Mickley, 1998; Oldnall, 1995). Leddy and Pepper (1998) identify ten conceptual models of nursing and three key conceptual models whereby the construct of spirituality is explicitly addressed by Neuman and implicitly addressed by Roy and Rogers within the meta-paradigm of person. The construct of spirituality is examined as it is conceptualized with each of the three key nursing models (i.e., Neuman, 2002; Rogers, 1970; and Roy, 1984).

Neuman Systems Model

The Neuman (2002) systems model is rooted in systems theory which fits within the change-as-stability paradigm of nursing models (Leddy & Pepper, 1998) and the reciprocal interaction world view (Fawcett, 2000). It is the only one of the nursing models cited by Leddy and Pepper (1998) that explicitly identifies spirituality as a component of the person. The Neuman Systems Model explicates spirituality as one of five variables of the person. The person in the Neuman Systems Model is defined as a client/client system. The client system is composed of five interacting variables: physiological, psychological, socio-cultural, developmental and spiritual. The spiritual variable refers to the influences of spiritual beliefs. Neuman (2002) contends that variability in development of the spiritual variable is noted and that the client may never recognize or develop the spiritual variable, although it permeates all other client system variables. Further, the spiritual variable is perceived as a continuum from total unawareness or denial of its potential to a consciously developed high level of spiritual understanding. Fulton (1995) has contributed to the development of Neuman's spiritual variable identifying six characteristics of spiritual well-being (meaning in life, inner peace, and relationships with self, other persons, God, or a higher being) which may assist in operationalizing the Neuman Systems Model enabling a holistic approach to nursing care. It is assumed by Neuman (2002) that each person is born with a spiritual energy force. A Judeo-Christian perspective is observed in the author's writing whereby Neuman (2002) states:

> The human spirit combines with the power of the Holy Spirit as a gift from God when the innate human force, or "seed," becomes catalyzed by some life event such as humility, joy, or crisis.... the author believes that the human spirit or soul returns to the God source to live on into eternity when death occurs and it is no longer needed to empower the living mind, soul and body. (p. 16)

The Neuman systems model of nursing provides a conceptual framework that delineates spirituality as an explicit aspect of the model. Fulton (1995) has delineated six characteristics of spiritual well-being thus providing nurse researchers and practitioners with some direction in framing research questions using the Neuman systems model as a conceptual lens to view nursing practice holistically. Limitations of Fulton's work include a narrow conceptualization of spiritual well-being by way of excluding the concepts of relatedness to the environment, transcendence, and creativity as an expression of one's spirituality. Further research on the spiritual variable of the Neuman systems model is required to develop middle-range theory and thus provide nurse practitioners and educators with a framework to further guide spiritual assessment and interventions more adequately.

Rogers' Science of Unitary Human Beings Model

The Rogers Science of Unitary Human Beings Model fits within the change-as-growth paradigm of nursing models (Leddy & Pepper, 1998) and the simultaneous action world view (Fawcett, 2000). Rogers' model is derived from a knowledge base gained from physics, mathematics, biology, history, philosophy, astronomy, anthropology, and other sources integral to the life process. In the prologue of *An Introduction to the Theoretical Basis of Nursing*, Rogers (1970) asserts that "man's biological, physical, social, psychological, and spiritual heritages become an indivisible whole as scientific facts are merged with human warmth" (p. xii). Rogers' conceptual model of nursing is based on the assumption that the life process is characterized by wholeness, openness, unidirectionality, pattern and organization, sentience and thought. Rogers' model was constructed on the assumption that the person is a unified energy field which is constantly exchanging matter and energy with an environmental energy field.

The meta-paradigm of person according to Rogers (1970) consists of having physical, biological, psychological, social, cultural and spiritual attributes which are merged into behavior reflecting the individual as a whole being. Further, in her description of the meta-paradigm of person, Rogers (1992) asserts that the individual is comprised of a human energy field which is an "irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from knowledge of the parts" (p. 29). Rogers does not explicate spirituality beyond the identified attribute cited nor does she provide any clarity as to what is the meaning associated with "spiritual attribute". Rogers' model does not provide any clear direction for nursing practice in regards to the construct of spirituality.

Roy's Adaptation Model

The Roy Adaptation Model fits within the change-as-stability paradigm of nursing models (Leddy & Pepper, 1998) and the reciprocal interaction world view (Fawcett, 2000). Sister Callista Roy, a member of the Sisters of Saint Joseph of Carondelet, derived her model from Harry Helson's work in psychophysics, specifically Helsen's Adaptation Theory, then further refined it by using concepts and theory from Dohrenwend, Lazarus, Malaznik, Mechanic and Selye (Marriner-Tomey, 1994). In Roy's (1984) conception of the meta-paradigm person, she asserts that the person "is an adaptive system with cognator and regulator acting to maintain adaptation in regard to the four adaptive modes" (p. 36). Roy does not explicitly refer to spirituality in her description of the meta-paradigm person; however, she does make reference to the person as a holistic adaptive system when discussing the goal of nursing. Roy (1984) asserts that the nurse "views each person as a whole and is concerned about the person's psychological, spiritual, and social well-being as well as physical well-being" (p. 256). In her

chapter, "Self-concept: Theory and Development", Roy (1984) defines the moral-ethical-spiritual self as "that aspect of the personal self which functions as observer, standard-setter, dreamer, comparer, and most of all evaluator of who this person says that he or she is" (p. 256). Further, Roy describes the moral-ethical-spiritual self as "the person's belief system, morals, and evaluator of who one is" (p. 259). Roy does not explicate spirituality beyond this reference in her description of the self-concept mode, thus does not provide any clear direction in relation to the inclusion of spirituality in relation to nursing education and practice.

Based on a review of the conceptual models of nursing put forth by Leddy and Pepper (1998) there is a need for further research in developing middle-range theory from conceptual models of nursing that explicitly provide clear direction in addressing spiritual issues for practising nurses who aspire to provide holistic nursing care in their practice. Reed (1992) asserts that the discipline of nursing has a rich knowledge base both conceptually and clinically to develop an epistemological foundation in the study of spirituality, reinforcing the idea that the discipline of nursing is at the first stage of theory development in relation to the construct of spirituality (Farran, Fitchett, Quiring-Emblen, & Burck, 1989). The discipline of nursing continues to move along a developmental continuum in regards to theory development related to the spiritual dimension (Newman, 1994; Parse, 1995; Watson, 1988; Neuman, 2002; Roy, 1984; Rogers, 1970). Further research in relation to the spiritual dimension of persons will add to the development of middle range theory in relation to conceptual models of nursing.

The construct of spirituality as conceptualized explicitly in theories of nursing also remains in the formative stages of development in the work put forth by Margaret Newman, Rosemarie Parse and Jean Watson. These three key nursing theories and their relationship to spirituality are explored in the following section.

Nursing Theories In Which Spirituality Is A Central Construct

Three nursing theories have included spirituality as a central construct in their theoretical formulations of nursing (Martsolf & Mickley, 1998). These nursing theories include Newman, Parse and Watson. Each theorist's work will be reviewed to explore the extent to which spirituality is integrated into their theory of nursing.

Newman's Theory of Health as Expanding Consciousness

Newman's (1986) Theory of Health as Expanding Consciousness was influenced by the work of Martha Rogers. Newman expanded Rogers' notion of humans as energy fields to encompass humans as unique patterns of consciousness. Newman (1994) asserted that the process of life involves movement towards higher levels of consciousness. According to Newman, this process "is facilitated by insight and involves a transcendence of the spatial-temporal self to a spiritual realm" (p. 43). Newman asserts that health is a reflection of an underlying pattern of the person-environment interaction which is a constantly evolving pattern of the whole. The notion of pattern recognition is central to the process of evolving to higher levels of consciousness (Newman, 1994). Newman equates spirituality with human interaction, an activity and role of nursing which seeks to assist clients to identify their patterns of interactions within their environment. The goal of nursing is to help clients move toward a state of expanded consciousness, a transcendence from physical boundaries toward a spiritual realm (Newman, 1994). The nursing strategy is one of "being with" versus "doing for", which enables clients to discover their own truths and rules which apply to their individual situations (Newman, 1994). This approach promotes a partnership within the nurse-client relationship which leads to an expansion of consciousness for the client and the nurse. Newman's conceptualization of the spiritual realm is abstract and does not provide

clear guidance to nursing practitioners regarding spiritual care as a component of holistic care. Psychiatric nursing is concerned with individuals gaining insight into their patterns of relating; however, when individuals are challenged with a mental illness such as schizophrenia or clinical depression, the aim of achieving higher levels of consciousness to the practitioner may not be pertinent in providing direction to nursing practice. Nurses may gain clarity from Newman's notion of equating spirituality with human interaction as a component of spiritual nursing care; however, Newman does not go far enough in delineating aspects of nursing strategies which would support spiritual care within the nursing strategy of "being with" in efforts to assist patients to discover their own truths. Newman's theory requires further research in developing a middle-range theory which would provide clearer direction to practitioners in addressing spirituality as a component of their practice.

Parse's Theory of Human Becoming

Parse's (1981) Theory of Human Becoming which is also built upon the work of Rogers, has an aim to reshape nursing's view of the person from a medical orientation to a human science orientation. Parse (1981) asserts the aim of nursing is to assist the client uncover meaning in human experience. Parse's theory evolved from nine philosophical assumptions, three being related to human becoming. Spirituality is not explicated in any of the assumptions; however, the attributes of spirituality such as meaning, value and becoming are salient components of Parse's theory. The construct of spirituality is not explicated in Parse's theory and is noted implicitly in the notion of human beings drawing personal meaning which is a central component of spirituality. Nursing practice conceptualized from Parse's theory would strive to illuminate meaning, synchronize rhythms and mobilize transcendence, which translates into nurses dealing with spirituality in practice situations.

Martsolf and Mickley (1998) suggest that because Parse's theory is focused on the attainment of meaning related to the lived experience, any research inquiry related to spirituality would be conducive to testing her theory using the research process developed by Parse for this purpose. Parse's theory and its focus on meaning making related to human experience is congruent with a phenomenological approach to research; however, it does not provide clear direction to nursing practitioners regarding spiritual care as an aspect of holistic care. Nursing practitioners may interpret Parse's theory of aiming to illuminate meaning, synchronize rhythms and mobilize transcendence as too abstract to translate into direct nursing interventions in caring for patients. Parse's theory requires further research in developing middle-range theory in order to provide clearer direction to practitioners in addressing spirituality as a component of their nursing practice.

Watson's Theory of Human Caring

Watson's (1985) Theory of Human Caring situates spirituality within the philosophical claims espoused in Eastern philosophy, incorporating the concepts of soul and transcendence. One value associated with Watson's theory is the acknowledgement of a spiritual dimension to life and internal power of the human care process. Watson's work published in 1985 was influenced by the works of Nightingale, Henderson, Rogers, Newman, Maslow, Heidegger, Erickson, Selye, Lazarus and the interpersonal and transpersonal elements espoused by Carl Rogers (Marriner-Tomey, 1994). Fawcett (2000) refers to Watson's work as a theory reflecting a metaphysical, spiritual, existential and phenomenological orientation. Watson's (1985) view of human life is based on her definition of the soul, which she refers to as "the geist, spirit, inner self, or essence of the person, which is tied to a greater sense of self-awareness, a higher degree of consciousness, an inner strength, and a power that can expand

human capacities and allow a person to transcend his or her usual self" (p. 46). Watson refers to human as "mind-body-spirit gestalt of whole being (not only more than sum of parts, but different)" (p. 10). Watson states that incongruence occurs between and among the mind, body and soul when disharmony is experienced by the person. This incongruence leads a person to experience threat, anxiety, inner turmoil, and may lead to a sense of existential despair, dread and illness. Further, Watson notes that the profession of nursing ought to be concerned with how disharmony develops and how the self can experience more congruence, thereby establishing harmony with the mind, body and soul.

Watson (1985) contends that the goal of nursing is to assist individuals to develop harmony within the body, mind and spirit and to find meaning in their existence and experiences. Watson does not clearly explicate a clear distinction between religion and spirituality, nor does her conception of spirituality appear to provide clear direction for nursing practice other than advocating for the mind-body-spirit connection also espoused by alternative therapies outside the discipline of nursing. Watson's theory requires further research in developing middle-range theory in order to provide clearer direction to practitioners in addressing spirituality as a component of their practice.

A review of the three key nursing theories in which spirituality is a central construct provides evidence of nurse theorists delineating the spiritual dimension of persons in their theoretical formulations of nursing theory. Further research is warranted with each of the grand theories of nursing in order to develop middle-range theory and provide nurse practitioners with research based tools and frameworks to guide the delivery of spiritual care in psychiatric nursing settings.

An observation of the past three decades has revealed that nurse researchers and theorists have begun to envision spirituality as being broader than religion (Barnum, 1996; Berggren-Thomas & Griggs, 1995; Carson, Soeken, Shanty, & Terry, 1990; Gaskins & Forte, 1995; Hasse, Britt, Coward, Leidy, & Penn, 1992; Hungelmann et al., 1985b; Neuman, 2002; Newman, 1994; Parse, 1995; Reed, 1992; Stoll, 1989; Travelbee, 1971; Watson, 1985). While the investigation of spirituality in the discipline of nursing has gained popularity over the past two decades, significant gaps still exist in the nursing literature in relation to what spirituality is; how it is defined and differentiated from religion (Barnum, 1996; Cawley, 1997; Dyson et al., 1997); how the concept can be integrated into nursing curriculum (Greenstreet, 1999; McSherry, 2000; McSherry & Draper, 1997; Piles, 1990); and how the concept is applied to clinical nursing practice (Barnum, 1996; Carson, et al. 1986; Clark, et al., 1991; Maddox, 2001; McSherry & Draper, 1998; Oldnall, 1995, 1996; Peterson & Nelson, 1987; Reed, 1987). The construct of spirituality and concept of religion will be addressed in order to provide clarity to an often blurred conceptualization of the two terms found in nursing literature.

Spirituality Defined and Described

Presently, a wide range of definitions exist as to what spirituality is and how it is perceived and experienced by individuals. Despite variations, there is a growing movement to view spirituality as an essential component in providing holistic care and to view spirituality as a multidimensional construct. The research literature in nursing has not provided any consensus as to an operational definition of spirituality nor a conceptual or theoretical framework of spirituality in which to guide nursing practice.

A number of nurse authors have defined the construct of spirituality over the past three decades. Authors such as Ellis (1980) define the construct as "a quality of having a dynamic and personal relationship with God" (p. 642), and O'Brien (1982) defines the construct as "... that which inspires in one the desire to transcend the realm of the material" (p. 88). Dombeck and Karl (1987) assert that spirituality is that "life principle that pervades and animates a person's entire being, including emotional and volitional aspects of life" (p. 183). Labun (1988) defines spirituality as:

> An aspect of the total person that influences as well as acts in conjunction with other aspects of the person...is related to and integrated with the functioning and expression of all other aspects of the person; has a relational nature which is expressed through interpersonal relationships between persons and through a transcendent relationship with another realm; involves relationships with and produces behaviors and feelings which demonstrate the existence of love, faith, hope and trust, therein providing meaning to life and a reason for being. (p. 332)

Shelly and Fish (1988) suggest that the spiritual component of a person involves two other aspects in addition to a sense of meaning and purpose in life: (1) a means of forgiveness; and (2) a source of love and relatedness. Reed (1991) claims spirituality is defined broadly in terms of the "human propensity to find meaning in life through self-transcendence; it is evident in perspectives and behaviors that express a sense of relatedness to a transcendent dimension or to something greater than the self, and may or may not include formal religious participation" (p. 15).

Haase et al. (1992) refer to spirituality as a phenomenon that varies among individuals and becomes personalized with awareness of its qualities and one's own spirituality. The authors note that spirituality serves as a root for a person which may be latent or prosper with growth. Critical attributes related to spiritual perspectives shared by the authors include: (1) connectedness with people, the environment, the universe and/or the individual's God; (2)

belief in something bigger than the self and a faith that positively affirms life; and (3) creative energy which is constant and dynamic. The authors identify three outcomes from their conceptual analysis: (1) a sense of purpose and meaning in life; (2) a sense of guidance of human values observable in one's conduct of behavior; and (3) self-transcendence beyond the present context of reality which assists individuals to rise above personal concern and the material realm. The authors indicate that people with a spiritual perspective recognize self-transcendence within themselves.

Pullen, et al. (1996) describe spirituality as "the possession of a self-defined belief related to an inherent life force, such as God, Brahma, or energy… that can be interconnecting, individualistic, or granted by a higher power" (p. 87), and is not measurable by any physical scientific means. Nolan and Crawford (1997) posit that individuals experience spirituality on four different levels which are concerned with: (1) how individuals relate to themselves; (2) how individuals relate to others; (3) how individuals experience relationships between and within groups; and (4) how individuals experience "a relationship with that which is transcendent, whatever the transcendent may mean to any individual" (p. 292). Wright (1998) views spirituality as the dimension of a person's being involving one's relationship with self, other, the natural order, and a higher power manifested through creative expressions, familiar rituals, meaningful work, and religious activities. O'Brien (1999) suggests spirituality is best understood in relation to a person's "attitudes and beliefs related to transcendence (God) or to the nonmaterial forces of life and of nature" (p. 4). Meraviglia (1999) defined spirituality as "experiences and expressions of one's spirit in a unique and dynamic process reflecting faith in God, or a supreme being; it is connectedness with oneself, others, nature or God; and an integration of the dimensions of body, mind and spirit" (p. 24).

Ameling and Povilonis (2001) offer a simplistic way to define spirituality as "meaning making" and describe spirituality "as the search for existential meaning or for the answers to life questions such as who am I? Why am I here?; What does it all mean?" (p. 16). The authors contend spirituality can be viewed as a process of discovery and development throughout a person's lifetime.

Labun (1988) notes that spirituality is expressed through institutionalized religion, mystical experiences, creative activity and behavior that conveys an altered spiritual integrity. Institutionalized religion includes prayers, rituals, religious communities and worship while mystical experiences include transcendence to another reality and provides hope, faith in a future and a sense of love and meaning to life. Labun suggests creative activity includes volunteer work, writing and poetry as ways to express feelings and to give meaning and hope to life experiences.

In summary, a variety of definitions regarding spirituality reflect a number of sub-concepts that could fall under the broader construct of spirituality. These sub-concepts include: meaning and purpose in life, connectedness and inter-relatedness to others, the environment, universe, and one's God, love, hope, faith, forgiveness, trust, belief in a God or Higher Power, transcendence, and creativity. The guiding definition of spirituality for this study is one reported by Morris (1995) who claims that the experience of spirituality is defined as "a guiding philosophy, a motivating force, an inherent quality, a hierarchical conscious state that eventually merges with the Absolute, a transcendent interconnected relationship with a higher being, and a transcendent harmonious interpersonal relationship" (p. 47).

Religion Defined and Described

Traditionally, from a Western perspective, the term spirituality is used synonymously with religion which has become one of the major barriers to understanding the construct of spirituality within the discipline of nursing (Barnum, 1996; Byrne, 1985; Carson, 1989; Cawley, 1997; Dyson et al., 1997; Labun, 1988; Morris, 1995; Narayanasamy, 1993, 1996; Oldnall, 1996). While a relationship exists between the concept of religion and the construct of spirituality, definitions and descriptions will be explored to assist in differentiating religion from spirituality.

A variety of definitions regarding religion were located in dictionaries of religion and nursing literature. For example, religion is defined as a system of faith and community of worship where human recognition of a superhuman controlling power exists and where there is belief in a personal God or gods entitled to obedience and worship (Fowler & Fowler, 1982). Kennedy (1984) defines religion as a system of beliefs about reality, existence, the universe, the supernatural, or the divine. This religious system includes practices such as worship, maintaining a moral code, prayer, contemplation, obedience, and meditation. Murray and Zentner (1985) define religion as "...belief in a supernatural or divine force that has power over the universe and commands worship and obedience; a system of beliefs; a comprehensive code of ethics or philosophy; a set of practices that are followed; a church affiliation; the conscious pursuit of any object the person holds as supreme" (pp. 474-475). Dombeck and Karl (1987) define religion as "an organized body of thought and experience concerning the fundamental problems of existence; it is an organized system of faith" (p. 183). Hinnells (1995) cites the best known definitions of religion as:

> The essence of religion consists in the feeling of an absolute dependence (Friedrich Schleiermacher); A religion is a unified system of beliefs and practices relative to sacred things...(Emile Durkheim); Religion is that which grows out of, and gives expression to, experience of the holy in its various aspects (Rudolf Otto); Religion is what an individual does with his solitariness (Alfred North Whitehead); Religion is the sigh of the oppressed creature... It is the opium of the people (Karl Marx); Religion is the state of being grasped by an ultimate concern (Paul Tillich). (p. 415)

Pullen et al. (1996) view religion as the "spiritual activity individuals or groups perform to worship, possess, or enhance their spirituality" (p. 87). Further, Bowker (1997) cites several defintions of religion including:

> "the belief in Spiritual Beings (Edward Taylor)".... "religious beliefs correspond closely with the phantasies of infantile life, mainly unconscious ones, concerning the sexual life of one's parents and the conflicts this gives rise to (Sigmund Freud)".... "as a set of symbolic forms and acts which relate man to the ultimate conditions of his existence (R.N. Bellah)" (p. xv).

Additionally, the world religions are divided into two traditions, Eastern and Western (Oxtoby, 1996a, 1996b). Within the Eastern traditions, Oxtoby (1996a) identifies the traditions of Hindu, Jain, Sikh, Buddhist and also cites East Asian religions as separate from the earlier traditions with the inclusion of Korean Shamanism, Confucianism, and Taoism. Within the Western traditions Oxtoby (1996b) identifies the traditions of the Jewish, Zoroastrian, Christian and Islamic. Gerardi (1989) noted that the three religions of Judaism, Christianity, and Islam all originated in the Mediterranean. They are all monotheistic in belief, and the scriptures of these groups focus on the salient perception that only one God exists who personally created the world as we know it and has revealed himself through historic events of the past. Gerardi (1989) suggests that nurses need to be aware that:

> Important to these western groups are their moral codes that reject stealing, lying, slander, covetousness, and adultery and stress honour of parents, honesty, kindness, and generosity as important social concerns. Despite the similarities of Judaism, Christianity, and Islam, each religion has its own style, its own inner dynamics, its

own special meanings, its own uniquness. Therefore, each religious group must be seen from the perspective of persons within that faith in order to fully grasp the meaning of life for that individual. (p. 77)

Eastern philosophical traditions tend to focus on the person as a spiritual being with a spiritual goal. According to Vedanta, a Hindu school of philosophy [cited in Carson (1989)], the spiritual journey consists of the individual's learning to recognise the self that resides within. The self, or the atman, as it is referred to, is said to be consciousness itself, absolute truth and bliss and is eternal. Hinduism refers to this cosmic reality as Brahma, believed to be the absolute or supreme consciousness. Brahma is characterised in the scriptures as Sat-chit-ananda, which is translated as truth-consciousness-bliss. Brahma is perceived to be the very source of all existence, from which emerges the manifest world of name and form, time, space, and causation. According to Martin (1989), in attempting to explain the self:

> The Scriptures often use an analogy to the ocean. The self, which was mentioned as being of the same nature as cosmic consciousness, is like an ocean of stillness and bliss. On its surface appear eddies, swirls, waves, and currents that are descriptive of our myriad passing thoughts, moods, passions, desires, and ambitions. The rise and fall of these waves in no way affects the existence of the ocean itself. Anyone actively engaged in following the spiritual path tries to go past the turbulent surface and tap into the deep stillness of the ocean, from which spring wisdom, clarity, and strength. (p. 117).

In accordance with this perspective, Martin (1989) contends that "if a sense of wellness or good health affects the spiritual journey, then the spiritual journey, in its own turn, bears investigation: It helps clarify the emotions and intellect and provides a greater sense of physical vitality. Thus, health and spirituality have reciprocal effects on each other" (p. 117). Western and Eastern perspectives on world religions provide a broad basis to begin to appreciate the significance of individual beliefs affiliated with one or more religious traditions.

In summary, based on a review of selected nursing literature there appears to be no consensus among authors as to how the construct of spirituality is defined although common sub-concepts emerge. These sub-concepts cited in the nursing literature include a sense of meaning and purpose to life, relatedness to self, others, nature, and a higher power, love, hope, faith, forgiveness, creativity, and transcendence (Ameling & Povilonis, 2001; Coward, 1994; Dombeck & Karl, 1987; Ellis, 1980; Harrison & Burnard, 1993; Haase et al., 1992; Labun, 1988; Lacocque, 1982; Moore, 1997; Nolan & Crawford, 1997; O'Brien, 1982, 1999; Pullen et al., 1996; Reed, 1991; Shelly & Fish, 1988; Wright, 1998).

Dyson et al. (1997) argue that if the nursing profession is serious about developing a .definition and conceptual framework of spirituality that encompasses the needs of all its clients, then nursing must move beyond viewing spirituality as being exclusively related to religion. It can be argued that nurses may be able to provide holistic care when they are able to differentiate clearly between what is meant by religious and spiritual care. Religious care is conceptualized as assisting patients to maintain their belief system and worship practices in contrast to spiritual care which aims to assist patients to identify meaning and purpose in their lives, maintain interpersonal relationships and transcend their lived experience in a given moment in time (Emblen, 1992). The lack of consensus about operational definitions of spirituality is a major problem for nurse educators, researchers and practitioners.

I view the construct of spirituality as broader than the concept of religion, encompassing other sub-concepts such as meaning and purpose, hope, faith and forgiveness, love and belonging, inter-relatedness to self, others, the environment, transcendence, creativity, and belief in one's God or a Higher Power. The next section examines the use of the nursing process and the relationship to spirituality in the discipline of nursing.

The Nursing Process and Spirituality

The nursing process is a common approach used in the discipline of nursing to guide nursing care planning and involves nursing assessment, analysis, diagnosis, planning interventions and evaluation of client outcomes (Stuart & Laraia, 2001). The North American Nursing Diagnosis Association (NANDA) has developed a taxonomic structure for the classification of nursing diagnosis that began in 1973, was formalized in 1982, and continues to develop and evolve at biennial conferences on the classification of nursing diagnoses (Fortinash & Holoday-Worret, 2000). The classifications strive for development and refinement of a standard language that assists nurses in making decisions for health care practices, such as diagnostic.reasoning, critical thinking and the continued development of nursing theory and knowledge (Carpenito, 1999; Fortinash & Holoday-Worret, 2000). Spiritual distress and spiritual well-being are two nursing diagnoses published by NANDA and are described as follows.

Spiritual Distress and Spiritual Well-Being

One approach to begin addressing how to conceptualize spirituality in psychiatric nursing is to consider what it means to experience spiritual distress. Spiritual distress in nursing literature is defined as "distress of the human spirit... a disruption in the life principle which pervades a person's entire being and which integrates and transcends one's biological and psychosocial nature" (North American Nursing Diagnosis Association, 1996, p. 47). Burnhard (1987) contends "spiritual distress is the result of total inability to invest life with meaning" (p. 377). Carpenito (1999) defines spiritual distress as a state in which the person experiences a disturbance in his or her belief system that provides him or her with a sense of strength, hope and meaning to life.

Frisch and Frisch (2002) claim that individuals who experience mental illness experience feelings of hopelessness and powerlessness. Further, the authors add, without any meaning or purpose, an individual may experience a lack of inner strength, face alienation from others, and lose any connection to other people. People who lose any positive sense of future and who give up on any hope that the world and those people close to them will meet their needs, often will experience hopelessness. Hopelessness and powerlessness are two examples of conditions which may lead to spiritual distress (Frish & Frish, 2002).

The National Interfaith Coalition on Aging (as cited in Carson, 1989) defines spiritual well-being as experiencing affirmation of life in a relationship with a higher power (as reported by the individual), self, community, and environment that nurtures and celebrates one's wholeness. Hungleman et al. (1985b) assert that spiritual well-being is "a sense of harmonious interconnectedness between self, others/nature, and Ultimate Other which exists throughout and beyond time and space" (p. 148). Fulton (1995) concludes that research findings suggest a reciprocal relationship between a client's spiritual well-being and his / her health. Fulton notes spiritual well-being includes a sense of meaning in life, inner peace and relationships with self, others, God, or a higher being. Espeland (1999) defines spiritual wellness "as the aspect of self that gives meaning and purpose to our lives" (p. 36). Ross (1997) defines spiritual well-being as the overall state of spiritual health that "is evidenced by the presence of: meaning, purpose and fulfilment in life; the will to live; belief and faith in self, others and God" (p. xv).

It is important to have consistent definitions of spiritual distress and spiritual well-being in order to provide psychiatric nursing educators and practitioners with a standardized language to begin addressing spirituality in the curriculum and in the clinical practice environments. In relation to guiding psychiatric nursing education and practice, it is imperative to identify what is

meant by the term spiritual needs which when unmet may trigger spiritual distress among client groups. Further exploration of spiritual needs will assist in providing clarity as to better comprehend what psychiatric nurses may focus on in conducting a spiritual assessment as part of holistic health assessment as a central component of their psychiatric nursing practice.

Nursing Assessment of Spiritual Needs

Shelly and Fish (1988) define spiritual needs as the need for meaning and purpose, love, relatedness and forgiveness. Highfield and Cason (1983) report spiritual needs as encompassing the need for meaning and purpose; the need to receive love and to give love; and the need for hope and creativity. Hungleman et al. (1985b) report six spiritual needs which include an individual's·ability to express love, concern, forgiveness for others, giving and accepting help, accepting and valuing self, and expressing life satisfaction.

Piles (1990) suggests three ways in which a nurse can assess a clients' spiritual needs: (1) assessment of the client's immediate environment: looking for materials such as a Bible; objects that have any significant meaning to the client; family members and friends in the client's environment including the way they talk to each other, the type of relationship they have and the feelings the client is left with after the family or friends leave the hospital; (2) identifying religious practices that are important to the client when he/she is not ill and the meaning the client makes of these practices in relation to the history of the client and the immediate stressors the client is experiencing as well as how this practice brings future hopes and a sense of spiritual integrity to the client; and (3) examining the three factors of meaning and purpose, forgiveness, and a sense of love and relatedness.

A qualitative study by Emblen and Halstead (1993) sought to explicate spiritual needs and interventions comparing the views of patients, nurses and chaplains. Nineteen surgical

patients, twelve surgical nurses and seven chaplains were interviewed in relation to respondents' understanding of the term "spiritual needs". Six categories were established as encompassing spiritual needs and include: being religious, values, relationships, transcendence, affective feelings, and communication. The authors claim that all six categories must be assessed to identify all of the patient's spiritual needs.

Ross (1997) contends spiritual needs include a lack of any or all of the conditions necessary to achieve spiritual well-being in relation to meaning, purpose, life fulfilment, will to live, belief, and faith in self, others and God. Hermann (2001) identified twenty-nine spiritual needs of 19 dying patients that were collapsed into six themes. They include the need for religion, companionship, involvement and control about decisions in their life; the need to finish business or resolve unfinished life tasks; and the need to experience nature and the need for maintaining a positive outlook.

Further, Charters (1999) explored the religious and spiritual needs of mental health clients in the acute inpatient and acute elderly wards of a residential setting in the United Kingdom. He reports a 50 percent response rate (89 responses out of a total 179) questionnaires. Eighty-eight percent of respondents reported having some kind of religious or spiritual beliefs. Sixty-nine percent reported engaging in some form of religious activity important to them such as praying, meditating, reading the Bible or attending religious meetings. The author reports 20 percent of respondents indicated that being admitted to hospital had in some way impacted their religious or spiritual life while 31 percent reported their religious and spiritual needs had not been considered in the nursing care they received. Nurses reported waiting for clients to express their needs as an individual's faith or spirituality was perceived as a private matter.

The significance of this study underscores the important role psychiatric-mental health nurses have in conducting spiritual assessments and psychiatric nursing care planning with their clients in order to begin to meet the clients' spiritual needs as an element of holistic nursing care.

A review of the nursing literature in relation to spiritual needs reflects a wide variety of spiritual needs. The context of clinical nursing practice on a surgical unit, a psychiatric unit and an oncology unit offer some unique considerations for practitioners to consider when assessing spiritual needs of their client groups. Nurses need to be aware of spiritual issues in order to be sensitive to clients spiritual needs irrespective of the context of their nursing practice. The next section will address spirituality and nursing research in relation to chronic illness and psychiatric-mental health nursing.

Spirituality and Nursing Research

The nursing research regarding spirituality has primarily focused on people living with a chronic illness and terminal illness. A review of selected nursing research focuses on nurses' and patients' perceptions of spiritual care, spiritual needs, spiritual well-being, spiritual interventions, spiritual coping strategies with patients diagnosed with cancer, and spiritual or religious experiences with persons diagnosed with advanced-stage HIV disease. The nursing research is compelling in persons living with cancer and Acquired Immunodeficiency Syndrome (AIDS) as to the positive effects hope, spiritual beliefs and religious practices have on persons' perspectives on health and spiritual well-being (Carson et al., 1990; Hall, 1997; Harrison, 1997; Highfield, 1992; Mickley, Soeken, & Belcher, 1992; Pace & Stables, 1997; Peri, 1995; Sodestrom & Martinson, 1987).

Piles (1990) conducted a study to determine to what extent spiritual care was being provided to patients by practising nurses in four regions of the United States. Three hundred questionnaires were mailed out and 176 (59%) were returned completed from the four regions. The findings revealed that: ninety-six and one-half percent of the nurses perceived holistic care to include spiritual care; eighty-seven and one-half percent did not agree that spiritual care could only be provided by clergy and ministers; sixty-six percent reported feeling inadequately prepared to perform spiritual care; and sixty-two percent suggested that spiritual care was addressed in the classroom. Respondents concurred that lack of time (87.1%) and lack of knowledge (70.6%) were obstacles to meeting spiritual care in practice; seventy-eight percent agreed that if educational preparation had occurred, then spiritual care would be provided to patients; and eighty-nine point two percent concurred that content related to spiritual care should be included in the curriculum. Piles reports that "a mental health nurse argued that many nurses deliberately avoid discussion of spiritual concerns because of their fear that reference to God or religion may enhance neuroses in psychiatric clients" (p. 37). Piles contends that in order to overcome this obstacle, spiritual care needs to be addressed in the curriculum of basic nursing programs from nursing assessment to nursing intervention perspectives. Piles argues that nursing skills are mastered in the lab after instruction in the classroom and that synthesis of skills is enhanced with opportunities for practice in the clinical environments (e.g., administration of medicines orally, topically, intramuscularly, intravenously; or sterile dressing changes). Piles contends that a lack of attention to the spiritual needs of clients may be related to nurses feeling uncomfortable with the topic partly because nurses lack specific knowledge about spirituality and lack the necessary assessment and intervention skills. In addition, Piles noted that some nurses are not confident with their own sense of spirituality and therefore tend

to avoid the topic with their clients. This claim is supported in the nursing literature (Charters, 1999; Price et al., 1995; White, 2000).

Hall (1997) provides an alternative view of theory addressing spirituality in people living with a terminal illness. Hall argues that quantitative measurements have substituted diagnostic reasoning and structured interview questions in place of simply listening and responding to patients in the moment during nursing encounters. Hall advocates for nurses to approach their patients with a listening presence that allows nurses to learn who the patients are and what their spiritual needs entail. Further, Hall notes that patients who are suffering with a terminal illness need a nurse who is caring and will support them as they move toward health within their illness.

Narayanasamy (1996) claims that people living with a chronic illness are at risk of experiencing spiritual distress due to the disharmony of mind, body and spirit. Features of spirituality in chronic illness are reported to include: disorganization and disruption, search for meaning, hope and strength, love and harmonious relationships. Narayanasamy identifies nursing skills needed to provide spiritual care to meet the spiritual needs of people living with chronic illness. These include self-awareness, communication skills, building trust, ability to offer hope, and being a catalyst for patients' spiritual growth. The author contends that the nurse who promotes spiritual care may influence the patient's goal to achieve spiritual integrity and well-being, thus, "the restoration of a harmonious balance between body, mind and spirit" (p. 416).

A study by Pace and Stables (1997) sought to determine if terminally ill patients with AIDS had greater religious and spiritual care needs than terminally ill patients living with cancer. The authors surveyed 55 hospice patients using the Correlates of Spiritual Well-Being

Scale (COSWEB), which is reported to measure spiritual well-being, loneliness, health hardiness, social support, functional status, and pain. Results indicate that patients with AIDS reported significantly lower spiritual well-being scores than did patients with cancer. Patients with AIDS reported significantly greater loneliness scores and significantly lower social support scores than other patients. The authors suggest patients with AIDS may have a lower sense of spiritual wellness than other terminally ill patients as a result of decreased support systems and loneliness.

In a related study, O'Neill and Kenny (1998) sought to identify strategies to support the spiritual dimensions of nursing care for people with HIV-related illness and AIDS based upon a review of the conceptual, theoretical and empirical knowledge within the context of nursing care for this population. Findings suggest people struggle with questions about meaning and purpose in life within the context of living with the illness and the experience of perceived losses which may hinder meeting spiritual needs. The authors report engaging in prayer, guided imagery and meditation may enhance the body's response and delay disease progression. Outcomes of when spiritual resources are utilized include personal growth, mastery, empowerment, and individual transformation. The authors contend that nurses can support their patients in providing emotional and physical comfort and help in their quest to find meaning in life.

Sodestrom and Martinson (1987) conducted a study to describe the spiritual coping strategies of twenty-five hospitalized patients with cancer and their nurses' awareness of these strategies. In this study, an individual's spiritual dimension refers only to a person's relationship with God or a higher being which provides meaning and purpose in life. The findings revealed that patients used a variety of resource people and spiritual activities to assist them in coping

with their illnesses. In relation to their coping behaviors, few nurses were able to identify their resource people and few knew of the spiritual activities their patients used to cope with their illnesses.

The results of the descriptive survey of spiritual coping strategies utilized by hospital cancer patients (N=25) are as follows: (1) spiritual activities included such things as prayer (84%); asking others to pray for them (84%); asking others to pray with them (64%); use of religious objects and/ or music (64%); use of religious TV or radio (64%); reading the Bible (56%); attending church (52%); reading other religious books (40%); memorizing Bible verses (36%); and requesting communion (32%); and (2) spiritual resource persons included family members (92%); clergy (76%); friends (68%); nurses (48%); and physicians (24%). The authors report that two statistically significant variables were patients' regular church attendance and perception of prognosis. Individuals who attended church regularly (once per week) were found to utilize more spiritual resource persons (t[15.7] = 3.56, p < .005) and activities (t[18.9] = 5.71, p< .001) during their hospital admission than those who did not attend church on a regular basis. Individuals who were aware of their poor prognosis utilized a greater number of spiritual activities (t[4.16] = 2.19, p < .05) than those individuals unaware of their prognosis. This study reports that eighty-eight percent of patients utilized an assortment of spiritual activities and resource people throughout their experience in coping with cancer. These findings coupled with patients' reported increase in awareness and practice of their spiritual beliefs (66%) since diagnosis supports the salient role that spirituality plays in the coping behaviours of patients who have a terminal illness.

Through interviews with twenty-five nurses and matching their responses with those of their identified patients in the study, Sodestrom and Martinson (1987) found that nurses'

awareness of their patients' spiritual coping strategies varied. The authors report that forty-four percent of nurses identified their patients' religious affiliation accurately; seventy-six percent of the nurses accurately identified that their patients found a sense of meaning and purpose in their lives through a connection with God; sixty percent of the nurses accurately identified their patients' use of religious objects or music; forty-eight percent correctly identified patients' use of Bible reading; forty percent correctly identified that patients prayed, requested others to pray for and or with them, and attended church for worship; twenty-eight percent correctly identified their patients' use of religious television or radio; and sixteen percent accurately identified that their patients would memorize Bible verses; sixty percent identified patients' reliance on family, nurses, and physicians accurately; fifty-two percent identified patients' use of clergy correctly; and forty-eight percent identified patients' use of friends correctly. The authors report that sixty-four percent of nurses in this study perceived that they were able to assess spiritual coping strategies as well as their peers and yet they also reported that none of the nurses believed they assessed these strategies very well. Further, nurses identified a greater number of patients' spiritual activities when they perceived knowing patients the same or better than other patients they had cared for previously.

Hall (1998) reports in her qualitative study of 10 men and women in advanced-stage HIV disease that having either spiritual or religious experiences helped individuals cope with their HIV disease. The author reports three major themes emerged from the data with sub-themes among each major theme. These themes include: (1) purpose in life emerges from stigmatization (multiple social rejections, activist for social change, community support, spirit, connections, purpose for life of HIV disease); (2) opportunities for meaning arise from a disease without a cure (one's life has importance, relationships with friends, family of origin); and (3)

after suffering, spirituality frames the life (occupational changes, accepting oneself, helping others, accepting of declining health, spiritual clarity, explaining life). Hall contends that for most of the participants, organized religion was a barrier to attaining spirituality until their anger was relieved. This occurred when individuals concluded that the values and beliefs of the religions that labelled and persecuted them were flawed by a lack of caring and authenticity, and when they embraced more authentic and cogent spiritual ideas.

Dein and Stygall (1997) examined studies relating to religion and coping with chronic illness in the context of palliative care. Findings suggest that religion is a common coping strategy which may provide positive effects in relation to adjustment. A practical strategy advocated by the authors is the utilization of the clergy as a member of the interdisciplinary team who may help patients with their spiritual needs and their efforts to find meaning in their experience of illness. The authors claim that nurses are in a unique position to pick up upon their patients' altered spirituality and referring their patients to chaplains may assist with coping while receiving in-patient hospital care.

A review of the selected nursing research regarding spirituality and chronic and terminal illness provides a range of perspectives on a number of research questions related to spiritual care, spiritual nursing interventions and coping strategies. This body of nursing research may assist in the development of psychiatric nursing curricula related to spiritual care in relation to client groups living with a chronic or terminal illness. The next section will address spirituality in psychiatric-mental health nursing education.

Spirituality in Psychiatric-Mental Health Nursing Education

Psychiatric-mental health nursing education trends are reflected in textbooks that offer nurse educators a variety of tools to examine spirituality in the context of psychiatric nursing.

Nurse authors differ in the amount of content included in their text books dealing with aspects of spirituality as a component of holistic nursing assessment and intervention. The range of content in psychiatric-mental health textbooks related to spirituality is from no mention of spirituality as a concept (Stuart & Laraia, 2001) to a few paragraphs explicating definitions of spirituality, religion, religiosity, spiritual well-being and the psychiatric nurse's role in applying the nursing process to case study exemplars (Burgess, 1997; Frisch & Frisch, 2002; Haber, Krainovich-Miller, McMahon, & Price-Hoskins, 1997; Johnson, 1997; Rawlins, Williams, & Beck, 1993). Quantitative tools for assessment of a patient's spiritual and religious needs are illustrated, such as the Spiritual Well-Being (SWB) scale by Ellison (1983) and the JAREL spiritual well-being scale by Hungelman et al. (1985a) both of which have a Judeo-Christian bias (Burgess, 1997). The SWB scale by Ellison has established reliability although Kirschling and Pittman (1989) note that it lacks construct validity. The JAREL scale requires further testing for validation and reliability (Fulton, 1995).

Fortinash and Holoday-Worret (2000) offer a complete chapter that explicates the construct of spirituality as being broader than religion; presents stages of faith in spiritual practice and interventions; examines spiritual assessment; and provides an overview of stages of faith and moral development. The spiritual dimension is based on seven axes of assessment for clinical practice which include belief and meaning, vocation and obligation, experience and emotion, courage and growth, ritual and practice, community, authority and guidance. Fortinash and Holoday-Worret highlight open ended questions for each of the seven axes to be considered to guide assessment of the client's spiritual dimension.

Carson (2000) has a holistic focus to her text book entitled "*Mental health nursing - the nurse-patient journey*" which is rooted in Judeo-Christian beliefs. Throughout the text the

author asserts the importance of integrating the love of God into the reader's theory-based expertise. This psychiatric nursing text book is organized into seven units comprised of: background to the journey, the nature of the journey, guiding the journey, travellers across the life span, the wounded traveller, the journey and society, and the journey forward.

Psychiatric-mental health nursing education trends are beginning to include the spiritual dimension of the human experience in varying degrees within psychiatric nursing textbooks over the past decade. Further research is warranted as to psychiatric nursing interventions and outcomes that address spirituality explicitly from the perspectives of client groups.

Maddox (2001) contends a spiritual assessment is an important component of a comprehensive health assessment. The use of a formal structured tool provides a beginning framework for beginning students to use as they gain confidence in their role as health care professionals in beginning to recognize spiritual distress in their clinical practice.

Greenstreet (1999) posits nurse educators have a poor record in educating nurses in the area of providing spiritual care. One major barrier to the inclusion of spirituality in nursing education and practice is that spirituality is synonymously used with religion which many nurses are cautious to address in their work (Boutell & Bozett, 1990; Bradshaw, 1997; Greenstreet, 1999; McSherry, 2000; McSherry & Draper, 1997; Narayanasamy, 1993).

Narayanasamy (1993) investigated 33 first level general nurses' awareness and preparedness to meet the spiritual needs of patients using a standardized questionnaire. Findings note that the practice of spiritual care by this group of nurses is infrequent and if it is provided, it is on an ad hoc basis. The author reports nurses have a strong awareness of patients' spiritual needs, but viewed spirituality as a religious matter. The author concludes nurses are unable to provide spiritual care because nurse education programs do not adequately prepare nurses to

provide spiritual care and that spiritual care is viewed as the domain of hospital chaplains and religious leaders.

Barriers preventing the inclusion of spirituality in nursing curricula include intrinsic and extrinsic barriers (McSherry, 2000; McSherry & Draper, 1997). Intrinsic refers to the political, economic and administrative support from the educational institutions themselves regarding inclusion of spirituality in curricula. Extrinsic barriers are referred to as external factors which may arise from the individual or society based on individuals' values, beliefs, cultural norms and religious affiliations. McSherry and Draper (1997) conclude that reasons for the omission of the spiritual dimension in nursing curricula are complex and diverse, noting that blaming nurse educators for the absence of spirituality in the nursing curricula is inadequate due to intrinsic and extrinsic barriers.

The literature pertaining to teaching spirituality in nursing provides ideas regarding explicitly integrating spirituality content into nursing curricula. Bradshaw (1997) provides suggestions for objectives and content relating to spiritual care in a post-basic palliative nursing course. Issues needing to be addressed by students include: exploring their own beliefs/ values, sources of hope, love and strength; exploring theories which use a multicultural approach to client care; development of communication and counselling skills, enhancing students' ability in the therapeutic use of self; and, examination of complementary approaches in addition to traditional practices as part of holistic nursing care.

Greenstreet (1999) claims what should be taught in nursing education is some consideration of the meaning of spirituality among nursing students, reflecting on their own spiritual values and beliefs. Greestreet suggests through the use of the nursing process, assessment of patients' spiritual needs should address the meaning and purpose of life events,

meaningful relationships, the need to give and receive love, personal need for forgiveness, and hope. Additionally, Greenstreet states nursing assessment of the seven components of spiritual distress (spiritual pain, alienation, anxiety, guilt, anger, loss, and despair) posited by O'Brien may also guide the practice of spiritual nursing care. Teaching students interpersonal skills will assist in conducting spiritual assessments such as active listening, observing, and questioning and having some knowledge of world religions are believed to be most relevant to assessing spiritual needs (Greenstreet, 1999). Greenstreet asserts teaching methods should promote participatory strategies in regards to assessing and meeting patients' spiritual needs and are dependent on the interpersonal communication skills of the student which can fluctuate between 'being with' the patient as opposed to merely 'being there'.

Nursing research in psychiatric-mental health nursing education is warranted in relation to the effects of the inclusion of content on spirituality and religion to client health outcomes. The next section will examine the expected role that professional bodies of nursing have in relation to providing holistic nursing care to client groups, and in particular the context of psychiatric-mental health nursing and research related to spirituality in psychiatric nursing practice.

Spirituality and Psychiatric-Mental Health Nursing Practice

According to nursing's Professional Code of Ethics (Canadian Nurses Association {CNA}, 1997; College of Registered Psychiatric Nurses of British Columbia {CRPNBC}, 2000), and nursing's standards of practice and competency documents (CFMHN, 1995; CRPNBC, 1995a, 1995b; Registered Nurses Association of British Columbia, {RNABC}, 1998; Registered Psychiatric Nurses of Canada {RPNC}, 2001), nurses are expected to provide competent holistic nursing care to client populations.

A paucity of nursing research exists in the context of psychiatric-mental health nursing related to the substantive area of spirituality and schizophrenia. Few research studies on spiritual care in psychiatric-mental health nursing practice delineate what it means to provide spiritual care from the clients' perspective. Nurse authors advocate that spirituality is an essential dimension of holistic nursing practice and can contribute to a sense of spiritual well-being for individuals who experience acute, chronic and terminal illnesses whether physical or emotional (Barnum, 1996; Carson, 2000; Fulton, 1995; Hall, 1997; Harrison, 1997; Highfield, 1992; Morris, 1996; Neuman, 2002; Peri, 1995; Price et al., 1995; Reed, 1987; Roy, 1984; Travelbee, 1971; Watson, 1988).

Najai-Jacobson and Burkhardt (1989) assert that holistic care must move beyond viewing patients as "bio-psycho-social" beings to explicitly include the spiritual dimension of the human experience. The dichotomy between theory and practice which exists in clinical milieus is attributed to being rooted in the explicit absence of spirituality in the majority of the conceptual models of nursing, nursing theories and nursing curricula (Boutell & Bozett, 1990; Carson, 1989; Shelly & Fish, 1988; Labun, 1988; Oldnall, 1995; Narayanasamy, 1993; McSherry, 2000; McSherry & Draper, 1997; McSherry & Draper, 1998). I believe that psychiatric-mental health nursing practice actually reflects the current state of theory development in relation to spirituality in psychiatric-mental health nursing education, reinforcing the need to develop a substantive theory in relation to the experience of spirituality among individuals living with schizophrenia.

In psychiatric nursing practice, there is clearly a lack of direction and clarity as to what is meant by the notion of providing spiritual care to persons living with a mental illness.

Carson et al. (1986) point out that nursing has become so technical and physiologically oriented that the idea of spiritual care creates a source of discomfort and embarrassment for some nurses. Additionally, nurses perceive that spiritual issues are not their concern and ought to be referred to the clergy (Carson et al.). The authors suggest that a nurse who lacks spiritual beliefs and awareness of these beliefs is ill prepared to deal with the spiritual care of their clients. Carson et al. note that when individuals enter the health care system, they bring their spiritual beliefs with them (e.g., belief in a higher power). Often, these beliefs may be intensified by the individual's mental illness and can influence both their recovery rate and their attitude toward treatment (Fehring, Brennan, & Keller, 1987). Ideally, I contend in order to provide competent holistic care, psychiatric nurses should be able to assist clients to meet their spiritual needs as competently as they assist them to meet their physical, psychological, socio-cultural, and developmental needs. Peterson and Nelson (1987) suggest that nurses in psychiatric settings have a unified method of dealing with spiritual issues of their clients: they ignore them and speculate that they are manifestations of the client's pathology (religious themes / delusions). Peterson and Nelson note that a twenty-three year old client hospitalized for suicidal ideation shared with a nursing student "I think about suicide. I'm afraid that if I do commit suicide I will go to hell. I don't have anyone to talk to. Sometimes I pray, but I wonder why God makes me think these things and why he makes me mentally ill" (p. 34). The authors report that in this instance the nursing staff ignored the religious content of the client's statement and that the client was asking one of the most basic questions known to humankind, "Why did this happen to me?" When nurses ignore this type of question, there is a lack of respect by not acknowledging the patient's religious orientation and a lost opportunity to begin exploring what meaning the patient draws from the experience of illness.

Peterson and Nelson (1987) note that suicidal clients may be struggling with a lack of meaning and purpose in life or guilt for which they can find no forgiveness and that clients with a need in the area of love and relatedness may have trouble believing in their own worth and value or in maintaining long-term relationships with other people. Peterson and Nelson illustrate this point by describing a case where one client, who had been hospitalized twice for inappropriate sexual behaviour, shared his despair with hospital staff by saying: "I have lost all hope; shortly after his discharge he went home and killed himself" (p. 35). The authors also report that clients often talk about having done something for which they cannot forgive themselves, or talk about things that others have done to them that they cannot forgive. They point out that a sense of love and relatedness is a significant issue for many clients with mental illness. This population often experiences a decrease in ability to establish and maintain social relationships due to their mental illness. Despite their ups and downs individuals living with mental illness have a need for closeness and unconditional acceptance.

According to Shelly and Fish (1988) the spiritual realm can be the person's most important stabilizing force and support system in dealing with physical or emotional illness, particularly when individuals can find meaning and purpose in life, a means of forgiveness, and a source of love and relatedness with others. In the discipline of nursing, and specifically psychiatric nursing, a review of the literature indicates that clients' spirituality is often unrecognized (Haber, et al., 1997; Piles, 1990; Reed, 1992). Psychiatric nurses need to be aware of human experiences for their patients that may lead to a sense of altered spiritual integrity (Labun, 1988; Piles, 1990; Reed, 1992).

Moller (1999) examined how to meet the spiritual needs of individuals who had been hospitalized for psychiatric treatment during psychosis. A total of 65 patients and 27 family

members participated in the study. Moller reports each focus group was equally composed of men and women representing Catholic, Protestant, nondenominational Christian, Jewish, Native American, and Eastern religions of Islam and Buddhism. No data is reported as to participants' psychiatric diagnosis, other than persons who have experienced psychosis. I would note for many psychiatric disorders and conditions, psychosis can be an outcome of the severity of a disorder or condition such as major depressive disorder, bipolar affective disorder, postpartum depression / psychosis, drug induced psychosis, and schizophrenia. Moller reports four themes emerged to describe spiritual needs during an inpatient hospitalization: comfort, companionship, conversation, and consolation. The author delineates 11 interventions for clergy/ spiritual leaders within the four emergent themes and they include: (1) comfort, letting the patient know you care, providing reassurance God hasn't left them and will still be there when discharged from hospital, being accepting of patients' needs; (2) companionship, visit me in hospital, remain in contact and welcome me back to church after discharge; (3) conversation, listen to me, be concrete in your responses to me, be real; (4) consolation, come prepared, be empathic not sympathetic, and reserve any sermons. The findings revealed that patients believed it was important to them to be asked about their spiritual beliefs and that they needed pastors or spiritual resources to provide interventions such as comfort, companionship, conversation and consolation while receiving inpatient care. I contend psychiatric-mental health nurses can draw upon this knowledge and facilitate interventions to support the spiritual needs of patients such as referral to services from hospital/ community clergy and spiritual leaders.

Sullivan (1993) conducted a qualitative study investigating 40 individuals who remained out of a psychiatric hospital for at least two years following a diagnosis of a severe

mental illness such as schizophrenia or bipolar disorder. Sullivan noted 48% of those interviewed believed that spiritual beliefs were a significant part of their success. Sullivan stated, "Spirituality can serve as an effective buffer against negative events and as a source of social support, and may provide a sense of meaning and coherence to life" (p. 125).

The notion of religious practices incorporated into nursing practice is addressed by Harrison (1993) who suggests prayer, rituals and worship are means by which nurses may facilitate patients meeting their spiritual needs. A study by Hammaker (1998) of mental health consumer needs suggests that church and religious affiliation may provide mental health consumers with a valuable resource within the continuum of services required for psychiatric rehabilitation. Hammaker reports that 39 percent of mental health consumers surveyed identified church or religious activities as important, suggesting that mental health practitioners set aside traditional avoidance of church and religious affiliation and that they listen to the needs and resources identified by mental health consumers. The major barrier to collaboration and partnerships between mental health services and religious institutions is reported as the failure to identify shared goals (Hammaker, 1998).

One study by Meitzen, Seime, and Ward (1998) sought to measure religious knowledge and clinicians' willingness to utilize such knowledge in psychiatric milieus. The authors concluded that 61% of clinicians utilized religious knowledge and 66% indicated they would initiate discussion of religious issues. Meitzen et al. (1998) contend that mental-health clinicians ought to have some understanding of the religious beliefs of their patients and that clinicians demonstrating 61% of their religious knowledge is inadequate "to comprehend the beliefs and presuppositions about life and the world which shape the inner dynamics of an authentically religious patient" (p. 7).

Two research studies examined mental health nurses' spiritual perspectives (Pullen et al., 1996) and mental health nurses' spiritual interventions (Tuck, et al., 1997). Pullen et al. (1996) investigated the spiritual perspectives of a convenience sample of 50 mental health nurses employed in a public facility using the Spiritual Perspective Scale (SAPS) developed by Reed. The SAPS instrument was developed to measure two components of one's spiritual perspective, first the extent to which spiritual values (VS) are held and second, how spirituality is expressed through spiritually related interactions (IS). The authors report no variables were identified as significant contributors to a nurse's spiritual perspective, but noted an overall high SAPS with the mental health nurses compared to other groups of nurses reported in other research literature by Reed. Three limitations of the study are cited that include a small convenience sample, spiritual data gathered with self-report questionnaires and the narrow scope of the SAPS tool. The authors report the sample of mental health nurses had higher scores on the SAPS than were previously reported in the literature using the same tool. The authors attribute the higher scores to higher number of years working as nurses and noted the nurses were of an older age group. The authors conclude that perhaps spirituality is a phenomenon that can best be studied using qualitative research methods.

Tuck et al. (1997) explored the spiritual nursing interventions provided by 50 mental health nurses in a long term, public mental health facility using a descriptive qualitative design of critical incidents. The study sought to answer two research questions: "What are the spiritual interventions made by mental health nurses in their everyday practice? Are there differences in their ideal, general, and actual implementation of spiritual interventions?" (p. 354). The authors report four categories emerged from the data analysis of the descriptive critical incidents. They include two categories focused on the nurse and her interactions with clients (being with the

client and doing for the client), and two categories focused on the client (facilitating the client to look inward and look outward). Facilitating behaviors of the client to look inward involved the use of prayer, participation in religious activities, inquiring about God, reading the Bible, guiding, and affirming oneself. Facilitating behaviors of the client to look outward involved seeking external resources such as ministers, social workers, chaplains and clergy. The authors contend by facilitating the seeking of external resources, the nurse empowers the client by giving the responsibility back to the client to seek out spiritual resources. The authors assert independent analysis of the data by three researchers supported an audit trail revealing dependability and confirmability of the findings.

Another study by O'Brien (1999) identifies seven common human experiences associated with altered spiritual integrity. Behaviors and associated experiences include: (1) spiritual pain--discomfort or suffering associated with one's human relationships as well as one's transcendent values and beliefs; (2) spiritual alienation--loneliness not fulfilled by interpersonal relationships; (3) spiritual anxiety -- fear of the unknown or impending doom of one's self or loved ones; (4) spiritual guilt--regret about one's lifestyle and the values and beliefs which have been expressed; (5) spiritual anger--feelings of injustice in a situation and blaming an intangible source or higher power; (6) spiritual loss--feelings of loss of aspects of life that had provided meaning and purpose; and (7) spiritual despair--feelings of hopelessness in ultimate values, beliefs and experiences leading to an inability to make any sense of life. Individuals living with a mental illness and who are hospitalized for psychiatric care have a high risk for altered spiritual integrity. Psychiatric-mental health nurses need to be aware of these behaviors in order to address spirituality in their practice.

Berggren-Thomas and Griggs (1995) suggest nurses who maintain a spiritual journey perspective are not required to assess a client's spiritual state or be concerned with ascertaining a healthier state. Berggren-Thomas and Griggs claim nurses should aim to meet clients on their personal spiritual journey by way of attentive listening, use of empathy, prayer for or with patients or mere conversation; thus nurses would allow their individual spirits to touch those of their patients along their patients' paths of spiritual growth. Berggren-Thomas and Griggs argue that what is required in the discipline of nursing is not a new conceptual framework of spiritual care but a "new mind-set of what it means to care for the spirit" (p. 9).

I disagree with the position put forth by Berggren-Thomas and Griggs and support the need for development of a substantive theory that may guide psychiatric-mental health nurses in conceptualizing how they may begin to address spiritual care in their practice in working with individuals living with schizophrenia.

A review of the selected literature related to spirituality and psychiatric-mental health nursing practice reaffirms the need for the construct of spirituality to be integrated into psychiatric nursing curricula in order to educate future psychiatric nurses and enhance their knowledge and skills in providing competent holistic care which addresses the spiritual dimension of clients living with a mental illness (Carson et al., 1986; Fehring, et al., 1987; Oldnall, 1995; Peterson & Nelson, 1987; Piles, 1990; Reed, 1991, 1992; Shelly & Fish, 1988; Sodestrom & Martinson, 1987; Swinton & Kettles, 1997). Further research is needed in relation to persons living with a mental illness in order to gain a deeper understanding of how individuals living with schizophrenia experience spirituality and how psychiatric nurses may begin to address their spiritual needs in clinical practice.

Conclusion

Nursing with its roots in religion until the time of Florence Nightingale has been influenced by the scientific paradigm and a variety of psychological theories and perspectives which have shaped nursing's thinking regarding spirituality and spiritual concerns. The spiritual dimension is concerned with that life principle which prevades the entire being and generates a capacity for transcendent values and a relationship with the transcendent. The discipline of nursing claims to be concerned about nurses providing competent holistic care; however, a false sense of clarity exists as to what is meant by providing holistic care, specifically in regards to spiritual care in psychiatric nursing education and practice. The construct of spirituality is complex and multidimensional, requiring further exploration and development. The literature on spirituality in nursing is rich in ideas and notions about the nature of the construct.

Nurse authors have different perspectives as to what spirituality is and where it occurs, within the individual and/or between the individual and another person, group, family or community. Nurse theorists and researchers (Fulton, 1995; Neuman, 2002; Watson, 1988), have recognized spirituality as paramount within the realm of health and healing and in the context of the nurse-patient relationship in particular. The spiritual dimension of the person is the most salient aspect of the person (Shelly & Fish, 1988) and often the most misunderstood, untapped resource for individuals with mental illnesses. A valuable part of the person is missed when spiritual care is not addressed and consequently psychiatric nurses fail to provide quality holistic care to their clients. Leininger (1991) notes that when the spiritual needs of a client are identified and met along with the other client needs, the client may transcend to a different level of being and becoming. When a client expresses concern about whether he/she has the strength

to live or die, the client is clearly thinking and talking about issues related to spirituality, that is searching for a sense of purpose and meaning about life in the context of their illness.

The nursing literature in relation to spiritual care in the context of psychiatric-mental health nursing practice remains sparse. Research instruments that have demonstrated validity and reliability in relation to the concept of spirituality as separate from other concepts are required for use in the discipline of nursing in order to develop middle-range theory and to guide psychiatric nursing education and practice. Research investigating spirituality within the discipline of nursing has demonstrated a need to integrate the construct into nursing curricula in order to assist in educating mental health professionals about the spiritual dimension of the human experience.

The spiritual dimension of an individual cannot be defined scientifically, and therefore many nurses do not consider it an important part of patient care (Boutell & Bozett, 1990; Bradshaw, 1997; Greenstreet, 1999; McSherry, 2000; McSherry & Draper, 1997; Narayanasamy, 1993). As psychiatric nursing moves into the 21st century, there is a need to begin looking at the client as a whole person, including the spiritual dimension. Spirituality and related concepts such as purpose and meaning, hope, faith and forgiveness, love and belonging, inter-relatedness to self, others, and nature, transcendence, creativity, and belief in a higher power, God, or energy are concepts that require further theoretical and empirical attention. Further inquiry into spiritual needs and spiritual care of both the recipient of care and the caregiver will enhance our understanding of concepts related to spiritual care in psychiatric-mental health settings. There is little research into the quality of life and the perception of what gives individuals living with schizophrenia a sense of spirituality during periods of

stable mental health and during exacerbation of symptomatology associated with the mental

illness, schizophrenia.

The following chapter will discuss the research methodolgy of grounded theory in the

tradition of Glaser and Strauss (1967) which was used for this research study and elements of

the research process, design and analysis.

CHAPTER THREE

Methodology

In this chapter, I will discuss the research methodology utilized for this study. The chapter includes an introduction to the specific research design, including philosophical underpinnings, elements of grounded theory methodology, selection and recruitment of research participants, recruitment procedure, characteristics of the participants, and procedures of data collection and analysis. The chapter concludes with discussions of ethical considerations and the strengths and limitations of grounded theory methodology.

Overview of Grounded Theory

The research method used for this inquiry was grounded theory in the tradition of Glaser and Strauss (1967). This research approach focused on delineating a contextually-grounded description and theoretical explanation of the experience of spirituality among individuals living with schizophrenia. Glaser and Strauss (1967) describe grounded theory research as an inductive research technique in which inductive analysis reveals an understanding of the phenomenon under study that is derived in the context of people's experiences and statements about those experiences. The primary purpose of grounded theory is to generate explanatory theory of human behavior (Burns & Grove, 1997; Glaser & Strauss, 1967, Glaser, 1992; Melia, 1996). The resultant explanatory theory, or substantive theory, is discovered through a systematic process of data collection and analysis related to the phenomenon of inquiry and then verified with the research participants (Burns & Grove, 1997; Glaser & Strauss, 1967; Morse & Field, 1995). Glaser and Strauss (1967) assert grounded theory is appropriate for research within the applied professions such as nursing, adult education and continuing education. Grounded theory research in the field of nursing is

primarily concerned with enhancing professional practice by better understanding the phenomena of inquiry (Morse & Field, 1995).

The development of theory is grounded in the data (Burns & Grove, 1997; Glaser & Strauss, 1967; Glaser, 1992; Keddy, Sims, & Stern, 1996). The types of research questions addressed in a grounded theory study include process type questions for which little theory has been developed, such as investigating and describing the experience of spirituality among persons who are diagnosed with schizophrenia (Bowers, 1988; Burns & Grove, 1997; Glaser & Strauss, 1967; Glaser, 1992; Morse & Field, 1995; Swanson, 2001).

Grounded theory research emerged from the discipline of sociology. It is based on symbolic interaction theory developed by George Herbert Mead. Symbolic interaction theory provides a lens through which researchers can explore how people define reality and how their beliefs are related to their actions (Burns & Grove, 1997). It contends that reality is constructed by attaching meaning to situations (Mead as cited in Burns & Grove, 1997). Meaning is expressed in terms of symbols such as words, religious objects, and clothing. These symbolic meanings are the basis for actions and interactions. Shared meanings are translated to new members through socialization processes (Melia, 1996; Morse & Field, 1995). For example, in the current study, participants related the experience of attending a clubhouse as promoting a sense of connectedness to other individuals who are accepting of their strengths and limitations associated with schizophrenia; therefore, attendees of the clubhouse are active co-creators of the meaning of being mentally ill and having chronic schizophrenia.

Grounded theory entails the simultaneous processes of literature review, data collection, question and hypothesis generation, and data analysis (Glaser & Strauss, 1967;

Glaser, 1992; Kendall, 1999; Melia, 1996; Morse & Field, 1995; Swanson, 2001). The grounded theory research process involves formulation, testing, and redevelopment of propositions until a theory evolves using the constant comparative method of data analysis (Glaser & Strauss, 1967; Glaser, 1992). For example, early in the interviews, one participant expressed conflict between his religious beliefs regarding sexual intimacy and his behavior with sex-trade workers. I asked other participants in subsequent interviews to respond to this participant's dilemma; i.e., conflict between religious ideals and sexual practices. This led to a further realization of the secrecy with which many participants guarded such information, particularly in their discussions with health care professionals. Participants validated at the conclusion of the research that their fear of being judged negatively by health care professionals and their internal conflict regarding their behavior resulted in sexual issues not being a topic of most client-practitioner interactions.

A grounded theory researcher investigates the nature and patterns of interaction and their meaning to the participants. The researcher must attempt to understand and capture the world from the participant's viewpoint (Burns & Grove, 1997; Glaser & Strauss, 1967; Glaser, 1992; Morse & Field, 1995; Swanson, 2001). Analysis of interactions consists of ascertaining the participants' self-definitions and shared meanings. The researcher must also consider the broader context to discover the shared meanings of individuals, families, groups, aggregates, and communities (Burns & Grove, 1997; Glaser & Strauss, 1967; Kendall, 1999; Morse & Field, 1995). One must examine the setting, the significance of the setting, and the larger social forces such as beliefs and behaviors that may influence behavior (Glaser & Strauss, 1967; Morse & Field, 1995).

Research Design

The research project was a grounded theory study. As discussed in the previous section, grounded theory is a qualitative, exploratory inductive research methodology (Bowers, 1988; Burns & Grove, 1997; Glaser & Strauss, 1967; Glaser, 1992; Merriam & Simpson, 1984; Morse & Field, 1995). Using grounded theory methodology challenges the researcher to: (a) facilitate a rigorous process of scientific research; (b) identify through bracketing personal biases and assumptions that may hamper interpretation of data; and (c) generate a sound explanatory substantive theory that is grounded in the experience of the participants and congruent with reality that it seeks to represent (Glaser & Strauss, 1967; Glaser, 1992; Morse & Field, 1995).

Researchers typically utilize interviews and observations as data collection methods to develop grounded theory (Melia, 1996). The identified processes of grounded theory research include coding of data (identification of properties and concepts that reflect the main ideas of statements generated by the participant and serve as building blocks for emerging data categories); theoretical sampling; use of memos (methodological notes and theoretical notes kept in order to serve as the basis for changes in the focus and direction of the interviews and observations); generation of core categories; and a final focus on the process of conceptual / theoretical sorting for the purpose of organizing the data in a manner by which the theory could be presented to others; i.e., in this study, as the emergence of a substantive theory related to the experience of spirituality for individuals living with schizophrenia.

There are some methodological issues associated with grounded theory research method that must be considered in research design, including forcing the data into

predetermined categories and premature categorization of the data without sufficient

theoretical sampling to determine negative cases and outliers (Glaser & Strauss, 1967;

Glaser, 1992). Dr. Barney G. Glaser (personal communication, February 20, 1998) stated it

is essential when doing grounded theory research to allow time and patience for the data to

emerge.

<div align="center">Philosophical Underpinnings of Grounded Theory</div>

Grounded theory is rooted within the philosophical orientation of symbolic

interactionism. Mead (1934), known as a social psychologist and pragmatist, developed this

theoretical perspective based on the interrelationship between mind, self, and society,

explicating an ontological position and epistemological framework for what was later

articulated as symbolic interactionism by Herbert Blumer (1969). Mead was interested in the

effect a social group has on the experience of the individual. Mead delineated a theoretical

explanation asserting minds and selves are social emergents, and language in the form of

vocal gesture is the mechanism for their emergence. Mead claimed consciousness is a

product of the interaction between person and environment and thus theoretically linked

mind, self, and society.

According to Wilson (1989), the challenge for the grounded theory researcher is to

examine the manner individuals define and construct their reality over time. Reality is

perceived as a continual process of emergence and change from the perspective of symbolic

interactionism. Wilson lists three principal assumptions of the symbolic-interactionist

philosophy:

1. individual meaning evolves through a process of interpretation;

2. human behavior is the outcome of meaning attributed to things in the environment of the individual; and,

3. interactions with others determine the meaning they attribute to things.

The focus of grounded theory research, arising from these assumptions, is the natural experience of the individual; therefore, in the current study, the focus of the investigation was on the participants' experience with spirituality, not their cognitions about spirituality.

Grounded theory researchers utilize themselves as a research instrument, exploring their own assumptions, biases, perspectives and interactions as a source of the data collection and analysis procedures (Paterson, 1994; Wilson, 1989). Thus it was necessary for me to identify my position in relation to the phenomenon of interest and clearly state my own biases and assumptions explicitly in chapter one in order to be aware of them and work at maintaining objectivity throughout the research process. This proved to be extremely valuable. For example, at the onset of the research, I assumed that the treatment of schizophrenia, including medications, would enable people with schizophrenia to experience spirituality in an enhanced way. The research data soon presented an alternative explanation; e.g., that the treatment of schizophrenia can actually function as a barrier to spirituality.

Elements of Grounded Theory Methodology

Data, properties, categories and hypotheses are elements of the grounded theory approach to research (Glaser, 1992; Glaser & Strauss, 1967; Keddy et al., 1996). Properties stemming from the data are descriptors of the categories. Tentative hypotheses are formulated as a result of the emerging categories which are described by the properties (Glaser, 1992; Glaser & Strauss, 1967). For example, initially, I hypothesized from the literature and my previous experience that participants' experience of attending Tuesday night bingo hosted by

the Mental Patients' Association promoted a sense of community, relatedness and connection with other individuals living with a mental illness. However, one participant commented that this was not sufficient; it was important to establish community with well people, as well as those with schizophrenia, to develop a broader and more balanced experience of spirituality. In subsequent interviews with other participants, I asked them to elaborate on their experience at the bingo by asking, *"Is the connection you experience there all that you need to experience spirituality?"*

Sample

Selection of Participants

The total sample size for the study consisted of 20 research participants diagnosed with schizophrenia. The purposive method of nonprobability sampling was used to select participants for this study. Accordingly, all participants were deliberately selected according to the theoretical needs and directions of the research study. Schumacher and McMillan (1993) describe purposeful sampling as the selection of "information-rich key informants...who are knowledgeable and informative about the phenomena the researcher is investigating" (p. 378). Participants were purposefully selected based on having a diagnosis of schizophrenia and their interest in providing information that would contribute to the development of substantive theory related to their experience of spirituality.

Greasley et al. (2001) claim that there are a number of issues to be considered in the selection of the sample for such research, such as the likelihood that some people with schizophrenia would be unwilling to talk about their experience with spirituality because of past negative experiences with religious delusions or because they were not well enough to focus on the researcher's questions. Another issue was the possibility of participant attrition

related to their mental illness/ exacerbation of symptoms over the course of the research study. Greasely et al. (2001) in their study used focus group interviews with patients and carers claiming "to subject mental health patients, users or carers to individual interviews on the topic of spirituality might cause great anxiety" (p. 631). Accordingly, it was possible that some participants were deemed suitable at the onset of the study but, because of changes in mental status, were not appropriate to be included in the study as the research progressed. None of these concerns came to fruition in the study.

Theoretical sampling was employed throughout the study. Theoretical sampling entails the researcher "jointly collects, codes, and analyzes the data and decides what data to collect next and where to find them in order to develop the theory as it emerges" (Glaser & Strauss, 1967, p. 45). Prior to the study, I identified several factors that might enhance or limit the experience of spirituality in schizophrenia. This list provided some initial sampling parameters. For example, as living alone may be a barrier to spirituality, I intended to include participants who lived in community, with a partner, and by themselves. Another way in which theoretical sampling occurred in the research was that I deliberately sought both men and women as participants. I chose to access agencies in which both men and women with schizophrenia would be likely to be clients. However, despite these efforts, only two women volunteered for the study. This may be reflective of the higher incidence of schizophrenia among men. The recruitment agencies represented a variety of treatment and support options in schizophrenia care, as well as financial and recreational resources. In addition, I sought participants from agencies in a variety of locations, both urban and rural.

Inclusion Criteria

The inclusion criteria for the selection of participants in the study included: adult persons who: (a) are over the age of 19; (b) have a known diagnosis of mental illness (schizophrenia); (c) are interested in talking about their experience of spirituality, however they define spirituality to be; (d) are able to describe their experience in English, (e) are oriented to person, place, time and situation; (f) have a stable mental status (able to maintain contact with reality); and (g) live in British Columbia.

Exclusion Criteria

The following were excluded from the study: (a) persons whose mental health is unstable and compromised as a result of discontinuing prescribed psychotropic agents, such as anti-psychotic medications, (b) demonstrate evidence of alterations in sensory perceptions (hallucinations), and (c) alterations in thought processes (delusions of persecution by this researcher, delusions of grandeur such as a belief they are God, the Messiah, or a Prophet). I conducted a mini-mental status assessment (assessment of participants orientation to person, place, time, situation, and for alterations in sensory perceptions and thought processes) prior to each interview session with each participant to ascertain if research participants were experiencing any alterations in thought processes, such as delusions of persecution or grandiosity, or alterations in sensory perceptions, such as auditory or visual hallucinations at the time of the interview.

Recruitment Procedure

Research participants for this study were recruited from the following sources: the Canadian Mental Health Association (CMHA); Mental Patients' Association (MPA); Coast Foundation; Vancouver/ Richmond Health Board's Community Mental Health Teams; and

St. James Community Services Society. Initial contact was facilitated by sending a letter to the executive directors of the organizations and/or through my personal contact with agency personnel (see Appendix II).

All agencies that were approached gave permission for access and posted an advertisement about the study on a central bulletin board or wall for approximately four months. In the poster, participants were requested to contact the researcher by telephone indicating their interest in volunteering to participate in the study. I provided those who telephoned an overview of the research study and answered their questions about the study.

Characteristics of the Participants

The description of the general characteristics of the research participants was derived from data collected from the participants themselves (see Tables 1, 2 and 3). The total number of research participants who consented to be in the study consisted of twenty individuals diagnosed with schizophrenia, two of whom were female and eighteen males. The mean age of participants is 51.1 years, while the mean age at the time of diagnosis with schizophrenia was 26.5 years. Thirteen participants (65%) reported having a religious affiliation while seven participants (35%) reported having no religious affiliation. The mean income for participants is $9,990.40, per annum. Relationship status was reported as: (a) single for fifteen participants (75%); (b) divorced for two participants (10%); (c) married for one participant (5%); (d) separated for one participant (5%); and (e) one participant (5%) lived with a common-law partner. The participants' mean of total hospital admissions for psychiatric care was 6.35. Twelve participants (60%) lived in an apartment, seven participants (35%) lived in a psychiatric boarding house, and one participant (5%) lived in a room of a transition house.

Table 1 - Participant Characteristics

Participant Number	Gender	Age	Age Diagnosed with Schizophrenia	Ethnic Background	Highest Level of Education Completed	Occupation
1	Male	35	26	Dutch/ Belguim	Master's of Science 3rd year of PhD in mathematics	Contract work Accounting Computers Government Benefits
2	Male	61	24	Mennonite	Grade 10	Government Benefits
3	Male	52	25	Irish/ Dutch	Grade 13	Mail Carrier Unemployed Government Benefits
4	Male	50	25	Irish/ Swiss	Grade 10 GED - USA	Unemployed Government Benefits
5	Female	58	17	British/ English	Grade 12 Equivalence	Nanny Unemployed Government Benefits
6	Male	56	22	Italian	Grade 9	Lawn Maint Unemployed Government Benefits
7	Male	48	43 *35	English	PhD (Bio-chemistry)	Part-time data entry Government Benefits
8	Female	63	25	Irish	Diploma Education	Teacher Book keeper Unemployed Government Benefits
9	Male	47	23	Western European	Grade 12	Street Performer Unemployed Government Benefits
10	Male	54	21	Scottish/ German-English	4th year Arts student; one course short of BA	Writer Unemployed Government Benefits

P#7 - (* reported having symptoms for eight years prior to formal diagnosis)

Table 1 continued - Participant Characteristics

Participant Number	Gender	Age	Age Diagnosed with Schizophrenia	Ethnic Background	Highest Level of Education Completed	Occupation
11	Male	55	35	Black, Born in Trinidad	B.A. 1969 (English)	Unemployed Labourer Government Benefits
12	Male	43	37	Polish	Two years University - Study - Polytechical	Unemployed Sales Life Insurance Government Benefits
13	Male	52	32	British/ Irish	Grade 10	Unemployed Poet, House Painter Government Benefits
14	Male	41	18	British	Grade 8	Contract re: answering telephones, & disp. cups Government Benefits
15	Male	43	27	French / English	Life Skills Community College	Student supported employment Program
16	Male	56	30	English/ Acadian	Two year post-secondary vocational	Unemployed Iron Worker Government Benefits
17	Male	51	22	English	University Study 1.5 years Arts	Unemployed Lifeguard Government Benefits
18	Male	60	22	English/ American	Grade 12 University Entrance	Unemployed Office Work Government Benefits
19	Male	41	20	Scottish	Grade 12	Unemployed Saw Mill Worker Government Benefits
20	Male	56	36	English/ Scottish/ Irish/French	Grade 12	Unemployed Engineer, Government Benefits

Table 2 - Participant Characteristics

Participant Number	Religious Affiliation	Income per Annum	Relationship Status	Number of Children & Grandchildren	Admissions to Hospital for Psychiatric Care	Prescribed Psychotropic Medications	Place of Residence
1	Roman Catholic	$10,368.00	Single	None	One	Risperdal Stelazine Propranolol	Apartment
2	United Church	$10,800.00	Single	None	None	Risperdal	Apartment
3	Protestant	$10,200.00	Single	None	Four	Risperdal Olanzapine	Psychiatric Boarding Home
4	None	$9,792.00	Single	None	Five	Risperdal Celexa	Apartment
5	None	$10,500.00	Single	None	Twelve	Risperdal	Apartment
6	Roman Catholic	$10,800.00	Separated	None	Twelve	Fluphenazine Decanoate	Psychiatric Boarding Home
7	Protestant	$10,200.00	Single	None	Three	Risperdal Paxil	Apartment
8	None	$10,812.00	Partnered Common-law	Two sons & one daughter one grandson & granddaughter	Eleven	Olanzapine	Apartment
9	None	$10,200.00	Divorced	One daughter & one grandson	Three	Risperdal	Apartment
10	None	$8,748.00	Separated	One son	Three	Clozapine	Apartment

Table 2 continued - Participant Characteristics

Participant Number	Religious Affiliation	Income per Annum	Relationship Status	Number of Children & Grandchildren	Admissions to Hospital for Psychiatric Care	Prescribed Psychotropic Medications	Place of Residence
11	Roman Catholic	$9,600.00	Single	None	Five	Olanzapine Loxapine	Apartment
12	None	$9,600.00	Divorced	None	Ten	Fluanxol Depot Prozac Procyclidine	Apartment
13	Protestant	$9,600.00	Divorced three times	Two son's	Four	Risperdal	Room in a Transition House
14	Quaker	$9,473.04	Single	None	Two	Fluphenazine Kemadrin Rivotril Olanzapine	Apartment
15	Christian Lutheran Church	$9,443.04	Single	None	Eight	Olanzapine Epival	Apartment
16	None	$12,000.00	Single	None	Thirteen	Olanzapine Valproate	Psychiatric Boarding Home
17	Anglican	$8,004.00	Single	None	Twenty	Loxapine Benztropine Clonazepam Lithium	Psychiatric Boarding Home
18	Roman Catholic	$9,344.00	Single	None	Five	Nozinan Zyprexia Clonazepam Divalproex	Psychiatric Boarding Home
19	Protestant Non-Practicing	$9,344.00	Single	None	Six	Seroquel Clozaril Effexor Clonazepam Divalproex	Psychiatric Boarding Home
20	United Church	$10,980.00	Married	Three adult step children	None	Thioridazine	Psychiatric Boarding Home

Table 3 - Participant Characteristics

Participant Number (n)	Gender	Mean Age	Mean Age Diagnosed with Schizophrenia	Ethnic Background	Highest Level of Education Completed	Religious Affiliation	Mean Income per Annum	Relationship Status	Mean Admissions to Hospital for Psychiatric Care	Place of Residence
n = 20	2 = Female 18 = Male	51.1 years	26.5 years	1 - Dutch 1 - Mennonite 3 - Irish 1 - Italian 8 - English/British 1 - Western Europe 2 - Scottish/German 1 - Trinidad 1 - Polish 1 - French	1 = Grade 8 1 = Grade 9 3 = Grade 10 1 = Grade 12 Equivalency 4 = Grade 12 1 = Grade 13 5 = Post-Secondary 1 = Diploma 1 = Bachelor Degree 1 = Masters Degree 1 = Doctoral Degree	4 - Roman Catholic 3 - Protestant 1 - Protestant Non-Practicing 1 - Quaker 2 - United Church 1 - Anglican Church 1 - Lutheran Church 7 - None	$9, 990.40	14 - Single 3 - Divorced 1 - Married 1 - Separated 1 - Common Law	6.35	12 - Apartment 7 - Psychiatric Boarding Home 1 - Room in a Transition House

Data Collection

Each participant was interviewed using a semi-structured interview guide (see Appendix V) on two separate occasions, lasting from twenty-five to ninety minutes in a mutually agreed upon location. In order to refine the interview questions and the data analysis procedures, I conducted a pilot study with three volunteer participants at the onset of the research. Coincidentally, one of the volunteers in the pilot study is a known advocate of mental health services to the provincial government on policy issues impacting persons with mental illness. I revised some interview questions because of the pilot study data. For example, I initially asked participants to tell me a story about what you remember when you first began to think about spiritual concerns and issues. The pilot participants appeared unable to answer this question effectively, saying they did not recall this information. I changed the question in subsequent interviews to focus on the participants' current encounters with spirituality. For example, I asked participants to tell me about their sources of spiritual inspiration or insight important to them.

Forty interviews were conducted with the 20 participants. Following the individual interviews, four focus group interviews were held to share and verify the findings. One participant elected to discontinue participation in the study during the second interview, after disclosing personal stress related to his religious beliefs. He stated he no longer wanted to answer any questions. Later, he decided to join a focus group at the end of the study and was an active participant in the focus group. One participant declined to attend the focus group due to feeling overwhelmed with the stress of moving from a boarding house into a hotel room on the day of the focus group. A second participant notified the researcher hours before the focus group indicating she had been diagnosed with shingles and reported feeling too

uncomfortable to attend the focus group. A third participant was contacted minutes prior to the focus group beginning and he reported he did not realize the focus group was on the scheduled day which was discussed with him over the telephone two days prior to the scheduled focus group. Two participants were no longer accessible by their home telephone numbers and did not have an opportunity to review the findings. Of the five participants who did not attend any of the focus groups, a hard copy of the findings was dropped off to the home addresses of three of the participants. Telephone contact was made with the three participants three days after dropping off the findings to elicit their feedback. There was no other attrition in the study.

A concern about conducting research with individuals who are living with schizophrenia is the possibility that their cognitive processes will reflect loose associations of ideas due to the effects of the mental illness and poverty of thought due to untoward effects of medications. This may result in their inability to articulate, describe and reflect upon their experiences. In fact, several of the participants of this study presented these thought patterns and this presented particular challenges to the researcher both in interviewing and in the analysis of the transcripts. One participant responded to my questions initially in an unrelated way. For example, he answered a question about significant others by stating that he had coffee in the group home. I learned to restate and rephrase questions at least once and then he answered the question appropriately. Another participant had extremely disorganized thinking. He commented that the interviews were very draining because of the energy he had to expend to stay focused on the researcher's questions. In the analysis of his transcripts, particularly when his statements were disjointed, I learned to highlight and link key words and phrases to obtain codes of data. I later validated these with him. Yet another challenge in

interviewing this population was the sensitivity that I required to obtain useful data, while at the same time not placing too much stress or any judgment on the participant. For example, although at times one participant's statements were difficult to follow, he was able to provide clear information at other times and he was obviously trying hard to stay focused on my questions as much as possible. His disorganized thinking became more pronounced as the interview progressed. I shortened his interviews to 25 minutes rather than share my observations with him. I did this because I knew there would be a second interview in which I could return to topics he had been unable to answer and because I believed that the research agenda did not supercede his need to be valued and respected.

Immediately prior to the first interview, the participants signed a consent form and completed a demographic questionnaire. Each participant was given a copy of the signed consent form for the study. The first interview focused on the participant's broad experience with spirituality as someone who has schizophrenia. For example, I asked, *"Tell me what does the word spirituality and religion bring to your mind?"* In the second interview, approximately three to four weeks after the initial interviews, I sought clarification about data from the first interview that were unclear or required expansion. I also posed additional questions (Appendix V) that had arisen in the participant's first interview and in interviews with other participants (*e.g., "Some people have commented that ---. What is your experience in this regard?")*.

All participant interviews were audio-taped and later transcribed verbatim by a typist. Following receipt of the transcription, I replayed the audio tape, comparing it to the transcript correcting any errors to ensure the transcribed account was accurate. I documented on the

transcript any significant changes in the participant's intonation or tone of voice, such as inflections or pauses that may have indicated an issue as meaningful (Field & Morse, 1995).

Additionally, I maintained field notes following participant interviews in which I recorded my observations related to each participant's physical appearance, components of their mental status (general appearance, affect, cognition, mood, speech pattern, thought processes, and sensory perceptions), home environment, verbal information that we exchanged before or after the tape recorder was turned off, and my impressions, thoughts and feelings in regard to the experience of interacting with the participant. For example, I documented my confusion about why a participant abruptly terminated an interview and wrote plans for discussing this with him at a subsequent conversation. These field notes became part of the data base and were used to facilitate interpretation of the research data.

I interviewed participants in a mutually agreed upon location. The locations included the participant's home, an office/ board room belonging to a non-profit organization such as Coast Foundation, a coffee shop or restaurant, classroom of a local community college, a study room of a local university library, and a room in a community centre. Although some interviews took place in public arenas, such as restaurants, I ensured that the participant and myself talked in secluded spaces (e.g., a corner table away from other patrons) in those arenas.

Data Analysis

Glaser and Strauss (1967) delineate a four-step procedure for data analysis when using grounded theory methodology. I adhered to the following four steps of constant manual comparative analysis developed by Glaser and Strauss (1967) as follows: The researcher collects the data and compares them for similarities, generating tentative categories and

assigning data to as many different categories as appropriate. The researcher also describes the properties of the categories, noting any insights that may have occurred during the process. The researcher attempts to integrate categories and their properties by changing the focus from comparing data with data to comparing data with the properties of the categories. The researcher groups similar categories by conceptual area and generates hypotheses. Additional data may be added and checked for "fit" into categories. Categories may need to be re-described or reordered. Data collection and analysis continue until saturation is reached. Saturation is reached when the categories are so completely described as to their properties that new data only add to the volume of the study and not to the theory.

When the researcher is convinced the "analytic framework forms a systematic substantive theory, that it is a reasonably accurate statement of the matters studied, and that it is couched in a form that others going into the same field could use" (Glaser & Strauss, 1967, p. 113), the theory is written in final form based on the coded data and research notes.

Glaser (1992) describes open coding as the beginning stage of the constant comparative analysis "before delimiting the coding to a core category and its properties or selective coding" (p. 38) where the researcher embarks upon the data with no preconceived codes, remaining entirely open. Glaser suggests to do so would be to "force full conceptual description on data with no questions about whether the links are relevant to any emerging theory that really explains how the participants process their main concerns" (p. 63). Glaser reports the core category emerges from the method of constant comparative analysis of the data and the coding begins only when the researcher is confident he or she has found a core variable.

Glaser and Strauss (1967) assert that the researcher using this constant comparative

method of data analysis must work simultaneously with the data, the categories, the

properties, and the emerging theory. As I have illustrated previously in this chapter,

hypotheses were continually developed, refined and challenged in the processes of data

collection and analysis. These led to further literature review and data collection.

Linkages between categories enabled the conceptual ordering of the emerging

categories. Theoretical saturation was achieved when concepts, categories and themes

consistently emerged and no new information was being discovered and this provided

direction for data collection to then cease. I used memos and diagrams as means of

accounting for developing hypotheses, and comparing and verifying findings as the analysis

progressed. For example, rigor was maintained by consistently checking to ensure the coding

categories portrayed the data as a whole. As discussed previously, I used theoretical sampling

in the study to ensure comprehensiveness and relevance of the data, and to ensure adequacy

was attained by assuring all categories were saturated. Analysis of the data took place using

open coding by identifying codes of data into sub-categories, then collapsing sub-categories

into broader categories to form a core category. For example, codes included participants

spending time with family members, celebrating holidays with family, going out to a movie

with friends, getting together with friends for a coffee, believing in God or Higher Power,

praying to God or Higher Power for better health, believing God or a Higher Power answered

their prayers, having access to a mental health care professionals, working with mental health

care professionals, and relying on mental health care professionals. These codes were

collapsed into sub-categories of being connected to family, friends, God or Higher Power,

and mental health care professionals. The four sub-categories were then collapsed into a broader core category of experiencing connection to or disconnection from significant others.

The final step of the research process, the writing of the emergent theory, is documented in Chapter Four. An explanation of the substantive theory describing the experience of spirituality among individuals diagnosed with schizophrenia is presented in that chapter.

Data Verification

Verification of data in this study occurred by the following processes: adhering to the simultaneous four-step constant comparative method of data analysis delineated by Glaser and Strauss (1967); consultation with a member of the doctoral thesis committee who has expertise in qualitative research regarding conceptual ordering of the emerging categories and themes; use of memos to account for the formulation of theory that indicated the types of coding, conceptual labels, theoretical notes, operational notes in terms of directives to the researcher regarding sampling, questions, leads to follow up on, and decisions regarding methodological procedures.

Further, maintenance of an audit trail in terms of ensuring accessibility and explication of raw data in electronically recorded material and field notes, data reduction and analysis documents, including the documentation of field notes, summaries and theoretical notes, data reconstruction, and synthesis, including listing categorical structures, such as themes, definitions, relationships of data, as well as connections to existing literature, (integration of concepts, and interpretations), process notes (methodological notes pertaining to procedures, decisions, strategies, and rationale, and the audit trail notes relating the substance and structure of the trail).

The final process was the facilitation of four focus group sessions where participants were asked to scrutinize the developing theory in order to determine if the description of their experience of the phenomenon spirituality was comprehesible and compatible with their experience, thus seeking verification of the validity of the substantive theory from the research participants.

<div align="center">

Trustworthiness

</div>

According to Guba and Lincoln (1981), establishing trustworthiness is central in qualitative research. Sandelowski (1986) presents a framework to establish rigor based on the work put forth by Guba and Lincoln (1981). Sandelowski identifies four acceptable criteria to demonstrate rigor in qualitative research: (1) truth value; (2) applicability; (3) consistency; and (4) neutrality. In this research study, the techniques associated with the four processes identified by Sandelowski (1986) were applied to establish trustworthiness.

Truth value.

The truth value of a qualitative inquiry resides in the discovery of human phenomena or experiences as they are lived and perceived by informants (Sandelowski, 1986). Truth is described by Sandelowski as being "subject-oriented rather than researcher-defined" (p. 30). Guba and Lincoln (1985) suggest credibility be the criterion against which the truth value of qualitative research be evaluated. A qualitative inquiry is reported to be credible when it presents faithful descriptions of a human experience in which other people recognize it after having read about it in a study (Sandelowski, 1986).

A major threat to the truth value resides with the closeness of the researcher-informant relationship (going native). Going native suggests that the researcher is enmeshed with informants and can no longer separate his or her own experiences from those of the

informants (Sandelowski, 1986). This researcher maintained clear professional boundaries throughout the research process adhering to the ethics of conducting research with human subjects at all times. Accordingly, the credibility of this research study is enhanced by this researcher describing and interpreting his own behavior as a researcher in relation to the behavior of the informants (Sandelowski, 1986) cited in the discussion section of chapter five.

Applicability.

Sandelowski (1986) suggests "the applicability of a qualitative inquiry resides in the premise that any informant belonging to a specific group is considered to represent that group" (p. 32). Anyone's experience that is articulated represents a perspective of his or her world view. The aim of qualitative research is to establish the meaning of informants' experiences in relation to the group of which they are members. Fittingness is suggested by Guba and Lincoln (1985) as the criterion against which the applicability of qualitative research be evaluated. Sandelowski states that "a study meets the criterion of fittingness when its findings can fit into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences" (p. 32). Furthermore, the findings of the study fit the data from which they are derived (Sandelowski, 1986).

Threats to applicability include the notion of elite bias and holistic fallacy. Informants are reported as frequently the most articulate, accessible or high-status members of their groups (Sandelowski, 1986). Sandelowski argues the researcher must establish the typicality or atypicality of events, behaviors or responses observed in the lives of the informants to ensure representativeness of the subjects and setting. As previously discussed

in the section on theoretical sampling, I have attempted to establish the typicality or atypicality of events, behaviors or responses by the way in which I sampled the participants and the triangulation of data collection (two individual interviews and one focus group interview).

Consistency.

Consistency is the third criterion put forth by Sandelowski (1986). Qualitative research emphasizes the uniqueness of human situations and experiences and the importance of experiences, which are not necessarily accessible to validation by the senses. Therefore, variation in an experience is sought (Sandelowski, 1986). Guba and Linclon (1985) propose auditability be the criterion of rigor to the consistency of qualitative findings. It is argued a study has consistency when the study and its findings are auditable. Auditability refers to the process of involving another researcher who should be able to follow the decision trail used by the investigator in the study and arrive at comparable and consistent conclusions with the same data, perspective and situation (Sandelowski, 1986).

Neutrality.

Neutrality is the fourth criterion, which refers to the freedom from bias in the research process and product (Sandelowski, 1986). Guba and Lincoln (1985) suggest confirmability be the criterion of neutrality in qualitative research. Sandelowski states "qualitative research emphasizes the meaningfulness of findings achieved by way of reducing the distance between investigator and informant and by eliminating artificial lines between subjective and objective reality" (p. 34). Additionally, qualitative researchers value subjectivity by way of subjective involvement of the investigators with their informants, emphasis on subjective reality or the meanings informants give to or derive from their life situations and experiences

(Sandelowski, 1986). Sandelowski proposes "engagement with rather than detachment from the things to be known is sought in the interests of truth" (p. 34). Sandelowski (1986) asserts confirmability refers to the findings and not to the subjective or objective stance of the researcher.

Auditability

Auditability was achieved when this researcher left a clear decision trail in regard to decisions made from beginning to its end. The decision trail should enable another investigator to follow the progression of events in the study and comprehend the logic (describing and justifying what was done and why). Sandelowki (1986, pp. 34-35) reports auditability is achieved by a description of:

1. how the researcher became interested in the subject matter of this study;

2. how the researcher views the thing studied;

3. the specific purpose of the study;

4. how subjects or pieces of evidence came to be included in the study and how they were approached;

5. the impact the subjects or evidence and the researcher(s) had on each other;

6. how the data were collected;

7. how long data collection lasted;

8. the nature of the setting(s) in which data were collected;

9. how the data were reduced or transformed for analysis and interpretation, and how they were presented;

10. how various elements of the data were weighted;

11. the inclusiveness and exclusiveness of the categories developed to contain the data;

12.   the specific techniques used to determine the truth value and applicability of the data.

In order to ensure auditability, I have maintained memos, field notes, coding instructions delineating actual placement of data into sub-categories, core categories and the manner in which different elements of the data were linked to each other. In addition, I attended to the criteria for rigor as established by Sandelowski (1986) by checking for the representativeness of the data as a whole and of coding categories and examples used to reduce and present the data; triangulating across data sources and data collection procedures to determine the congruence of findings among them; checking that descriptions, explanations, or theories about the data contain the typical and atypical elements of the data; deliberately trying to discount or disprove a conclusion drawn about the data; and obtaining validation from the participants themselves.

<div align="center">Ethical Considerations</div>

I addressed the ethical considerations inherent in this study in the following ways. I informed all potential participants about aspects of the research that might influence their willingness to participate in the study. I described the purpose of the research and made every effort to ensure protection of participants from any physical or emotional harm or danger. I obtained the participants' consent before they participated in the research project. Consent was obtained in written form, indicating participants' understanding of the research and consent to participate in the project. A statement about the participants' right to withdraw from the study at anytime without penalty is cited on the consent form (see Appendix III).

Data for this study were secured in a locked file cabinet in a designated location. Numbers (Participant #1, 2, 3, 4) were designated to participants in order to ensure their anonymity. A participant's name has never appeared on any document that could be traced

back to the person. At the conclusion of the study, all identifying information will be destroyed. The research study commenced after approval from the University of British Columbia Ethics Review Committee, Behavioral Sciences Screening Committee, related to conducting research with human subjects (see Appendix I).

<div align="center">Strengths and Limitations</div>

There are a number of strengths of the research design, such as that it provided thick, rich descriptive data relating to the spiritual dimension of individuals diagnosed with schizophrenia. It also led to the development of substantive theory in relation to the experience of spirituality among individuals diagnosed with schizophrenia and provided an opportunity to gain a deeper understanding as to the qualitative aspects of the spiritual dimension of the human experience.

Limitations associated with this design included the volunteer nature of the sample. Sandelowski (1986) cautions that informants who "volunteer are frequently the most articulate, accessible, or high-status members of their groups" (p. 32). Participants in the current study represented a high level of occupational and social functioning as all participants lived in the community in either semi-independent or independent housing. It is also possible that the participants in this study volunteered because they have had generally positive experiences with spirituality, and that those who have had negative experiences, or who have not considered spirituality as significant in their lives, would not have volunteered to participate in the research. Another limitation may be that there is a possibility that some participants wanted to please the researcher by responding with the "right" answer to the interview questions. I am a health care professional and all of the participants had extensive history with health care professionals. They may have responded to the research, and to

myself as researcher, in the context of their previous history attempting to provide me with answers they perceived I wanted. Therefore, I reinforced the idea that, *"there is no right answer"* to any questions posed by making statements such as, *"There are many valid opinions on this but I wondered what your ideas were on this subject"*. This research shares the limitation of other qualitative research studies; e.g., limited generalizability to other persons with chronic schizophrenia.

<center>Summary</center>

In this chapter, I have presented an overview of the research approach of grounded theory and the design used in the research study. Data were collected from 20 research participants in a total of 40 semi-structured interviews and four focus group interviews. A final substantive theory that arose from the data will be presented in chapter four.

CHAPTER FOUR

Findings

In this chapter, the substantive theory that arose from the data, spirituality as connection, will be presented in two sections. The first section focusses on the umbrella theme of spirituality as connection. The second section focusses on the experience of spirituality among persons living with schizophrenia in which connection and disconnection from one's spiritual self, significant others, God/ higher power, community, and nature are integral to the participant's spiritual self. Integrated into each section of the findings are the contributing factors and outcomes of participants' experiences of connection and disconnection in relation to their spiritual self.

Spirituality as Connection

Participants in the pilot study experienced difficulty defining spirituality. Subsequent revisions to questions in the interview guide (see Appendix V) facilitated more in-depth, thick descriptive accounts by participants in being able to describe and articulate how they experienced their spirituality as discussed in chapter three under data collection. Although participants struggled with direct questioning about what spirituality was, they were able to conceptualize spirituality as being very complex with many inter-related elements. Spirituality was conceptualized by the participants as an experience of connection. Connection was viewed by participants as being in touch with one's identity as a unique person. The idea of connection was defined by participants as being connected to their spiritual self when their mind, body and spirit were all together. One participant explained "when I am mentally well, all parts of me [mind, body & spirit] are together and I am in

touch with my spiritual self… it is hard to be in touch with your spiritual self when you are hearing voices in your head that are not real".

Disconnection was viewed by participants as being out of touch with one's identity as a unique person when experiencing psychosis. The idea of disconnection was defined by participants as being disconnected from their spiritual self when their mind, body, and spirit were not all working together. Many participants spoke about experiencing a disconnection between their mind, body, and spirit when mentally ill. One participant stated when he was mentally ill he experienced "taste, touch and smell hallucinations… my mind, body and spirit are not connected because of a chemical imbalance in my brain". Despite alterations in participants' thought processes and sensory perceptions, participants were able to articulate their experience of spirituality as not only internalized but also contextually based.

The notion of spirituality as connection experienced by persons living with schizophrenia entails a complex set of structures and processes occuring simultaneously. Participants living with schizophrenia experience spirituality within the context of living with a chronic illness. Living with a chronic illness was an ongoing challenge for the participants whose wellness/ illness perspective was continually shifting based on a dynamic interplay of structures and processes. The experience of spirituality as connection to and disconnection from one's spiritual self, significant others, community and nature was fostered or hampered by the participants' degree of wellness/ illness perspective. Participants believed the experience of connection was integral to their experience of spirituality. Participants described their internalized experiences of spirituality as connecting to or disconnecting from their spiritual self (mind, body & spirit), and contextually based as being connected to or disconnected from significant others, community and nature.

Conceptually, they viewed spirituality as connection as being situated on a shifting continuum of connection / disconnection from one's spiritual self, significant others, community, and nature relative to participants' sense of their wellness / illness perspective. Participants described connection in terms of how connected they were to their spiritual self (body, mind & spirit), significant others (family, friends, God / higher power, and health care professionals), community (a community of persons diagnosed with mental illness, a community of persons who were well, a faith community, and the community in which they lived), and nature.

Spirituality was considered by the participants to be integral to their wellness perspective; anything that disconnected them from their spirituality resulted in their feeling disconnected from their spiritual self on some level. Although they acknowledged that it was possible to be connected in one realm (e.g., with nature) but to experience disconnection in another, most participants concurrred that significant disconnection in any one or more than one realm could negatively influence their wellness perspective. For example, some participants experienced some disconnection from their spiritual self and family but experienced significant connection with friends or health care professionals and reported being well. Others acknowledged some degree of connection to their spiritual self and friends but were significantly disconnected from family and health care professionals. They described themselves as being ill.

When connection to one's spiritual self, significant others, community or nature was significantly disrupted or impaired, the participants experienced a disconnection from their spiritual self. This disconnection was associated with perceptions of being ill and feelings of loneliness, alienation, isolation, guilt, fear, hopelessness, helplessness, and powerlessness.

The Experience of Spirituality

The experience of spirituality among the participants reflected an internalized and contextually based conceptualization of the construct of spirituality. The internalized conceptualization of spirituality is reported as particpants' connection to or disconnection from their spiritual self. The contextualized conceptualization of spirituality is reported as participants' connection to or disconnection from significant others, community, and nature.

Connection to the Spiritual Self

Being connected to their spiritual self was described by most participants as being united with one's body, mind, and spirit. Four of the participants acknowledged this to be integral to their experience of spirituality but were unable to articulate a description of connection to self. Being connected to one's spiritual self was described by most participants as a significant connection that fostered in them the ability to experience a range of spiritual experiences with themselves, others and with nature. These participants identified the following as strategies to achieve connection to their spiritual self: taking prescribed atypical antipsychotic medications, maintaining their health and a healthy lifestyle, use of prayer / meditation, caring for self and others, and engaging in creative activities.

Strategies Used to Achieve Connection to Spiritual Self

Participants in the study used a variety of strategies to achieve connection to their spiritual self. Most participants identified taking prescribed atypical antipsychotic medications as a dominant strategy while many participants identified maintaining their health and a healthy lifestyle as a means to achieve connection to their spiritual self in addition to taking the prescribed atypical antipsychotic medications. Most participants indicated the use of prayer / meditation as strategies to achieve connection to their spiritual

self. Most participants identified that caring for self and others and engaging in creative activities were used as strategies to achieve connection to their spiritual self.

Taking Atypical Antipsychotic Medications.

Most participants described the experience of taking prescribed atypical antipsychotic medications more positively than taking the typical antipsychotic medications and reported fewer side effects that resulted in increased degrees of connection to their spiritual self.

> I didn't have the voices and I didn't have hallucinations... and over the year I developed a lot of needs and wants... I learned to enjoy things, I learned to appreciate things... you know, at that point I wasn't sick but I took medication... and I have an interest in life again... my spirituality keeps me from being suicidal or from being alone, isolated and suffering.

> I think it was September or so of 1995... I took the medicine and gradually I started to hear what was around me and, um, then the other senses followed, you know, the hallucinations stopped, I saw through the delusion that I was God, you know, I saw through the delusion that I was everywhere that I could only be one place at a time, you know, I thought I was God and I was everywhere and so forth and, uh, and it is strange like whatever was causing these hallucinations in the first place disappeared once I took the medicine.

> I was on haldol which is one wild drug. You're quiet but you're stupid. You can't think. You can't carry on a conversation... then stelazine for twenty-five years, twenty-five years of living hell, I had no sense of my spiritual self... now I am taking Olanzepine for two years and my schizophrenia is gone... I have peace of mind, there is no turmoil... the meds helped quieting the brain, I have no symptoms, I have peace of mind... I am now able to think and concentrate about my spirituality.

Maintaining Health and a Healthy Lifestyle.

Many participants stated that their health and a healthy lifestyle were means of staying connected to their spiritual self (mind, body & spirit). Many reported having stopped smoking tobacco cigarettes within the last five years and those who currently smoked stated they intended to quit in the near future because they desired to live healthier lives. Many reported abstaining from drinking alcohol and using illicit street drugs for similar reasons.

A few participants reported using marijuana on a daily basis for "medicinal purposes" as a way to enhance the connection to their spiritual self. One participant stated "It helps me stay at peace with the world as it is".

Many participants reported that part of feeling connected to their mind, body and spirit was to feel well physically. These participants agreed that maintaining a balanced diet, in part, helped them to feel physically, mentally and spiritually well. Most participants attempted to maintain a balanced diet, whether they were preparing the food at home or having their meals at a clubhouse for persons with mental illness where the food was prepared by staff. One participant spoke of making an appointment to see a nutritionist to assist him in meal planning. He stated "I saw a nutritionist; she put me on a low calorie diet... three meals a day, having three out of the four major food groups, you know, so I am trying to eat more nutritious foods, you know".

Being connected to their spiritual self was noted by several participants who described participating in physical activities to enhance their level of connection to mind, body and spirit, such as walking, swimming, and "working out" in the local community centre gymnasium. One participant spoke about going to the gym for the past four years as a means to maintain balance between his mind, body and spirit stating "I go to the gym, like, uh, six, six days a week or so...I only went for four days one week, uh, that was the lowest I have ever done for a long time... I do it to keep my body healthy... it is good for my soul when my body is healthy too". Participants agreed that regular and sufficient sleep was a significant means of maintaining their physical and mental wellness thus enhancing their connection to their spiritual self and their wellness perspective.

Use of Prayer / Meditation.

Most particpants perceived that prayer was a way to attend deliberately to their spiritual self. The use of prayer and/ or meditation was reported by these participants to have enhanced their ability to experience connection to their spiritual self. One participant explained, "I had a friend who had been praying that I would get well... and I prayed that I would get well... and look at me, I do, I feel very well". Another said, "I call out to the Lord in desperation, help me, Lord, save me, Lord, I feel I'm going to die, you know, if my health isn't right... I resolve it by calling out to the Lord in prayer". Another participant claimed,

> I find that, uh, prayer helps with talking to God, uh, and a lot of the time I'm thinking thoughts but I'm directing them towards God... I find that helps me to be stable and uh, and to keep my mind focused because as a schizophrenic, one has difficulty concentrating and focusing on things.

Four participants described the use of meditation as a way to enhance feeling connected to their spiritual self.

> I've been meditating for thirty years, twenty minutes a day sometimes an hour and a half, two hours, generally around an hour, sometimes it's as little as forty minutes but usually I get three meditations in a day... the meditations can't get anymore peaceful or blissful but I sit down and I meditate for twenty minutes and I say wow, you know, that, that hit the spot, you know... to get myself well, the meditation did it.

One participant used chanting as a form of meditation to connect to his spiritual self. He noted,

> I really do more chanting [than prayer]... it is very soothing. I, I especially chant when I'm experiencing high anxiety and, uh, it is very soothing for me to; I'll just chant, until I become at one with myself, for example, something silly, uh, hurry up and slow down, hurry up and slow down, hurry up and slow down, hurry up and slow down and that can be very soothing too, to, to speak the words.

Participants indicated meditation was a technique used to assist in feeling connected to one's spiritual self and acknowledged this was hard to achieve when experiencing psychosis. One

participant explained, "I feel comfortable using meditation when I am in public or in private… I will meditate until I become that one with myself, to be grounded, to center myself, to feel more connected as one… which is hard to do when you are hearing voices in your head".

Caring for Self and Others.

Being connected to their spiritual self (body, mind & spirit) enabled most participants to engage in self care activities of daily living, such as caring for self, maintaining their own living accommodation in some cases, and making a contribution to society in some meaningful and productive way. These participants claimed that being able to do any of these activities added to their own sense of purpose and meaning in their lives. One participant who lived in an independent housing situation explained that when he was connected to his mind, body and spirit, he needed to feel productive in this way.

> I do the day to day stuff, the everyday stuff, aside from the committees and stuff I'm on, everyday stuff; it may not sound like much to you but making my own meals, keeping my own place, having a place of my own, things of that nature and it is just the simple things but they mean a lot.

In this study, all of the participants believed that essential to their spiritual self was having their basic needs met. Many particpants noted that having clean and safe housing was a turning point for them in wanting to live. Three participants who had been living in a bachelor's apartment for the past one to four years noted,

> I was thinking a decent place to live made a hell of a difference to me, all these little one room basement suites, and then I moved into, uh, a decent bachelor apartment, subsidized housing, boy, that was marvelous… so it made a big difference to me, it really has… as much as the medication, um, it is just as important as the medication I take.

> Well I think it's, uh, it's the most important thing because, you know, because normally we're born and we live with our parents in such conditions and then we

move out and get a wife or whatever and it's normal to have a nice place to be; suddenly this is gone and you end up really lonely in skid row with cockroaches and everything… for me it was everything, they gave me an apartment and a new lease on life, now I live the way that is good for my mental health and I don't have to worry about money, it's my reality that I can come out of the shell and enjoy life because I have my base, my home, and I can, and, and, everything else falls into place… it's tremendous differences, it's unbelievable how, how different, how important it is for me to have a nice place to live… and then that's a beginning and base for everything throughout your life.

I think it's important; I've got a pretty good apartment just across the street here, Coast owns it and I pay Coast my rent and I'm pretty happy with that; it's really good; it's really upbeat; I'm… I don't really look at myself as disabled and things like that as I did on skid row.

Many participants believed that people who were living on the streets and whose basic needs for shelter, food, and clothing were unmet, were less fortunate than themselves. Most participants, when feeling connected to their spiritual self, expressed their desire to help others less fortunate than themselves in any way they were able to. Participants reported some ways of helping others less fortunate included assisting persons in wheelchairs with their mobility in crossing the street, reading to others who could no longer read themselves, and helping the poor and hungry by volunteering in soup kitchens and by giving them money and food.

Many participants reported engaging in some form of volunteer work and expressed their desire to engage in some form of paid meaningful work as a part-time venture. Being a volunteer in some capacity enriched participants' spiritual self by providing them with a sense of purpose in life and added meaning to their life experiences. One participant related "I've been doing some volunteer work, uh, for the Seven Thirty Club and the Housing Society in my community, and I'm in contact with people who have a room there; it is pretty

simple work but it helps me and it helps them a lot... the re are people who are worse off than I am".

Engaging in Creative Activities.

Most participants described participating in some form of creative activity when feeling connected to their spiritual self (mind, body & spirit); that in turn added meaning to their life experiences thus enhancing their spirituality. Participants reported a variety of creative activities that they engaged in which enabled them to feel an inner sense of peace and comfort and in some cases allowed them to think about things that were greater than themselves and the everyday trials and tribulations of living with a mental illness. From the participants' accounts, a reciprocal relationship is evident in that creativity fosters connection to one's spiritual self and connection to one's spiritual self fosters one's ability to be creative. Expressions of creativity by three participants included writing a book for publication about their experience of living with schizophrenia which the participants noted added meaning to their life experiences. One participant noted he expressed his spirituality through writing and painting in this way:

> I find I experience a sense of inner peace and comfort by just writing about my story [life experiences since being diagnosed with schizophrenia] and this is something I painted... this is what I painted so you can also see there is a theme going through the picture, so this is what I do to get in touch with my inner peace.

Three other participants reported writing poems as a means of creatively expressing their spirituality. The poems reflect their life experiences of living with schizophrenia and one participant noted he has been selling booklets of his poems since 1998. One participant noted that he expressed his spirituality through his ability in composing classical music. He related,

> I have a keyboard at home, I compose music... it is, uh, classical, I write mostly... I showed people my music and they like it; the others like it; I just play myself... I

have a whole lot of songs... I just find it soothing to compose it and listen to it; it is like wow.

Other creative expressions of spirituality by participants when experiencing connection to their mind, body, and spirit included playing the guitar, singing, cooking, sewing, knitting, quilting, photography [people & nature portraits], painting, listening to music, reading, listening to audio-books, drawing pictures, and furniture finishing, all of which participants claimed gave meaning to their life experiences and enriched their spirituality.

Disconnection from the Spiritual Self

Being disconnected from one's spiritual self is described by participants as having lost touch with one's identity as a unique person. Many participants talked about being disconnected or cut off from their body, mind and/ or spirit, thus being disconnected from their spiritual self. Participants identified two common factors of disconnection from their spiritual self which include alterations in their sensory perceptions (hallucinations) and thought processes (delusions). Many participants stated that the disconnection from their spiritual self was a direct result of their mental illness and the change in their brain chemical functioning that occurred in schizophrenia.

> There's a disconnection between my spirit and my body and because of this disconnection my perceptions changed and what I use to depend upon became questionable... living with schizophrenia has been devastating because the things that you used to do, you can no longer do necessarily... because that part of my brain was shut off, the connection to my spirit and my body was shut off.

> My body and spirit are not connected properly because I believe I am spirit and flesh... and somehow I became demon possessed, demonic forces in control with free reign over my mind... you might not believe it but that's okay, I have taste, touch and smell hallucinations as well... I don't hear voices, that's one thing I'm glad, I'm really thankful for.

One participant described his experience of being disconnected from his body as, "I feel like I'm in an unlimited number of bodies... disconnected from my body. I was under the delusion I had many bodies and actually I had none because I wasn't really aware of my own body". Another participant reported when he was mentally ill he was disconnected from his spiritual self while he was experiencing grandiose delusions stating "I thought I was God... I had lots of responsibility for the whole world... it was terrible... being God".

Some participants related the experience of being disconnected from one's body, mind and spirit as the outcome of treatments for schizophrenia, specifically typical antipsychotic medicines.

> Taking medication for the past 7 to 8 years... I still find myself almost in a trance... I'm really not making any progress towards my true spirit... my soul/spirit is suppressed by the medications... being on medication, it is like my soul/spirit can be partly out of my body... I'm like a tree that sleeps and while the tree sleeps, it has no sense to find its soul. It may have the five senses, but it has no way as to really, really dig up what it wants, like it used to... for the past seven, eight years.

In the above participant's accounts, taking the prescribed typical antipsychotic medications caused the participant to perceive himself as almost in a catatonic state relating his present experience to the analogy of being like a tree. In this state, the participant stated he was unable to work towards achieving his own spirituality and therefore was disconnected from his spiritual self as a result of the prescribed treatment with a typical antipsychotic medication.

Three participants experienced disconnection between mind and spirit in relation to conflicts they experienced between their philosophical values and religious beliefs and their desire for sexual intimacy which further disconnected them from their spiritual self. For example, one participant described his angst as a result of hiring a sex trade worker to meet

his needs for sexual intimacy. In discussing relationships he has experienced with women, he reported, "I've never been able to sustain a legitimate relationship with a woman, you know". He elaborated, "In regards to relations with prostitutes... it's the only way I can, I can have some kind of sexual release other than masturbation is with a prostitute, you know... it's kind of embarrassing and a hard pill to swallow". He explained that his father attended the same church as he did and had expressed unhappiness with his son's decision to hire sex trade workers. His father had allegedly strongly discouraged this conduct as such behavior was perceived to be contrary to their religious beliefs. He reported his psychiatrist also discouraged him from hiring the services of sex trade workers for health reasons. He noted he has not used the services of any sex trade workers for about one year stating, "That is something to take pride in". The participant concluded, "I like to practice clean living and having my health, and I think relations with prostitutes aren't healthy, uh, spiritually, physically, mentally and financially."

Another participant experienced conflict between his religious beliefs and his desire for sexual satisfaction.

> I'm almost sixty years old and, uh, when the Catholic church, they say it is a sin to day dream about sex and a sin to, to uh, look at a picture of a beautiful girl in the *Playboy* magazine and it is a sin to masturbate and, uh, I don't agree with them... but I don't know if I want to be a Christian which, uh, seems to have helped a lot of people and in some ways I do believe in Christ but I can't entertain any thoughts and I find it almost impossible not to and, uh, I'm not sexually active now, I'm sort of sexually dead but, uh, you know, I see a woman walk by and she looks really good... those thoughts occur to me and I think I've committed a sin.

From the participants' accounts, conflicts between their religious beliefs and their desire for sexual intimacy engenders distancing behavior in order to mediate the dissonance between body needs and religious beliefs. If the spiritual self is realized primarily in the context of

religion, this distancing results in a disconnection from one's spiritual self and alienation from one's religious community.

Some participants acknowledged that using substances such as alcohol, marijuana / tetrahydrocannabinol (THC), crack, cocaine, and lysergic acid diethlamide (LSD) had enhanced their experience of disconnection to their spiritual self. As one participant who used marijuanna and LSD explained,

> Before then [when he did not take these substances], I didn't have any of these hallucinations, I was ordinary but, uh, I was still psychotic in the sense of my awareness that my body wasn't normal; I wasn't very aware of my body when I took these substances ... I took it, I took it four or five times but that wasn't very clever.

Another participant described using alcohol, crack and cocaine to overcome his feelings of guilt, powerlessness and hopelessness related to his schizophrenia. He related "when the doctor says your, your illness is incurable, purposelessness, well I'm down to just living one moment at a time. That's the only thing I can do at my age and I do feel lonely at times". From the participants' accounts, a negative outcome of living with schizophrenia led participants to seek release by using substances such as alcohol and drugs as a way of managing unbearable feelings of loneliness, powerlessness, and hopelessness which in turn blurred their experience of reality and further disconnected them from their spiritual self. Participants in this study claimed that their experience of being disconnected from their mind, body, and spirit was a major factor affecting their disconnection to their spiritual self.

From the participants' accounts as discussed in the focus groups, being connected to their spiritual self was significant to their spirituality and added meaning to their life experiences. Participants acknowledged that their spiritual self was enriched as a consequence of being connected to their mind, body, and spirit. Participants acknowledged

that contributing factors associated with their connection to their spiritual self included taking prescribed atypical antipsychotic medications, maintaining their health and a healthy lifestyle, use of prayer / meditation, caring for self and others, and engaging in creative activities. Participants claimed that outcomes of being connected to their spiritual self included feelings of peacefulness, happiness, confidence, and being proud of making healthier lifestyle choices. Participants acknowledged that contributing factors associated with participants' disconnection to their spiritual self included a change in their brain chemical functioning, accepting treatment of typical antipsychotic medications, tendency not to use prayer or meditation, use of substances and experiencing conflicts between their philosophical values and religious beliefs and their desire for sexual intimacy. Participants claimed that outcomes of being disconnected to their spiritual self include feelings of loneliness, fear, alienation, powerlessness, despair, and hopelessness.

<div align="center">Connection to Significant Others</div>

Spirituality as connection to significant others was described contextually by participants as encompassing connection to family, friends, God /Higher Power, and health care professionals. All participants defined their experiences of connection in terms of having a relationship with another person and / or their God/ Higher Power. For most participants, these connecting people were family members, although several participants who reported being disconnected from family identified friends and others who are mentally ill or health care professionals as those with whom they experienced connection. Most participants (two-thirds) expressed experiencing a connection to God or a Higher Power in addition to being connected to family, friends or a community of others who are mentally ill or with people who do not have a mental illness.

Participants stated that their experience of living with schizophrenia had caused them to feel disconnected from significant others, including members of their families, friends, God or a Higher Power, and health care professional caregivers. Many participants acknowledged it was hard to be connected to others when they experienced disconnection between their mind, body and spirit, especially when experiencing auditory and visual hallucinations. As one participant explained, "it is hard to be connected to other people in the sense of hearing voices and seeing things... because I'm, I'm not, I'm not at the house, simply I don't exist when I'm ill, when I'm psychotic".

Connection to Family

The experience of being connected to family was described contextually by participants as an important connection to significant others relating to participants' spiritual self. Three-quarters of participants experienced connection to family as being maintained by way of in-person visits, telephone contact, and letter writing. One participant said he was connected to his wife, despite being separated from her and disconnected from his mother and siblings. He explained, "I've got nobody in the world. Uh, well I still phone my wife three or four times a day and we still love one another but we're not together, you know". Another participant stated she was connected to her mother, despite a turbulent relationship. She claimed having her two grandchildren added meaning to her life as she never expected to be a grandmother and she takes pleasure in spoiling her grandchildren whenever possible. One participant explained how his older brother fostered connection with family by providing him with family "updates".

> I don't usually, I don't usually phone but usually if there's something happens like my brother phoned me a few weeks ago, yeah, he was the one who initiated, you know, because like, like he's got a lot of money so he phones for one thing, that's the main

thing really so because he was telling me like my dad had a knee operation a few years ago and I saw him at Christmas time and he was really having trouble walking, you know, you could, he had, how he uses a cane and a brace and my brother phoned me and he told me that he got dad into a new facility for working out and it sort of like a whirlpool where it massages his knee and he was telling me he was, he was looking after dad that way, you know, so, yeah, so that was the latest, any news on, on those fronts my brother will phone me… and things like that, you know, like, you know, he's the one who does a lot of the things like that and he lets me know what's happening.

Participants reported varying degrees of connection to specific family members: their mothers, fathers, sisters, brothers, children and grandchildren. Many commented that their illness had increased their awareness and appreciation of experiencing connection to family.

I was always away working but when I was in the hospital, they [family] used to, if they were in town or, or nearby, you know, not busy, they would come and visit me and then I would go visit them when I get out… but my mother I phone her every month and I go see her every, about every six, about twice a year I go see her.

The last time I spoke to my daughter was around father's day four years ago and, uh, we, it's a bit of a ritual now, we call, I call her on Sundays, uh, most Sunday and, uh, we speak at length with each other and, uh, I say words to my grandchild who vocalizes back over the phone and I speak with my son-in-law from time to time… we're planning… a trip for me out to Toronto where they are… by plane and they're going to help me with the plane fare, uh, and I'll go for a month and then return to Vancouver.

One participant talked about visiting his family in another province once a year in the summer stating "every time I go home to be with my family a bit, I sort of have to readjust myself to the way they live and because they live, they live functional lives as opposed to dysfunctional lives that rubs off on me… its good to be around them, it helps".

From the participants' accounts as discussed in the focus groups, being connected to family members was significant to their spiritual self and added meaning to their life experiences. Participants acknowledged that their spiritual self was enriched as a consequence of being connected to family members. Participants claimed that outcomes of

being connected to family included feeling a sense of belonging, being loved, being valued as

unique individuals and cared for.

In relation to disconnection from family, most participants talked about missing the

family relationships they had prior to becoming mentally ill and becoming disconnected from

their families as their mental illness became more evident and debilitating over time. Some

participants (one-quarter) reported having no contact and being completely disconnected

from their families. Several participants reported having difficulties with their parents and or

siblings while growing up or in their young adult years; this led to their experiencing feelings

of rejection and alienation. Many participants reported being disconnected from family

members when they required hospitalization as treatment. One participant recounted,

> I want a deep relationship but like I said, I can't get back to the spirit... you know, you know, you're suppressed... you're in a cob web... you're somewhere and you give up trying, you give up trying, you know because you can't seem to, it's not like it use to be, you know, a long time ago, I gave up, I could never get close to my sister or brother or mother after I was in the hospital... the first time, I never had that close relationship with them hardly again"... like I mean, I crave to be close to all three again... I'll never be close to all three again... like it was back in 1976.

Another participant commented on his disconnection from his family. He was the third

youngest of two sisters and seven brothers. He stated that his disconnection with family was

exacerbated as a result of not being listened to by family members when he felt distressed;

that in turn increased his disconnection from his family. Over time he reported he lost any

connection with family members other than seeing his sister and sister-in-law a couple of

times each year.

> Having a sister who used to have worked in a mental health hospital in Saskatchewan... the Riverview version... I think that biased her because they didn't have a good idea how to treat the mentally ill in those days... she did not correctly interpret what I needed and what I could do... and also feeling oppressed by my brothers as those younger than me were protected by the older brothers who were

> domineering... my brothers didn't think I was their kind of guy, you know... they believed I should be stressed into becoming more of a macho man... more aggressive.

Another participant described his disconnection from family as having a twofold cause; first, moving to a new city and province to attend graduate school, and secondly, when he became ill, not knowing what was happening to himself or being able to explain to others what was happening regarding his mental status.

> Relocating to a new city for the purposes of attending university, I lost all of my support systems... I was in the hospital for three months in 1994 and when they first diagnosed me then... it was a difficult time in my life, going to university... my cross had gotten heavier... but this (schizophrenia) was a new low, it was more like my brain stopped working and that is when the demonic started to tinker with my thoughts... I didn't realize how serious my illness was.

One participant explained,

> I've got a sister and I haven't seen her for about six years; she's out in Langley and she never phones me or never invites me out and I phone her and she's friendly with me but I feel a certain disconnection with her... I don't know what the reason is, whether it has anything to do with my illness... but now it seems as though maybe she thinks of me as a problem, that she feels, well, I don't know, I've never asked her do you think I'm a disgrace to the family... but there's that possibility but she's friendly to me on the telephone, I mean she never phones me, she never invites me out...

Most participants (three-quarters) had some form of connection to someone in their families, either a parent, a sister or a brother, their children or grandchildren. Eight participants reported having a connection to all members in their family. Some participants who experienced disconnection from family members expressed feeling hopeful of reconnecting with family members in the future.

From the participants' accounts as discussed in the focus groups, being disconnected from family members was significant to feeling disconnected from their spiritual self. Participants acknowledged that their spiritual self was being depleted as a consequence of being disconnected from family members. Participants concurred that outcomes of being

disconnected from family included feeling a sense of loneliness, alienation, rejection, ineptitude, inferiority, unimportance, and feelings of being unloved.

Connection to Friends

The experience of connection to friends was described contextually by participants as a second important connection relating to participants' spiritual self. Most participants stated connection to a friend or friends was important in their experience of spirituality. They described being connected to friends as doing things with them such as eating a meal together, going to a movie, talking together, going out for coffee, and being a mentor.

One participant described being connected to friends in her relationship as a mentor with other people who have a mental illness.

> I'm doing sewing, I have kind of a, I'm an example to a lot of the younger mentally ill people that they kind of talk to me and they say I'm not sick, you know, and they still are, I've been where they are so they like to talk to me... I have lots of phone calls... I have lots of good friends now, all the mentally ill people... I inspire them to sew and they've lost their confidence just the same way as I did and I get them started... I really don't have friends among other people.

Another participant described being connected to other people in his boarding home. "The people here at the house... they are important while I'm living here... I go to the store for my friend, we talk... go for walks and we, we have the movie night and we have the choir".

However, several participants described their experiences of being "used" by other people who were mentally ill and reported they preferred to do things alone, such as going for coffee,

> Well usually by myself now because, I mean, with other people, with other people, it seems, you know, they'll sit and talk to, they want, they want me to buy them coffee, that's the only reason why they're around me, they're just using me and I know I've got to get, I've got to get a lot tougher to overcome that because I mean, here I am, I get a couple of hundred bucks more than everybody else and I haven't saved a penny since I've been here, do you know what I mean?

Participants described friends as making a difference in their lives. As one participant elaborated, "they're willing to listen to me and, um, share their lives with me, you know, the things they do". Many participants talked about hoping to have relationships with new people they could call friends in the future. One participant went to a clubhouse for persons with mental illness, "knowing that I'm gonna meet people, um, I'm going to meet new people and get to know them, that makes me go because I'm very interested in doing that, you know, to know new people". Participants talked about having or wanting to know people as friends.

From the participants' accounts as discussed in the focus groups, being connected to friends was significant to their spiritual self and added meaning to their life experiences. Participants acknowledged that their spiritual self was enriched as a consequence of being connected to friends. Participants claimed that outcomes of being connected to friends included feeling a sense of belonging, happiness, and being valued as unique individuals.

In relation to being disconnected from friends, some participants gave up on the idea of developing any long term friendships while others expressed frustration with continually spending their own money on coffee or cigarettes for others. All participants spoke about how living with schizophrenia fosters a disconnection from friends due to either being diagnosed with schizophrenia and /or being hospitalized for treatment of their schizophrenia. Most participants recalled having friends while growing up.

> I knew I had friends, but I knew I had no friends, you know. And I saw a sadness, not like I wanted to leave them but they weren't really there anyway … I don't have anybody on a day-to-day basis as a friend… no true friends on a day-to-day basis… I had to learn how to be a loner once I got on those medications from Riverview, I had to learn how to be a loner, I grew up with friends but you know, I mostly got in touch with them, they never mostly got in touch with me… it's pretty hard to beg all your life even beg when you haven't got friends but it just ended in some way or another… it's a lot of loneliness and fear as a result of having schizophrenia… making friends… it's hard to trust people.

I never had too many friends, for example, uh, I only had a few close friends or one best friend in high school and, uh, so then, uh, when I got ill, I didn't even have one best friend… my problems just got worse having no friends.

Another participant described his experience of being admitted to a psychiatric hospital and being disconnected from others as "like being dead… it was like a living cemetery". Another participant stated that he attributed his inability to get well to not having friends. "I don't know that I was well but I was not in need of hospitalization; I couldn't develop, I had nobody, no family member or no group of friends outside the family facilitated my going on from there with my life". One participant, who lived in a psychiatric boarding home, described his disconnection from others in this way,

Well, I mean the only thing we've got in common here is that we all have been in a mental hospital at one time in our lives and we all live here… that's about, that's about all it is… I'm not close to anyone… nobody you'd say is a friend, I don't, no friends is not a word I use very lightly… I don't think about finding ever, long lasting friendships anymore, I don't, I don't struggle to find it anymore.

Most participants expressed a desire to have relationships with people who they would consider to be their friends in the future. Many participants described having at least one person in their life whom they regarded as being a friend and whom they valued.

From the participants' accounts as discussed in the focus groups, being disconnected from friends was significant, adding to their sense of being disconnected from their spiritual self. Participants acknowledged that their spiritual self was negatively impacted as a consequence of being disconnected from people they perceived to be friends. Participants claimed that outcomes of being disconnected from friends included feeling a sense of loneliness, alienation, rejection, and being unimportant.

Connection to God or a Higher Power

The experience of connection to God or a Higher Power was described contextually by participants as a significant connection to their spiritual self. Most participants (two-thirds) described being connected to God or a Higher Power as being significant in their experience of spirituality. Those who stated they believed in God, also talked about the use of prayer and reading the Bible to enhance their connection to God, rather than allegiance to a particular religious denomination or church. Participants reported praying for others, praying for God to provide guidance when faced with uncertainty and for better health. Participants indicated the deliberate use of prayer afforded them a sense of comfort, peace and strength. Many participants reported the concepts of faith, love and forgiveness as being significant to their religious values and beliefs. Participants who denied the existence of a God but related to a Higher Power shared similar values.

> I believe in God and I pray everyday but I don't go to church… I never went to church as a youngster, my family weren't religious but I do believe in God and Jesus… I believe God is a supreme being… I use to read the Bible. I don't read it now but I used to read the Bible, I read it all the way through.

> I believe in God; I believe in love not religion; I believe in loving God, love of all; I believe my own Catholic religion but to me religion, the word religion itself doesn't mean that much to me because a lot of people are false, uh, like… love your, your fellow man and love yourself, you know, that's what religion means to me… prayer is a wonderful experience; I've changed, you know; it changed me, the prayer… it made me a better person… it is reassuring, you know, just comfort, comforting; prayer is comforting, it's, uh, very helpful.

> The most important thing in my life, uh, I'd say to be at peace… at peace with other people and with the God that I believe in… I believe God actually did heal me to a certain extent because I was very, uh, out of it and dull, you know, and I couldn't think clearly… the nurses and doctors were taking care of me so it's, uh, I think, I think God worked through them to a certain extent.

The idea of forgiveness was reported by fifty percent of participants as being an important element of their connection to God or a Higher Power and as an element of their spirituality. One participant talked about Jesus Christ as, "when He died, He brought forgiveness of sins through his death and his sacrifice, uh, that would allow God to forgive us our sins". One participant described his beliefs about others who make mistakes in life stating "they're human too. They make mistakes, so I think, well, you've got to learn to forgive them… that is the word forgiveness… everybody should practice that word". Another participant described when he sinned, " I feel guilty and that's not a good feeling… well, I ask for forgiveness from the Lord and from others too". One participant reported,

> I pray to God and I seek his presence and I ask him to, to forgive my sins and… that ·
> keeps me centered, you know, or, or God is, God is sort of like the stabilizing factor
> in my life and I don't, I wouldn't change anything, I think like my life, like, uh, like I
> think like if, uh, if he wants me to take medication for my schizophrenia, I take my
> medication and things like that.

A few participants, who reported believing in a Higher Power, talked about it in the context of the philosophy of Alcoholics Anonymous (AA) and Emotions Anonymous (EA). One participant explained she attended an AA meeting, Alanon, because her husband was drinking and found comfort in working through the first four steps of the twelve step program. She reported receiving inspiration by reading through the AA daily meditations and the EA meditations from the *Today* book.

> Like I read them everyday for four years, those two books. It really changed quite a bit
> of my my thinking… I was almost incapable of putting on my cloths in the morning
> because I couldn't decide what to wear, you know, so I'd turned everything over to
> the higher power, I'd say what will I put on today and then I would quickly go pick it
> out like He, it gives me, uh, self confidence getting in touch with a higher power.

> In relation to disconnection from God or a Higher Power, some participants (six)

stated they did not believe in a God or Higher Power. A few participants who believed in a

God spoke of their pain and suffering when experiencing psychosis because of the disconnection from God that they experienced during psychotic episodes. They reported questioning their relationship with their God during these times.

> Because of this disconnection, my perceptions changed and what I used to depend upon became questionable... questioning perceptions of God as being good or evil... uncertainty of trusting God to bring me out of it... and be well again.

Several participants stated they felt disconnected from God or a Higher Power when they perceived that God was not hearing their prayers. Participants identified outcomes of being disconnected from God or a Higher Power as feeling powerlessness, loneliness and alienation.

From the participants' accounts as discussed in the focus groups, being connected to God or a Higher Power was significant to their spiritual self and added meaning to their life experiences. Participants claimed that their spiritual self was enriched as a consequence of being connected to their God or a Higher Power. Participants claimed that outcomes of being connected to God or a higher power included feeling a sense of peacefulness, love, glory, happiness, and contentment. Additionally, from the participants' accounts, being disconnected from God or a Higher Power was viewed as being significant to feeling disconnected from their spiritual self. Participants noted that their spiritual self was being negatively influenced as a consequence of being disconnected from God or a Higher Power. Participants claimed that outcomes of being disconnected from God or a Higher Power included feeling a sense of loneliness, alienation, rejection, uncertainty and feelings of being unloved.

Connection to Health Care Professionals

The experience of connection to health care professionals was described contextually by participants as being engaged in significant supportive relationships with their community psychiatric nurses and psychiatrists. These health care professionals assisted them in maintaining their connection to their mind, body, and spirit which added meaning to their lives and to their wellness perspective. Connection to health care professionals (psychiatric-mental health nurses and doctors) was noted to be an important connection to significant others for participants' spirituality. Many participants identified a connection to their community mental health team as being important to their sprituality and their wellness. Most participants were connected to a community mental health team where they received ongoing follow-up care by their community psychiatrist and community psychiatric-mental health nurse/ therapist. Many participants reported having a positive relationship with their nurse/ therapist. The relationship was viewed as being strong and positive particularly if the nurse/ therapist shared similar spiritual values and beliefs and were open to talking about spiritual beliefs with participants..One participant noted "I thought I could talk about God to him [nurse]. He knew what I was talking about… he understands how I'm thinking and why and he says come talk to me and I go and I tell him what I am thinking". Another participant shared his insights about connecting with his community psychiatric nurse who shared similar spiritual values and beliefs as a Christian, "she has more beliefs common with me than my last therapist… her world view is in more synch with mine than the last one… and that helps me a lot". Several participants believed health care professionals were doing "God's work" by just helping others in their journey living life with a mental illness.

Another participant emphasized that health care professionals should be authentic, genuine and empathic in the relationships they have with consumers as a means of enhancing relationships with mentally ill people and meeting their spiritual needs. One participant added,

> As far as the community mental health team goes and seeing some of the nurses on the team every two weeks or so, I found that it gave me a door into a rational world, a door of my own, a way of stepping outside myself and saying, okay, P, you are psychotic, you know, it's not your fault, you are living in a fantasy world and you have to find the real world, and the team gave this to me, opened that door for me to find, to view myself as psychotic and realize that I was mentally ill, and it was very effective in that way.

Two participants perceived their spiritual beliefs were simply ignored by their health care professionals as any part of their psychiatric-mental health care. In discussing spirituality as an element of holistic care, one participant noted health care professionals needed to first "recognize them, and respect them, and just, uh, talk about them… spirituality, yeah, that's important, I think your spiritual beliefs has a lot, is related to your outlook on life… they can discuss it with you, I think spiritual beliefs are very important because they influence your outlook on life".

In relation to disconnetion from health care professioanls, four participants reported not being connected to their health care professionals. They reported interacting with them, answering questions raised by the health care professionals, but did not express any sense of connection to them in a meaningful way. One participant reported not trusting the health care professionals in his psychiatric boarding home, perceiving they were nonsupportive of him favoring other co-residents. He turned to his minister for spiritual support. Another participant expressed very clearly he perceived his spiritual beliefs "were none of their business and if it became so, then things were really getting out of hand". Four participants

who were disconnected from health care professionals regarding their spiritual beliefs indicated they sought spiritual support from their minister or pastor.

From the participants' accounts as discussed in the focus groups, being connected to health care professionals was a significant relationship they experienced in supporting them to maintain connection to their mind, body, and spirit and added meaning to their life experiences. Most participants acknowledged that their spiritual self was enriched as a consequence of being connected to health care professionals. These participants claimed that outcomes of being connected to health care professionals included feeling a sense of happiness, being cared for, being respected and being treated with dignity as unique individuals.

Additionally, from the participants' accounts, being disconnected from health care professionals was viewed as being significant to feeling disconnected from their spiritual self. Four participants acknowledged that their spiritual self was negatively influenced as a consequence of not trusting their health care professionals and perceiving their spiritual beliefs were not any business of health care professionals. These four participants concurred that outcomes of being disconnected from health care professionals included feeling a sense of uncertainty, distrust, frustration and not being cared for with respect and dignity.

Connection to Community

The experience of connection to a community was described contextually by participants as being engaged in significant relationships within a community of persons diagnosed with mental illness, a community of persons who were well, a faith community, and the community in which they lived. Participants reported experiencing relationships with

others in a community context enhanced their connection to their spiritual self which added meaning to their lives and to their wellness perspective.

Connections to community were viewed by the participants as important components of their spirituality. Most participants described being connected to a community of others with mental illness.They achieved these connections by going to a drop-in center and a clubhouse for persons with mental illness. Many participants described being connected to a community of others who were well. Connections to others who were well included meeting people at places of worship, at a community recreation center or library as well as visits to their community mental health office.

Five participants living in one psychiatric group home reported attending a weekly group called "the faith journey group" to enhance their connection to their community and spiritual self. The faith journey group is conducted every Tuesday morning by a Father from the Anglican church affilated with the St. James Community Service Society. The aim of the faith journey group is to have a structured meeting time for individuals living in the psychiatric boarding home in order to have an opportunity to talk about any issues about their lives with a member of clergy. One participant described his enjoyment of attending the faith journey group in this way, "I haven't been going every week but I try to… I enjoy it… the board with the, the paper on it and the writing that the Father [priest] puts on it and, uh, the coffee break helps… going to the group, being with others, it makes me happy during lunch and during the afternoon".

Some particpants emphasized the importance of having a drop-in center or clubhouse for persons with mental illness where they could experience a sense of acceptance, belonging and community. One participant explained,

> You wake up in the morning and I think why would I want to get out of bed and take a shower and go out, why? Because you go to Coast [Foundation], you meet nice people, you spend time and you get the best experience possible and that really makes me move into action, I take action because it is gonna feel good when you do these kinds of things.

Another participant described his experience of being accepted by others in attending a clubhouse in his community for persons with mental illness.

> Now I have people that accept me. They, well many people accept me here and they think I'm an okay guy, you know… my psychiatric needs in this clubhouse setting have been dealt with better than any other place… this place has done the most to renew my spirit than any, any place… it's the best place I've ever known".

Many participants described the importance of being connected to a community of well persons in addition to a community of ill persons. For some participants, having time with their community mental health nurse and psychiatrist were the only well people they experienced any connection to in their lives. They sought connections to a community of well persons primarily through a meeting place of worship, the local community recreation center, library and gymnasium. One participant described his need to be with people who are well in this way.

> I have to interact with well people… I enjoy talking to healthy people, uh, I enjoy talking to people who are healthy because I have a nice exercise of expressing myself, I can know that you understand what I'm saying, that gives me satisfaction that I'm able to say something that makes sense… this helps me increase the quality of relationships, it helps me feel better about myself when I make sense to well people.

Another participant reported the significant role of his local community center in this way,

> I try to be active, I come to the community center just about everyday and I work out and so like I, it's really made a big difference to me, this, this right now, this connection with the center, it's so important to me now, it really plays a pretty big part of my whole life style right now.

In relation to disconnection from community, participants spoke of disconnection from community as not having a common place to go where they could feel comfortable with some sort of group or "community". One participant described disconnection from community as, "not having anywhere to go where you had a sense of belonging and community support... not having a place to go and being able to separate from family". Another participant expressed "feeling left out because of not belonging to any organized group" in his community. He stated he was "lacking in trust with denominational leaders" and he decided to stop going to church because he perceived his mental health and religious needs were not being met.

This separateness from a church community contributed to his sense of isolation and disconnection from others; however, he stated that this had the unexpected outcome of enhancing his connection to self. He claimed, "I felt uniquely connected to [my] spirit and maybe especially more so when I felt disconnected to society". Another participant stated that disconnection from community occurred among people with schizophrenia because of the public and government's discriminatory practices in dealing with people diagnosed with schizophrenia.

> I think we are people... with a diagnosis who are still discriminated against, mainly because we have a diagnosis... people with schizophrenia are at the bottom of the mud pile as we are... people with schizophrenia are discriminated against... the mental health budget is very, very limited relative to the one in five people who get mental illness at some time in their life... there are not enough resources that our volume deserves and demands without being heard.

He perceived that this discrimination was most obvious in the lack of provincial funded resources in communities for people living with a mental illness. He strongly advocated for equitable community services for consumers of mental health services, suggesting that

innovations such as a clubhouse or community center for persons with mental illnesses in all rural and urban communities would increase their connection to their spirituality contextually (connection to a community of others living with a mental illness) and involvement within their home community. One participant claimed,

> When Coast (Foundation) is closed and you wake up in the morning and you don't really have, uh, and it's real, you feel bad because you don't have anywhere to go and anything to do and you're trying to, you're trying to push yourself into finding something, you know, it makes you feel humiliated like, you know, I've nobody to call, I have nobody to see, nobody to go with.

From the participants' accounts as discussed in the focus groups, being connected to a community was a significant relationship for participants as they experienced meaningful relationships with others, which enhanced their spiritual self as a result of giving meaning to their life experiences. Participants acknowledged that their spiritual self was enriched as a consequence of being connected to a community of others. Participants claimed that outcomes of being connected to a community of others included feeling a sense of belonging, happiness, and being valued as worthwhile and unique individuals. Additionally, from the participants' accounts, being disconnected from a community was viewed as being significantly disconnected from their spiritual self. Participants acknowledged that their spiritual self was negatively influenced as a consequence of experiencing disconnection from a community. Participants reported outcomes of being disconnected from a community included feeling lonely, rejected, isolated, alienated, humiliated, and helpless.

Connection to Nature

The experience of connection to nature was described contextually by participants as being in nature. Most participants (two-thirds) claimed that experiencing connection to nature enhanced their spiritual self. Some participants experienced nature by walking near the ocean

or in the forest, seeing the mountains, blue skies, and white clouds. Other participants

described experiencing connection to nature by witnesssing birds singing, or by watching

eagles fly, squirrels gathering food, and ducks swimming. Three participants described their

connection to nature in this way:

> Oh, I walk, I go down to English Bay and when we've had a nice summer day
> and see the sun going down, I find that inspiring and I, I'll look for a flower or
> something like that and I'll think, oh, there's something that the creator put
> there for us to enjoy these beautiful flowers.

> I look at, I look at the, uh, nature as God's artwork, you know, like I, I go, okay, like I,
> I don't... for instance, seeing the trees, the leaves falling in the winter and spring
> come back to life again and so, and that's an example of God's artwork... I don't
> know if I'm blessed but seeing a rabbit in the park, I see squirrels, I see this eagle who
> flies at me and I'm thinking... wow, this is really fantastic, you know... like that's the,
> that's like food to the soul.

> I think nature is important in terms of its, uh, you see God's creation in nature, you
> can see something spiritual in nature, like animals, the plants, the beauty of it all,
> being in nature, feeling at peace and tranquil by the effects of what you see, the effects
> of what God has made so wonderfully... it's inspiring, you know, being in nature and
> appreciating God's creation.

Being in nature and seeing the bigger picture was perceived by most participants as being

hopeful and sustaining to their spiritual self. Further, for many participants experiencing

connection to nature was related to engaging in a reflective appreciation for the beauty and

awe of nature. Participants noted that seeing nature in all its splendor increased their

awareness of being a part of something greater than themselves. Participants in the focus

groups reported that being connected to nature and by being in nature enhanced their spiritual

self and wellness perspective.

In relation to disconnection from nature, some participants experienced disconnection

from nature which in turn added to their disconnection from their spiritual self. Being

disconnected from nature was described by participants as being unable to go outside for

walks, or being unable to be outside enjoying the sun, clouds, wind, trees, plants, mountains, and sea. Most participants believed that nature was "a window to your spirit". One participant said, "Other than going to the community swimming pool and a few trees… I don't have a connection to animals unless I'm out in the forest or something… but nature does bring… the spirit of God, you know". Some participants reported the adverse effects of the typical antipsychotic medicines were a primary contributing factor prohibiting them from walking and being outside, thus experiencing disconnection from nature. One participant who was being prescribed Stelazine explained:

> My body felt like it was a ninety year old and I couldn't go out for walks properly, although I tried, something made me feel really old… and you know how there's a certain rhythm to walking; well I lost that rhythm to walking but I'm gaining it back slowly… so there's a certain joy in walking in nature which I've lost…

Participants who experienced significant neurological adverse effects from prescribed typical antipsychotic medicines were hampered in their ability to be outside experiencing nature.

In relation to being disconnected from nature, one-third (seven) of the participants identified that they were not connected with nature because of the side effects of the antipsychotic medications they experienced, limited social interactions with others and were reluctant to engage nature alone. Five participants lived on Vancouver's East side and feared for their own safety when outside alone from their boarding home due to the risks and potential for crime in their neighbourhood.

Participants who were unable to be a part of nature because of the adverse efects of their medication, lack of social supports and relationships, or the neighbourhood they lived in tended to avoid being in nature. Although they talked longingly about being a part of nature,

they were unable to do so and therefore they stated they felt disconnected from experiencing spirituality in the context of being in nature.

From the participants' accounts as discussed in the focus groups, being connected to nature was a significant connection as they experienced a greater sense of their spiritual self in relation to the work of the Creator, giving meaning to their life experiences. Participants acknowledged that their spiritual self was enriched as a consequence of being connected to nature. Participants claimed that outcomes of being connected to nature included feeling a sense of inner peace, hopefulness, wonder, and awe. Additionally, from the participants' accounts, being disconnected from nature was viewed as being significant to feeling disconnected from their spiritual self. Participants acknowledged that their spiritual self was negatively influenced as a consequence of not experiencing nature. Participants reported outcomes of being disconnected from nature included feelings of powerlessness, helplessness, loneliness, alienation and isolation.

Summary

The findings presented in this chapter document the study participants' experience of spirituality as connection. Individuals living with schizophrenia in this study experience spirituality within the context of living with a chronic illness. Within this study, the complex processes of shifting perspectives of spiritual well-being (connection) and spiritual distress (disconnection) are situated on a continuum of shifting perspectives of wellness / illness perspectives and are reflected in the two major study themes of connection and disconnection. These shifts in perspectives, from being connected to or disconnected from one's spiritual self occur in response to the positive and negative symptoms associated with their chronic mental illness.

Major sub-themes explicated from the findings of this study support that participants' experiences of spirituality were significantly influenced, either positively or negatively, by the dynamic interrelationships between the individual and their perceptions of family, friends, God or Higher Power, health care professionals, communities of others (ill others, well others), and nature. In turn, participants in the study experienced a higher sense of spiritual well-being when they employed the identified strategies used to achieve connection to their spiritual self.

Spirituality was experienced by the study participants as being internalized and contextualized. Internally, spirituality was experienced by participants as a connection to / disconnection from their spiritual self (mind, body and spirit). Contextually, spirituality was experienced by participants as a connection to / disconnection from significant others (family, friends, God / Higher Power, and health care professionals), community (a community of others who were also mentally ill, a community of well others, a faith community, and the community in which they lived), and nature.

Strategies explicated from the findings of this study which were used to deliberately achieve connection to participants' spiritual self included taking prescribed atypical antipsychotic medications, maintaining their health and a healthy lifestyle, use of prayer / meditation, caring for self and others, and engaging in creative activities. Participants reported how they experienced connection to / disconnection from their spiritual self, significant others, community and nature. Participants identified contributing factors which enhanced their connection to significant others, community and nature and outcomes of being connected to / disconnected from their spiritual self, significant others, community and nature were delineated.

Participants' accounts of their experience of spirituality clearly reveals the experience of disconnection to one's spiritual self, significant others, community and nature is compounded as a result of living with a mental illness such as schizophrenia. From the participants' accounts, many of their interactions with others are situated within an illness context, so their unique strengths may not be nurtured as they often interact primarily with other people who are also living with a mental illness. From the participants' accounts, disconnection from their spiritual self often lead to further disconnection from significant others, community and nature. This disconnection occurred because when participants felt disconnected from their spiritual self, they tended to withdraw from social activities, ignore prescribed treatment regimes by health care professionals, and in some instances used alcohol or drugs, which in turn led to further disconnection from their spiritual self.

From the participants' accounts, connection to their spiritual self often led to further connection to significant others (family, friends, God or a Higher Power, health care professionals), community and nature. This connection tended to occur because participants were more likely to attend to their overall health practices, engage with other people (family and friends), attend social activities within their own communities, and go out for walks individually or with others.

In essence, a spiraling effect may occur with being connected or disconnected. If health care professionals do not recognize and intervene in the downward spiral of disconnection, someone with schizophrenia may become totally disconnected from their spiritual self, significant others, community, and nature which further disconnects them from their spirituality. The next chapter addresses a summary of the research project, conclusions, discussion, and implications.

CHAPTER FIVE

Summary, Conclusions, Discussion, and Implications

This chapter provides a summary of the research project, followed by a discussion of the substantive theory, spirituality as connection, within the context of shifting perspectives of living with a chronic mental illness. Spirituality as connection is delineated to illustrate the dynamic interplay of the complex structures and processes of the participants' experience of spirituality. Contributing factors and outcomes associated with connection to and disconnection from one's spiritual self, significant others, community, and nature are delineated. Conclusions are drawn from the findings of this research study and a discussion of the findings is presented regarding insights from the study. Implications for psychiatric nursing curricula, education, practice, and research are presented. The chapter will end with recommendations for further inquiry and an account of the study's limitations.

Summary of the Findings

The purpose of this research study was to discover, using grounded theory methodology in the tradition of Glaser and Strauss (1967), how individuals living with schizophrenia describe how they experience spirituality. The goal of the study was to ascertain how the experience of spirituality is socially constructed by individuals living with schizophrenia and to begin to explicate implications for psychiatric nursing curricula, education, practice, and research. This has significance because psychiatric-mental health nurses are expected to be competent in providing holistic nursing care (mind, body and spirit) to client populations. The lack of research in this substantive area served as justification for undertaking this inquiry.

Twenty adults who self-reported living with schizophrenia and who were living in a large urban area were recruited. Participants were selected who met the inclusion criteria: (a) being 19 years of age or older, (b) having a known diagnosis of schizophrenia, (c) expressing an interest in talking about their experience of spirituality in English, (d) being stable, (e) living in British Columbia, and (f) willing to volunteer. Participants were interviewed on two separate occassions in mutually agreed upon locations such as coffee shops, private offices of community club houses for persons with mental illness, study rooms in local university libraries, and participants' homes.

The researcher compiled demographic data on all participants which were reported as participant characteristics in Chapter Three. The twenty participants ranged from 35 to 63 years of age with a mean age of 51.1 years. One of the eighteen male participants was Black, while the two female and seventeen male participants were all Caucasian. Participants had been living with schizophrenia, on average, for a range of 24.6 years. Participants' highest level of education ranged from grade eight to a doctoral degree in bio-chemistry. Seven participants denied having any religious affiliation while the remaining participants reported religious affiliation as Roman Catholic (four), Protestant (four with one participant being non-practicing), United Church (two), Quaker (one), Anglican Church (one), and Lutheran Church (one). The mean income per annum for study participants was $9,990.40. Fourteen participants reported being single, three reported being divorced, one married, one separated, and one particpant reported being involved in a common-law relationship. Study participants had a mean of 6.35 admissions to hospital for psychiatric care. Twelve participants lived in independent living situations (apartments), seven participants lived in a semi-structured living situations (psychiatric boarding houses) and one participant lived in a transition house.

Transcriptions from the 40 semi-structured, audio-taped, in-depth interviews were analyzed using the constant comparative method of grounded theory. Four focus groups were conducted to present study participants with the emerging substantive theory of spirituality as connection and to invite participants to comment further on the emerging themes and subthemes in relation to the accuracy of participants' experience of spirituality. Comments from the particpants in the focus groups were incorporated into the substantive theory of spirituality as connection.

The findings from the study reveal that all participants living with schizophrenia described the experience of spirituality as connection. Conceptually, all participants' experience of spirituality was internalized and most participants' experience of spirituality was contextualized. The substantive theory of spirituality as connection is conceptualized using two primary subthemes: connection to and disconnection from one's spiritual self, significant others, community, and nature. Participants' experience of spirituality as connection was described as being internalized when their minds and bodies were working harmoniously together in order to attend deliberately to their spiritual self; hence, a connection to mind, body and spirit working together was experienced. Participants experienced disconnection from their spiritual self when experiencing positive symptoms associated with their schizophrenia such as auditory hallucinations and delusions of grandiosity or persecution. Participants identified the following as strategies to achieve connection to their spiritual self: taking prescribed atypical antipsychotic medications, maintaining their health and a healthy lifestyle, using prayer / meditation, caring for self and others, having access to clean and safe housing, and engaging in creative activities.

Spirituality as connection was experienced contextually in relation to being connected to or disconnected from significant others (family, friends, God or a Higher Power, and health care professionals), community (a community of mentally ill others, a community of well others, a faith community, the community in which they resided), and nature.

The substantive theory of spirituality as connection emerged from the data and is linked to factors which contribute to feeling connected to or disconnected from participants' spiritual self, significant others, community, and nature. Participants sought strategies and activities that influenced their ability to be connected to their spiritual self and in doing so, these strategies and activities provided their lives with meaning in the context of living with a chronic mental illness. Meaning in the lives of participants came from being connected to their spiritual self which in turn fostered connections with significant others, community, and nature. Having meaning in their lives provided participants with a window to their self-identity as unique individuals living with a chronic mental illness. When participants experienced disconnection from their mind and body as a result of experiencing the positive symptoms of schizophrenia such as auditory hallucinations and delusions of grandiosity or persecution, they were unable to attend deliberately to their spiritual self. This, in turn, for many participants triggered further disconnection from significant others, community and nature which translated into losing meaning that they derived in their lives when experiencing wellness. The research findings are congruent with the substantive theory of spirituality as connection because they reveal that one's experience of connection and disconnection to one's spiritual self is constantly shifting from foreground to background in one's life in response to various internal and contextual factors. Wellness-in-the-foreground is associated

with being connected to one's spiritual self, while illness-in-the-foreground is associated with being disconnected from one's spiritual self.

The structure and context associated with the substantive theory of spirituality as connection includes the nurse-client relationship, environment, and psychiatric nursing interventions. Processes associated with the substantive theory of spirituality as connection to health care providers include therapeutic communication and ways of being/ being present. Outcomes associated with the substantive theory of spirituality as connection include coping and adaptation, connecting, leading to spiritual well being or alterations in coping and adaptation, disconnecting, leading to spiritual distress.

Spirituality as Connection

The substantive theory "Spirituality as Connection" which was derived from the data analysis using grounded theory methodology indicates that spirituality for study participants involves a dialectical process in which one strives to be connected to one's spiritual self (body-mind-spirit), significant others (family, friends, God / Higher Power, health care professionals), community (others who have a mental illness, others who are well, a faith community, the community in which they lived), and nature while at the same time, experiencing situations and incidents that promote disconnection. Study participants living with schizophrenia were neither entirely connected or disconnected in their spirituality. Rather, they experience shifts in the foregrounding of connection and disconnection that affects how they are able to experience spirituality. For example, someone who is experiencing auditory hallucinations because of the illness and adverse effects as a result of treatment modalities from their medication, such as dystonia will likely see the disconnection of their lives as paramount (i.e., in the foreground). They will experience difficulty

connecting to their spiritual self, significant others, community, and nature and may "lose touch" with their spirituality. However, someone who is able to sustain connection because he/she is not experiencing any symptoms associated with their illness or adverse effects of medications is likely to experience spirituality within the connections they have to their spiritual self, significant others, community, and nature.

As a process, participants in the current study experienced varying degrees of connection and disconnection between their spiritual self, significant others, community, and nature. This process involved a dynamic shifting perspective that changed over time based on a variation of factors and outcomes. A schema of contributing factors to experiencing connection and disconnection from one's spiritual self, significant others, community, and nature with subsequent outcomes is presented in Figure 1. Among the 17 factors contributing to connection, exemplars include: reconnecting with one's spirit through prayer and meditation, attending drop-in centers for persons living with a mental illness, and walking / hiking in nature. Outcomes of feeling connection include feeling peaceful, love, contentment, being accepted, and nurtured by others. Among the 14 factors contributing to disconnection, exemplars include: the effect of the illness on relationships with other people, the stigma of being in a psychiatric ward, being unemployed, and taking typical anti-psychotic medications. Outcomes include feeling powerlessness, isolation, rejection, and alienation. The substantive theory of spirituality as connection emerged as the core category of the research findings for this study as presented in Chapter Four. The substantive theory of spirituality as connection reflects the structures and processes of the experiences of spirituality (internalized and contextualized) among persons living with schizophrenia in which connecting to and disconnecting from one's spiritual self, significant others,

Spirituality as Connection

- Experienced as a dialectic between feeling connected and disconnected to one's spiritual self, significant others, community, and nature.

Factors that contribute to feeling connected:
- learning to reconnect with one's spirit through use of prayer, meditation, contemplation;
- reconnection to God, Higher Power; belonging to a faith community;
- having faith and belief in forgiveness of self and others, reading the Bible;
- experiencing a sense of belonging [family, friends and community];
- being loved and appreciated as a unique and worth-while person;
- having access to a community of others with mental illness if needed and to a community of others who are not living with a mental illness;
- attending drop-in centers for persons with a mental illness;
- being in nature and appreciating God's creation;
- learning to communicate clearly with others in the normal world;
- making a contribution to society by reaching out to help others as a volunteer and or by being employed;
- participating in faith/ worship services;
- transcendent approaches to illness / transcends the effects of illness [support from family, friends, health care professionals, enable one to overcome self-concerns in order to remain actively involved in relationships, activities and life in general];
- having access to semi and independent clean, safe housing;
- regular exercise, balanced diet, abstinence from alcohol and drugs;
- prescribed atypical medicines;
- having shared spiritual values with health care professionals;
- use of technology, use of computers/world wide web

Factors that contribute to feeling disconnected:
- the effect the illness has on oneself [symptoms], others [fear] and society's response to oneself when ill [discrimination];
- questioning belief and one's relationship in one's God or Higher Power;
- treatment approaches used, being hospitalized prescribed typical antipsychotic medications and discontinuing prescribed medications;
- the process of isolation from receiving treatment to protect self and others [being hospitalized for treatment of illness, medications, losing contact with people];
- being unemployed;
- use of substances (alcohol and drugs);
- decreased sleep;
- change in their brain chemical functioning;
- choosing not to use prayer or meditation;
- conflicts between philosophical values and religious beliefs and expressions of sexuality;
- losing contact with family and friends;
- having spiritual values and beliefs ignored by health care professionals;
- not having a common place to go with others living with a mental illness;
- perceived discrimination from the public and government policies.

Outcomes of connection include feelings of:
- peacefulness, love, glory, happiness, confidence, contentment;
- being proud of healthier lifestyle choice;
- being valued as a unique person, being cared for, respected and treated with dignity from health care professionals;
- being hopeful for the future, having a sense of purpose and life having meaning;
- trust with others over time, being accepted and nurtured by others, inner peace, hopefulness, wonder, awe, wellness;
- a sense of belonging to a community;
- being in control and getting on with one's life.

Outcomes of disconnection include feelings of:
- powerlessness, hopelessness, uncertainty, distrust, frustration, fear, despair, uncared for, isolation, humiliation, helplessness, unimportance, unloved, loneliness, alienation, rejection by others, illness.
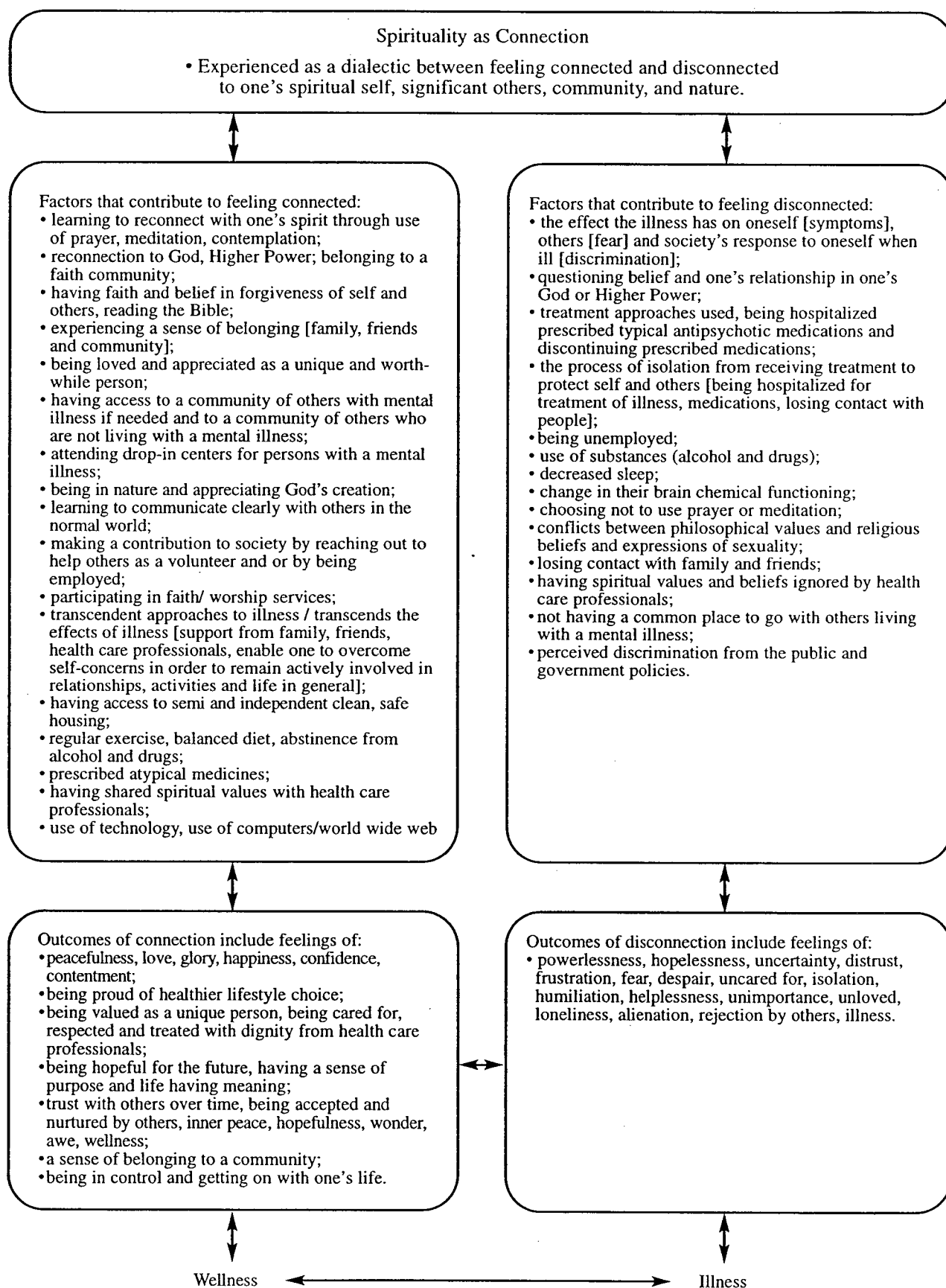
Wellness ←———————————→ Illness

Figure 1 - Schema of factors contributing to being connected to and disconnected from one's spiritual self, significant others, community, and nature, and subsequent outcomes reflecting the experience of spirituality as connection among persons living with schizophrenia

community, and nature are integral to participants' experience of spirituality. The participants' experiences of connecting to and disconnecting from one's spiritual self, significant others, community, and nature is viewed in the context of the Shifting Perspectives Model of Chronic Illness (Paterson, 2001).

Paterson (2001) constructed the "Shifting Perspectives Model of Chronic Illness" derived from a metasynthesis of 292 qualitative research studies. Paterson contends the shifting perspectives model of chronic illness explicates the variations in persons' attention to symptoms over time, in ways that seem ill-advised or harmful to their health. Paterson posits "that living with a chronic illness is an ongoing and continually shifting process in which an illness-in-the-foreground or wellness-in-the-foreground perspective has clear specific functions in the person's world" (p. 21) which reflect the person's needs and current realities.

Paterson (2001) refers to the perspective of illness-in-the-foreground when the person's focus is on his or her illness, symptoms, suffering, and associated losses and burden experienced as a result of his or her chronic illness. The perspective of wellness-in-the-foreground is described as appraising the chronic illness as an "opportunity for meaningful change in relationships with others and the environment" (Paterson, p. 23). Paterson reports a common theme in research findings where participants espouse having good or excellent health despite having significantly impaired physical functioning. In viewing wellness-in-the-foreground perspective, Paterson asserts the self emerges as the source of one's identity and self-concept and not the compromised physically ill body. As reported by participants in this study, many participants who were living in community settings experienced shifting perspectives of their chronic mental illness-in-the-foreground to wellness-in-the-foreground. Participants reported their health as being "well" despite living with some level of cognitive

impairment associated with their schizophrenia. In relation to the findings, wellness-in-the-foreground seems to be related to connecting to one's spiritual self, significant others, community, and nature, while illness-in-the-foreground is related to disconnecting from one's spiritual self, significant others, community, and nature.

Participants in this study experienced varying degrees of connection to and disconnection from their spiritual self, significant others, community, and nature that seems to be correlated to the dynamic shifting perspectives of wellness-in-the-foreground or illness-in-the-foreground. The degree of connection to and disconnection from one's spiritual self is related to participants' perceived level of mental illness and/or wellness. Shifting degrees of connection to and disconnection from participants' spiritual self is associated with alterations in their physiological and psychological wellness. The alterations in participants' wellness are compounded by the participants' inability to attend to activities of daily living in the context of living with a chronic mental illness. For example, attending to one's own personal hygiene, riding a bus to visit family and friends, or shopping for groceries added complexity and challenges to their activities of daily living and their connection to significant others, community, and nature.

In viewing participants' shifting degrees of connection to and disconnection from their spiritual self as a process of their experiences of spirituality, patterns emerged reflecting the structures of the Shifting Perspectives Model of Chronic Illness posited by Paterson (2001). Participants described their experiences of disconnecting from their spiritual self, significant others, community, and nature when they experienced exacerbations in symptoms from their schizophrenia, thus shifting their perspective into illness-in-the-foreground. Additionally, participants described their experiences of connecting to their spiritual self,

significant others, community, and nature when they were free of positive symptoms such as delusions and hallucinations, thus shifting their perspective into wellness-in-the-foreground and enabling them to attend deliberately to their spiritual self, significant others, community, and nature. The participants' shifting perspectives of illness-in-the-foreground and wellness-in-the-foreground influenced their connection to and disconnection from their spiritual self. A schema was constructed from the data, delineating the themes, sub-themes, contributing factors and outcomes associated with connection to and disconnection from one's spiritual self, significant others, community, and nature. Contributing factors and outcomes to feeling connected and disconnected are explicated in the schema (see Figure 1).

<div style="text-align:center">Conclusions of the Study</div>

The study's findings suggest a number of conclusions about the experience of spirituality among individuals living with schizophrenia:

1. Spirituality was experienced by participants as being connected to or disconnected from their spiritual self, significant others, community, and nature.

2. Participants experienced varying degrees of connection to and disconnection from their spiritual self and further, the foregrounding of connection or disconnection is dependent on many factors.

3. Participants identified various strategies they used to achieve connection to their spiritual self which in turn fostered connections to significant others, community, and nature.

4. Wellness and connection to participants' spiritual self have a reciprocal relationship where one leads to the other and many of the factors that interfere with achieving wellness also interfere with participants' connection to one's spiritual self.

5. Most participants believed spirituality was an important part of who they are as unique individuals and were open to talking about spiritual issues with their health care professionals (psychiatric-mental health nurses and psychiatrists) recognizing spirituality as a significant part of their health, wellness, and being.

6. These individuals living with schizophrenia said that they enjoyed talking about their experience of spirituality as research participants on a one-to-one basis and that they would welcome other opportunities to participate in qualitative research in the future.

<div align="center">Discussion of the Findings</div>

A number of salient insights were derived from the research findings and are delineated to illustrate how the findings offer a new perspective and conceptualization · regarding the substantive theory of spirituality as connection among individuals living with schizophrenia. The insights have been clustered into three sub-sections and include: spirituality as being significant, fostering connections and fostering relationships with health care professionals. This section will conclude with a discussion of the researchers' perspective regarding some of the critical issues in interviewing individuals living with schizophrenia.

<div align="center">*Spirituality as Being Significant*</div>

One salient insight is the recognition that spirituality is a significant entity among study participants' well-being and that not attending to spirituality had some significant implications for the person. In Chapter Two, I referred to the nursing literature in which it is apparent that spirituality is often neglected in nursing practice, and specifically psychiatric nursing practice, and the implications of this are salient. Significant findings that have not been reported before include the observation that people with schizophrenia experience

disconnection from their spiritual self, significant others, community and nature as part of the nature of their mental illness; thus they are able to articulate connection in a way that perhaps those without schizophrenia could not express as clearly. For example, participants often referred to times in which they were symptomatic as times when they experienced disconnection from their spiritual self; they compared that to times when they were asymptomatic. Because of this insight not only did they not take for granted their spiritual self, but actually sought to stay connected to their spiritual self. This was significant to them as it was deliberate.

One of the major insights of this research is the significance of spirituality for the participants and the decisions and efforts that they made to sustain their connection to nature. One participant in this study made reference to his experience of spirituality using an analogy to being a gardener and another to being a tree. One participant described his experience of spirituality using the analogy of soil in the garden, referring to the idea that if the soil is not right, a plant cannot grow; so experiencing positive health and wellness enables his spirit to grow and develop. Another participant reported that being prescribed typical antipsychotic medications for the treatment of his schizophrenia interferred with his ability to experience spirituality using the analogy to being a tree. The participant felt his sense of spirituality [connection to his spiritual self] was suppressed by the medications interfering with his inability to progress towards his true spirit, viewing himself as a tree that sleeps, having no sense to find its soul.

In the above participants' accounts of their experience of spirituality relating to the analogy of a gardener and a tree, the symbolism reflects the need to have their spirit deep rooted in soil that is nourishing and is sustaining. This in turn may enhance the ability of their

spiritual self to grow and flourish in achieving a heightened sense of spiritual well-being in the context of living with a chronic mental illness. The analogies of the gardener and tree illustrate that connection to one's spiritual self requires certain nutrients and roots. Schizophrenia, its treatment and the response of one's self and others to the illness can provide essential nutrients to foster connection to one's spiritual self but can also inhibit connection by interfering with the person's ability to use nutrients or the efficacy of their root system in striving for connection to their spiritual self.

Another significant insight derived from the study was that the struggle for participants to regain connection to their spiritual self is associated with considerable courage, creativity, and a renewed sense of self. Most participants experienced some form of loneliness, alienation and rejection from significant others as a result of having a mental illness. Many participants did not initially recognize the severity of their mental illness but through involuntary psychiatric treatment, the process of healing demanded courage with the emergence of a new identity of viewing self in the context of living with a chronic mental illness, schizophrenia. The process of becoming isolated from significant others as the symptoms of the illness became more pronounced challenged participants to remain connected to their spiritual self and significant others. In order to be connected to their spiritual self and significant others, participants required a fair degree of intentionality to attend deliberately to their spiritual self. Participants identified strategies to achieve connection to their spiritual self. Additionally, participating in creative activities added meaning to their life experiences which in turn supported their connection to their spiritual self, thus providing themselves with a renewed sense of self.

Spirituality was viewed as being significant among study participants and was reported to be a salient part of their overall health and well-being. Spiritual assessment and intervention as elements of holistic health promotion need to be addressed in psychiatric nursing curricula. The debate in the nursing literature continues to evolve as to how spirituality is defined and differentiated from religion, what are spiritual needs and how can nurses best address spiritual needs in their practice? The major consensus from the nursing literature about spirituality in nursing curricula is the glaring absence (Bradshaw, 1997; Greenstreet, 1999; Maddox, 2001; McSherry, 2000; McSherry & Draper, 1998). Concepts such as purpose and meaning of life events, meaningful relationships, personal need for forgiveness, and hope are reported as concepts that are associated with the construct of spirituality in nursing literature (Bradshaw, 1997; Greenstreet, 1999; Maddox, 2001; McSherry, 2000). From the current study, one of the major barriers in psychiatric nursing education regarding integration of spirituality in curricula is the need for valid and reliable assessment tools that address the qualitative elements of spirituality as experienced by individuals living with a mental illness.

Fostering Connections

A number of insights emerged from the study which reveal strategies and interventions that fostered connections to participants' spiritual self. Chapter Four reported that participants identified strategies that fostered connections to their spiritual self. Insights regarding other strategies fostering connections to significant others, community, and nature also emerged from the study findings. These included fostering connections to families, a community of others with mental illness, faith communities through religious affiliation, the

use of prayer as an intervention to fostering connection to one's spiritual self, and connections to nature.

The discovery that connections to one's spiritual self can be fostered by others emerged from the study findings. Families and significant others can have a profound effect on the spirituality of individuals living with schizophrenia. Participants valued any connections to family and significant others who provided them with a sense of being accepted and nurtured for who they were as unique individuals. Having a sense of belonging to family and significant others added meaning to their life experiences and enriched their connection to their spiritual self. This finding is supported in the literature where one study explored the perspectives of 35 persons with schizophrenia using focus groups regarding meaning of quality of life and factors important to quality of life (Labiberte-Rudman, Yu, Scott, & Pajouhandeh, 2000). Findings reveal three primary themes: managing time, connecting and belonging, and making choices and maintaining control. The theme of connecting and belonging was reported as being significant to the study participants' quality of life.

A salient insight from this study is ways that individuals living with a mental illness can provide a connection to a community of others living with a mental illness. Additionally, findings from this study also support the need for connections to be fostered by others from a community beyond those who are living with a mental illness.

The study also revealed that religious affiliations can enhance connection to one's spiritual self by way of feeling a sense of connection to a faith community. Belonging to a faith community offers individuals opportunities to participate in religious practices, receive social and emotional support, be involved in community services, and often may "strengthen

a sense of personal coherence of being a whole person" (Fallot, 2001, p. 112). Many participants in the current study experienced connections to a faith community. Fostering connections to a faith community for individuals interested in religious affiliations may enhance their connection to their spiritual self.

The use of prayer as an intervention to enhance connection to one's spiritual self emerged from the study findings. Prayer enabled twelve participants in the current study to focus on something other than their symptoms and helped them to experience connection to their spiritual self. The use of prayer among study participants in connecting to their spiritual self reqiured a degree of intentionality. This was more easily accomplished when participants were not preoccupied by symptoms of their illness such as hallucinations and delusions. Although no research studies were found on the relationship between prayer and individuals with mental illness such as schizophrenia, there is a growing body of scientific studies that suggest prayer and meditation contribute to physical and mental well-being (Lindgren & Coursey, 1995; Siegel, 1986; Sloan, Bagiella, & Powell, 1999). Participants in the current study reported the use of prayer and meditation as important spiritual strategies they employed which enhanced their level of connection to their spiritual self.

A qualitative study by Sullivan (1993) investigated 40 participants who remained out of a psychiatric hospital for at least two years following a diagnosis of schizophrenia or bipolar disorder. Sullivan claimed, "Spirituality can serve as an effective buffer against negative events and as a source of social support, and may provide a sense of meaning and coherence to life" (p. 125). He found that 48% of those interviewed believed that having spiritual beliefs was a vital part of their ability to remain out of hospital. All participants in the current study lived in the community and did not report explicitly that having spiritual

beliefs were a central part of their success to remain out of hospital. Participants did indicate their physical, mental and spiritual well-being were key to them experiencing wellness-in-the- foreground.

Connection to nature was significant to participants' experience of their spiritual self. Most participants' experiences of being connected to nature positively impacted their experience of connection to their spiritual self. Many participants in the current study who had experienced alienation from their family and friends as a result of living with schizophrenia did not experience alienation from nature. Being in nature and feeling connected to nature shifted participants' focus from all of the losses they endured and the negative challenges of living life with schizophrenia to experiencing a sense of spiritual well-being. Most participants claimed being in nature and appreciating the beauty and awe of nature (witnessing the animals, plants, and environment) increased their awareness of being a part of something greater than themselves. Participants' connection to their spiritual self was reported as being enriched by being in nature. Additionally, being in nature for participants, particularly as a shared experience with others, was noted by participants to be a joyful experience as this also took one's focus off oneself and one's illness. Participants' experience of being in nature was reported as adding to a sense of peace, comfort, and happiness in being a part of the bigger picture of God's creation. Findings from this study hold implications for recreational therapy and other therapeutic interventions such as horticultural therapy that ought to be considered as interventions to foster connections to nature as part of psychiatric nursing care.

Smith (1998) suggests horticultural therapy, which uses gardening, plants, floral materials, and vegetation to stimulate clients' interest in their surroundings, leisure and

vocational skills, offers psychiatric patients a process of engaging with plants and gardening resources to achieve therapeutic ends. Smith reports that after a few sessions of horticultural therapy, clients discussed their concerns more openly with their psychiatric health care professionals. Findings from the current study in relation to participants' connection to nature as an aspect of their own spiritual self extends the therapeutic ends of horticultural therapy beyond leisure and vocational value. As reported in the current study, the notion of going for a walk and being in nature among many study participants promoted connection to their spiritual self. This is a new way of viewing the potential of horticultural therapy as an adjunctive therapy in relation to fostering connection to one's spirituality.

Fostering Relationships with Psychiatric-Mental Health Care Professionals

Fostering relationships with psychiatric-mental health nurses was viewed as a significant resource in promoting connection to one's spiritual self. Most participants in the current study believed psychiatric-mental health care professionals can either foster connection to or disconnection from participants' spiritual self. The one major insight that emerged from the findings in regard to psychiatric mental-health care professionals was their neglect in addressing their patients' spirituality as being important. Participants stressed the significance of talking openly and directly with clients about the role spirituality may have for them in their lives as unique individuals. Some health care professionals were identified as powerful facilitators of connection while others enhanced the sense of disconnection. Much of this relates to health care professionals' willingness to interact and talk openly about spirituality with their clients living with schizophrenia.

In a related study, Brammer (2000) sought to determine how nine persons with schizophrenia experienced connecting with mental health professionals using grounded

theory methodology. Brammer constructed a model of "connecting through humanness" where persons with schizophrenia determined whether mental health professionals were being helpful or not helpful through a process of "sizing up" the mental health care professional. Being helpful was viewed by the participants in Brammer's study as meeting three criteria: understanding, compassion, and normalcy. Persons with schizophrenia perceived themselves as connecting with mental health care professionals on the basis of mutual humanness. Throughout interactions with mental health care professionals that were perceived as being "not helpful", persons with schizophrenia perceived themselves as being regarded as an illness or as "schizophrenics" (Brammer, 2000). The findings from the current study are consistent with Brammer's findings where participants experienced a positive connection to their health care professionals when the participants were treated as unique and valued individuals with respect and dignity by their psychiatric-mental health nurses. The findings from the current study go beyond the work developed by Brammer as participants noted they experienced a stronger relationship and connection to their psychiatric-mental health nurse when they shared similar spiritual values and beliefs and were open to talking about them with participants as part of receiving psychiatric-mental health care. Connecting to significant others (psychiatric-mental health care professionals) was integral to the spirituality of most participants in the present study.

Few studies were located that specifically focused on the spiritual perspectives of mental health nurses and on spiritual interventions employed by mental health nurses (Pullen et al., 1996; Tuck et al., 1997). Findings of the study by Pullen et al. (1996) indicated the sample of mental health nurses [n = 50] had a greater spirituality perspective [SPS score mean 5.334, SD = .56] than other previous studies in the literature using the SPS scale

developed by Reed and that spirituality among mental health nurses increases with adult development.

In a study on spiritual interventions, Tuck et al. (1997) identified spiritual interventions provided by mental health nurses. These include being with the client, doing for the client, facilitating the client's looking inward (prayer, religious activities, reading the Bible, affirming oneself) and facilitating clients to look outward (utilization of external resources such as ministers, social workers, chaplains and clergy). Findings by Tuck et al. have utility for psychiatric nursing education and practice by way of explicitly referring to spiritual interventions as being with the client, facilitating access to religious scripture and objects such as a Bible, cross/ Rosary and access to worship services when hospitalized for psychiatric treatment. Fourteen participants in the current study claimed they believed in God or a Higher Power, eight participants reported attending church services regularly, and twelve participants used prayer in order to attend to their spiritual self.

Kirkpatrick et al. (1995) reported a qualitative study where fifteen mental health clinicians (nurses, vocational counselors, social workers, psychologists, chaplaincy caregivers, occupational therapists) identified hope-instilling strategies for their clients with schizophrenia. The hope-instilling strategies included: building a therapeutic relationship with the client based on open communication, trust, being present, listening, and valuing the person; facilitating success with the client by setting and meeting realistic goals both in and out of hospital; connecting to successful role models with the client by linking them to another individual with schizophrenia who had success in some part of his or her life; managing the illness with the client through health teaching in relation to medication management and symptom control as a precondition to begin examining other aspects of their

lives in which their schizophrenia had interfered; educating clients and others in the community regarding what it is like to be living with schizophrenia; and recognizing that individuals with a chronic illness live fulfilling lives.

Findings from the study by Kirkpatrick et al. (1995) have relevance to the participants' experience of spirituality as connection in the current study regarding connection to significant others (health care professionals) and community (others with a mental illness). Participants in the current study claimed their connection to their spiritual self was enriched when their health care professional shared similar spiritual values and beliefs and was open to talking to participants about clients' spirituality. Several participants believed their health care professionals ought to be authentic, genuine and empathic in their interactions with clients in building a trusting relationship. Kirpatrick et al. noted that connecting clients to successful role models with schizophrenia helped with instilling hope. This finding is consistent with several participants' accounts in the current study. They acted as role models to other persons with schizophrenia either by being a friend to them or by teaching them how to sew or how to use a computer.

The research findings of the current study suggest nursing interventions that will help people living with schizophrenia to foster connection to their spiritual self. In the present study, five participants reported psychiatric mental health professionals could not do anything to support their spirituality, as this was perceived by the participants to be out of the realm of what mental health professionals were expected to do. Six participants indicated mental health care providers could support their spirituality by: (1) being open to talking about spiritual issues and concerns and respecting participants' need to talk about spiritual issues; (2) giving them reality feedback in relation to any altered perceptions; (3) focusing on the

quality of the relationship through open, honest, genuine, empathic communication; being kind and caring; and (4) ensuring access to religious scripture and objects such as a Bible, cross/ Rosary and access to worship services when hospitalized for psychiatric treatment.

Moller (1999) conducted two focus groups with 65 patients and 27 family members to explore what was needed from their pastor / spiritual resource, to better meet spiritual needs of consumers on an inpatient psychiatric unit. Four themes emerged from the study and include pastors / spiritual resource in providing comfort, companionship, conversation, and consolation. These findings have the potential to be extended explicitly into psychiatric nursing curricula by way of promoting involvement of the clergy and spiritual resource persons in patient care as salient members of the interdisciplinary health care team.

Findings of studies in the broader nursing literature on nursing interventions to meet clients' spiritual needs suggest nurses can contribute to clients' connecting with their spirituality through use of the nurse-client relationship, through the use of therapeutic communication skills, and through creating a therapeutic environment. For example, Clark et al. (1991) suggest nurses provide five major spiritual nursing interventions and include "establishing a trusting relationship, providing and facilitating a supportive environment, responding in a sensitive manner to clients' beliefs, integrating spirituality into quality assurance plans, and taking ownership of the nurse's key role in the health care system" (pp. 74-75). Emblen and Halstead (1993) report that the five common nursing interventions for spiritual care from their research were talking with clients about spirituality, offering prayer, reading scripture, being present, and making a referral to a spiritual counselor. Nursing interventions identified by oncology nurses include presence, touch, active listening, reality surveillance, values clarification and inspiring hope (Poncar, 1994). Engebretson (1996) ·

posits spiritual nursing interventions include the use of prayer, instilling faith and hope, connecting with God, meditation, and listening to music. McRoberts, Sato, and Southwick (1999) report spiritual nursing interventions identified by psychiatric nurses in their study included referring clients to the clients' personal clergy, praying privately for their clients, praying with clients, offering to pray with the client, and reading spiritual writings with the client.

Connections fostered by mental health care providers who have advocated for clean and safe housing also had a significant impact on participants' spiritual self. Questions that arise about clean and safe housing for this researcher include: is it the fact that clean and safe housing was such a need that having it acknowledged helped people feel connected to a community, or was it the fact that health care professionals were people who recognized them as human beings with needs and valued them enough to advocate for clean and safe housing on their behalf?

When participants had a clean and safe place to live, they recognized there were other people in the community who cared enough about them to support this basic need. For several participants, having a clean and safe place to live took them away from living on the streets or in bug infested hotel rooms and gave then a sense of meaning, purpose and hope which they reported prevented them from being suicidal. This is significant because the British Columbia Schizophrenia Society (2001) notes 40% of individuals living with schizophrenia attempt suicide and 10% of all people living with schizophrenia successfully complete the act. It is unclear if persons who commited the act of suicide were homeless.

In summary, the findings of the current study suggest that participants' experience of spirituality as connection provides a new way of viewing the role of psychiatric-mental health

care professionals who may provide spiritual care as an element of holistic care among clients living with schizophrenia in achieving connection to their spiritual self, significant others, community, and nature. The substantive theory of spirituality as connection is presented in which individuals living with schizophrenia experienced varying degrees of connection to or disconnection from their spiritual self. Connection to and disconnection from their spiritual self, significant others, community, and nature was influenced by their shifting perspectives of chronic mental illness-in-the-foreground to wellness-in-the-foreground. Contributing factors and outcomes of participants being connected to and disconnected from their spiritual self, significant others, community, nature, and outcomes were reported.

Implications for Further Research

Critical Issues in Interviewing Individuals Living with Schizophrenia

Researcher challenges that were encountered in interviewing the participants arose from alterations in thought processes and the relaying of ideas in a logical focused manner by most participants. The primary alterations in thought processes associated with schizophrenia and manifested by most participants included derailment of ideas, loose association of ideas, tangential, and circumstantial thinking. These alterations in thought processes provided challenges to interviewing participants in the study. Five strategies recommended to mitigate these challenges included (1) raising the most important questions at the beginning of the interview, (2) posing refocusing questions when participant responses were unrelated to the original question raised, (3) restating a question in concrete terms, (4) monitoring participants' reactions to questions perceived to be unclear and moving onto new questions, recognizing there would be another opportunity to interview the participant and review the interview transcription, and (5) minimizing the amount of environmental distractions while

interviewing. Another effective strategy with this participant group was the use of focus groups which proved to be helpful, particularly after two interviews had taken place with the participant and a rapport was established with the researcher. The focus groups served as a third interview and provided an opportunity to clarify the developing substantive theory with participants.

In relation to data analysis, a major challenge became evident with the interview transcripts that revealed alterations in thought processes. A strategy used to mitigate this challenge included the use of a highlighter in highlighting key ideas and meanings attached to ideas. This strategy assisted this researcher with open coding and capturing the essence of participants' experiences when the flow of ideas reflected derailment, loose associations, tangential and circumstantial thought processes.

Implications for Psychiatric Nursing Curricula

This section of the chapter is an exploration of the importance of the findings to the discipline of nursing, and specifically, psychiatric nursing education, practice and research.

Psychiatric Nursing Education and Practice

The substantive theory of spirituality as connection depicts participants' shifting perspectives of being connected to and disconnected from one's spiritual self, significant others, community, and nature. One important finding for psychiatric nursing educators and practitioners is to be cognizant that when participants experienced disconnection from their spiritual self due to exacerbations in their symptoms such as hallucinations, delusions, and altered cognition, their spiritual needs continued to persist as they were feeling disconnected from their spiritual self. Psychiatric nursing education should teach students how to approach people with schizophrenia, about how to assess spiritual needs, how to provide psychiatric

nursing interventions addressing their spiritual needs, and how to foster connection, rather than avoid discussions regarding spirituality. For example, sitting with the individual client, listening and communicating empathy, and asking direct questions about the clients' spiritual beliefs, ascertaining how the psychiatric nursing student may assist the client in promoting connection to their spiritual self and significant others is a starting point. Interventions such as horticultural therapy and walks in nature are worthy of consideration in promoting connection to one's spiritual self and nature.

The substantive theory of spirituality as connection derived from the current study raises implications for psychiatric nursing curricula and education. One important implication is the potential changes to psychiatric nursing curricula with the incorporation of themes from the current study into courses that focus on holistic health assessment addressing the spiritual dimension of clients living with schizophrenia, specifically focusing health promotion strategies upon their lived experience of spirituality as connection to their spiritual self, significant others (family, friends, God or Higher Power, health care professionals), community and nature explicitly. Contributing factors promoting connection to and disconnection from one's spiritual self may assist students in their holistic health assessments of clients living with schizophrenia and planning collaborative psychiatric nursing goals and interventions to promote client wellness and spiritual well-being.

The findings from the current study will influence this researcher's own classes and clinical instruction with student psychiatric nurses when focusing on the spiritual dimension of the client's lived experience of spirituality to include addressing explicitly the themes and sub-themes as elements of health assessment and promotion in clinical practice settings; for example, in working with student psychiatric nurses in the clinical practice setting, assessing

their clients' experience of spirituality as connection to or disconnection from one's spiritual self and significant others by way of using direct open ended questions while conducting holistic health assessments.

In regard to psychiatric nursing curricula, conference presentations or workshops addressing student psychiatric nurses and practitioners, the findings from the current study will also influence this researcher's focus of attention as to how to approach health assessment and promotion explicitly focusing on the experience of spirituality among persons living with schizophrenia; for example, taking time to have conversations with clients about their spiritual values and beliefs and promoting spiritual health assessment regarding clients' connection to one's spiritual self, significant others, community, and nature as elements of spiritual health promotion.

In reviewing psychiatric-mental health nursing textbooks (Antai-Otong, 1995; Burgess, 1997; Carson, 2000; Fortinash & Holoday-Worret, 2000; Frisch & Frisch, 2002; Haber et al., 1997; Johnson, 1997; Rawlins et al., 1993; Stuart & Laraia, 2001; Townsend, 2000), the notion of connection to one's spiritual self as described by participants in the current study is absent from the psychiatric nursing literature. Based upon the findings from the current study, connection to one's spiritual self as described by participants is a significant finding and ought to be addressed explicitly in future revisions to psychiatric nursing textbooks with respect to individuals living with schizophrenia.

The substantive theory of spirituality as connection and the strategies identified by participants with schizophrenia in the current study to achieve connection to their spiritual self are noteworthy of being added to revised psychiatric nursing textbooks. Additionally, revised psychiatric nursing textbooks ought to consider the importance of contributing factors and

outcomes identified by study participants associated with becoming connected to and disconnected from one's spiritual self, significant others, community and nature. This may serve in guiding spiritual health promotion interventions for other client groups living with schizophrenia.

The implications from the present study regarding interventions psychiatric-mental health nurses could or should do in efforts to meet their clients' spiritual needs are supported by the literature. Twelve participants in the current study echoed the need for psychiatric nurses to deal with spiritual issues openly by asking direct questions and talking with clients about their spiritual beliefs and the role their spirituality has for clients as part of psychiatric nursing care. The interventions reported by participants in the current study and by nurse researchers have the potential to contribute to taxonomy of spiritual nursing interventions to guide psychiatric nursing curricula and practice.

Research Needed for Psychiatric Nursing Education and Practice

There are a number of research issues that relate to addressing the spiritual needs of clients through holistic health assessment and health promotion as elements of psychiatric nursing curricula and for psychiatric nursing practice. These issues include the need to: (a) further explicate what spiritual needs are for individuals living with schizophrenia; (b) explicate how clients define spiritual care; (c) delineate a definition of spirituality for the discipline of nursing; (d) develop self-awareness of one's own spirituality among psychiatric nurse educators and practitioners; (e) develop nursing curricula from a holistic nursing perspective of beliefs and values associated with spirituality from different world views; (f) develop a spirituality assessment tool to guide psychiatric nursing education and practice; (g) further strengthen the interpersonal models of communication in psychiatric nursing

curricula; (h) validate spiritual interventions for psychiatric nursing practice; (i) develop a typology of spiritual nursing assessment and interventions; and, (j) identify environmental barriers to nursing administrators and practitioners regarding the delivery of psychiatric nursing care addressing spirituality for client groups.

In relation to addressing clients' spiritual needs, research is needed to delineate what spiritual needs are for individuals living with schizophrenia and what psychiatric nursing interventions are most helpful in meeting patients' spiritual needs in psychiatric-mental health nursing contexts. Findings from the current study have the potential to assist psychiatric nurse educators in beginning to delineate spiritual needs as connection to and/or disconnection from participants' spiritual self, significant others, community, and nature. Ross (1997) asserts nurse educators and practitioners need to be aware that people who report being atheists and agnostics may also experience spiritual needs such as the need to make sense of their life experiences. Seven participants in the current study reported no religious affiliation and three participants reported viewing themselves as atheists. Oldnall (1996) suggests that nurses pay little attention to spirituality in their practice because of a lack of personal understanding and guidance from nurse theorists and educators. Fifteen participants in the current study echoed the lack of attention paid to their spirituality when receiving psychiatric nursing care by mental health care professionals and reported they would welcome any conversation about their spiritual beliefs as part of their psychiatric care. Oldnall (1996) and White (2000) assert that nurse theorists and educators have neglected to address explicitly spirituality in any way helpful to guide holistic nursing practice. Nurses report lacking confidence in their ability to assess and provide spiritual care in the context of holistic care to client groups and authors suggest that with increased awareness, confidence

and ease when talking about spirituality, nurses will be more effective in providing spiritual care (Charters, 1999; Price et al., 1995; White, 2000). Further research is needed in relation to focusing on spiritual care as defined by client groups and the impact of such spiritual care on health promotion and healing. Clark et al. (1991) suggest nursing should give priority to conducting research that focuses on spiritual care as defined and needed by the patients themselves. Some participants in the current study articulated their perceptions of what psychiatric-mental health nurses could do to support their spiritual needs, for example, asking clients directly about spiritual beliefs and being genuine and empathic in the form of verbal communication with clients in building a trusting therapeutic alliance.

In relation to nursing and psychiatric nursing education, there is a need to delineate a conceptual and operational definition of spirituality and to differentiate the term spirituality from religion in the discipline of nursing (Bradshaw, 1997; Golberg, 1998; Greenstreet, 1999; Kendrick & Robinson, 2000; McSherry, 2000; McSherry & Draper, 1997; Narayanasany & Owens, 2001; Price et al., 1995; Sellers & Haag, 1998). A second research issue in this area is the need for increased awareness among psychiatric nurse educators and psychiatric nurse practitioners about their own spirituality and the significance of recognizing that mental health clients have spiritual and religious needs (Charters, 1999; Narayanasany, 1993; Price et al., 1995; Sellers & Haag, 1998). Another research issue for psychiatric nursing education is to increase awareness among students regarding the environmental barriers to nurses providing spiritual care in nursing practice settings; this is related to inadequate staffing levels, lack of time, space, peace and quietness with patients, and privacy (Golberg, 1998; Oldnall, 1996; Narayanasany & Owens, 2001; Ross, 1997). There is also a need to develop a typology of spiritual nursing interventions to assist in organizing and categorizing concrete

nursing actions deemed helpful by participants into a conceptual schema for nurse educators, researchers, practitioners and students (Ross, 1997).

In relation to psychiatric nursing curricula, there is a need to develop a comprehensive holistic health assessment tool where spiritual and religious needs from different world views are explicated to enhance content in nursing curricula and to guide nurses in meeting the spiritual and religious needs of their clients. This is echoed in the literature (Charters, 1999; Sellers & Haag, 1998; Swift, 1994). Another research issue in this area relates to the need for psychiatric nurse educators to have a conceptual understanding of spiritual interventions in order to develop a spiritual ontology and epistemology for nursing and articulate these into nursing curricula which may guide psychiatric nursing research, education and practice (McSherry, 2000; Price et al., 1995; Sellers & Haag, 1998). A third research issue relates to the need to explicate psychiatric nursing interventions perceived by participants to be helpful in meeting their spiritual needs such as talking openly about their spiritual beliefs and values as elements of holistic health. There is also a need to explore teaching/ learning strategies that facilitate students' learning how to provide spiritual care. As noted by Price et al. (1995), nurse educators need to role model spiritual care to their students as few nurses learn to provide spiritual care intuitively. Additionally, Narayanasany and Owens (2001) claim emerging research is showing that spiritual care in nursing improves the quality of life for client groups and has the potential to be rewarding and satisfying to nurses, leading to improved role satisfaction and morale among nurses.

A further research issue for psychiatric nursing curricula posited by Golberg (1998) is for nurses to have acquired excellent interpersonal communication skills from their education programs and to be able to lay aside their personal needs and focus on their clients.

Implications for psychiatric nursing education include ongoing curriculum evaluation and change related to research outcomes associated with the integration of interpersonal communication models and theory as major threads in psychiatric nursing curricula and program course offerings for continuing professional education of interpersonal communication models to practicing nurses. Communication models have the potential to influence psychiatric nursing curricula beyond basic communication skills such as warmth, respect and empathy to include the therapeutic communication skills of genuineness, open probes, advanced empathy, self-disclosure, confrontation, immediacy, situational and interpersonal problem solving (Gazda, Childers, & Walters, 1982; Montgomery, 1993; Montgomery & Webster, 1994; Smith, 1996; Wondrak, 1998).

Additionally, connections fostered by health care providers who have advocated for clean and safe housing also had a significant impact on participants' spiritual self. A question that arises about clean and safe housing for this researcher was it the fact that clean and safe housing was such a need that having it acknowledged helped people feel connected to a community, or was it the fact that health care professionals were people who recognized them as human beings with needs and valued them enough to advocate for clean and safe housing on their behalf?

When participants had a clean and safe place to live, they recognized there were other people in the community who cared enough about them to support this basic need. For several participants, having a clean and safe place to live took them away from living on the streets or in bug infested hotel rooms and gave them a sense of meaning, purpose and hope which they reported prevented them from being suicidal. This is significant because the

BCSS (2001) notes 40% of individuals living with schizophrenia attempt suicide and 10% of all people living with schizophrenia successfully complete the act.

Recommendations for Further Psychiatric Nursing Research

Nursing research suggests that many nurses feel inadequately prepared to address their patients' spiritual needs (Boutell & Bozett, 1990; Bradshaw, 1997; Greenstreet, 1999; Maddox, 2001; McSherry, 2000; McSherry & Draper, 1997; Narayanasamy, 1993). Research in the context of psychiatric nursing education and practice is needed to provide clarity and direction for the integration of spirituality in providing competent holistic health assessments and interventions to individuals, families, groups and communities. Directions for further research come from questions raised by this researcher as a result of this research project are based in the context of psychiatric-mental health nursing, and include the following questions:

1. What is the experience of spirituality for the following groups whose lives have been touched by someone diagnosed with schizophrenia: (a) women living with schizophrenia in the community; (b) homogeneous groups of individuals living with schizophrenia (women and men) who are situated in larger provincial psychiatric institutions; and (c) family members of individuals living with schizophrenia?

2. With regard to length of time since being diagnosed with schizophrenia: what are the views on spirituality among persons newly diagnosed with schizophrenia in contrast to persons living with schizophrenia for more than five, ten, fifteen, and twenty years?

3. With respect to health care professionals: (a) what specific behaviors inhibit or foster connection? (b) how does health care professionals' experience of spirituality interface with and affect that of people with schizophrenia? (c) how might student nurses best learn

how to assist people with schizophrenia to meet their spiritual needs? and (d) what is the experience of community and in-patient psychiatric-mental health nurses regarding spirituality with client groups and the role it serves in relation to health promotion?

4. With respect to nature and therapeutic approaches for providing spiritual care in the context of holistic psychiatric-mental health nursing care include: what are the spiritual outcomes of specific psychiatric nursing practices, such as horticulture therapy, and recreational activities that take place out in nature?

5. With respect to spiritual practices: what is the significance of faith and prayer on clients' sense of health and spiritual well-being who are living with schizophrenia?

6. With respect to pharmacological treatment modalities for persons living with schizophrenia: what is the significance of being prescribed atypical versus typical anti-psychotic agents on their experience of spirituality?

7. In relation to questions related to other psychiatric illnesses include: (a) what is the experience of spirituality with other populations diagnosed with mental illnesses / disorders such as Major Depressive Disorder, Anxiety Based Disorders, Bipolar Affective Disorders, and Eating Disorders? and (b) what are the contributing factors of connecting to and disconnecting from one's spiritual self, significant others, community, and nature with other populations living with mental illness?

8. In relation to national and international perspectives, how is spirituality experienced by other individuals living with schizophrenia in: (a) other provinces in Canada; (b) in other countries in North America; and (c) other countries around the world?

9. In relation to the health care setting context which is influenced by the historical, political, social, and theoretical influences of the biomedical model: what are the barriers

influencing the construction of a spiritual healing milieu for persons living with schizophrenia and other types of mental illness.

<div align="center">Limitations of the Study</div>

In qualitative research, the researcher is an instrument that may introduce biases. I have explicated my own assumptions in Chapter One and have worked consciously at suspending any judgment or biases that would interfere with the research process and emergence of themes with the research data. Although these steps were executed, I note that some researcher bias is possible in this study, such as believing the experience of spirituality among persons living with schizophrenia is qualitatively different than other persons living with a chronic or terminal illness.

A second limitation for this study is the characteristics of the sample population. All participants were relatively well, living in the community in either independent housing (apartment) or semi-independent housing (psychiatric boarding home). I acknowledge that the participants represented a sample of people with schizophrenia that was unique in regard to a high level of social and occupational functioning. For example, all participants were generally articulate and expressed an interest in spirituality and housing. Future research should consider how spirituality is experienced by those with other attributes, such as individuals living with schizophrenia who are homeless or institutionalized in provincial psychiatric mental health centers. The findings can only be generalized to other persons living with schizophrenia in similar medical and economic conditions. Two women and 18 men made up the sample size, with all but one participant being Caucasian. All participants in the study volunteered and had a keen interest in talking about their experience of

spirituality. Many of the participants lived in independent housing situations, reflecting a high level of occupational and social functioning.

Schizophrenia like any other psychiatric disorder is a constructed label and because so many disorders and conditions have been misdiagnosed, it can be questioned whether people with schizophrenia may also be living with a clinical depression and or an anxiety disorder. In this study, participants who self reported having a diagnosis of schizophrenia were considered for inclusion in the study and no measures were taken to rule out anyone who may have also had clinical depression or an anxiety disorder.

Conclusion

The findings of the current study provide psychiatric nursing educators and practitioners with significant insights into the experience of spirituality among twenty individuals living with schizophrenia. Spirituality, conceptualized as connection and situated as shifting perspectives of connection and disconnection in the foreground, provides psychiatric nurse educators and practitioners with a new lens of viewing spirituality among persons living with schizophrenia. The notion of spirituality as connection to and/or disconnection from one's spiritual self offers a new perspective to mental health professionals in promoting spiritual health and wellness for client groups living with schizophrenia. Factors identified by study participants which contribute to feeling connected to and disconnected from one's spiritual self offer psychiatric nurses educators and practitioners with insights into the salient role these factors have in the spiritual health and well being of individuals living with schizophrenia. Further research in relation to the factors that promote or inhibit connection to and disconnection from one's spiritual self is warranted.

The findings of the current study add to a growing body of knowledge the importance of viewing spirituality broader than religion in the context of living with a chronic mental illness. The subtantive theory of spirituality as connection has the potential to guide psychiatric nursing curricula in relation to teaching psychiatric nursing students elements of a spiritual assessment and the significance of connection to and disconnection from one's spiritual self among individuals living with schizophrenia. The current study findings reinforce the significance of assessing clients' spiritual beliefs as part of psychiatric nursing care. Psychiatric-mental health professionals tend to avoid any discussion of spiritual or religious ideas with clients who are psychotic often fearing they may reinforce a client's delusions or pathology (Charters, 1999; Greasley et al., 2001; Moller, 1999; Nolan & Crawford, 1997; Piles, 1990). However, this research points to the imperative for psychiatric nurses to include spirituality in health assessment and psychiatric nursing care planning.

The findings from the participants' perspectives in the current study do not support avoidance of addressing spirituality by psychiatric-mental health professionals and reinforce the need for mental health care professionals to deal explicitly with spiritual beliefs as an element of holistic health promotion which in turn may serve to enhance clients' connection to their spiritual self. Professional codes of ethics and standards of practice documents state nurses are expected to provide competent holistic nursing care to client populations (CFMHN, 1995; CRPNBC, 2000; CRPNBC, 1995a, 1995b; RNABC, 1998; RPNC, 2001).

Psychiatric-mental health professionals who believe they may be helping clients by ignoring any talk about spiritual or religious beliefs may in fact be facilitating clients' disconnection from their spiritual self, significant others, community, and nature by neglecting to address spirituality explicitly as an element of holistic health promotion. Some

participants in the current study suggested that ultimately it was their spirituality that prevented them from commiting suicide, something psychiatric-mental health nurses need to be cognizant of when choosing to address spirituality explicitly as an element of their psychiatric nursing practice in caring for individuals living with schizophrenia. The significance of talking about spirituality with individuals living with schizophrenia provides evidence psychiatric-mental health nurses should address spirituality explicitly in their psychiatric nursing practice in caring for individuals living with schizophrenia.

Perhaps we in psychiatric-mental health nursing have been reluctant to address spirituality both because of our own ambiguity about spirituality and because of the fear of what such a conversation would do to a person living with schizophrenia. However, this research provides support for a different view and points to having a more systematic dialogue among psychiatric-mental health nurses about the role of spirituality in their practice.

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APPENDIX I

Ethical Approval

The University of British Columbia

APPENDIX II

Letter of Initial Contact

THE UNIVERSITY OF BRITISH COLUMBIA

**Centre for the Study of
Curriculum and Instruction**
Faculty of Education
Vancouver, B.C. Canada V6T 1Z4

Tel: (604) 822-6502
Fax:(604) 822-8234

Letter of Initial Contact

Dear (Contact Person),

I am a PhD student in the Centre for the Study of Curriculum & Instruction, Faculty of Education, University of British Columbia. For my doctoral thesis, I am conducting a study which explores the perception and experience of spirituality among persons who have been diagnosed with schizophrenia. I anticipate the results of this research will inform nurse educators, psychiatric nursing students and psychiatric nurses as to aspects of the spiritual dimension experienced by individuals who are living with a mental illness, specifically schizophrenia.

In order to carry out this research, I will need 20-25 volunteers who: (1) are over the age of 19; (2) have a diagnosis of schizophrenia; (3) have an interest in, and experience with their own sense of spirituality, however they personally define that to be; and (4) are able to describe and articulate their experience in English and are oriented to person, place, time and situation. I would require approximately 4-6 hours of the participant's time over the course of the study.

I will conduct 2-3 interviews with each participant. During the first interview, I will be interested in hearing and recording how persons with schizophrenia describe the experience of spirituality. During the second interview, I will raise any questions from our first interview to clarify responses and constructed meanings. I will raise additional questions that will attempt to uncover deeper meanings of the participants experience of spirituality. The interviews will be audio-taped and transcribed for research purposes only and will be kept strictly confidential. Following the completion of the interviews, participants will be invited to meet for approximately one hour in a focus group with other participants. I will share my interpretation of the findings and seek feedback from participants in the study. Any concerns or disagreements participants have regarding my interpretations will be heard and the description altered to more accurately reflect the participant's experience. Information gained in this group will be incorporated into the final description of the theory. At the end of the study, an honorarium of $25.00 will be offered to each participant in order to acknowledge appreciation of their time.

APPENDIX III

Participant Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

**Centre for the Study of
Curriculum and Instruction**
Faculty of Education
Vancouver, B.C. Canada V6T 1Z4
<u>Consent Form</u> Tel: (604) 822-6502
Fax: (604) 822-8234

A PhD thesis research study on:
The Perception of Spirituality among Individuals Living with a Mental Illness,
Schizophrenia: Implications for Psychiatric Nursing Curricula -
A Grounded Theory Approach

Description of the Research:

This thesis research project will be conducted by myself, Michel Tarko, a doctoral
candidate in the Centre for the Study of Curriculum and Instruction, Faculty of
Education, University of British Columbia. The purpose of the study is to hear,
document and enhance the understanding of the perception and experience of
spirituality among individuals living with a mental illness, specifically schizophrenia
and identify implications for psychiatric nursing curriculum development.

Participation in the study is voluntary. You may withdraw from the study at any time
during the research without prejudice. You may also refuse to answer any questions at
any time. You are being invited to participate in this research project because you have
schizophrenia and are interested in talking about your own perception and experience
of spirituality.

If you agree to take part in the study, you will be interviewed by myself on at least two
occasions for approximately 1-1.5 hours of your time. I will conduct two - three
interviews which will be audio-taped and transcribed verbatim. At the beginning of the
first interview I will identify yourself as participant #1, #2, etc., as a means of ensuring
absolute confidentiality. All references to you in the study will be made according to
your assigned participant number.

During the second, and possibly the third interview, you will be presented with
interpretations of previous interviews describing concepts, categories and themes
emerging from what you have described during the interview session. You will be
asked to comment on the accuracy of these accounts. Any concerns or disagreements
you have regarding the material will be recorded and the description will be changed to
more accurately convey your experience.

APPENDIX IV

Demographic Questionnaire

Demographic Questionnaire

A Grounded Theory Study of the Experience of Spirituality
Among Persons Living with Schizophrenia

Participant Number # _____

Name: _____

Address: _____

Telephone: _____

Date of Birth(Year/Month/Day): _____ / _____ / _____

Gender: Female ( ); Male ( )

Ethnic Background: _____

Occupation: _____

Full-time:_____Part-time:_____

Unemployed:_____   Income:_____

Time since last employed: _____

Highest level of education: _____

Relationship Status: Single ( ); Married ( ); Separated ( ); Divorced ( ); Partnered ( )

Number and ages of children:_____

Current Religious affiliation (if any):_____

Length of time since diagnosis of schizophrenia:_____

Current Prescribed Medications:_____

_____

APPENDIX V

Interview Guide

The experience of Spirituality among persons living with Schizophrenia
Semi-Structured Interview Guide

1. Tell me who you are?

2. Tell me what about you matters most?

3. Tell me what makes you the person that you are?

4. Tell me what does the word spirituality bring to your mind?

5. Tell me what does the word religion bring to your mind?

6. Tell me what are your thoughts about God or a higher power?

7. Tell me about what sources of spiritual insight/wisdom/inspiration are important to you?

8. What are your thoughts about going to church/organized ritual?

9. How does going to church/religious ritual influence your life?

10. Tell me how does your faith/spirituality/convictions guide your decisions day-to-day?

11. Tell me how do you distinguish between right and wrong; what is good and harmful?

12. Tell me what is at the heart of your religion/belief/faith/convictions/commitments?

13. Tell me where/when/or how you experience God/your faith/convictions?

14. Tell me how you express your faith/convictions (how do you live out what you believe)?

15. Tell me what do you pray about/or who do you pray for?

16. Tell me what thoughts (religious/beliefs/faith/convictions/commitments) have an influence on your life?

17. Tell me what experiences of (religion/belief/faith/convictions/commitments) have an influence on your life?

18. Tell me what you think happens when you die?

19. Tell me what you think happens in heaven?

20. Tell me what in life is important to you?

21. How is that important to you?

22. What difference does it make for your life?

23. Tell me what gives you a sense of purpose in life?

24. Tell me a story about your life living with a mental illness?

25. Tell me what spiritual questions or comments you may have, or have thought of after taking with me today?

26. Tell me how could your spiritual life be a part of your life when you are receiving psychiatric care you receive in a hospital setting/community setting?

27. In what way does your (spiritual/religious) life make any difference to the kind of psychiatric care you receive in a hospital setting/community setting?

28. What would you like health care professionals to do with you and for you to support your faith/convictions/spirituality beliefs when receiving psychiatric/mental health care?

END OF INTERVIEW A

As the research study proceeded, questions became more focused and specific in order to explore the variations and depth of emerging categories. During the second interview, after clarifying questions were raised about interview A, the following questions about life may were raised during interview B:

1. What are your thoughts and feelings about life in general?

2. What meaning does life have for you?

3. What kinds of things add meaning to your life?

4. What do you see as your life's purpose?

5. What in life motivates you?

6. What in life is important to you?

7. How important is health to you?

8. How do you view your present situation?

9. What do you think caused your illness?

10. What do you think 'heals' illness?

11. What spiritual practices have you used to deal/cope with your mental illness? (your schizophrenia)?

12. How would you describe the relationship between your faith/convictions/beliefs/ commitments and health & illness?

13. What events, if any have affected your beliefs about health and illness?

14. How satisfying has your life been?

15. What would you like to change if you could?

16. What does the future hold for you?

17. How much control do you think you have over what happens in life?

18. What influences does this belief have on your life/life-style?

19. What gives you strength to carry on?

20. What comforts you in times of problems/crisis? How do you overcome times of problems in life?

21. Who are the important people in your life and how do they make a difference?

22. Who are your friends? What do you do when you spend time with them?

23. What would you like to do with them?

24. What are your creative abilities?

25. When do you feel most creative?

26. Describe activities that make you feel creative?

27. How much satisfaction do you derive from these activities?

28. How often do you engage in these activities?

29. What activities do you find personally fulfilling or absorbing?

30. What are your sources of Joy?

31. What are your sources of strength?

32. What events, if any influenced your beliefs?

APPENDIX VI

Ethical Approval

Vancouver / Richmond Health Board

APPENDIX VII

Vancouver / Richmond Health Board

Confidential Agreement for Researchers

APPENDIX VIII

Sample Participant Interview Transcription

Participant #8 - Interview A
February 1, 2001

R: Today is Thursday, February 1, 2001 and I'm interviewing participant #8 and this is interview A. Good morning, nice to meet you.

P: Same. (laughs)

R: The first question that IÆm going to raise with you is if you can tell me a bit as to who you are.

P: I'm (P)

R: Yeah, and I know you filled out the demographic sheet but if you could tell me where you're at in your life and what kinds of things you do.

P: You mean that IÆm sixty-three years old and

R: Yeah.

P: I'm on handicap pension and, the ___ pension they call it, the disability. Um, I'm doing sewing, I have kind of a, I'm an example to a lot of the younger, mentally ill people that they kind of talk to me and

R: Em, em.

P: And they say IÆm not sick, you know, and they still are.

R: Em, em.

P: I've been where they are so they like to talk to me.

R: Yes.

P: I have a lot of phone calls.

R: Yes. And are you involved in anything in the sense of people making that contact with you or how is it that they know?

P: Yes, really, I'm in a mind and body group with the CMHA.

R: Okay.

P: And the walker, a person comes three times a week from CMHA and takes me for a walk.

R: Yes.

P: Because I'm, I'm so frightened sometimes so I can't go into, outdoors by myself. And once I get out there, I don't know what I'm scared of but

R: Yeah.

P: I'm not inside, you know, (laughing)

R: Yes. Okay. Anything else you like to tell us about or tell me about who you are?

P: Um, I'm a mother and a grandmother and

R: And how many children do you have?

P: I have three children and two grandchildren and a grand child that I never see that's nineteen years that was born to my youngest son when he was sixteen.

R: You've got four grandchildren?

P: Three.

R: Three grandchildren.

P: Like he's the third.

R: Yeah.

P: The other two I didn't think I'd ever have and the boys were so late before they had them (laughing)

R: Yes.

P: And my daughter has no intention of having children and she has no intention of having anything to do with me either.

R: Em.

P: (laughing) I mean I don't know what else I do.

R: Okay. I'm wondering, um, what matters the most to you in life? What things are important to you?

P: That I do the will of God and I know if I can understand and do his will I'll be happy.

R: Em, em. And what kinds of things do you do that, uh, you would say are the will of God?

P: Um, well, he wants to be patient with these mentally ill people, you know, and give them my time or my money and my, and, uh, but everything I have I should share with them and, uh, a lot of them tell me, can you tell me what you're or on or I wish I was as well as you like I've done, worked through the Emotions Anonymous and through the Recovering Co-operative Program and self help groups that they all help.

R: Yes.

P: And I have now the most marvelous nurse (laughing) this English Korean and he's a great nurse and, uh, and then there's a Dr. (name) I had Dr. (name) for fourteen years too and, in the mental health and he made a lot of difference by getting me off the, those horrifying medications they had us on for years (laughing)

R: Em, em. Now with the new medications that are out?

P: Yes.

R: Yes.

P: They're still giving people the old ones and seeing if they can manage on them

R: Yes.

P: Just to save money, you know,

R: Yes.

P: They don't save money because they keep going back into the hospital and that costs money.

R: Yeah.

P: I think my Alan(drug) costs, uh, four hundred and forty-fours dollars I think a month to take those two pills everyday. (laughs)

R: Em, em.

P: Yeah, but that's a lot cheaper than putting me in the hospital for

R: Yeah.

P: Awhile.

R: Yes.

P: You know.

R: It keeps you well?

P: Yes.

R: Other things that you do that you're, um, living your life in the sense of God's will?

P: I ask him before I do things. IÆm now again trying to read the bible through, I started in December, um, through the, a little thing I picked up at the Salvation Army guiding me through the bible.

R: Yeah.

P: Um, I was raised Anglican, to age twelve, at age twelve and then my dad wouldn't let me be confirmed, he wanted me to go to the United Church. I never found much there so I didn't really go to church for awhile and then, uh, I became a Catholic when I was twenty in order to marry a Catholic and when my oldest boy was about eight, I got fed up with the Catholic Church and didn't attend any church. And then I would think that God had directed me to do certain things and I'd pray that I wanted to serve him and then he's testing me, he took away my family and my house and (chuckles) sent me out here to B.C. to live by myself. My two boys joined me out here but I'm not supporting them, I never have.

R: They're adults?

P: Yeah.

R: Yes.

P: And then they work like the young adults if you know?

R: Yes.

APPENDIX IX

Exemplars Illustrating Sub-Themes of

Spirituality as Connection

Exemplars illustrating each sub-theme of spirituality as connection

Connecting / Wellness

Self

I didn't have the voices and I didn't have hallucinations… and over the year I developed a lot of needs and wants… I learned to enjoy things, I learned

to

appreciate things… you know, at that point I wasn't sick but I took medication… and I have an interest in life again… my spirituality keeps me from being suicidal or from being alone, isolated and suffering.

I think it was September or so of 1995… I took the medicine and gradually I started to hear what was around me and, um, then the other senses followed, you know, the hallucinations stopped, I saw through the delusion that I was God, you know, I saw through the delusion that I was everywhere that I could only be one place at a time, you know, I thought I was God and I was everywhere and so forth and, uh, and its strange like whatever was causing these hallucinations in the first place disappeared once I took the medicine.

Significant Others
Family

I've got nobody in the world. Uh, well I still phone my wife three or four times a day and we still love one another but we're not together, you know.

I don't usually, I don't usually phone but usually if there's something happens like my brother phoned me a few weeks ago, yeah, he was the one who initiated, you know… he was telling me like my dad had a knee operation a few years ago and I saw him at Christmas time and he was really having trouble walking, you know, you could, he had, how he uses a cane and a brace and my brother phoned me and he told me that he got dad into a new facility for working out and it sort of like a whirlpool where it massages his knee and he was telling me he was, he was looking after dad that way, you know, so… any news on, on those fronts my brother will phone me.

I was always away working but when I was in the hospital, they (family) used to, if they were in town or, or nearby, you know, not busy, they would come and visit me and then I would go visit them when I get out… but my mother I phone her every month and I go see her every, about every six, about twice a year I go see her.

Friends

They're willing to listen to me and, um, share their lives with me, you know, the things they do".

I'm gonna meet people, um, I'm going to meet new people and get to know them, that makes me go (to Coast) because I'm very interested in doing that, you know, to know new people.

I'm an example to a lot of the younger mentally ill people that they kind of talk to me and they say I'm not sick, you know, and they still are, I've been where they are so they like to talk to me… I have lots of phone calls… I have lots of good friends now, all the mentally ill people… I inspired them to sew… I really don't have friends among other people.

God/ Higher Power

I believe in God and I pray everyday but I don't go to church… I never went to church as a youngster, my family weren't religious but I do believe in God and Jesus… I believe God is a supreme being… I use to read the Bible. I don't read it now but I use to read the Bible, I read it all the way through.

I believe in God, I believe in love not religion, I believe in loving God, love of all, I believe my own Catholic religion but to me religion, the word religion itself doesn't mean that much to me because a lot of people are false, uh, like… love your, your fellow man and love yourself, you know, that's what religion means to me.

The most important thing in my life, uh, I'd say to be at peace… at peace with other people and with the God that I believe in… I believe God actually did heal me to a certain extent because I was very, uh, out of it and dull, you know, and I couldn't think clearly… the nurses and doctors were taking care of me so its, uh, I think, I think God worked through them to a certain extent.

Community

You wake up in the morning and I think why would I want to get out of bed and take a shower and go out, why? Because you go to Coast (Foundation), you meet nice people, you spend time and you get the best experience possible and that really makes me move into action, I take action because its gonna feel good when you do these kinds of things.

Now I have people that accept me. They, well many people accept me here and they think I'm an okay guy, you know… my psychiatric needs in this clubhouse setting have been dealth with better than any other place… this place has done the most to renew my spirit than any, any place… it's the best place I've ever known".

Nature

I look at, I look at the, uh, nature as God's artwork, you know, like I, I go, okay, like I, I don't… for instance, seeing the trees, the leaves falling in the winter and spring come back to life again and so, and that's an example of God's artwork… I don't know if I'm blessed but seeing a rabbit in the park, I see squirrels, I see this eagle who flies at me and I'm thinking… wow, this is really fantastic, you know… like that's the, that's like food to the soul.

Exemplars illustrating each sub-theme of spirituality as disconnection

Disconnecting / Wellness

Self

There's a disconnection between my spirit and my body and because of this disconnection my perceptions changed and what I use to depend upon became questionable… living with schizophrenia has been devastating because the things that you used to do, you can no longer do necessarily… because that part of my brain was shut off, the connection to my spirit and my body was shut off.

My body and spirit are not connected properly because I believe I am spirit and flesh… and somehow I became demon possessed, demonic forces in control with free reign over my mind… you might not believe it but that's okay, I have taste, touch and smell hallucinations as well… I don't hear voices, that's one thing I'm glad, I'm really thankful for.

Significant Others
Family

I want a deep relationship but like I said, I can't get back to the spirit… you know, you know, you're suppressed… you're in a cob web… you're somewhere and you give up trying, you give up trying, you know because you can't seem to, its not like it use to be, you know, a long time ago, I gave up, I could never get close to my sister or brother or mother after I was in the hospital… the first time, I never had that close relationship with them hardly again"… like I mean, I crave to be close to all three again… I'll never be close to all three again… like it was back in 1976.

Relocating to a new city for the purposes of attending university, I lost all of my support systems… I was in the hospital for three months in 1994 and when they first diagnosed me then… it was a difficult time in my life, going to university… my cross had gotten heavier… but this (schizophrenia) was a new low, it was more like my brain stopped working and that is when the demonic started to tinker with my thoughts… I didn't realize how serious my illness was.

I've got a sister and I haven't seen her for about six years, she's out in Langley and she never phones me or never invites me out and I phone her and she's friendly with me but I feel a certain disconnection with her…I don't know what the reason is, whether it has anything to do with my illness… but now it seems as though maybe she thinks of me as a problem, that she feels, well, I don't know, I've never asked her do you think I'm a disgrace to the family… but there's that possibility but she's friendly to me on the telephone, I mean she never phones me, she never invites me out…

Friends

I knew I had friends, but I knew I had no friends, you know. And I saw a sadness, not like I wanted to leave them but they weren't really there anyway … I don't have anybody on a day-to-day basis as a friend… no true friends on a day-to-day basis… I had to learn how to be a loner once I got on those medications from Riverview, I had to learn how to be a loner, I grew up with friends but you know, I mostly got in touch with them, they never mostly got in touch with me… it's pretty hard to beg all your life even beg when you haven't got friends but it just ended in some way or another… it's a lot of loneliness and fear as a result of having schizophrenia… making friends… it's hard to trust people.

Friends continued

Well, I mean the only thing we've got in common here is that we all have been in a mental hospital at one time in our lives and we all live here... that's about, that's about all it is... I'm not close to anyone... nobody you'd say is a friend, I don't, no friends is not a word I use very lightly... I don't think about finding ever, long lasting friendships anymore, I don't, I don't struggle to find it anymore.

God/ Higher Power

Because of this disconnection, my perceptions changed and what I use to depend upon became questionable... questioning perceptions of God as being good or evil... uncertainty of trusting God to bring me out of it... and be well again.

Community

I think we are people... with a diagnosis who are still discriminated against, mainly because we have a diagnosis... people with schizophrenia are at the bottom of the mud pile as we are... people with schizophrenia are discriminated against... the mental health budget is very, very limited relative to the one in five people who get mental illness at some time in their life... there are not enough resources that our volume deserves and demands without being heard.

When Coast (Foundation) is closed and you wake up in the morning and you don't really have, uh, and it's real, you feel bad because you don't have anywhere to go and anything to do and you're trying to, you're trying to push yourself into finding something, you know, it makes you feel humiliated like, you know, I've nobody to call, I have nobody to see, nobody to go with.

Nature

Other than going to the community swimming pool and a few trees... I don't have a connection to animals unless I'm out in the forest or something...
but nature does bring... the spirit of God, you know.

My body felt like it was a ninety year old and I couldn't go out for walks properly, although I tried, something made me feel really old... and you know how there's a certain rhythm to walking, well I lost that rhythm to walking but I'm gaining it back slowly... so there's a certain joy in walking in nature which I've lost.

(n = 20) Exemplars of participants statements illustrating their experience of connecting or diconnecting from their spirituality.