SPIRITUALITY AND DEPRESSION: THE ROLE OF SPIRITUALITY
IN THE PROCESS OF RECOVERING FROM DEPRESSION

by

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Abstract

Increasingly, nurses and other health care providers promote holistic care options and there is, correspondingly, a growing trend towards recognizing and advocating the inclusion of spirituality in patient care. However, the understanding and provision of spiritual care in psychiatric nursing practice, especially how spirituality helps in recovering from depression has not kept pace with this trend. Given the increasing recognition of the influence of spirituality in health and healing, a deeper understanding of how spirituality helps patients recover from depression would be of value to health care professionals in the provision of care. The purpose of this study was to explore the role of spirituality in recovering from depression, and to develop a greater understanding of how spirituality affects the recovery process of depression.

Significant knowledge can be gained from participant's stories of what spirituality means to them and how it has helped them to recovery from depression. Thus the research design utilized for this study was qualitative narrative inquiry as outlined by (Lieblich, Tuval-Mashiach and Zilber, 1998). Eight face to face interviews were conducted with individuals who identified themselves as having depression and who identified that spirituality has helped them in recovering from depression.

The findings of this study revealed that spirituality played a significant role for the participants in their recovery from depression. The study also revealed that spirituality was experienced as connections (god/higher power, self, others, and nature), and through these connections participants found meaning and purpose

in their lives. The implications for this study is that it will inform nurses, nurse educators, and other health care practitioners of the importance of patients spirituality in the course of their recovery from depression. This information will also enable nurses to assess clients spiritual needs and provide an atmosphere for clients to express their spirituality. The findings of the study will contribute to nurses providing formal and informal spiritual interventions when caring for patients who are depressed.

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This study has made me become more aware of my own spirituality, which began two decades ago when I first met my late Guru, father-in-law, and brother-in-law who has taught me that spirituality is not only doing good deeds but also thinking good thoughts, having good feelings, and protect all living things. Their teachings have given my life direction, meaning and purpose.

Chapter 1

Introduction and Background

There is increasing scientific interest as well as professional and public recognition, concerning the influence of spirituality in health and healing (Piedmont, 2001). Empirical evidence in both quantitative and qualitative research indicates that spirituality does have an influence in health and healing (Ameling & Povilonis, 2001; Burkhardt, 1993; Chiu 2000; Narayanasamy & Owens 2001; Potts, 1996; Pargament, Smith, Koenig & Larson, 1998; Tongprateep, 2000; Tuck, McCain & Elswick 2001). A review of 84 studies in the areas of alcoholism, stress, depression in the elderly, mental health nurses' spiritual perspectives and nursing interventions revealed that only 12 address the issue of mental health and spirituality. (Bowden, 1998; Chiu, Emblem, Van Hofwegen, & Meyerhoff (2004); Klass, 1998; Pullen, Tuck, & Mix, 1996; Tuck, Pullen & Wallace, 2001). Of these, a mere four address the important area of spirituality and depression.

Historically, psychiatric practice has ignored or excluded spiritual factors either by remaining neutral or by manifesting an occasional antagonism towards religion. Freud was influential in putting forth the idea that religion was irrelevant if not clinically harmful, labeling it "an obsessional neurosis," (Meador & Koenig, 2000). However, recently Psychiatrists have recognized the fact that spirituality is not acknowledged in their practice or in their education (Hassad, 2000; Josephson, Larson, & Juthani, 2000; Puchalski, Larson & Lu, 2000) and have emphasized the importance of addressing religious and spiritual issues in psychiatric residency programs. The Diagnosis and Statistical Manual of mental health disorders (DSM IV-TR) (APA, 1994) now includes religion and spirituality as relevant sources both

of emotional distress and support. This trend is also shown in nursing by identifying spiritual distress as a nursing diagnosis. In the United Kingdom, the government and the professional organizations of Registered Nurses, Midwives and Health Visitors have established guidelines and standards in the Patient's Charter to address the issue of patients' spirituality (McSherry & Draper, 1998). Despite this recognition of the spiritual dimension in psychiatric education and in psychiatric practice, the expression of spirituality can be viewed as delusion or hallucination, rather than an example of growth or spiritual healing (Morrison & Thornton, 1999).

Larson, Sawyers, & Mc Cullough (1998) compiled a report from a conference on scientific research on spirituality and health. This report acknowledges the influence of spirituality in health but also indicates the need for ongoing research since spirituality and health issues are not clearly defined and are therefore poorly understood. Another reason Larson et al. offer in appealing for additional research is that such work is still in its infancy and substantial effort still needs to be focused on the conceptual and theoretical underpinnings of spirituality and religion. Furthermore, they suggest the use of appropriate measurements to capture the true essence of spirituality. As they put it, "State-of-the-art studies are needed to evaluate the efficacy of spiritual and religious interventions for specific psychiatric disorders such as depression" (p. 63).

Recognizing the importance of spirituality in health and healing, the personnel at the Canadian Mental Health Association of British Columbia dedicated their spring, 2001 issue of their Mental Health Journal (BCM Hj) to address spirituality and recovery. In that issue, several individuals told how

spirituality had either helped them or their loved ones recover from Bipolar Disorder, Depression, Schizoaffective disorder and Schizophrenia. The individuals described how mental illness was a struggle for them and for their family members and how faith in God and spiritual practices had helped them recover from illness. For all of these individuals spirituality was realized through four means: seeking meaning and purpose in life, providing hope and courage, experiencing the unconscious mind, and believing in a higher power. The individuals suggested that a community church also helped to provide a supportive network, as well as a place to identify God, to establish faith, and to socialize with like minded people.

Given the increasing recognition of the influence of spirituality in health and healing (Thoresen, 1999), a deeper understanding of how spirituality helps patients recover from depression would be of great value to health care professionals. Thus the lack of research in this substantive area served as justification for undertaking this inquiry. To this end, the present study will provide empirical evidence concerning how spirituality has helped individuals recover from depression.

Purpose

The purpose of this study was to explore the role spirituality can play during a recovery from depression. The goal of the study was to understand how the experience of spirituality is constructed by individuals recovering from depression.

Assumptions

There are two assumptions in this study. The first assumption is that spirituality in whichever ways it is practiced (or according to whichever beliefs or values it holds for an individual), actually does speed recovery from depression. The second assumption is that despite the obvious fact that spirituality is very personal and can only be defined by an individual, there are, as stories of spirituality from individuals with various mental illness in the *BCMHI* suggests, common themes for any definition of spirituality and these can be generalized to apply usefully to new populations.

Research question

The question for this study is: What is the experience of spirituality in recovering from depression?

Definitions

Depression

For this study, depression will be defined according to the World Health organization (2005) http://www.who.int/health_topics/depression/en/ whose description of depression is emulated by the Mood Disorders Association of British Columbia Canada (2005) <http://www.mdabc.ca/unipolar.htm>. This common definition follows:

Depression is a common mental disorder that prevents with depressed mood, loss of interest or pleasure, loss of motivation, feeling of guilt or low self-worth, feelings of deep insecurity, preoccupation with failures or

inadequacies, anxiety and hopelessness, increase or decreased sleep and appetite, low energy and fatigue, and slowed thinking or indecisiveness. These problems can become chronic or recurrent and can lead to substantial impairments in an individual ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide (Retrieved January 12, 2005).

Spirituality

Spirituality and its English stem 'spirit' are both derived from the Latin root *spiritu* meaning breath or life. (Sanskrit 'prana,' Greek 'pneuma,' and Hebrew 'ruach' all share the association with life and breath (Larson et al.1998). For the purpose of this study spirituality will be understood as seeking meaning and purpose in life. Meaning refers to a belief in the ontological significance of life, the ability to make sense of life situations and derive a sense of purpose from existence (Martsolf & Mickley, 1998). According to Elkins, Hedstrom, Hughes, Leaf, & Saunders (1988) meaning fills the "existential vacuum" with an authentic sense that life has purpose; the 'will to meaning' is a basic human drive which provides us with answers to life questions. Purpose involves evaluating one's life both under ordinary circumstances and when faced with a life crisis such as illness or death. We questions of who we are, why something is happening to us or what our purpose in life might be. Such questions enable us to evaluate our lives and situations and *sometimes* to engage in acts of help to others (Ameling & Povilonis, 2001; Chiu, 2000; Narayanasamy & Owens 2001; McSherry & Draper, 1998).

Victor Frankl's (1984) description of life in the Nazi Concentration camps exemplifies how humans can find purpose and meaning even in the most

degrading and inexplicable circumstances. Frankl sought meaning and purpose by adopting an almost Buddhist attitude of acceptance when faced by seemingly intolerable circumstances. According to Frankl, by accepting your situation, life can never cease to have meaning and purpose even when one is deprived of everything or facing death.

Pre understanding of spirituality

By practicing Hindu and Buddhist philosophies under the tutelage of an enlightened Guru, or teacher, I have come to understand spirituality as the expression of the very human need for meaning and purpose in life. This search is central to our existence. It launches each of us on our life journey. Whether our journeys involve joy, sorrow, struggle, loss, failure or success, our spiritual understanding deepens through each of our experiences. In understanding our personal journey, we come to know who we are and who we will become precisely by knowing, loving and being with others.

Summary

Increasingly, nurses and other health care providers promote holistic care options and there is, correspondingly, a growing trend towards recognizing and advocating the inclusion of spirituality in patient care. Unfortunately, the understanding and provision of spiritual care in mental health practice, especially how spirituality helps in recovering from depression has not kept pace with this trend. Therefore, it is important to continue to conduct research to provide empirical evidence on the influence of spirituality in recovering from depression.

Furthermore, given the increasing recognition of the influence of spirituality in health and healing, a deeper understanding of how spirituality helps patients recover from depression would be of great value to health care professionals. To this end, the present study will examine implications for psychiatric nursing practice, education, and research on how spirituality has helped individuals to recover from depression.

Chapter 11

Literature Review

That depression can have significant negative effects on many aspects of a person's life and that the pursuit of spirituality has a positive effect on people's lives are widely acknowledged facts. This chapter presents a review of the literature concerning spirituality. The review encompasses conceptual and theoretical perspectives of spirituality, as well as empirical evidence concerning spirituality's impact on peoples' lives. This will provide a foundation for assessing the state of spirituality in contemporary nursing practice.

The literature review conducted for this study derives from the CINHALL, Medline and Psych INFO databases. Searches focused on the years 1980-2005 and used the following key words and word pairs: spirituality, depression/spirituality, spirituality/recovery, spiritual care, spirituality/mental health, and spirituality/mental health nursing. Reference lists from selected articles were also reviewed for the relevant articles. Further literature reviews will be conducted as this study progress, in order to support and deepen its findings.

Conceptualization of Spirituality

To gain a better understanding of spirituality, several writers have attempted to define it, but the definitions are all quite vague and there are ongoing debates about the need to distinguish spirituality from religion or religiosity. From the literature reviewed from this study, the common points of any definition of spirituality are that it is a subjective religious experience and that it may or may not include institutionalized religion (Larson et al.1998), The most

common attributes used to describe spirituality are: 1) it is a transcendent or spiritual state accompanied by a sense of existential meaning or purpose; [which will be described here in slightly different terms than those used in chapter one]; 2) it provides a deep sense of hope; 3) it includes the ability to establish deep interpersonal connections; and 4) it is somehow involved with religious practices.

1. *The transcendent*

The most common theme in any definition of spirituality is an element termed "the Transcendent". 'The Transcendent' can be described as a relationship with self and the ultimate other. "God or [a] Divine being" (Baldachino & Draper, 2001; Chiu, 2000; Wilt & Smucker, 2001). This state is an ongoing process that makes an individual's life a quest to be in relationship with this mastery (Chiu). It involves an appreciation of a dimension beyond the self and continually expanding self-boundaries (Reed, 1991). Other researches have describe spirituality as a way of being and experience that evolves through awareness of a transcendent dimension which is characterized by certain identifiable values in regard to self, others, nature, life and whatever one considers being the "Ultimate" (Elkins et al. 1988).

Narayanasamy (1991) proposes that in striving for self-transcendence, one will encounter a relationship with the other in some form. It is the striving for meaning, purpose, and knowledge of the transcendent that has personal, communal and public aspects. All of these serve as indicators of spirituality (Klass, 1998; Reed, 1991). What can be drawn from these definitions is that with

the transcendent there is a level of reality that exceeds the limits of human existence and that there is more to us than we first perceive.

2. Hope

According to Ross (1995), hope is a positive and potent spiritual practice with the power to pull us through difficult times. It is a ray, a beam, a glimmer; the break in the clouds; the light at the end of the dark tunnel, *and* it can make a profound difference in whether one lives or succumbs to death. Viktor Frankl (1984) has passionately described how hope contributed to his survival in a Nazi concentration camp, while countless other inmates who gave in to hopelessness and despair, died. According to Frankl, hope is how we view our lives, it is often discovered in unexpected places and it can be learned through practicing patience, an ability to tolerate delays, and a willingness to let events unfold in their own time. It is a mixture of courage, confidence, persistence, and the determination to keep going no matter what happens. Hope increases our self-esteem and well-being. We have hope when we can say, all will be well, and mean it (Carson, Soeken, Shanty, & Terry, 1990; Naryanasamy, 1991).

3. Establishing deep interpersonal connections

Connection is viewed as the relationship with self, with others (family friends and coworkers), with God, the higher power or ultimate other and the environment (nature) through intentional commitment and caring (Burkharat, 1994). According to Burkharat "the Relationship with the ultimate other incorporates both mystery and trust, and a sense of being connected with something greater than, and part of oneself" (p. 18). Spiritual people claim to be

aware that everything is interrelated; in time, space, and our very being.

(Burkharat; Chiu, 2000; Martsolf & Mickley, 1998). Ironically, the spiritual practice of connections teaches that separateness itself is an illusion. (Bowden, 1998; Burkharat;).

4. Religious practices

There is a wide variety of recognized religious practices. They include belief in God, church attendance, uttering prayers; reading religious materials, having faith in God, practicing religious rituals (such as attending retreats), worshiping images that represent God, doing yoga or other meditations which place the body, mind and spirit in a state of calmness that allows the person the possibility of experiencing the inner or higher self. (Ameling & Povilonis, 2001; Narayanasamy & Owens 2001; Martsolf & Mickley, 1998; McSherry & Draper, 1998)).

Reporting on the scientific research concerning spirituality and health, Larson et al. (1998), concluded that while definitions of spirituality should not be so narrow that they exclude religion or other cultural factors, they should also not be too broad to lose their utility. Larson et al proposed the following criteria for a practical description of religion and spirituality:

The feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term "search" refers to attempt to identify, articulate, maintain, or transform. The term "sacred" refers to a divine being or Ultimate Reality or Ultimate Truth as prescribed by the individual. AND/OR: A search or quest for non-sacred goals (such as identity, belongingness, meaning, health, or wellness) in a

context that has its primary goal the facilitation of the above criterion .AND: The means and methods (e.g., rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people (p. 21).

With such a variety of differing definitions of spirituality at our disposal, it seems clear that spirituality should not be defined simply and, indeed, it is a complex, multidimensional construct that poses a challenge for researchers and practitioners. To date, the challenge implicit in the complexity of spirituality has left nurses ill-informed about its meaning, and badly equipped to address their patients' spiritual needs and concerns (Greasky, Chiu, & Gartland, 2001; Martsof & Mickley, 1998; McSherry & Draper, 1998). If nurses are to provide spiritual care, of course they must be able to understand and identify what it is, so that they can make an informed assessment of patients' needs and provide appropriate intervention to meet those needs.

Theoretical perspectives concerning spirituality

For nursing practitioners the theoretical underpinnings of spirituality are still underdeveloped. In some nursing conceptual models or theories, the concept of spirituality is either embedded or is a major concept. Models in which spirituality exists as an imbedded concept occur in Mayra Levine, Dorothy Johnson, Sister Callista Roy, Madeline Leninger and Martha Rogers (Alligood & Marriner-Tomey, 1997; O'Brien, 1999). In Levine's model, she views human beings as highly adaptive creatures in constant interaction with their environments. Humans are also seen as integrated wholes whose behaviors respond to internal

and external environmental stimuli. The external environment is comprised of three components: the perceptual, the operational, and the conceptual. The conceptual environment includes a person's culture, language, thinking, personal styles and spirituality. But although Levine includes spirituality as a conceptual environment, she does little more to explain or explore spirituality. Only one study used Levine's model to measure spirituality. In 1993, Shafer and Potylycki conducted a descriptive study concerning the fatigue associated with heart failure. They used Levine's model to measure the spirituality of their subjects. Participants identified that spiritual activities as an intervention to manage fatigue, but unfortunately there was no explicit identification of what these activities were or how, specifically, they helped in relieving fatigue.

In her model of a behavioral system, Johnson identified seven sub-systems. These are 1) attachment and affiliation, 2) dependency, 3) indigestive, 4) eliminative, 5) sexual, 6) aggressive, and 7) achievement (O'Brien, 1999). Johnson adds that one of the behavioral sub-systems of affiliation relates to one's own beliefs concerning God or a spiritual being. However, no study was found that actually measured spirituality using Johnson's behavioral model.

In her adaptation model, Roy, views the person as a whole compromised of parts that function as a unity for some purpose. She identifies a moral-ethical-spiritual self as a part of this whole (Alligood & Marriner-Tomey, 1997; O'Brien, 1999). In this section of the self, a person answers existential questions, such as "who am I and what do I believe". By posing and pursuing answers to these questions, a person is seeking to access his or her beliefs and values. Health care

professionals can use Roy's model to assist the individuals in adapting to changes or challenges in their lives by means of their own intrinsic spiritual resources. Unfortunately, no study has been found that utilized Roy's model to measure spirituality.

Leninger's theory concerns two major concepts: care and culture. Cultural care was sensitive to a patient's values, beliefs, norms and life practices, including their religious beliefs and practices (Alligood & Marriner-Tomey, 1997; O'Brien, 1999). In this model, spirituality was not specifically identified as an aspect of religion or of religious practices. However, when Ray (1984) used Leininger's model to study institutionalized classifications of caring and she did identify spiritual caring as a sub-category of caring.

Roger's model, called 'the science of unitary human beings,' does not use the word spirituality to describe unitary humans (Alligood & Marriner-Tomey, 1997; O'Brien, 1999). However, Smith (1995) later used Rogers model to compare patterns of power and spirituality both in polio survivors and in people who have not had polio. These findings indicated that power was positively related to spirituality ($r=.34$, $p<.005$). Polio survivors manifested the same power ($t=.44$, $df=250$, $p=.33$ and greater spirituality than people who had not experienced polio $t=3.79$, $df=250$, $p<.001$). This result indicates that patterns of human field change are related to surviving polio. Smith suggested that the results supported Roger's notion that when humans are subjected to negative environmental influences and pathological changes, their outcomes can still attain unity with nature and an evolutionary becoming. Using Rogers subtle model, Sherman

(1995) studies nurses' willingness to care for aids patients and using comparative variables such as spirituality, perceived social support, and death anxiety. The findings from this study supported Rogers theory of unitary human beings only in that an awareness of spirituality is embedded in but not explicitly addressed by the model.

Only a few theorists include spirituality as a major concept in their models. For example, in her systems model B. Margaret Newman identified spirituality as one variable that contributes to the client's basic structure and wellness state. She is also careful to note that spiritual awareness can occur at any point in the life cycle and that the development of spiritual awareness empowers the client system toward well-being by positively directing spiritual energy to the mind and *then* to the body (Newman, 1995). Later, Clark, Cross, Deane and Lowry (1991) used Newman's model to guide a qualitative study of spiritual needs in adults with previous hospitalizations. In depicting energy flow between nurses and patients, the participants included spirituality as part of the basic structure of energy resources, thus illuminating Newman's notion that a spiritual variable is basic to all organisms.

Newman (1995) viewed humans as unique patterns of consciousness. Implicit in her notion of human consciousness was its movement towards a higher level of insight that facilitates a transcendence of the spatial-temporal self to a spiritual realm. Frayback (1993) applied Newman's model to perceptions of health from individuals with terminal illnesses. These findings suggested that the

spiritual aspect of a person's life is connected to having a relationship with a higher power, recognizing one's mortality and striving for self-actualization.

Parse's 'theory of human becoming' is based on nine philosophical assumptions of which three are of human becoming. The basic principles of human becoming are attributes of spirituality including meaning, value, and becoming (Parse, 1981). No study has used Parse's model exclusively as a framework, but Smucker's (1996) phenomenological study of the essence of spirituality established findings congruent with the evolving nature of humans as addressed by Parse, Rogers and M. Newman. Unfortunately, the author did not state precisely how spirituality was related to the evolving nature of humans.

Finally, Watson's (1988) theory of Human Caring focuses on nurse-patient interactions and is based on spiritual-existential and phenomenological orientations. The spiritual dimension in her theory is the elaboration of the soul which, is identified as the inner-self, spiritual self, or 'geist.' She emphasizes that an empathetic caring relationship facilitates the patient's movement towards a higher state of spiritual awareness. Stiles (1994), phenomenological study of nurse-family interviews in a hospice, identified themes of positive spiritual experiences in the relationship between these families and the nurses.

Empirical Evidence of Spirituality

Several studies have demonstrated that spirituality has a positive effect on peoples' lives and on the outcomes of their illnesses. In these studies, the attributes that measure spirituality are religious belief, spiritual support, spiritual care, and transformation or gaining insight.

Religious belief

In a quantitative study, Murphy et al. (2000) measured religious beliefs and practices among clinically depressed people. Their measurement scales did not list characteristics but focused rather on measuring religious belief, attendance at worship, private religious practice, hopelessness and depression. These findings reveal that religious belief is positively related to lower levels of hopelessness and is only indirectly related to depression. The analysis of results was not clear as to whether spiritual characteristics were measured or if they were included as part of the religious belief or practices. Therefore this research does not support the role of spirituality in depression.

Hawkins, Tan and Turk (1999) conducted a quantitative study to measure the effectiveness of Christian cognitive-behavioral therapy (CCBT; $n=18$) to that of traditional cognitive behavioral therapy (CBT; $n=11$) in a group of depressed Christian inpatient adults. The findings revealed a significant correlation between a reduction in depression and an improvement in spiritual well-being (SWB) ($p < .0005$) and that both groups demonstrated significant reductions in levels of depression ($p < .0005$) and improvements in SWB ($p < .0005$). Also, the findings revealed significantly higher overall SWB scores for those in the CCBT program ($p < .01$). The results of this study controlled for all demographic variables and homogeneity as well as all the subjects responded to the same questionnaires and were of the same religious beliefs (Orthodox Christians) and background. Depression was measured pre and post treatment using a reliable tool (Beck

Inventory Depression Scale) and level of SWB was also measured pre and post group. However, the sample size for this study method was small and as such decreases the possibilities of reliability and generalizability.

Other studies have examined the role of spirituality in the context of religion in positive and negative coping with major life events (Pargament et al. 1998) Pargament et al. examined subjects' negative and positive religious and spiritual insights as they coped with major life events following the Oklahoma City bombing. The findings suggested that religious approaches to coping were reflected variously in relationships with God, religious forgiveness, collaborative religious coping, a sense of spirituality and spiritual connection, religious purification, benevolent religious appraisal and religious focusing, and a trustworthy worldview. The authors noted that spirituality was not specifically measured in any of the multiple items instruments scales, but factors that suggested spirituality was identified. These are seeking spiritual support by searching for comfort and reassurance through God's love and care; searching for spiritual cleansing through religious actions; seeking a sense of connectedness with transcendent forces and spiritual discontent was expressed with expressions of confusion and dissatisfaction with God. However, it is noted that the findings of this study cannot be generalized because of its cross-sectional design and the absence of a longitudinal study but it does support the notion that some form of spiritual coping did occur.

Koenig (2000) using patients' self-ratings, clinicians' ratings, and clinical interviews to assess symptoms of depression, found an inverse relationship

between religious coping and depression in men hospitalized for medical illnesses, regardless of how depression was measured. Koenig stated that religion might have acted as a buffering agent against adverse effects of stress and depression, in addition to contributing to life-satisfaction and well being. He asserted that private forms of religious coping, as well as the more public coping strategies (such as church attendance) may serve as a buffer against a wide range of mental disturbances.

According to Oxman, Freeman & Manheimer (1995), when specific physical outcomes are analyzed, (such as blood pressure or recovery from surgery), several studies suggest that a spiritual, meditative lifestyle is associated with positive health effects. Their study of 232 open heart surgery patients found that those who had no strength or comfort from religion were three times as likely to die compared to those with some strength and comfort. This suggests that religion, as part of ones spirituality plays a role in recovery and should be incorporated into his or her care

Spiritual support

Spiritual support has also been identified as a contribution to personal well-being, especially under conditions of high stress. Maton (1989) in studying high life-stress examined the relationship of spiritual support to self-esteem and depression in recently bereaved parents. Regression analysis revealed that spiritual support was positively related to self-esteem for this group of people. In a prospective longitudinal analysis with a pre-college depression controlled group, spiritual support was positively related to personal-emotional adjustment

to college for the high life-stress of the first-semester college freshman. The high life-stress of this group was identified as three or more life events.

The difference between the two studies is perhaps a result of the personal attachment to the affected child, and an inability to ease the suffering of the one they love. The stress-buffering role of spiritual support was examined in two diverse samples. In the first study, recently bereaved (high stress) parents and less recently bereaved (low stress) parents attending 'Compassionate Friends' mutual help groups comprised the sample. In the second study, the sample consisted of first-semester college freshmen who had experienced three or more uncontrollable, stressful life events (high stress) and those who had experienced two or fewer such events (low stress) during the previous six months. A three item support measure, based in part on items shown to be predictive of well-being in previous research, was devised and used in both studies.

In addition to the spiritual support predictor, social support variables were also assessed, allowing a comparison of the relative predictive utility of the two different domains of perceived support. Finally, while the bereaved parents' research was limited to cross-sectional analyses, the college freshman study was prospective (longitudinal) in nature, using pre-college support measures to predict adjustment to the first semester of college. Therefore there is no comparison, but they both demonstrated that spiritual support is useful in reducing stress and increasing coping.

In exploring the relationship between spirituality and HIV, Tuck et al. (2001) conducted a quantitative pilot study to examine the spiritual and psychological

factors in persons living with HIV. Spirituality was measured in terms of spiritual perspective, spiritual well-being and spiritual health. Measuring tools for each one of these variables were used. Correlational analyses were used to examine the nature of relationships among spirituality and the psychosocial factors of perceived stress, uncertainty, psychological distress, social support, coping strategies and quality of life. The results showed significant relationships ($P < 0.01$) where quality of life was positively related to social support; physical social and functional well-being; and appraisal-focused coping, while negatively related to uncertainty, perceived stress, psychological distress in the form of avoidant and intrusive thought, and emotion-focused coping. Likewise, the spirituality measures demonstrated significant relationships with the study variables of emotional well-being, spiritual health and spiritual perspectives, which were positively related to quality of life and social support ($P < 0.01$).

Robinson and Kaye (1994) studied the relationship between spiritual perspective, social support, and depression in care giving wives of persons with dementia and non care giving wives of healthy adults. The study was a descriptive co relational study that measured multiple dimensions of social support and depression was measured using the Hamilton Depression Scale. Using Person r correlation for analysis, the results indicated a statistical significant negative relationship between depression and perceived availability of support in caregivers ($r = .56$, $p < .05$). Caregivers reported less perceived availability of support. Non-caregivers who reported significantly more expressed support were less depressed ($r = .46$, $p < .05$). Frequency of contact with social

network for caregivers were significantly related to the use of social support ($r=.54$, $p<.05$) and available social support ($r=.55$, $p<.05$). These relationships were reported as not significant for non-caregivers. As for the spiritual perspective dimension the results were reported as non significant and the hypothesis that proposed a positive relationship between spiritual perspective and social support was rejected ($p=.052$). In this study spiritual perspective has not shown to have an impact on depression and items to measure spiritual perspective were not identified.

Spiritual care

In a study of Oncology Nurses practices of spiritual care Taylor, Amenta & Highfield (1995), found that nurses provided spiritual care through sharing personal experiences, praying with their patients, discussing spiritual issues such as life and death, discussing fears, anxiety, attending to patient's family, expressing benevolent attitude, providing religious materials, using touch and being present with their patients enabled their patients to feel as sense of hope and self worth. Nurses also reported that from some of their interventions, they experienced personal growth and felt that they were providing holistic care which is important for their patients' well being. They also reported that from some of their spiritual interventions, patients reported personal growth, by finding meaning and purpose in their lives through acceptance of their illness. However, despite providing spiritual care, some nurses felt only moderate comfort in their ability to provide spiritual care. This suggests that more education should be provided to nurses if they are to feel more confident to provide spiritual care and

if the nursing profession embraces the concept that spiritual care is essential for total patient care.

Pullen and Tuck (1996) conducted a study on spiritual perspectives of 50 mental health nurses, who are RN's, and 43 being females, and 6 males in a public health facility. The spiritual health perspectives were measured using a 10 item spiritual perspective scale (SPS), which measured individual's spiritual perspective to the extent where spirituality permeates one's life and how one engages in spiritually related interactions (SI) by measuring spiritual values and how spirituality is expressed through SI. The instrument was said to have high reliability as indicated by Chonbach's alpha coefficient of .90. The findings revealed that spiritual variables and SI there were significant differences in spiritual variables between younger and older nurses, $p < .03$, but no difference in SI scores between the age groups. Limitations identified in this study is the small sample size, the small male sample, the collection of data was by self reported questionnaires and the narrow scope of the SPS, which was only whether the nurses had any spiritual training or education program and what was their religious affiliation. Another limitation of this study is that the SPS variables were a one word or number answer. It is not clear from the findings and discussion from this study whether the nurse's spiritual perspectives influenced their spiritual interactions with clients and if so what those interactions were.

Harrington (1995) conducted a qualitative study to examine nurse's perceptions of the nature of spiritual nursing care in relation to "normal: nursing care and the adequacy of nursing education as preparation fro providing spiritual

care. She interviewed 18 female and 2 male nurses of whom 10 worked in hospice care and 10 in a variety of settings with at least two years experience as a registered nurse. From four open ended questions responses resulted in the emergence of 29 themes that led to the construction of a model to explain the nurses spiritual care. In this model the findings suggested that the nurses delivering spiritual care are influenced by their practice settings and nursing education which together impacted on the quality of spiritual care they provided. Seven nurses of the ten who worked in hospice care indicated that they had greater opportunities, a more supportive environment, and more resources to implement spiritual care than nurses working in acute care. Majority of the nurses from both settings felt it was difficult to work in a cure-oriented setting where the focus is on disease rather than on the person. There was no mention of how many nurses, but the author noted that nurses felt their original nurse training did not prepare them for spiritual care giving and that they had no role models or other in service education. The nurses identified spiritual care as having a dialogue and listening to their clients, exploring issues, praying, and providing tender loving care.

Transformation or Gaining insight

Studies of alcoholism and abstinence have shown that about 90% of alcoholics return to drinking within four years of abstinence with 50-60% relapsing within the first three months following treatment (Bowden, 1998). This recidivism is sometimes attributed to the fact that most of the treatments provided are based on the medical model of etiology and the alcoholic (Bowden).

However, Larson and Larson (2000) reviewed several studies (Brizer, 1993; Brown & Peterson, 1991; Miller, 1998; Schaler, 1996) concerning the inclusion of spirituality in the treatment of alcoholism have shown that there is sustained and ongoing recovery for alcoholism when people were able to take. In Brizer's study of alcoholic's religious lives, he found that those who were low in religious commitment abused alcohol more than those who had a higher religious commitment. Likewise, in drug abuse treatment, Miller found that those who were drawing upon spiritual resources made a significant difference in the outcomes of their treatment. In these studies, spirituality and practicing the principles of Alcoholics Anonymous were a powerful force in achieving abstinence.

Bowden (1998) demonstrated that people who were able to experience a transformative state by internalizing their abstinence from alcohol found their recovery more sustainable than those who did not utilize internal and transformative process. She relied on a Heuristic inquiry, a branch of existential-phenomenology psychology and reflective phenomenology to describe how some alcoholics gained insight into internal aspects of life (Bowden). In this study, insight was gained through self-discovery and exploration with other alcoholics. Through this process, a clearer understanding into the inner aspects of human experience was illuminated. Spirituality in this instance was captured in the experience of release, gratitude, humility, tolerance, forgiveness and being at home.

In a qualitative study, Chiu (2000) explored the lived experience of spirituality in Taiwanese women with breast cancer. The findings revealed four

major themes representing the subjects' spirituality. These are living reality, creating meaning, connectedness and transcendence. Living reality included living with the encounter, taking full responsibility and appreciation of life, people, and beloved things. These were expressed in the form of increasing consciousness or awareness of life situations and live them in a different or more real way; it was an "important turning point" (p.37) and illuminated their view of their lives. Taking full responsibility increased the patients' independence, reduced their anxiety and increased their assertiveness. The women generally also felt less self pity. In showing appreciation the women learned to live each day at a time to its fullest. They appreciated their family, friends, time and God (Chiu).

In Chiu's (2000) study, creating meaning included finding purpose and meaning of life, finding alternative way of life/restructuring life experiences, and practicing religion. Theses meanings were experienced in the forms of engaging in artistic activities, redefining their femininity by accepting how they look, and religion helped by offering belief that their God is looking after them through pilgrimage and mountain climbing. Connectedness involved relationship with self, others, God/deity, and power. Theses were experienced through inner consciousness that created self knowledge, and feeling of self-worth and believing that they can conquer their illness, which was realized by helping others through volunteering, and being needed or being loved. Connectedness also helped with family members sharing and attending to daily chores and the subjects themselves helping others. Relationship with God occurred in attending church or temple and prayers or chanting. Transcendence was experienced

through suffering, liberation, opening to life and death and healing experience. Suffering was seen as a way of experiencing spirituality and therefore did not feel real. Liberation was to let go of everything and engage in the fullness of being. And instead of fearing death the women learned about death and how it is connected to life. Finally, the healing experience was realized through acceptance and life becoming into balance, wholeness and harmony. Letting go of grasping is when a person is merged with the universal, a symbol of transformation of some kind (Chiu). This study demonstrated a full spectrum of how spirituality can help people with their illness or facing the possibility of death.

Summary

There is no clear consensus on the definition of spirituality and the present theories do not fully embrace or address the multitude dimensions that explain spirituality. However, some studies have used theories that address spirituality. Through separate constructs, religion and spirituality are intimately linked since spirituality is at the core of religion. Spirituality in various forms has shown to help people to recover or manage their illnesses in a more meaningful way. Therefore, it is reasonable to suggest that spirituality would have similar effects on people suffering from depression and as such should be studied more in this population.

Chapter III

Research Method

In this chapter, I will discuss the research method and rationale for selecting this research method. I will also describe the method for sample selection, data collection procedure, and the analysis process. This will be followed by discussion on issues of rigor and ethics and human rights. The chapter will conclude with a summary of the discussions.

Qualitative research method is most appropriate when little is known about a phenomenon (Morse & Field, 1995). This research method seeks to understand words, stories or lives of the people that are under investigation (Sandelowski, 1995). It is acknowledged that quantitative research methods such as using questionnaires or surveys interviews are not suitable for research questions that seek to understand the experiences of people's lives and the meaning they give to those experiences (Polkinghorne, 1997; Sandelowski). Therefore, the qualitative research method used in this study will be narrative inquiry that explores the understanding of spirituality in recovering from depression. The focus of narrative inquiry is to construct worlds of meaning and to make sense out of people's experiences (Sandelowski, 1991). Narratives are a natural way of capturing the narrator's interpretation of linking events or experiences of the past, present and into the future (Sandelowski).

In the social sciences there is an increased recognition of the contribution of narrative inquiry as a path to improved knowledge about nursing care as well as a method of nursing research (Lieblich, Tuval-Mashiach and Zilber, 1998; Mishler,

1986; Sandelowski, 1991) and its potential in understanding human experiences (Polkinghorne, 1997). According to Polkinghorne narrative inquiry is both a process and a product that provides a story where events are linked in meaningful sequences. The product of the story is a representation of the events of a person's life and the process is the reconstruction of the narrator's life in a way that conveys the meaning he or she attaches to it (Arvay, 1998). However, Arvay also suggests that the reconstruction of stories can be influenced by a person's cultural norms of story telling techniques, by the context in which the narrative is being written or the relationship between the story-teller and the receiver. Narrative inquiry allows the expansion of human understanding while at the same time acknowledges that no knowledge is complete, exact or static.

Clandinin and Connelly (1994) write from their interest in personal experience methods in the social sciences and develop a strong case for the study of narrative as a mode of inquiry. They start from the basis that social sciences are founded on studies of human experience and therefore experience is a justifiable starting point and key term for all social science inquiry. They also acknowledge two positions that they seek to navigate between. One position is the epistemological argument that experience cannot speak for itself; we can only ever have a representation of experience in the form of a text. The other position is that all meaning is embedded in texts and in the forms by which they are constructed and interpreted; therefore the study of texts and their deconstruction is a proper focus for inquiry.

Narrative inquiry is suitable to explore the understanding and experiences of people's lives from their stories and the meaning they placed on those stories (Sandelowski, 1991). In this study, the use of a qualitative narrative inquiry design was valuable in exploring the experience of spirituality because it transfers experiential knowing into textual telling. This process provided a voice to the participant's experience of depression and how spirituality helps them to recover from depression. Furthermore, the narrative approach lends itself to story telling and has demonstrated the appropriateness of viewing the individual as the expert to his or her experiences. It is through the exploration of an individual experience that a common understanding and meaning of life can be achieved. Indeed, using narrative approach can capture the essence of life experiences in its true form. Thus it is acceptable that if researchers seek to gain more understanding about the process of health in human beings, narrative inquiry is not only an appropriate but also a necessary technique.

While it is recognized that the narrative mode of inquiry can follow a variety of approaches to collect data, such as face to face interviews, surveys, or video recordings (Lieblich et al. 1998), for the purpose of this study, the focus of data collection will be face to face interviews, which are then audio recorded.

In the narrative mode of inquiry, it is understood that the storyteller has knowledge of the story that is being told and that the reader or the listener is the audience. Therefore, both roles, (that of the teller and that of the listener or reader) are crucial to exploring the understanding of the story (Coffey & Atkinson, 1996). Storytelling involves knowledge of linguistic forms of the narrative structure

and focuses on aspects of meaning in the language use (Lieblich et al. 1998). It is important to understand how individuals use language to describe spirituality so that a thorough understanding is revealed on experience of spirituality and how it helps in recovering from depression. Thus, narrative inquiry, as a method, is considered well-suited to explore the meaning of spirituality and its role in recovering from depression.

Sampling Selection and Criteria

In narrative inquiry, sampling requires the inclusion of individuals who are knowledgeable of the phenomenon under investigation and who can best able to tell a story that will inform the research question (Lieblich et al, 1998; Morse & Field, 1995). The sample size for this study consisted of eight English speaking adults from a western Canadian city. Two of the participants were males and six were females, who were recruited from mental health community-based organizations. The participants identified themselves as having had depression and that they have recovered from their depression. They also expressed that spirituality played a role in their recovery from depression.

The researcher attended one of the MDABC regular meetings and presented the research proposal and to seek interested participants. Information about this research and a contact number (Appendix A) was posted on the agency's website for interested participants. A contact person from the CMHABC and the MDABC acted as a liaison between the researcher and the potential participants. The contact person obtained telephone numbers of interested participants and forwarded them to the researcher. The researcher then

contacted the interested individuals and explored the possibility of their participation in the research study and answered their questions. During this contact the researcher explained the purpose and procedure of the study and a verbal consent was obtained. At this time, a convenient time and place was arranged for the actual interview.

Data Collection

To strengthen the validity of data collection, more than one approach to data collection was employed to reveal the role of spirituality in recoveries from depression. These are field notes from the face to face interviews in which the researcher recorded the setting, the interactions between the participant and the researcher and their various individual behaviors. These field notes included a reflective journal where the researcher recorded her thoughts and insights.

Procedure

Before the interview began, the researcher reviewed the purpose of the study, obtained a formal, written consent (Appendix B), and a signed copy of the consent form was given to the participant. The researcher also informed the participants that the interview will be audio-taped and ensured the participants understand their participation in the study. At this time the researcher offered to give the participants a completed copy of the research study and they accepted the offer.

Eight in-depth face-to-face interviews were conducted over a six week period. Each interview lasted approximately one hour. The interviews began with an open-ended trigger questions such as "Tell me about your depression?" or

"Tell me about your journey to recovery?" (Appendix C). The researcher ensured that the questions remained open-ended and the participants determined the pace and general content of the interview. More focused questions were asked to expand on the information on spirituality or to stimulate the discussion (Appendix 3). As data collection proceeded from participant to participant, questions that arose from the preceding transcripts were utilized in the remaining interviews.

Recording of Data

Data was audio taped at the time of the interview and the tapes were transcribed verbatim to provide an accurate record of the interview. Each transcript was reviewed with the tape to ensure accuracy. Field notes were kept during each interview; these included verbal and nonverbal behaviors of the participant, the setting, a description of the participant, rapport between the investigator and the participant, and a description of my own behavior, thoughts, and ideas. Once gathered, the data were analyzed using Lieblich et al. (1998) and Mishler (1995) framework for data analysis.

Data Analysis

According to Morse and Field (1995) the underlying research tradition with any type of data analysis is to make sense of all individual datum by organizing, providing structure and making a collective pattern of meaning out of the raw data. Morse and Field also suggests that in qualitative analysis the process is to read the narrative data several times in search of meaning and deeper understanding and then to fit the data together in forms of categories or themes for conceptualization. Therefore it is the responsibility of the researcher to

present the data accurately to reflect the real experience of each participant. This is especially true, since the researcher is also the instrument of interpretation. Her analysis must be rigorous, systemic, and accurate in order to be credible. Thus the process of rigor must be followed accurately throughout the process of analysis. To this end, the process of analysis was drawn from Mishler's (1986) framework for analysis and Lieblich et al's (1998) holistic-content perspective model of classification and organization for narrative analysis.

Mishler identified three elements for narrative analysis, including structure, interpersonal factors, and content.

Structure

In structural analysis, portions of the text are internally connected through systemic and meaningful devices. To achieve this, the stories were viewed in an open-ended fashion to elicit the present, past and future of the story and to make sense of the events as they were told (Sandelowski, 1991). Polkinhorne (1997) discusses the importance of plot in a story and argues that all stories have a plot. He conceded that plots can indicate the beginning and end of narratives, provide criteria for event selection, temporally order the events that move towards the conclusion, and clarify the contributions of events within the story to the whole.

Interpersonal factors

Interpersonal factors at how the story might be told differently if it were to be told to a different person or audience, or in a different context. The context of a text is a critical element in how a story unfolds. It can be affected by many factors such as where the interview took place, the mood of the interviewer or the

narrator, the physical environment where the story was being told or whether the story was being recorded and how it was being recorded. For example, audio taping and videotaping can have a very different impact on the ease of storytelling (Mishler, 1986). Therefore, it is necessary to remain aware that a story is the narrator's presentation of life events at a given moment in time or place and is always shaped by the context in which it is being told. In this sense, the researcher is the audience and the one to whom the narrator is exposed; this unique aspect of the context must be openly discussed in the analyses sections.

Content

This third and final element looks at the analysis of the data where themes are interpreted in relation to each other. This thematic type of analysis reveals cultural values that illuminate the personal identities of storyteller and audience (Mishler, 1986). This, in turn, qualifies the individuality of each story element in the context of the general cultural themes of the entire story. These three elements of narrative analysis as suggested by Mishler (1995) were utilized in the analysis of the data and will be discussed in detail in chapter four.

The holistic-content perspective as outlined by Lieblich et al (1998) focuses on the content of the whole story of the individual and analyzes each part in light of the content that emerges from the whole story. To achieve this, they suggested a five-step approach: 1) "read the material several times until a pattern emerges, usually in the form of foci of the entire story, 2) put your initial and global impressions of the case into writing, 3) decide on special foci of content or themes that you want to follow in the story as it evolves form

beginning to end, 4) Using colored markers mark the various themes in the story, reading separately and repeatedly for each one, and 5) keep track of your result in several ways: Follow each theme thorough out the story and note your conclusions" (pp. 62-63). These steps help to gain a thorough understanding of the stories by reading with an open mind and let the text speak and for the researcher to pay attention to any significant aspects of the text that might be useful for analysis. For example, how the story is opened or what evaluations are made of the experiences described, is there any disharmony in the story or any exceptions to the general impression? (Lieblich et al.1998).

In addition, notes should be taken in a journal of impressions of the story and questions about its content, structure or events that stands out. Furthermore, the data can be organized by taking careful notes about when a theme starts, when it ends, in what context it is being told, and about what transitions are used between themes. Draw columns and rows to separate the themes and keep separate files for each story (Lieblich et al.1998, pp 62-63)

To achieve holistic content as suggested by Lieblich et al. (1998) the researcher read the stories several times and key words and statements were highlighted and labeled to form broad themes These broad themes were then grouped into narrower themes (Appendix E) and finally into one main theme: Connections and three sub themes: relationships (God or a Higher Power, self, others, and nature), surrender, and meaning and purpose as depicted in Figure 1. These themes will be discussed in chapter four.

Research Question: What is the experience of spirituality in recovering from depression?

Figure 1: Thematic Relationships of Spiritual Connections

Ensuring Study Rigor

According to Sandelowski (1986), in the field of nursing research there are limited discussions about how to make qualitative research rigorous "...without sacrificing its relevance" (p. 27). She believes that qualitative research is a blend of scientific rules and artistic imagination, and suggests that every human experience should be viewed as unique and truth should be viewed as relative. Sandelowski (1993) cautions that in striving for scientific rigor we "...succumb to the illusion of techniques" (p.1) and as such destroy our understanding of good

qualitative work that ensures trustworthiness. In evaluating Guba and Lincoln's 1981(as cited in Sandelowski) criteria of truth-value, applicability, consistency, and neutrality as a test for rigor; Sandelowski has expanded their criteria to fit with her suggestion of the artistic nature of qualitative research and to maintain the uniqueness of human experience. With this in mind she suggested audibility, credibility and fittingness as strategies for achieving rigor in qualitative research, especially in human subjects.

Audibility

According to Sandelowski (1986) audibility occurs when "...any reader or researcher can follow the progression of events in the study and understand their logic...and when a description, explanation or justification" (p. 34) is provided for the purpose of the study; and the process and structure in which the study was conducted. To achieve audibility Sandelowski suggested that the following should be clearly stated:

1. How the researcher was interested in the subject matter.
2. How the researcher view the thing studied.
3. How the subjects were recruited.
4. How the study impacts on the subjects or the researcher.
5. How long data collection lasted.
6. How the setting played a role when the data was collected.
7. How the data was reduced or transformed for analysis, interpretation, and presentation.
8. How various elements of the data were weighted?

9. How the categories were developed inclusively and exclusively to contain the data.

10. How specific techniques were developed to determine the truth value and applicability of the data.

(Sandelowski 1986, pp.36-37)

To achieve audibility the researcher followed all of Sandelowski's (1986) suggestions. No data or process of the study will be destroyed upon completion of the study. The researcher also outlined all of the steps taken to reach decisions and provide explanations for the decisions. For example, the researcher will keep all notes in sequential order and make explicit the method used to form themes from the data as outlined in Appendix E.

Credibility and fittingness

Credibility and fittingness in qualitative research refer to the truthfulness and applicability of a study (Sandalowski, 1986). There are four main strategies to managing threats to credibility and fittingness. They are: (1) checking that the data is representative both as a whole and in the coding of categories, while providing examples of techniques used to reduce and present the data; threats to credibility and fittingness can also be reduced by (2) checking that descriptions and explanations of the data contain the typical and atypical elements of the data. Further means of limiting threats to credibility and fittingness include (3) deliberately trying and discounting or disproving erroneous conclusions drawn about the data. A further means of limiting such credibility threats involves (4) obtaining validation about all observations from the subjects (Sandelowski).

To achieve credibility and fittingness, the researcher presented the findings as true to the data by conducting member check. This was done by giving all the participants the data analysis to read for accuracy of their stories. All eight participants reported that the analysis reflected their stories and commented that they were happy with the results. The researcher also provided the transcripts to her thesis committee members to read and met frequently with them to give input in very stage of the analysis process.

Ethics and Human Rights

Upon receipt of Ethical approval (Appendix F) from the Behavioral Research Ethics Board (BREB) at the University of British Columbia (UBC), the study was commenced. Prior to each interview the investigator explained the purpose of the study and procedures to the participant. The participants were given a written consent form to sign and a written letter of the study to take home (Appendix A and B). The participants were informed verbally as well as in writing that their participation is entirely voluntary and that they can withdraw at any time during the interview or withdraw their data any time during the study and that their health or the care they are receiving will not be compromised. They were further informed that they can refuse to answer any questions or discuss any particular issue. My background in psychiatric nursing enabled me to identify if a participant became emotionally troubled and to make appropriate referral for care or treatment. One participant became tearful while telling her story and was given the opportunity to discontinue the interview but choose to continue. She assured me that she was not unduly upset and that she was fine to continue so we

continued the interview. By the end of the interview she was more composed and stated felt comfortable leaving. .

The confidentiality and anonymity of all of the participants was ensured by the use of code numbers (1, 2, and 3) rather than the participants' names during data collection and analysis. The codes matching the participants' names and tapes were kept in a locked drawer to which only the researcher will have access. Once the study is completed, all identification and codes will be destroyed and the tapes will be erased according to the BREB guidelines for UBC. Finally, none of the participant's names were ever used in any document or in the analysis that would reveal their identity.

Summary

In this chapter, the researcher has outlined her research methods and provided some discussion of the technique of narrative inquiry in the social sciences. She has also provided the rational for her choice to use narrative inquiry in this study. Finally, methods of sampling, data collection criteria, descriptions of the process of data analysis, a discussion of how rigor will be addressed and how ethical standards will be maintained this study have all been provided in the preceding pages.

Chapter IV

Findings

The purpose of this study was to explore the role spirituality plays during recovery from depression. The research question that guided this study was, "What is the experience of spirituality in recovering from depression"? This chapter presents an in-depth analysis of the stories of spirituality during a recovery from depression.

The chapter begins with a brief description of the demographic characteristics of the participants; this is followed by a discussion on the three components of narrative analysis as they apply to the interviews for this study including structure, interpersonal factors, and content, as outlined in chapter three. Finally, the chapter concludes with the data analysis itself.

The participants' ages ranged from 26-62, with one age 46, four in their mid fifties and two in their early 60's. There were six women and two men. Four of the women and both men were employed. Seven participants identified themselves as Christian and one was Muslim. All of the participants experienced depression in their teens with the exception of one whose onset began earlier at age 12 and another whose onset began much later at age 52. The study took place in a western Canadian city.

General Characteristics of the Interview

The interviews contained a dense amount of information describing the experiences of depression and spirituality. All participants were quite willing to tell their story and all stated that it was the first time they had been given the

opportunity to speak about their spirituality in relation to their depression. They all discussed how they had become aware of their spirituality in the depths of depression and all asserted that spirituality had helped them in recovering from depression. Collectively the subjects expressed hope that telling their stories would help health care professionals become aware of significance to their clients of spirituality. The interviews were then analyzed for structure, interpersonal factors, and content. In this analysis, recurrent themes are extracted and presented with illustrative excerpts from the interviews.

Structure

In the interviews, narratives about depression and spirituality were easily identified. All these narratives had an obvious beginning, middle, and end. The narrators began by stating when they first experienced depression and how it affected them, when they were first aware of their spirituality, how their spirituality developed through the course of their depression, the meaning it has for them, and the present role of depression and spirituality in their lives.

Interpersonal factors

This section examines the subjects' narratives and considers whether they would have been told differently to someone other than the current researcher. There is no doubt that the stories were probably shaped in structure, content and context as a result of the relationship that was established between the researcher and these participants. The researcher had explained her interest in spirituality and her experience working as a nurse in a depression program in the mental health system. All participants expressed their comfort in telling their

stories. For most of the participants it was the first time they have had the opportunity to talk about their spirituality. One participant stated, "I needed to tell someone I was so ashamed the only thing I did at this point was pray all the time, which is why I volunteered for this study". Another participant said, "I don't talk about my spirituality very often. It's been very affirming for me." Yet another volunteer subject observed, "some of these things I don't talk about to other people about which is why it's nice to talk to you".

Clearly, there was no hesitancy in telling the stories. Everyone seemed willing to tell his or her story and was not distracted by the presence of an audio tape-recorder. Guided questions were used to illicit more in-depth responses: (for a list of these questions, see Appendix D). There were no periods of long pauses which might have suggested discomfort. One participant, however, was tearful as she articulated her losses in life. At this point she was given the choice to discontinue the interview or to take a break, but instead she chose to continue with the interview.

The interviews began with an open question to the all participants asking them to tell their story about depression. Usually the interviews ended with the standard question asking if there was anything else the participant wanted to say or if they had any questions for the researcher. The participants tended not to add anything but often said that they were happy to have been of help and would be interested to know the results of the study.

Overall the interview settings were conducive to the interview. There were no distractions during the interviews because there was no other person present

in the private houses or offices. Thus, the stories were able to develop very well. A more detailed discussion of the stories will now follow in the content section.

Content

In this section the analysis of the narratives will be accompanied by examples from the participants' stories, which will serve to illuminate the account of spirituality in each case and also the points common to all cases. I began the analysis by reading the transcripts and then listening to the tapes to guarantee the transcripts' accuracy. Conveniently, this enabled me to immerse myself in the data. During this process I began to re-experience the feelings I had had during the interviews, particularly, the feeling of sadness over the struggles each participant had undergone as a result of his or her depression. The triggers for this empathetic sadness included alcoholism, losses of job, attempted suicides (more frequently expressed simply as having suicidal thoughts), relationship breakdowns, and heroic efforts to live with cancer. To be honest, however, simultaneously as I re-experienced this sadness, I also felt relieved that they were willing to speak to me about their experience with their illnesses, their struggles in life and about their spirituality. Most importantly I was very grateful that they spoke about how spirituality had saved their lives, and they had developed or discovered the will or courage never to give up.

The content of the stories was clear and each narrator presented his or her own story quite vividly. After carefully reading the narratives several times and placing them in the context of spirituality, it became clear that all the narrator's viewed spirituality as an association with religion/religious belief such

as God, faith, fate and destiny. It was also quite clear that these views were not necessarily connected to religion or religious belief. Spirituality for these participants was understood as something “personal...private, not scientific; a container, a filter, a shield; believing in God; doing concrete things; helping others; and having understanding of things”. These concepts suggest that for the participants, at least, spirituality is very complex and multidimensional.

To help me analyze the data, I used a thematic approach to grasp the embedded themes. Even though it was difficult to separate the themes because they were interwoven and not independent, it seems necessary to isolate and extract them in order to show their importance to spirituality in general. The core theme that emerged was connections and the major sub-themes were 1) the importance of *relationships* especially those with God or a higher power, the relationship to the self or to oneself, relationships with significant others, and the relationship with nature; 2) the second major sub-theme that emerged concerned *surrender*, the ability, impulse or need to give up control, to stop fighting, to give in, and to let go or turn it over; 3) the third sub-theme concerned the importance that *meaning and purpose* had in the lives of these subjects. This took a variety of forms including those of faith, karma, destiny, but also included offering oneself to perform volunteer work helpful to others, and something that I call ‘reframing’. (Figure1). The core theme connections will be described first and followed by the sub themes with their component elements. In addition participants’ own perspectives on spirituality was explored during the study,

which will also be presented as a useful means of achieving a working definition of spirituality from a client's perspective for the health care professional.

Theme: Connections

All the participants described *connections* as the most important and strongest experience of their spirituality. Connections were described as a relationship with God or a Higher Power, a relationship with self, a relationship with others and/or a relationship with nature. Connections were significant because one characteristic symptom of depression is becoming disconnected from one's environment. Participants spoke of this disconnection as a gradual withdrawal from significant others, and friends, but this disconnection included not taking care of one's self in small ways like not exercising to maintain physical health, not eating adequately, or not being able to work. One participant stated that in the depth of his depression, he did "not know who he was or where he was". Connections were frequently expressed through the participant's faith and belief system, which might or might not involve an active religious connection. Religious connection was obviously important to all the subjects, however, since all seven participants identified themselves as Christian or Muslim.

Spirituality-as-connection was described by one participant as enabling him to "function in society....[by] being fully conscious on a daily basis....not living in a vacuum....[but] being open to the world". The experience of spiritual connection has helped this participant remain aware of what is going on in his life on a daily basis and suggests that he is able to manage his activity of daily living with some ease.

Another participant described connection as more than religious connection. For her connection included forming relationship with everything and everyone.

The experience of spirituality as connections were dependent upon the participant's ability to develop a relationship with God or Higher Power, relationship with self, relationship with others, and relationship with nature. Therefore, in forming connections through these relationships participants were able to cope with their depression. The following elements are examples of how the participant's connections shaped their spirituality.

Sub-them: Relationships

Relationship with God or a Higher Power

All of the participants described their experience of connection to God or a Higher Power and expressed this as an essential element of their spirituality. They spoke of having strong faith and belief that God or a Higher Power is there to guide and protect them "in good times as well as in bad...". One participant recalls believing in God from age three and felt that God was always part of her life. Another participant at age 12 believed God saved her life when she was about to commit suicide because she did not know how to solve a deep emotional problem. She cried out for God's help and he was there to stop her by letting her "drop the spoon of poison" and since then she has always placed her faith in God. Strategies that participants used to foster their relationship with God or a higher power were, praying to God, talking to God, feeling God's physical presence, reading the bible or Koran, and spiritual books, listening to spiritual

music, attending church, and surrendering to God by accepting their life situation, giving in, letting go, and handing over their problems

Participants discussed the importance of prayers in their lives, especially at times of distress and when experiencing suicidal thoughts. Prayers were used as a medium to connect with God or a Higher Power to ask for help and guidance, which was felt by all the participants. For the participants prayers also produced a sense of "peace...comfort...strength to go on...saved my life...." One participant stated that in the depths of her depression she could not do anything and contemplated suicide and stated that "... the only thing I knew how to do was to pray and pray all the time...More than I've ever done in my life". For another participant prayers not only helped him to cope with his depression but it also helped him to recover from alcoholism. He stated that:

"...as far as a 'higher-power goes, you can't smell it, you can't feel it, you can't touch it ...I think prayer is a big part of spirituality...if you pray to this entity and ask for help, then there's something happens. You feel the shift is being fully conscious not living in a vacuum and being open to the world. This shift has happened to me because after 10 years...I am healthier emotionally, physically, and spiritually than I have ever been as a human being".

Participants felt that prayers were used as a medium for connecting with God or a Higher Power and that the prayers had helped them through the most difficult period of their lives and still do. In addition to prayers participants read religious and spiritual books.

To help create peace and calmness, and keeping in touch with God most participants identified reading as very helpful. The bible, the Koran (Muslim holy book) and spiritual books were identified as the most common reading material;

and listening to spiritual music. One participant said she set "goals to spend time to read the bible" as it keeps her faith going. Another participant stated that she kept a journal of her spiritual experiences and found it very helpful to keep her grounded in her belief and faith that God is there to help her. As well, when she was feeling severely depressed she contemplated suicide but by reading her Koran she felt that she was not ready to die. She stated that there is a passage in the Koran that her father read when he was depressed and he kept in his wallet all the time and she did the same. She kept the passage in her chain pendent. She strongly believed that the words in that passage kept her faith in God and that God had saved her life. God was the only person she could trust at that time. She also stated that she felt the physical presence of God. She expressed this belief vividly by stating that:

"... I used to visualize a lot the hand of God holding me, someone putting his arms around my shoulders...I remember taking my dad's Koran. The version he has is very poetic and I found the poetry very comforting... give me a sense of peace..."

Some participants found that when their depression was at its worst their faith and belief in God has helped them from committing suicide. They believed that going to church has helped them to "Being a Christian and accepting Christ" and this has helped them to build on their faith. Going to church has also helped them to connect with others through support from the congregation. The following statements illuminated one participant's faith and belief in God. An important point for this subject was

"...knowing that God is always there. If there is nobody else there, God is there...probably the biggest impact about my belief in God has had on my depression is when I have been suicidal, I have

really turned to God ...my faith has probably been the thing that's most kept me from hurting myself".

Speaking to God was another strategy some participants expressed as a way to foster their relationship to God or their Higher Power. Speaking to God helped them to hand over their problems to him and strongly believed that in doing so they did not worry over their problems and they were eventually resolved. One participant who could not sleep at night during her depression described speaking to God by saying, "Okay God, what is it you want me to hear? If he can't get your attention in the day time because you are so busy, maybe he wants it at night". In addition, when her problems seemed insurmountable she would hand over them to God by stating "I can't do it - 'turn it over', turn it over "you handle it... " Another participant's experience with speaking to God was when she wanted to commit suicide but at that moment asked "*Oh God, help me*" and believed He came to her help by letting her drop the spoon (already mentioned) that had poison in it. She believed this experience made her feel that she is a "beloved child of God"; suggesting that she has a very close relationship with God and stated that the "Majesty of God is keeping me going from committing suicide".

Relationship with Self

The element of connection described herein as 'Relationship with Self' was defined by participants as an inner consciousness which was reflected in their understanding of what was happening to them and what they needed to do to manage their own lives and illnesses. This ability to self reflect as a result of their spiritual connection and religious beliefs enabled participants to be in tuned

into their body, mind, soul or spirit and to readily perceive the need to take care of each of these at the appropriate time. One participant stated that he was "conscious on a daily basis" of what is happening to him. Several participants felt their illness had placed them on a journey to find their soul. This searching for the soul could be seen as trying to get in touch with their inner self and is reflected in the following statements: "I see my journey and I don't know whether this is, I believe that it is the soul that is important, the soul, the soul is in the body, and we take care of the body and anything can happen".

Strategies that were used to take care of the body, mind and soul or spirit were, physical exercises such as walking and swimming, eating a balanced diet, doing yoga and meditation. All the participants stated that doing things that helped them physically and emotionally had helped them to connect to their spiritual self. For example, swimming and walking were found to be very relaxing. Several participants stated that doing Yoga and meditation felt very peaceful and took them "to a spiritual place".

Meditation helped participants to get into a "deep consciousness" and experience spiritual feelings of peace and comfort that would not have experience otherwise. The meditative state had "significantly changed how I am in life through my spiritual practice, my awareness, my being in the moment".

Having a relationship with one's self has helped each of the participants to take better care of themselves and thus to overcome their depression. Some also believed that their depression was a journey into their spirituality and they are learning so much about themselves and of others. For example, all the

participants stated that their depression has made them more sensitive and caring to others and are more aware of world issues, especially with regards to showing empathy for those in need. Participant also felt that the experience of depression helped them to put things in “perspective and in balance” in that the “good balances out the bad thing in life’. These statements suggest that they have seen beyond the negative things in life, those which helped them face their life challenges with grace and wisdom.

Relationship with others

Spirituality as a connection to others was described contextually by these participants as a relationship with significant others. The ability to connect in these relationships was identified by the participants as very important and helpful in coping with their illnesses. These connecting relationships were with family members such as husbands and wives or with children and other family members. Others felt connected to their church congregation, friends, support groups such as Alcoholics Anonymous (AA) and the Mood Disorder Association (MDA) psychiatrist, counselor, or a “spiritual healer”.

All the participants described some form of disconnection with others during their depression. They felt they wanted to be alone and did not feel like being among people, contacting people, and not being able to go to work. One participant described feeling so disconnected during her depression that she “...went into a closet and lock the door.” Participants described that being able to connect to God or a Higher Power enabled them to establish good relationships with their husbands/wife, their children, other family members, and their parents

were a source of support and this helped them to cope with their depression and make connections to God or a Higher Power and to their spiritual self. One participant stated that "My second husband was an enormous model for me and we spent three and a half years of tremendous martial bliss and he died suddenly". Another said that:

"My dad, he was a tremendous amount of support he used to share often about he went through depression. My husband is a huge part of it, but my mom was there before I even met my husband so...she's been there as my advocate to the doctor, helping me with my meds, and uh, just being there".

Later in the interview, she added, I

"....am really close to my two nieces and my brother and his wife and it is kind of that faith that keeps me getting up and going, yeah, I see that God gives me the strength to go about and do those things".

For some participants being connected to a church congregation provided not only spiritual support but also social support and for one participant it was her main support.

"The support group that I had there was very important and I knew that I had those people who were praying for me and who cared was part of my own spirituality is that we see evidence of God's love in relationships with other people".

Connecting to people in AA and Al Anon has also helped participants cope with their depression and alcoholism. This support helped them to realize that they have a responsibility for their recovery, which was expressed by one participant as:

"AA helped me to a certain point and then I had to go one step further by doing that, I've come to know who I am...what it takes for me to function in society today and there's a spiritual connection with all that. In the last three years I have been seeking outside

help with a counselor who's helping me realize there's more to life than making money".

Participants found that connecting with people through their work helped them have a much better understanding of their purpose in life. One participant identified a writer whom she felt taught her a lot about her life struggles as expressed in the following statement:

"That connection that people have with each other and understanding that there is a purpose...a big part of my spirituality I spent twelve years in Al Anon...One of the important people in my life {is a writer}...she writes about life as a symbolic journey ...and the archetypes and like, with my daughter and all the pain I've had she's in my life to teach me things".

Another participant stated that she has been fortunate to have contact with some wonderful spiritual people (a Canadian native healer, her therapist who does soul retrieving, and a teacher who does breath workshops) who has changed her outlook on life and who has helped her to recover from her cancer and depression. Meeting these people has given this participant an opportunity to do "something for myself...and I am "spiritually cool".

Participants' descriptions of relationship to others as spiritual connection indicated a desire for relationships with people to help them cope with their depression. Many participants described at least one significant other person in their life who is their spiritual support to help them connect with God or higher Power and to their spiritual self.

Relationship with nature

Participants described the experience of connecting to nature as something that helped them also connect to their spiritual self. All the participants

spoke of appreciating and admiring nature as a very important factor in the healing process of their depression. They experienced nature by admiring the trees, ocean, mountains, a walk in the park or by the ocean and simply being aware of the environment that surrounds them, which produced experiences of "contentment, peacefulness and comfort". Participants felt that being aware of the natural setting around them kept them in touch with their thoughts and feelings and described this as a "litmus test" to alert her that she is not doing very well when she "is not able to see the color of the tree or the reflection of the sun on the water." For this interviewee, connecting to nature felt like being in a meditative state.

"I could go into nature and just sort of flow into it melt into it the universe". Nature was described as more than living things; everything around them and a source of healing: "it all that surrounds us ... the chain of life doesn't end with just those things that breathe...just the way things are perfectly connected".

The experience of connecting with nature illuminated many participants spirituality and they felt a deep connection with God or their Higher power who has given them the gift of respecting nature. One participant expressed her respect for nature in the following statement:

"...that higher being is those transcendent in the mode and in picking the dead squirrels off the road and placing it gently on a tree I am honoring that of God that alive and the squirrel and the earth and the rocks and everything that is. ...I see the majesty of God in every rock that supports our feet and the water that dresses the earth".

Participants described connecting to nature as a fulfillment and satisfaction with life, gaining a sense of meaning and purpose in life through a

“sense of deep reverence, respect for nature, and becoming one with the universe”.

Sub-theme: Surrender

Surrendering is another concept participants described as a way to connect to God or a Higher Power, to self, to others, and to nature. This was explained both as the realization and the acceptance that they were not fully responsible for their own depression. Such a realization helped them to accept their life's struggles. All the participants expressed a positive attitude towards life after they were able to surrender to God or a Higher Power. This acceptance has enabled them to have a better understanding of their depression and enabled them to move forward and do what is required to get better. Surrendering through acceptance of their illness was by “give up control, stop fighting, giving in, letting go, and turn it over (to a higher power).” Following the philosophical principles of the AA and Al Anon was also identified as a way to surrender to God or a Higher Power.

In order for participants to accept their depression and work towards recovery, they found it necessary to “give up control, stop fighting, giving in, letting go, or turn it over” to God or a Higher Power. In doing so they were able to develop an understanding that they were not alone in their struggles and that they were not fully responsible for what was happening to them. One participant explained that he “surrendered himself to God” and that “God is responsible for what He has done, for He has created me and He is responsible for me and does not let go of that responsibility for He is God.” By surrendering himself to God,

this participant was able to connect with God because he truly believed that God took him over to protect him from dying and from being admitted to a psychiatric hospital permanently.

Another participant said, "Sometimes I just think I just have to quit struggling I could, happily spend my life in meditation in the woods". Still another participant believed that it was by surrendering to God or a Higher Power he was able to accept his depression and alcoholism. After that he was able to seek help and to begin to take care of himself. He describes his act of surrender in these words:

"...Let go, and "let God...to accept that you have depression...it's a oxymoron ...it's called "surrender to win" it has to do with acceptance"

Another participant recalled going to Al Anon meetings in order to understand her husband's alcohol problems. When her problems seemed insurmountable, she would then hand over them to God by stating "I can't do it - 'turn it over', turn it over "you handle it... and just wait" She believed that by speaking to God he has shown her a way to manage her problems by believing that if you hand over your problems to Him He will take care of them for you. This belief was expresses as "There would be something when you just think...I think that it is really the belief...I don't think that I will ever have a depression like I had, again".

This participant believed that she had grown spiritually and that she now had a much greater understanding of God's power as she has seen his power at

work not only through her depression but in the course of dealing with cancer, which she was now free of.

Finally, all the participants believed that God or a Higher Power had helped them to cope with their depression; specifically that He had saved their lives by preventing them from committing suicide. For some participants believing in a Higher Power has helped them not only to recover from depression but from other illnesses such as alcoholism and cancer. Believing in God or a Higher Power has also helped participants to feel connected to themselves, to others, and to nature.

Sub-theme: Meaning and Purpose in Life

All participants describe the ability to find meaning and purpose in life as the act of learning from their illness and reaching out to help others. In most interviews, meaning in life was described as the ability to make sense of life situations involving suffering accompanied by a further ability to derive a sense of purpose from these situations. These abilities often included some belief in karma, fate or destiny, as well as the habit of asking "Why me" questions meaningfully. Participants also shared the tendency to volunteer and to reframe their illness, and engage in altruistic behavior.

Oddly, the experience of spirituality through depression has given these people an opportunity to evaluate their lives and to relocate themselves with a new perspective that finally makes sense to them. Spiritual connections to God or a higher power, to self, to others, and to nature have also helped participants achieve such meaning and purpose. The participants' ability to learn from the

suffering of their illnesses resulted in their self-development and in their ability to accept faith or destiny.

In seeking meaning and purpose, participants expressed a strong belief in karma, fate or destiny; they also questioned who they are, and asked why something was happening to them and, more generally, what their purpose in life was. One participant, for example, referred specifically to a phase of asking such questions: "Why me? Yeah I went through that Why me? Why did I have to go through this? I don't think anyone's given anymore than they can handle". These questions enabled the participants to evaluate their lives and to engage in acts of helping others.

The sense of meaning was generally experienced in the following terms: "You feel the shift...[it] is being fully conscious not living in a vacuum and being open to the world". Purpose for the participants in this study involved evaluating their lives both under ordinary circumstances and when faced with a life crisis such as their illness.

Although, properly, Karma suggests that what we endure in our current life is from our past life and what we do in our current life will affect our future life, the participants in this study described Karma, fate and destiny simply as a belief that God or a Higher Power had a plan for them. This belief and their connection both to others and to themselves helped them to find meaning and purpose in their lives after depression. Participants stated that their depression was not a punishment but a gift; even though at times it was unbearable and almost cost them their lives. Seeing depression as a gift allowed participants to move

towards the next step in their lives. Ultimately, experiencing depression had a positive benefit for these participants. They felt they would not have met their respective spouses, met the people they have met nor have the jobs they had without it. One participant described the positive or beneficial aspects of her depression in this way:

"I don't think I would have met my husband if I weren't depressed. Just the chain of events that led me to meeting him, I wouldn't be working to help other people not have to go through what I went through... I wouldn't be doing all the self-care things I do now that really help me and keep me well and I'm happier now than I was before I ever got depressed... So I think the fact that I had to get that bad, its still a positive thing...I am a strong believer in things like fate and destiny".

Another participant reported a remarkably similar experience:

"We go to this meeting, it's a full room and there's this seat empty right beside me five minutes into the meeting this beautiful blonde woman comes in and sits beside me, we've been together ever since Yea, so was that divinely inspired or was that coincidence".

Another participant stated meeting a variety of people including her psychiatrist, a spiritual healer, and other people at a soul retrieval workshop was not a coincidence. She believed that her connection to these people helped her to connect with her spiritual self or has helped her to develop her own spirituality to be her spiritual connections and described herself as "spiritually cool" for meeting them and having all the spiritual experiences she has had. Other participants also felt that it was their fate and destiny to meet the people who they have in their lives and who are teaching them about themselves and their illnesses. Participants also explained that one of their purposes in life is to help others and engage in volunteer work to fulfill this purpose.

Volunteering and doing things for others were generally seen by all participants as spiritual work. One participant's form of volunteer work was spending time as a companion for children in hospice care.

"I volunteer... and I find this very spiritual because I am helping the children and creating a happy time. Like what can you do to put smiles on their faces...Just being present, a voice to listen to".

Other volunteering positions included being an advocate and support person for the mentally ill and giving material things to those in need. By engaging in these acts, participants felt they were giving back something to their community. They felt they were lucky to be alive and to have the will to help others who are not as fortunate as they are for having God as their protector and guidance. Satisfaction from helping others provided meaning and purpose for participants and demonstrated a sense of altruism.

Reframing depression created a sense of meaning and purpose for participants by viewing their depression as human growth experience thus enabling them to be more sensitive to others. Seeing depression as a personal catalyst of opportunity for spiritual growth helped participants engage in acts of helping others through their volunteer work. As one put it, "the worst things that happen to you are the best learning opportunities...thank-you...you are my teacher...thank you for this depression". Another found meaning in life after joining AA. The feeling of spiritual connection through AA enabled participants to feel a sense of contentment purpose and hope.

"When I first got into recovery I thought my life was over...when you are forced with serious psychiatric problems you get more healthy and more happy than people who don't think about it... I think that it's spiritual that I am taking a closer look at who I am" I'm much

more happy and well grounded person than when I first got into AA I've come to know who I am... what it takes for me to function in society today".

Participants' experience of meaning and purpose in life that expressed their Karma, fate or destiny occurred through acts of helping others and through their increasing ability to view their depression as an integral phase in their human growth. These experiences facilitated the participants' connection to God or a Higher Power, to others, to themselves, to nature. In addition, all these connections enabled them to cope with their depression and other illnesses, because they experienced 'spirituality' through a wide variety of connections, participants were asked to define what spirituality meant for them.

The Perspective of Spirituality

Participants were asked for their definition of spirituality. The descriptions were variegated and unique. Spirituality was defined as "personal...private, not scientific; a container, a filter, a shield; believing in God or a Higher power; something that gives life meaning; doing concrete things; helping others; and having understanding of things".

Similarities among the participants view were having faith that someone such as God or a higher power would be there to help them in times of struggle and the belief God was there for them. One said,

"if you pray to this entity and ask for help, then there's something happens. You feel the shift is being fully conscious not living in a vacuum and being in the open world." No one is given more than they can take and their illness was given to them as a test to make them stronger".

Spirituality meant openness to other religions, faith or spiritual practices, caring for others, and showing tolerance and acceptance of others though matter who they are:

"I see that God gives me the strength to go about and do things...caring for other people and loving other people. I have been able to see that person apart from their action and there is a spiritual part of myself that I think I have that gift from God having worked with lots of different types of people my faith has become stronger".

Spirituality was also described as encompassing more than religious belief or faith. It was described as taking responsibility for your life and doing the things that will aid in your recovery and what will make you a better person. This was explained as:

"Spirituality is different for every person. Spirituality is not just attending church...I also do self improvement, self awareness and then work towards self acceptance....I think is spiritual and which has been very helpful to me is reading, and journaling".

The descriptions of spirituality from the perspective of the participants suggested that spirituality is very complex and multidimensional and perhaps cannot be given a simple definition. It is important, however, that caregivers understand the strands of similarities that exist in their clients' descriptions of spirituality. Health care professionals need to know what spirituality can mean and the role it can play in those suffering through depression.

Summary

In this chapter the analysis of the findings were presented as three components that emerged from a narrative analysis. These were structure, interpersonal factors and content. In the content section I identified and

described the main theme; connections and three sub themes. The major sub-themes that emerged were 1) the importance of *relationships* especially those with God or a higher power, the relationship to the self or to oneself, relationships with significant others, and the relationship with nature; 2) the second major sub-theme concerned *surrender*, the ability, impulse or need to give up control, to stop fighting, to give in, and to let go or turn it over; 3) the third sub-theme concerned the importance that *meaning and purpose* had in the lives of these subjects. In addition, the participants' own perspectives on spirituality which were presented as a useful means of achieving a working definition of spirituality from a client's perspective for the health care professional.

Conclusion

The findings of this study described how spirituality played a vital role in recovering from depression. The development of these participants' spirituality was significantly influenced by forming connections to God or a Higher Power, to self, to others, and to nature. My analysis also revealed that, in forming these connections, participants were able to surrender their struggles and symptoms to God or a Higher Power in order to cope with their depression, to develop meaningful relationships, and ultimately to find meaning and purpose in their lives. In addition to forming spiritual connections, these participants' experiences of spirituality was also understood as something "personal...private, not scientific; a container, a filter, a shield; believing in God; doing concrete things; helping others; and having understanding of things". The major theme of spirituality as connections evolved from participants' narratives of their

experiences with managing their depressive illnesses. Although spirituality is a very complex and multidimensional construct; in this study, spirituality as connection was a major theme found throughout the participants narratives (figure 1).

Chapter V

Discussions, Summary, Implications and Conclusions

In this final chapter the discussions on the findings of the study will be presented, followed by a summary of the study, the implications of the study, and the conclusions drawn from the study.

Discussion of the findings of the study

The purpose of this discussion is to address key findings that emerged from the research study described in chapter four. The existing literature was used to provide theoretical support for the interpretations that might be made about the findings. The research question that guided this study was. "What is the experience of spirituality in recovering from depression"? A number of salient insights were derived from the research findings and were delineated to illustrate how the findings offer a new perspective about spirituality as a connection among individuals with depression. The insights have been clustered into two sub-sections and include spirituality as connections through relationships and creating meaning from these relationships. The discussion begins with a summary from the findings on spirituality as connections and concludes with a proposed conceptualization of spirituality.

Spirituality as connections through relationships

The findings of this study shed light on the influence of spirituality on depression by providing an understanding of the way in which spirituality was experienced as relationships or strong interpersonal connections. In general,

participants reflected the views of other individuals who have had positive spiritual experiences that enabled them to recover from their depression.

The conceptualization of spirituality can be described as a developmental and evolving process. From these participants' descriptions, the nature of spirituality appears to be shaped by one main theme --extrapersonal connections-- comprised of three sub-themes or motifs: the first concerns relationships with God, with a Higher Power, with the self, with others, and with nature; the second sub-theme concerns surrender or a accepting position of humility; the final sub-theme concerns finding personal meaning and purpose. The findings of this current study correspond with Tarco's (2002) study of the experience of spirituality among persons living with schizophrenia. In Tarco's study participants also experienced spirituality as connections through relationships (God, with a Higher Power, with the self, with others, and with nature) and found meaning and purpose in life through these connections.

Participants in this current study first became aware of their own spirituality by being able to form a connection to God or a Higher Power. Through this connection they were able to surrender their struggles with depression to that Higher Power and in doing so they were able to start the process of accepting their depression and working towards recovery. The most significant impact of connecting to a Higher Power was through prayer and in some cases this prevented participants from committing suicide. It would be reasonable, then to suggest that the ability to connect to God was a useful protective element. This finding is significant because --tragically-- suicide is the most serious and fatal

symptom of depression (Townsend 2005). Although there was no research studies found on the direct relationship between prayer and suicide prevention in depressed individuals, there are increasing numbers of scientific studies whose findings suggest that prayer contributes to physical and mental well-being (Lingren & Coursey, Larson & Groening 1998; Tarco 2002). Further studies also indicate that attending religious services reduces suicide (Larson & Larson, 2002). Groening and Larson (2001) reviewed 68 studies that examined the relationship between suicide and spirituality or religion. Of these 84% found lower rates of suicide or more negative attitudes towards suicide among the more religious.

In addition to forming relationship to God or a Higher Power, working towards recovery required that participants form relationships with their spiritual self, with others such as their therapist, their church congregation, families, and with nature. Participants identified strategies and activities as described in chapter four to help them foster these connections. These connections were associated with courage, creativity, and a renewed sense of self.

The above findings reflect the observations made by Lindgren and Coursey (1995) regarding the factors that contribute to spirituality as connection. In their study on spirituality and serious mental illness in a group of 30 individual, Lindgren and Coursey found that participants believed that their spirituality included a relationship with God through church attendance and this provided spiritual support. In this current study spiritual support was found in relationships with participants church congregation, their therapist, friends, families, and

through support group such as AA and MDA. The support of AA corresponds with Koenig and Larson (2001) systemic review of 86 studies that examined spiritual/religious commitment, including following the principles of AA and alcohol use. Of these studies 88% found lower alcohol use/abuse among the more religious, including the high risk group of adolescents and young persons. The findings of this current study also correspond with Sullivan's (1993) study of 40 participants who have been hospitalized for two years following a diagnosis of schizophrenia or bipolar disorder. Sullivan claims that spirituality encompasses social support, support of a higher power, and the sense of belonging to a community and that when participants were able to discuss their spirituality with others it helped them to reduce stress, depression and feelings of hopelessness. In this current study once participants were able to make connections with others they were able to accept that they are not alone in their struggles and not totally responsible for their depression, and this sense of connection provided meaning and purpose in their lives.

Spirituality as creating meaning and purpose

Participants in this study found meaning and purpose through the experience of their illness, in their beliefs in karma, faith or destiny and also through voluntary work. These factors have helped participants to strengthen their spiritual self and to recover from their depression. This finding is supported by studies that examine a relationship between faith and lower rates of depression. Braam, Beekman, Deeg, Smit and Tiburg (1997) study religiosity as a protective factor. In their comprehensive study with a one year follow-up on

depressed individuals and individuals who were not depressed, Braam et. al found that people who hold a strong religious faith as compared with those who did not had only 38% odds of not becoming depressed as compared to those who did not have a strong religious faith. Braam et. al study also corresponds with McCullough and Larson's (2000) twin study, which revealed that those who participated in religious group and highly valued their religious faith as apposed to who did not were 20-60% less likely to experience a major depressive episode.

The experiences of participants in this current study with depression have given them an opportunity to evaluate their lives and place them in perspectives that makes sense for them. They now feel paradoxically that their depression was given to them as a gift to make them a better person and to reach out to help others. Thus, in seeking meaning participants deliberately sought ways in which to restructure their lives, to find alternate ways to live their lives, new ways of coping through their values and belief in faith and karma. Participants in this study also questioned who they are, why something is happening to them or what their purpose in life is. This type of questioning is not new for people who are going through depression or suffering such as coping with cancer or HIV. Chiu (2000) and Hall (1998) suggested that these questions enable us to evaluate our lives and situations and sometimes to engage in acts of helping others. Certainly, participants in this study did engage in acts of helping others through their employment and through volunteer work.

Chiu's (2000) study of 15 Taiwanese women living with cancer found that having had cancer allowed these women to restructure their lives in ways that created meaning and purpose for them. The women engaged in volunteer work, some of which included leadership role, which was untraditional for the women, they explored their creativeness by engaging in art work, and found solace in their belief in Karma or faith. All these actions helped the women to feel needed and loved and ultimately created new meaning and purpose in their live.

Likewise, Hall (1998) studied patterns of spirituality in 10 patients with advanced HIV disease found that the patients found spiritual meaning and purpose in life from stigmatization, from accepting that they have a disease without a cure, and from the suffering they endured from the illness. From these experienced the patients became more hopeful knowing that all people will eventually die and that they have a lot of life to live before they die. They became more hopeful, accepted health care information and actively sought social support. They also found meaning in life by finding ways to help others. As well, Roberts, Brown, Elkins and Larson (1997) conducted a survey in England with 108 women undergoing treatment for various stages of gynecological cancer and found that 93% of these patients said their religious faith has helped them to developed a sense of worth and sustain their hope.

The findings of this study are also supported in the definition of meaning in life. According to Martsolf and Mickley (1998), 'meaning' refers to a belief in the ontological significance of life, the ability to make sense of life situations and derive a sense of purpose from existence. Elkins et. al (1988) suggests that

meaning fills the “existential vacuum” with an authentic sense that life has purpose and that purpose involves evaluating one’s life both under ordinary circumstances and when faced with a life crisis such as illness or death. Likewise, Frankl (1984) suggests that by accepting your situation, life can never cease to have meaning and purpose even when one is deprived of everything or facing death. These descriptions correspond with the descriptions the participants provided in their narratives that once they accepted their depression and their situation they were able to find meaning and purpose in life.

In addition to the participants’ experience of spirituality as connections, they also described spirituality as “personal...private, not scientific; a container, a filter, a shield; believing in God; doing concrete things; helping others; and having understanding of things” These descriptions speak to the confusion in the literature on the definition of spirituality or theory to explain how it helps in recovering from depression (Allgood & Marriner-Tomey, 1997; O’Brien, 1999). Research is more orientated towards religious healing (Baldacchino & Draper, 2001; Murphy, Ciarrocchi, Piedmont, Cheston & Peyrot, 2000; Weaver, Flannelly, Koering & Larson, 1998) and as nurses; we tend not to emphasize the spiritual dimension of human nature (Macrae, 1995). These researchers suggest that the reasons for this lack of emphasis is varied, but the most common ones has been identified as, lack of knowledge among nurses and other health care providers about the meaning of spirituality, it is used synonymously with religion, and health care providers including nurses are not aware of their own spirituality or religious belief and how it can influence their practice. This notion is true in this

current study in participants narratives, which suggests that they did not believe that their therapists or doctors would understand their spiritual experience and therefore did not discuss it with them,

In this study participants did not feel comfortable discussing their spirituality with their therapist because they were afraid it would be construed as “delusional” and they did not feel that they will be understood. These feelings of being misunderstood are not uncommon in psychiatric practice, as expressing spirituality can be viewed as symptoms of psychosis, rather than growth or spiritual healing (Larson & Larson 2002; Morrison & Thornton, 1999). Participants clearly felt that there is a lack of recognition of what constitutes clients’ spirituality and spiritual needs resulting in a lack of appropriate assessments and interventions to meet those needs. This lack of recognition is further complicated by the fact that, the existing literature views spirituality as more of an association with religion (Larson & Larson, 2002). An example of this lack of recognition of client’s spirituality was also identified in a study conducted by Baetz, Griffin, Bowen, and Marcoux (2004).

Baetz et al. (2004) conducted a quantitative study of 1204 psychiatrists who are registered with the Royal College of Surgeons of Canada and 157 psychiatric patients from a Canadian on line survey (n = 67) and from a local mental health clinic (n = 90). In their study Baetz et al. compared psychiatrists and psychiatric patients spiritual and religious beliefs, attitudes, and practices. They found that psychiatrists 54% had lower levels of spiritual beliefs and practices than did patients 71%. In addition the patients 53 % felt it was important

to have their beliefs addressed in treatment and 47% felt it was important to know their psychiatrists spiritual and religious orientation in seeking care

The findings from this current study revealed that spirituality encompasses more than religion. That it is one's spiritual beliefs and values that involves taking responsibility for your well being, trusting in others, practicing a healthy life style, accepting your struggles by handing it over to God or a higher power, use the experience of your illness as growth, and helping others. Thus if spirituality were to be conceptualized from the findings of this study, it would be that: it is a discovery of one's inner self in relation to God or a Higher power, to others and to nature, and finding meaning and purpose in life.

Summary

The purpose of this study was to explore the role spirituality plays during a recovery from depression, using narrative inquiry methodology. A qualitative narrative inquiry design was chosen for this study because it lends itself to story telling, which is best suited for the research question: "What is the experience of spirituality in recovering from depression?" Furthermore, the researcher was interested in gaining an in-depth understanding the experience of spirituality in recovering from depression. In using this method, the participants were able to narrate their experiences with spirituality with minimal interruption, which provided thick descriptions of their experiences. A quantitative design would not have revealed thickness in the experience of spirituality because using itemized questionnaires would limit the scope of spiritual experience from the perspective of the participants.

Data collection occurred through eight face to face, audio-taped interviews with eight adult men and women from a western Canadian city who identified themselves as having had depression. The goal of the study was to understand how the experience of spirituality is constructed by individuals recovering from depression. There were two assumptions in this study. One was that spirituality in whichever ways it is practiced (or according to whichever beliefs or values it holds for an individual), plays a role in recovering from depression. This assumption was realized in the findings of this study through participants' narratives of spirituality, which involved their belief in God or a Higher Power and through strategies and actions they engaged in to manage their depression. The second assumption is that despite the fact that spirituality is very personal and can only be defined by an individual that there are similarities in the experiences of spirituality. This assumption was also realized from the findings of this study, which is that there are common themes for any definition of spirituality and these can be generalized to apply usefully to new populations.

The findings of this study as described in chapter four illuminated the influence of spirituality in recovering from depression. In this study participant narratives revealed connection as the core theme to their spirituality and that spirituality was significant for their recovery from depression and their overall health and well being.

Implications

Several implications arise from the findings of this study for nursing practice, for nursing education, and for nursing research. Although there is

generally an increase in health care literature on the experience of spirituality in recovering from depression, in the psychiatric nursing literature paucity still exists on the link of depression and spirituality. Moreover, the researched findings have not been translated into clinical practice from my personal experience as a nurse working in psychiatry.

Implications for nursing practice

The results of this study contribute depth and clarity to the understudied phenomenon of spirituality in psychiatric practice. The findings contribute knowledge and understand of the role of spirituality in recovering from depression, and how it is perceived and interpreted by individuals recovering from depression. Also, that there is a connection between spirituality and health, and meaning in life. This study has significance for nursing practice, especially those working in the psychiatric field because psychiatric-mental health nurses are expected to be competent in providing holistic care, which include the mind, the body and the soul or spirit (Townsend, 2005).

Spiritual awareness and its practice in nursing dates back to Florence Nightingale's era: "For Florence, spirituality is intrinsic to human nature and is our deepest and most potent resource for healing" (Macrae 1995, p. 8). With this belief, she exemplified a professional nursing practice that was based on spiritual principles.

In this study, participants' narratives about spirituality as connection and how it helped them to recover from depression will assist nurses to understand this phenomenon in greater depth. Knowing more about spirituality and that

spirituality is an evolving process will assist nurses not only to identify their clients' spirituality but also to identify their own spiritual development and how this may affect their practice and the clients they care for. Without this knowledge nurses will not feel comfortable addressing clients' spirituality. For example, knowing that spirituality is more than religious belief or church attendance, and that it could involve acts of helping others, taking responsibility for self, seeking support from others, and admiring nature will assist nurses to create an environment that will allow clients to experience and express their spirituality. In doing so, nurses can incorporate all aspects of client's spirituality into their care.

The process of doing this research has made me more aware of my own spirituality and I have become more appreciative of clients spirituality in my clinical practice. I explicitly ask clients what spiritual/religious beliefs and values they hold in regards to their depression and whether these have helped them to cope with their depression. For those who held strong beliefs and values about spirituality they have indicated that it helped them to cope with their depression in ways that participants expressed in this study.

Considering the findings from this study, how then does the nurse provide spiritual care in his or her practice? To do this, nurses must first know what constitutes spirituality and be aware of their own spirituality, and engage in some form of spiritual encounter with their clients. However, to engage in this type of encounter, trust must be developed between the client and his/her health care provider as indicated by participants in this current study. Ways in which nurses can build trust with their clients is by practicing attentive listening and showing

respect (Arnold, 2003, chapter.10). For example, nurses can demonstrate to their clients that they are listening by using communicating techniques such as restatements and clarification (Arnold), which will help the nurse to enter into the client's world and determine his or her meaning. This encounter will also show respect for the client experience. Once the nurse enters into the clients' world, he or she is able to share the clients realities thus enabling both of them to work toward developing a sense of meaning and purpose of the clients' experience.

This study is even more relevant for nursing practice because the Registered Nurses Association of British Columbia Standards of Practice includes showing respect for patients, be an advocate and provides education for patients. Nurses can achieve these standards by showing respect for patients' spiritual experience and subsequent needs. Especially, that nurses are the ones who are at the forefront of patients care and as such are the one who are most likely to recognize patient's spiritual needs.

Implications for nursing education

This section of the chapter will explore the importance of the findings of this study to nursing education. Spirituality was viewed as significant in recovering from depression among study participants and was identified as important for their overall health and well-being. Therefore, spiritual assessment and intervention as elements of holistic health promotion need to be addressed in nursing education, specifically in psychiatric nursing education. The debate in the nursing literature continues to struggle with the definition of spirituality and what are spiritual needs, and how can nurses' best address spiritual needs in their

practice (Alligood & Marriner-Tomey, 1997; Bradshaw, 1997; Maddox, 2001; McSherry, 2000; McSherry & Draper, 1998; O'Brien, 1999).

Although spirituality is identified by Fontaine and Fletcher (2003) as a component is the nurse-client relationship and that it helps nurses to connect with their clients' it is not included in the main stream of nursing education or in psychiatric nursing education. This is evident in some of the psychiatric nursing text books that have none or minimal discussion on the topic of spirituality (Boyd, 2005; Kneisl, Wilson & Trigoff, 2004; Stuart & Lairia, 1998; and Townsend, 2005). Therefore, educators must be the ambassadors for spiritual education and provide the expertise and support the notion that nurses spiritual development must begin in the classroom and extend into the students' clinical practice areas. In doing do, this will help students learn about their own spirituality and that of their clients. Educators should also use the research evidence in their teachings and in clinical practice, which shows that clients' spirituality is important for their well-being and for recovery form various illnesses.

An important finding in this study is that participants' experience spirituality as connection (to God, to a Higher power, to the self, to others or to nature) and that such a connection to God or a Higher Power has prevented them for committing suicide. Thus, when teaching students to care for clients who are experiencing suicide, future nurses should be thought how to assess clients' spirituality in relation to suicide, how to assess spiritual needs, how to provide nursing intervention to address these needs, and how to foster connection, rather than avoid discussions regarding spirituality. Students can foster connection by

spending time listening to the client and communicating empathically, and by asking direct questions of clients' spiritual beliefs. Taking clients for walks, sitting in a garden or park can be interventions to assist clients to connect to self and to nature, connections that emerged from the findings of this study.

Spirituality or spiritual concerns should become required courses for undergraduate as well as graduate nurses rather than elective courses or as periphery of general nursing education. Furthermore, spirituality should have an interdisciplinary approach and nurse educators should collaborate with other disciplines to provide the holistic perspective as so often espoused for nursing practice. Specifically, in psychiatric practice the different disciplines, such as social worker, occupational therapist, psychologist, nurses and psychiatrists, work more closely on a day to day basis with clients to provide biological, psychological, and psychosocial therapies to clients. Therefore nurse can use this opportunity to advocate for the inclusion of spirituality into clients' care.

Finally, nursing educators must take leadership in the dissemination of literature on the significance of clients' spirituality and spiritual practice, provide workshops on spiritual care for registered nurses and other health care practitioners, and demonstrate spiritual practices with their students. When students are enlightened by their teachers, there is a possibility that they, in turn will enlighten their clients and others in their environment.

Implications for future nursing research

As the literature suggests in chapter two, there is a paucity of research in spirituality and depression in the field of psychiatric practice; specifically, in

nursing to explain the role of spirituality in the recovering from depression. Thus, the purpose of this study was to gain an in depth understanding of how spirituality helps individuals in the process of recovering from depression. This understanding will help nurses and other health care providers to identify client's spiritual practice and need, so that they can provide appropriate assessments and interventions to meet those needs.

In considering the lack of understanding to explain spirituality in relation to connection and as a means to aid recovery from depression; it is necessary to conduct research to develop a theory that will provide a framework for spiritual assessment and interventions. Such a framework will include factors such as those delineated in the current research as components of spirituality. The development of theory will provide a way for identifying and expressing the essence of spiritual practice (Walker & Avant, 1995). The proposed model (see Figure 1, p.6) from the findings of this current study creates a possibility for the development of a theory to explain spirituality as connections from the perspective of individuals recovering from depression.

Research on how nurses and other disciplines in psychiatric view and practice spirituality in their respective practices are also necessary. This will serve to alleviate the feeling of distrust participants in this research felt about expressing their spirituality. Moreover, we live in a diverse society of multiculturalism and as such spirituality from person to person, race to race, culture to culture, and within individuals and cultures might vary. Therefore, I

believe that future research can assist nurses and other health care professionals to fully understand their clients' spiritual beliefs and values.

Besides the question and the implications of this study mentioned thus far, there are several other questions derived from this study that are worthy of investigation in the future: (1) Are there differences in spirituality across different cultures? (2) Are there differences in spirituality between men and women? Are there differences in spirituality between younger and older adults? (3) Is spirituality experienced as connections in all cultures? (4) Do all cultures view spirituality as significant in recovering from depression? (6) How do psychiatric nurses view spirituality and is their view different from other disciplines in psychiatric practice? (7) Are nurses aware of their own spirituality and is there a difference between male and female nurses view? (8) How do nurses incorporate their clients' spirituality into their practice? (9) Do hospitalized depressed clients view and use spirituality the same way non hospitalized clients do? The purpose of developing studies to answer the proposed questions is to gain a general sense of how spirituality is viewed across cultures, gender, and ages. The question on health care professionals will aid in understanding the essence of spirituality from the perspective of health care professionals thus adding depth in providing spiritual care. Finally, the question on hospitalized and non hospitalized clients will aid in understanding if there is a difference in how the two groups of clients view and utilize spirituality for coping with their depression. It will also help practitioners to provide appropriate assessments and effective interventions.

Conclusions

In this final chapter I have presented a discussion of the study findings, a summary of the study, and implications for nursing practice, nursing education and nursing research. This study has attempted to investigate and describe the experience of spirituality in recovering from depression. Spirituality was conceptualized from a thematic approach with the main theme as connection and three sub themes of connection: relationships (God or a Higher Power, self, others, and nature), surrender (giving in, letting go, hand over), and meaning and purpose (karma/faith/destiny, and volunteering). These themes provide a proposed model for the conceptualization of spirituality.

The findings of this study provide psychiatric nurses, educators, and other health care practitioners with significant insights into the experience of spirituality among individuals with depression. Spirituality as connections to God or a Higher Power, to self, to others, and to nature, as well as surrendering of their struggles with depression, and finding meaning and purpose in life has enabled participants to recover from depression. Strategies and actions used to from these connections will provide nurses, educators and practitioners with new knowledge and insights into the salient role these factors have in the spiritual health and well-being for individuals with depression.

The current study findings also reinforce the significance of assessing client's spiritual beliefs such as karma/faith/destiny so that spiritual needs can be established and interventions implemented to meet those needs. Psychiatric mental-health professionals tend to avoid discussions or dismiss clients' spiritual

or religious ideas who are deemed delusional fearing they may reinforce the delusions (Larson & Larson, 2002). However, this current research supports the importance for nurses and other health care practitioners to include spirituality as part of their health assessment and in their practice.

The participants of this current study do not support the avoidance of addressing clients' spirituality. On the contrary, they would have liked to have an opportunity to discuss their spirituality with their therapist. Therefore, nurses and psychiatric practitioners must explicitly explore clients' spiritual beliefs or the topic of spirituality so they can enhance the clients' spiritual connections. Professional codes of ethics and standards of practice documents state that nurses are expected to provide competent holistic nursing care and to respect client's values and beliefs (Canadian Foundation of Mental Health, 1995; Canadian Registered Psychiatric Nurses of British Columbia, 2000; Registered Nurses Association of British Columbia, 1998; Registered Psychiatric Nurses, 2001).

Moreover, participants in this study identified that their spiritual connection to God or a Higher power prevented them from committing suicide. This is significant for psychiatric nurses and practitioners must be cognizant of when assessing clients suicide ideas and when discussing clients spiritual beliefs.

The finding of this study adds to the growing body of knowledge on the importance of viewing spirituality from a broader perspective other than from a religious perspective in the context of depression. Spirituality as connection has potential for inclusion in nursing education in relation to teaching nursing students elements of a spiritual assessment and the significance of connection to

one's spiritual self. Future research should continue to address the limitations of this study and to address future research questions proposed in this current study.

Conducting this study had provided new insights for the researcher on the strength of participants' spiritual belief and attitudes, and how these has given them hope and strength, even when faced with the thought of suicide.

Participants not only show signs of hardiness and resilience, they also showed compassion for those in needs and reached out to help others.

APPENDICES

Compensation:

You will not receive any direct benefits from your participation. However, we hope that the information obtained will help nurses gain a better understanding of how spirituality help you to recover form your depression. From this understanding, they can promote the use of spirituality into their practice. . If you wish, we can provide you with a summary of the study.

Contact

If you have any questions or want to know more about this study, please contact Dr. Carol Jillings at the UBC, at 604-522-7479.

If you have any concerns about your rights as a participant in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8596

Consent

Your participation in this study is entirely voluntary. You may withdraw from the study at any time without any effect, or the health care you receive.

Your signature below indicates that you have received a copy of this from for your own records.

Your signature indicates that you consent to participate in this study.

_____
Signature of Participant

_____
Date

_____
Signature of Researcher

_____
Date

March 17, 2004

APPENDIX C

Trigger questions

- 1) "Tell me about your depression?"
- 2) "Tell me about your journey to recovery?"
- 3) "How did you know that spirituality helped you in recovering from depression?"
- 4) "What does spirituality mean to you?"
- 5) "How does spirituality fit into your other treatments?"
- 6) "Did your spirituality change over time?"

APPENDIX D

Participant Information Form

Name: _____

Age: _____

Date of Birth: _____

Gender: _____

Occupation: _____

APPENDIX E

Broad themes

God/higher power: someone looking after ; God is always there; Majesty of God
 is keeping me going from committing suicide
 Being a Christian accepting Christ
 God took over my body, my will; saved me; guide me
 Prayer: give comfort, contentment, peace, strength to go on
 Volunteer as a means of helping
 Afraid of mental hospital, not delusional
 God's voice taken for delusions
 Spirituality is not psychiatry
 Faith in God , fate and destiny
 Reading the bible and Koran
 Spirituality personal, private, not scientific, a container, a filter, a shield
 Prayer saved life
 Diary for spiritual writing
 Yoga exercise
 Meditation spiritual music
 Nature: walks, ocean, mountain, trees beauty around
 Meaning: learning from illness; became a better person. Not living in a vacuum
 Purpose
 Hope
 Connectedness: to universal power; part of the whole
 Transcendent
 Balance
 Perspective
 Visualization
 AA and Al Anon spiritual sets of rule
 Letting go/ giving in stop fighting/being in control
 Spiritual dream: meaning. God given intervention to save self
 Pray for clarity and step back
 Soul retrieval; breath work; sweat lodge; spiritual healing
 Spiritually cool
 Self awareness; better understanding; Acceptance
 God hugging
 God speaking
 Journey
 Learn from others
 Karma
 Learning from ancestors
 Doing for others
 Taking responsibility

Initial themes flow chart

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