COMMUNITY MENTAL HEALTH PROFESSIONALS' PERSPECTIVES ON INCORPORATING SPIRITUALITY IN THEIR CARE OF CLIENTS WITH SERIOUS MENTAL ILLNESS: A QUALITATIVE INQUIRY

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B.S.N., The University of British Columbia, 1993

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

Nursing

THE UNIVERSITY OF BRITISH COLUMBIA

August 2005

ABSTRACT

Spirituality has emerged as an important component of mental health care. A growing amount of empirical evidence and theoretical development exists on the effects of spirituality and positive mental health outcomes. Consumer perspectives as well as Canadian mental health policies advocate for the inclusion of psychological and social health determinants such as spirituality in order to decrease the mortality and morbidity associated with serious mental illness (SMI). Multidisciplinary teams of professionals in the community provide the majority of mental health services. Despite these initiatives, little is known about how mental health professionals incorporate spirituality in community practice settings.

The purpose of this research study is to explore the perspectives of community mental health professionals' (CMHP) in relation to the incorporation of spirituality in their professional practice. An interpretive descriptive research design using constant comparative method, and inductive content analysis has been used to uncover the perspectives of CMHP about incorporating spirituality in their care of clients living with SMI. Three focus group interviews were also conducted with CMHP (n=22) to explore multidisciplinary points of view.

Findings of this study reveal that CMHP understanding of spirituality as well as their experiences of working within a multidisciplinary team influenced the incorporation of spirituality. CMHP understood spirituality to be an important aspect of life, personally and for their clients. The significance of spirituality was defined by three main attributes. These include, connection, religious and cultural beliefs, meaning and purpose. These attributes were viewed to either positively or negatively affect their client's mental health. Additional resources for coping, encouragement of health

behaviors, and prevention of risk behaviors such as suicide were associated with positive mental health outcomes. Negative mental health outcomes were associated with client's increased anxiety related to their spiritual and or religious expectations, past traumatic experiences and avoidance of medical treatment. Participants experienced three main challenges to incorporating spirituality. These included boundaries of their professional role, the lack of team support and the dominance of biomedical frameworks. Focus group discussions served as a model for education and allowed a place for CMHP to share their experiences about incorporating spirituality.

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ACKNOWLEDGEMENTS

I would like to express my deepest thanks and appreciation to friends and family who helped me to succeed in completing this thesis. To my mother who always expresses her love through providing me with traditional home made meals. To my close colleagues, Patrick De Sousa and Sarojni Rajakumar who's support gave me encouragement and enabled me to persevere throughout our graduate program. I wish to especially thank my husband for all his support in helping me to achieve my goals and for listening. My sincere thanks go to the directors of all of the mental health teams and to Dr. Jim Thorsteinson who supported this research study by assisting with participant recruitment. This work would not have been possible without the dedication of the mental health professionals who willingly took time away from their work to participate in this research and who provided me with the valuable insights that were gained in this study. My sincerest respect and appreciation also goes to the members of my thesis committee. To Dr. Anne Dewar who provided me with encouragement, guidance and support needed in order to achieve this work, thank you. To Ms. Paula Tognazzini who's enthusiasm and belief in me helped me overcome obstacles. To Dr. Geertje Boshma who assisted me in developing the final stages of preparing this thesis. I would like to express my gratitude to all of you. Finally, I would like to acknowledge my spiritual teacher, Eknath Easwaran for teaching me the lesson that the only true value to work is if it can be used to help others. I hope that the knowledge gained from this work will in some small way help to improve the quality of life for those living with mental illness.

CHAPTER 1:

INTRODUCTION

Background

Spirituality has a deep significance for people with serious mental illnesses (SMI). A recent Canadian study by Baetz and colleages (2004) revealed that 79% of mental health consumers considered themselves spiritual and/ or religious in some way. Research indicates that mental health clients often use their spiritual beliefs and practices to manage their illness experiences (Baetz, Griffin, Bowen & Marcoux, 2004; Sheridan et al., 1992; Chiu, Morrow, Ganesan, & Clark, 2002; Corrigan, McCorkle, Schell, & Kidder, 2003; Greasley, Chiu & Gartland, 2001; Josephson, Larson & Juthani, 2000; Mueller, Pleyak & Rummans, 2001; Tarko, 2002). Furthermore, mental health clients believe that spirituality plays an important role in their recovery process and have suggested incorporating the spiritual aspects of their lives with their mental health care (Corrigan et al., 2003; Greasley, Chiu & Gartland, 2001; Hill et al., 2000; Josephson, Larson & Juthani, 2000; Lindgren & Coursey, 1995; Longo & Peterson, 2002; Sheridan et al., 1992).

Despite client perspectives, studies concerning spirituality and mental health indicate that barriers exist for incorporating a client's spirituality with their mental health care (Baetz et al., 2004; Greasley, Chiu & Gartland, 2001; Hill et al., 2000; Josephson, Larson & Juthani, 2000; Longo & Peterson, 2002; Pullen, Tuck & Mix, 1996; Sheridan et al., 1992). Barriers to incorporating spirituality into mental health practices include:

1) lack of conceptual clarity on what is meant by spirituality by researchers and clinicians;

2) an emphasis on biomedical approaches to care and treatment for persons living with SMI;

3) psychiatric bias toward the association of spirituality with psychopathology;

4) ethical concerns that are related to incorporating spirituality with mental health care; and

5) lack of professional education in spirituality, religion and health. (Baetz et al., 2004; Corrigan et al., 2003; Grabovac & Ganesan, 2003; Greasley, Chiu & Gartland, 2001; Hill et al., 2000; Josephson, Larson & Juthani, 2000; Longo & Peterson, 2002; Sheridan et al., 1992).

Currently the concepts of religion and spirituality are increasingly distinct within western society (Hill et al., 2000). Studies on the perspectives of health care consumers, including individuals living with SMI, have shown that traditional views that simply define spirituality with religiousness are no longer held. Spirituality is defined more comprehensively to include a sense of connectedness to nature, humanity, connectedness to self or others, the transcendent or ultimate reality, and the need to find purpose and meaning. Spirituality may or may not include a religious practice or belief system (Chiu et al., 2004; Greasley, Chiu & Gartland, 2001; Post, 1998; Tanyi, 2002; Tarko, 2002; Zinnbauer, Pargament & Scott, 1999). Although spirituality is often contextualized within a religious tradition, this need not be the case (Post, 1998). In other words, a person can be spiritual and not espoused to a religious tradition or to the notion of a particular god (O'Connor, 2000). Thus, in order to incorporate spirituality, mental health professionals must be sensitive to client perspectives that may or may not define spirituality as part of their religious or cultural belief (Greasley, Chiu, & Gartland, 2001). In this study, I define spirituality broadly to include religiousness as well as other aspects of an individual's cultural belief.

The global trend toward de-institutionalization of individuals with serious mental illnesses has influenced Canadian mental health policy. The majority of treatment and

care of individuals with SMI now occurs in the community sector (Health Canada, 2002). It is recommended that community mental health services provide coordination of services and treatment to individuals living with SMI based on client centered approaches to care (Health Canada, 2002). Client centered approaches to care involve addressing important health indicators such as psychological and social health determinants that include an individual's spirituality. Despite recommendations, the existing community mental health services, mental health policies and programs have neglected to incorporate the client centered approaches that incorporates an individual's spirituality and instead emphasize biomedical approaches to care.

In biomedical approaches to mental health care, psychiatric epidemiology is largely oriented toward the identification of etiological factors, pathogenic mechanisms and risk factors for pathological states (Levin & Chatters, 1998). Today there is a growing recognition in mental health that clients represent themselves as integrated beings whose physical, emotional and spiritual welfare are interdependent (Grabovac & Ganesan, 2003; Koenig, 1998; O'Reilly, 2004) and that psychological and social aspects of spirituality may provide salutogenic or protective mechanisms that prevent morbidity and promote health (George et al., 2000; Levin & Chatters, 1998). Thus, an emphasis on biomedical approaches to care prevents mental health practitioners from incorporating important health determinants such as spirituality.

Another barrier to incorporating spirituality in mental health care is attributed to psychiatric bias that associates spirituality with psychopathology. This bias is influenced by the historically complex relationship between religion, spirituality and mental illness (Grabovac & Ganesan, 2003; Josephson, Larson & Juthani, 2000; Longo & Peterson, 2002; Thielman, 1998).

The association of spirituality with psychopathology was influenced by Freud and others who believed that spirituality directly contributed to mental illness (Josephson, Larson & Juthani, 2000; Larson & Koenig, 2001; Thielman, 1998; Tulbolt, 1996). Theilman (1998) observes that, as late as the 19th century, the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM III) continued to suggest that religious or spiritual themes were associated with psychopathology. The most recent amendments to the DSM IV, however, have re-categorized religious and spiritual problems as being distinct from those involving psychopathology and are now classified as a condition that requires clinical attention by mental health specialists (Koenig & Pritchett, 1998; Theilman, 1998). Although some psychiatric disorders overlap with spiritual themes and may be presented as religious delusions, these aspects of an individual's spirituality have been shown to have no correlation with psychosis (Gartner, Larson & Allen, 1991; Zinnbauer, Pargament & Scott, 1999). Currently, research in spirituality and health indicate that individuals' spiritual and or religious beliefs and practices are associated with positive mental health outcomes (Ellison & Levin, 1998; Freedland, 2004; Gartner, Larson & Allen, 1991; George et al., 1988; Larson & Koening, 2001; Larson, Sweyers & McCullough, 1988; Levin & Chatters, 1998; Pargament & Brant, 1998; Theilman, 1998).

Incorporating spirituality into mental health practice also concerns professional competency. Some key ethical questions that pertain to professional competency issues for mental health practitioners include: 1) should spirituality be addressed in the context of mental health practice? and 2) are mental health practitioners competent to address and incorporate client's spirituality?

Research suggests that individual beliefs have a powerful influence on their choice of treatment and mental health outcomes (Beatz et al., 2004; Chiu et al., 2002).

Thus it is important that practitioners acknowledge their client's spirituality and how it affects their mental illness. Individuals living with SMI acknowledge that spirituality plays a significant role in their lives and have expressed the need to incorporate spirituality with their care (Baetz et al., 2004; Corrigan et al., 2003; Greasley, Chiu & Gartland, 2001; Lindgren & Coursey, 1995). Studies examining client perspectives on spirituality have found that mental health client's felt devalued by practitioners who ignored their spirituality and were reluctant to disclose their spiritual beliefs for fear that their spirituality would be confused with symptoms of illness (Baetz et al., 2004; Greasley, Chiu, & Gartland, 2001; Lindgren & Coursey, 1995). It is therefore relevant for professionals to acknowledge the role that spirituality may have on the lives of clients living with SMI (Phillips, Lankin & Pargament, 2002).

Research that has examined the perspectives of mental health clinicians has indicated that practitioners do not feel competent to address or incorporate their client's spirituality for fear of negatively affecting client outcomes and an inability to examine their own spirituality (Baetz et al., 2004; Greasley, Chiu, & Gartland, 2001; Phillips, Lankin & Pargament, 2002). Contrary to professional fears, investigators that have explored the nature and impact of interventions that focus on spirituality have shown that clients highly value the ability to share their spiritual beliefs and have not experienced psychological disturbances by discussing their spirituality (Lindgren & Coursey, 1995; Phillips, Lankin & Pargament, 2002). In most cases clients have benefited from being able to explore an area that is often neglected in the mental health service setting and have often thought a great deal about their spiritual beliefs and how their beliefs affected them (Lindgren & Coursey, 1995; Phillips, Lankin & Pargament, 2002).

In order to incorporate spirituality in mental health practice, professionals must also be ethically concerned with their own attitudes, beliefs and values related to spirituality and how these personal factors impact client care. Some researchers have suggested that there is a potential for professionals to impose their own views in caring for their clients (Sheridan et al., 1992). Mental health professionals however, who avoid examining their own spiritual attitudes and beliefs run the risk of potentially being ineffective or harmful in addressing their client's spirituality and are therefore ethically obligated to acknowledge their own spirituality.

Professional competency also concerns the lack of professional education in spirituality and mental health. Many researchers acknowledge that educational preparation in matters related to spirituality are severely lacking in all disciplines involved with mental health care (Grabovac & Ganesan, 2003; Greasley, Chiu, & Gartland, 2001; Sheridan et al., 1992). A recent survey conducted by Grabovac and Ganesan (2003) on Spirituality and Religion in Canadian Psychiatric Residency Training programs found that of 14 programs only 4 had mandatory academic lectures concerning the interface of religion, spirituality and psychiatry. Although the four programs also provided case-based or clinical experience only a maximum of four hours total were devoted to didactic teaching. Findings from this survey also showed that only 43% of psychiatric residency programs offered case-based supervision to interested students. The authors conclude that most Canadian psychiatric training programs are inadequate when compared to the demands of clinical competency that are required to address spirituality with psychiatric patients.

Sheridan et al. (1992) found similar results when they interviewed professional counselors, clinical psychologists and social workers on the academic training they received in religious or spiritual domains. In Sheridan et al's sample, 328 participants

acknowledged that attention to spiritual and religious dimensions in caring for their clients was relevant but 79% (n=259) of participants responded to have had no training in their graduate programs. Similar findings were revealed in Greasley, Chiu and Gartland's (2001) study on Spiritual Care in Mental Health Nursing. In their study, community mental health nurses did not feel competent to incorporate spirituality in their care of client's with SMI due to a lack of educational preparation within nursing programs. Nurses indicated that the quality of interpersonal care was directly affected by their limited education and training about how to incorporate spirituality with their practice. Nurses in Greasley et al's study also suggested that education on spiritual and religious domains need to be multidisciplinary in order to be congruent with current mental health practices that include multidisciplinary frameworks. They suggest incorporating practice models that address spirituality including both religious and non-religious aspects of client beliefs.

Significance

Mental disorders comprise approximately 12% of the global burden of disease and represent 5 of the 10 leading causes of disability (Goldner, Snider & Mozel, 2003). In Canada, approximately one in five Canadians will suffer from mental illness in their lifetime, amounting to roughly six million people (Dubois, 2003). The World Health Organization (WHO) projects that prevalence of mental illness will increase to be 15% of the global burden of disease by the year 2020 (WHO, 2001). The most severe of these illnesses represents a huge cost in terms of human misery, disability, economic loss and psychosocial distress to individuals, families and societies (WHO, 2001).

Mental illness carries with it the burden of substantial mortality and significant morbidity (Canadian Alliance on Mental Illness and Mental Health [CAMIMH], 2003). At least 50% of individuals who are living with SMI self-medicate to the point of abusing

illegal drugs or alcohol, as compared to only 15% of the general population of Canada or the US (BC Partners for Mental Health and Addictions Information, 2003). Suicide is also a known risk factor for those living with SMI. Approximately 4,000 people a year die in Canada prematurely as a result of the severity of their illness (CAMIMH 2003; Health Canada, 2002).

A growing body of research now exists on the relationship between spirituality and positive mental health outcomes (Baetz et al., 2002; Ellison & Levin., 1991; Gartner, Larson & Allen, 1991; George et al., 1988; Larson & Koenig., 2001; Larson, Swyers & McCullough, 1998; McCullough et al., 2000; Mueller, Pleyak & Rummans, 2001; Pargament & Brant, 1998). Studies indicate that certain aspects of spirituality such as religiousness i.e., religious attendance to specific behavioral beliefs and practices, may result in improved overall health and well-being, greater longevity, decreased psychotic symptoms, decreased length of hospital stay, and a decreased incidence and prevalence of suicide and substance abuse for individuals living with SMI (Ellison & Levin, 1998; Freedland, 2004; Gartner, Larson & Allen, 1991; George et al., 2000; Josephson, Larson & Juthani, 2000; Koening & Larson, 2001; McCollough et al., 2000; Mueller, Pleyak & Rummans, 1991).

Theoretical explanations for the association between spirituality and positive mental health outcomes have been attributed to the salutary mechanisms of spirituality (Ellison & Levin, 1998; George et al., 2000). These salutary mechanisms are significant for individuals living with SMI as many continue to experience social isolation and stigma, are challenged by the severity of symptoms that may impede their ability to cope, and often suffer with co-occurring disorders such as drug and alcohol abuse.

Thus, individuals who prescribe to spiritual beliefs and practices tend to adopt healthier lifestyles, enhance their coping abilities in dealing with stress of illness, and

broaden their social resources (Beatz et al., 2002; Booth & Martin, 1998; Chiu et al., 2002; Ellison & Levin, 1998; Freedland, 2004; George et al., 2000; Idler & George, 1998; Josephson, Larson & Juthani, 2000; Larson & Koenig, 2001; Levin & Chatters, 1998; Lindgren & Coursey, 1995; McCullough et al., 2000; Mueller, Pleyak & Rummans, 2001; Tepper, Rogers, Coleman, Malony Newton, 2001). Furthermore, spirituality may improve mental health outcomes by assisting individuals to find purpose in their lives, help clients manage challenging symptoms caused by mental illness, and assist individuals to cope with societal stereotypes (Longo & Peterson, 2002). If spirituality has the potential for improving health outcomes for individuals suffering from SMI, then it is clinically relevant that community mental health professionals (CMHP) incorporate this aspect of their client's lives with their mental health care.

Research Problem

Spirituality is significant to the lives of many individuals with SMI. There is now convincing evidence to suggest that spirituality may be associated with positive mental health outcomes and that clients with SMI may benefit from the salutary effects that spirituality may provide. Studies based on client perspectives have shown that spiritual practices are often used as alternative resources for managing illness symptoms and that clients want these aspects of their lives included in their mental health care (Beatz et al., 2004; Chiu et al., 2002; Josephson, Larson & Juthani, 2000; Peterson & Longo, 2002; Tarko, 2002).

Reviews of studies based on care provider perspectives have indicated that several barriers exist for incorporating a client's spirituality with their mental health care. Although most of the care and treatment for individuals living with SMI occurs through community based services, there is currently a paucity of research that pertains to multidisciplinary perspectives of CMHP on incorporating spirituality with mental

health care. Therefore, examinations of multidisciplinary perspectives about spirituality in providing care for individuals with SMI are necessary.

Purpose

Thus, the purpose of this study was to explore the perspectives of community mental health professionals about incorporating spirituality in their care of individuals with SMI.

Objectives

Three objectives for this study included:

1. To analyze how CMHP conceptualize and understand spirituality in their professional practice with SMI clients.
2. To identify challenges that may exist in incorporating spirituality within community mental health practices.
3. To describe how multidisciplinary teams incorporate spirituality.

Research Question

To meet the objectives, I asked the following research questions.

1. What are community mental health professional's perspectives on spirituality in relation to their professional work with clients?
2. How do community mental health professionals incorporate spirituality in their care of clients living with SMI?

Assumptions

Based on my clinical observations as a community mental health professional, the following are my assumptions for the study.

Mental health practices continue to operate under biomedical frameworks that do not facilitate psychosocial aspects of clients' lives; including their spiritual beliefs and practices.

Barriers exist that impede the ability for mental health professionals to integrate alternative health resources that include spirituality for individuals living with SMI.

DEFINITION OF TERMS

Community Mental Health Professionals (CMHP)

CMHP include professionals from various disciplines who provide care and services for clients with serious mental illnesses (SMI). CMHP operate within team based work environments that are multidisciplinary in nature and typically include professionals from various disciplines such as: social work, medicine and psychiatry, occupational therapy, nursing, counseling psychology, or drug and alcohol counselors. CMHP provide treatment, assessment and coordination of services for individuals living with SMI. The CMHP role may include case management and consultation services for individuals with SMI.

Serious Mental Illness (SMI)

SMI is determined by diagnosis, disability, and duration, and usually includes major affective disorders, schizophrenic disorders, severe anxiety disorders and personality disorders. These disorders often cause major distress and significant functional impairment for individuals (Health Canada, 2002; Schinnar, Rothbard, Kanter, & Yoon, 1990).

Spirituality

For the purpose of this study, I have defined spirituality as a multidimensional concept, subject to a variety of interpretations and including several core attributes. Such attributes include an individual's sense of connectedness and relationship with self, other, or nature, and higher power or God; an individual's ability to transcend personal boundaries; individual's search for purpose and meaning; a sacred dimension; and may include an individual's religion (Chiu et al., 2004; Hill et al., 2000; Reed, 1991; Tanyi, 2002).

CHAPTER 2:

LITERATURE REVIEW

This review of the literature includes studies that examine the concept of spirituality as it is conceptualized in health care literature. Social and historical factors that have led to our current understanding of spirituality and its relationship with mental health are also discussed. The second section of this review includes barriers that have been identified to incorporating spirituality in mental health practices and a description of the salutary mechanisms of spirituality associated with positive mental health outcomes.

Conceptualization of Spirituality

Spirituality is derived from the Latin root *spiritus*, meaning breath or life force, designating simply a person of the spirit (Hill et al., 2000). Wilt and Smucker (2001) describe the roots of the word *spirit* to mean breath, or breathe of God and inspiration. Nevertheless, the concept of spirituality means different things to different people and thus has led to confusion among researchers and health care professionals (Greasley, Chiu, & Gartland, 2001). Currently, no single definition encapsulates all aspects of spirituality within the health and allied health literature, though a growing consensus exists among researchers that spirituality is a broader concept than religion and that religion is only one of a variety of ways of understanding spirituality (Chiu et al., 2004; Miller & Thoresen, 2003; Nolan & Crawford, 1997; Wilt & Smucker, 2001). Some authors have described the concept of spirituality as an elusive and non-tangible construct that is multidimensional and subjective (Tanyi, 2002; Tarko, 2000; Wilt & Smucker, 2001). The multidimensional qualities associated with spirituality have been identified in a number of reviews.

Tanyi (2002) investigated the meaning of spirituality and how it has been defined within the health care literature over the past 30 years. The author reviewed 76 articles and 19 books that discussed the concept of spirituality. The findings indicated several defining attributes associated with spirituality, including: 1) belief and faith in a higher power or a personal god; 2) sense of connectedness either to others or to oneself, and which could be expressed through activities such as prayer or presence; 3) supreme purpose or meaning; and 4) inner strength and peace that comes from an individual's belief or faith. Based on the analysis, Tanyi proposed the following definition of spirituality that entails a

> Personal search for meaning and purpose in life, which may, or may not, be related to religion, and pertains to connection with self-chosen and/or religious beliefs, values, and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being – this connection brings hope, peace and empowerment. (p. 506)

Tanyi (2002) added that the results of spiritual connections made are forgiveness, joy, and a heightened sense of physical and emotional well-being that enable one to transcend beyond hardships.

A recent integrative review of the concept of Spirituality in the Health Sciences, by Chiu and colleges (2004), explored how the concept of spirituality has been reported in the health literature in the last decade. The body of research was based on a sample of 73 research articles related to spirituality and included both quantitative and qualitative reviews. Their findings revealed several themes associated with the concept of spirituality, such as: "Spirituality as a life force; meaning making; making most of life now; a sense of connectedness with self, others, nature and higher being; transcendence/transacting self-preservation and religious practice" (p. 9). A thematic analysis was done in order to develop a conceptual definition of spirituality. Four central

themes include: 1) existential, 2) transcendence, 3) connectedness, and 4) power, force and energy.

Miller and Thoresen (2003) in their review of spirituality, religion, and health discuss the concept of spirituality as a broader concept that is distinguishable from the concepts of religion and religiousness. Broadly defined, Miller and Thoresen define spirituality as a latent construct that is not observed directly but can be inferred from observations. Latent constructs are complex and usually multidimensional, with no single measure of dimension being likely to capture their essential meaning. Although spirituality can be used to describe characteristics of an individual, the attributes of spirituality may or may not be present in an individual (p. 28). The authors maintain that spirituality is concerned with two principal themes, human experience and the immaterial aspects of life.

Miller and Thoresen (2003) describe the immaterial features of life as, that which is not perceptible by the physical senses, and are related to aspects of life that are experiential such as the transcendent, sacred, holy, or divine. Other aspects of spirituality may be directly observable such as spiritual practices including prayer and spiritually motivated behavior such as caring for others. The behaviors, beliefs and practices of spirituality in some cases overlap with the concept of religiousness but are distinguished by subjective experiences held by an individual.

The following studies pertain to the specific attributes associated with spirituality from the care provider and patient perspectives.

Spirituality as Connection

A recent study by Tarko (2002) specifically addressed how 20 individuals living with schizophrenia defined spirituality. In the study, Tarko used grounded theory methodology and developed substantive theory of "spirituality as connection," where

one strives to be connected to one's spiritual self (mind-body-spirit), and significant others (family/friends, God/higher power, or health professional). This process also included a connection to one's faith community and nature. Viewing spirituality as connection enhances psychosocial supports and will be further discussed in the section on salutary mechanisms of social support. Strategies used by mental health clients to maintain their spiritual connection involved prayer and meditation, attendance at drop-in centers, and engaging in activities that added meaning to their life experience.

Another study by Faver (2004) explored the concept of spirituality with social care-giving. The author's conceptualization of spirituality was based on Ochs's (1986, 1997, as cited in Faver, 2004) model of relational spirituality, where the elements of spirituality were relatedness to others, connectedness, and spiritual development. Spiritual development was defined by the insight of interconnectedness and the process of coming into relationship defined spiritual development with reality. Faver further defined spirituality as a reality that involves recognizing other people's perspectives that complement, challenge, and expand our own. In Faver's study, a grounded theory methodology was used to uncover the perspectives of spirituality from 50 female social workers and social reformers. From the interviews of participants, four major categories were found that defined the social care providers' perspectives of spirituality. These included: 1) connection to the sacred source that included connection with a source of love and strength beyond themselves, 2) connection with their work, 3) relationship with supportive communities, and 4) relationship with their clients. The participants mentioned that they were sustained by spiritual practices such as prayer, meditation, and church attendance.

Spirituality as Purpose and Meaning

Finding meaning and purpose in life is a central concept associated with spirituality and has been significant for individuals who experience suffering during illness. In Lindgren and Coursey's (1995) two-part study on spirituality and SMI, the researchers sought to investigate how spirituality affected the thoughts, illness, and lives of people with SMI, and to understand if spirituality could have a therapeutic benefit in terms of self-esteem, depression, hopelessness, purpose in life, and spiritual support (Lingren & Coursey, 1995). The study used individual interviews that focused on how participants felt their spiritual beliefs affected their lives and their illness. The second part of the study involved the intervention of a spiritual support group. The results showed that purpose in life was the most important theme identified throughout the study for both the participants in the spiritual support group and the interviewees. Sense of meaning and support was measured by using Crumbaugh's Purpose in Life Test (1968).

Narayanasamy (2004) conducted a qualitative study on the spiritual coping mechanisms in chronic illness. Fifteen patients, who were living with chronic illnesses including leukemia, chronic liver disease, and melanoma, were interviewed about their spiritual coping mechanisms. Following the interviews, a phenomenological method of analysis revealed themes describing spiritual coping as providing meaning and purpose, connectedness with others, and God. Findings from this study suggested connectedness with God and others, and the search for meaning and purpose were important spiritual coping mechanisms during chronic illness. The study highlights that chronic illness evokes a need for spiritual pursuits in terms of the search for meaning and purpose for individuals with a faith connection, as well as those individuals who declared no spiritual or religious connection. One of the central tenants of this study was that

chronic illness can evoke spiritual ways of coping, described as the search for meaning and purpose by those living with chronic illness. SMI is similar to chronic illness in that both illnesses have episodes of acuity and chronicity that involve a degree of suffering and distress. It follows then that individuals with SMI could also benefit from spirituality by learning new ways of spiritual coping that ultimately gives their lives meaning and purpose.

Spirituality as Transcendence

The transcendent is a common theme associated with spirituality and is concerned with something beyond and within ourselves, enabling us to find meaning in life, particularly during times of suffering and illness (Emblen & Pesut, 2001; Reed, 1991; Wilt & Smucker, 2001). Reed (1991) studied spirituality and mental health in older adults and showed that transcendence was important in emotional well-being, and described transcendence as a process that expanded self-boundaries. Reed's definition of transcendence includes a human ability to find meaning in life through self-transcendence. This is expressed through behaviors related to a transcendent dimension and may or may not be achieved through formal religious participation.

In Mulkins, Morse and Best's (2002) study on complementary therapy use in HIV/AIDS, grounded theory methods were used to explore how participants were able to transcend their illness experience. Transcendence of illness experience for the participants was described as "transcendental revaluing of one's spiritual and psychological states in which one comes to disregard, not only one's bodily ailments, but one's body per se" (p. 309). Transcendence for the participants was going inside themselves to find purpose and meaning. Participants in this study used meditation, praying, journaling, accepting, and forgiving as spiritual resources that enabled transcendence. The finding of this study suggests that the model, finding a way to live

(as transcending illness), may be applicable to other individuals who experience suffering through illness, such as with persons with SMI.

Chiu's (2000) study described and defined transcendence through the cultural perspectives of Taiwanese women living with breast cancer. In the study, transcendence was an evolving process, described by four essential themes. The essential themes that evolved from the participant experiences included: 1) giving meaning to suffering, whereby suffering was a path to experiencing transcendence; 2) liberation of the personal and merging with the universal; 3) opening to life and death, which involved acceptance; and 4) healing with compassion as returning to a sense of wholeness and harmony.

Spirituality and Religion

Conceptualizations of religion and spirituality are, and continue to be, subject to diverse interpretations influenced by cultural and historical events (Chiu et al., 2004; Hill et al., 2000; Zinnbauer, Pargament & Scott, 1999). The current cultural worldview identified within the health care literature describes religion and spirituality as becoming increasingly distinct (Corrigan et al., 2003; Emblen, 1992; George et al., 2000; Hill et al., 2000; Larson, Sweyers & McCullough, 1998; Longo & Peterson, 2002; Miller & Thoresen, 2003; Zinnbauer, Pargament & Scott, 1999). Today, these terms are no longer assumed to mean the same thing.

Traditionally, the term spirituality was synonymous with religion (George et al., 2000). Some authors have concluded that the rise of secularism and disillusionment with religious institutions throughout the 1960's and 1970's contributed to more polarized definitions of religion and spirituality within Western cultures (Hill et al., 2000; Larson, Sweyers, & McCollough, 1998; Oman & Thoresen, 2002; Zinnbauer, Pargament & Scott, 1999). This cultural differentiation resulted in the present trend that

views spirituality as having to do with personal experience, while religion is perceived as having more to do with demands of tradition, and thus might be perceived as a hindrance to spiritual experiences (Zinnbauer, Pargament & Scott, 1999). Hill et al. (2000) suggest, "religion may stipulate behavior patterns and adherence to practice certain forms of religious expression, characteristics that many forms of spirituality do not support or even resist" (p. 58).

Miller and Thoresen (2003) differentiate the concept of religion from spirituality and define religion as primarily associated with societal institutions that are primarily concerned with material aspects of phenomena. Religion(s) as defined by Miller and Thoresen are "differentiated by particular beliefs and practices, requirements of membership, and modes of social organization" (p. 28). What is spiritual or transcendent may be a central interest and focus, but religions are also characterized by other non-spiritual concerns that are related to one's cultural, economic, political, and social goals (Miller & Thoresen, 2003).

Religion and spirituality are derived from different root origins, but traditionally, were intertwined in their cultural meanings (Hill et al., 2000; O'Connor, 2001; Zinnbauer, Pargament & Scott, 1999). Religion is derived from the Latin root *religare* or *religio,* meaning to tie together or organize core beliefs and behaviors (O'Connor, 2001). Hill et al. (2000) interpreted religion as "signifying a bond between humanity and some greater than human power," and suggested that the concept of religion has become increasingly refined in modern society, moving from "an abstract process to a more fixed objective entity expressed through a definable system" (p. 57). Modern perspectives view religion as associated with religiousness, which includes an affiliation with a formal religious institution or denomination and attendance to church or temple and other places of worship (Hill et al., 2000; Josephson, Larson & Juthani, 2000). *Religiousness*

is related to religion, whereas spirituality, at the level of the individual, may or may not be related to religion (Miller & Thoresen, 2003).

Emerging conceptualizations of spirituality and religion may be described differently within modern points of view, though they are not fully independent. Central to the experience of both religion and spirituality is the attribute of the sacred (George et al., 2000; Hill et al., 2000; Zinnbauer, Pargament & Scott, 1999). Other elements of conceptual overlap include the fact that religiousness and spirituality can often co-occur (Hill et al., 2000). Beliefs and experience that are an aspect of traditional religiousness, i.e., attendance to institutions of faith, prayer, meditation, and reading from scriptures, are also spiritual if they are done by an individual in search for the sacred (Hill et al., 2000). Conversely, spirituality can, but not always, occur in the context of religion. The practice of spirituality can lead people to become religious, though a person can be spiritual without espousing any particular religion. Also, a person can be spiritual, but not necessarily an atheist (Hill et al., 2000; O'Connor, 2001).

The conceptualization of religion and spirituality are becoming more distinguished, as evidenced by the research on spirituality and health (Hill et al., 2000). Moreover, this trend may be influenced by historical and cultural events that continue to shape our perspectives on spirituality.

The current view within the health literature acknowledges the concepts of spirituality and religion as becoming more distinct; however, Larson, Sweyers and McCollough (1998) suggest that defining spirituality too narrowly may exclude religion and other cultural factors that may be part of an individual's spirituality. On the other hand, the authors suggest that defining spirituality too broadly may lose its utility. Miller and Thoresen (2003) add that although the meaning of these words continue to evolve

with the concepts of religion becoming narrower over time and spirituality becoming broader, that the degree of distinction of these concepts also varies across cultures.

To address the various perspectives that exist, I define spirituality broadly, and refer to its areas of similarity and difference from religion and cultural factors.

Relationship between Spirituality and Mental Health

Historical Context

Historically, the relationship between spirituality and mental illness is complex. From the point of view of spirituality, the concept was confounded and conflated with mental illness. The idea that supernatural forces caused disease of the mind was prevalent throughout the middle ages, a period given to belief in demonic possessions and the practices of exorcism (Larson & Koenig, 2001). Not until the scientific revolution in the 18th century did science discount the role of demons and supernatural causes in mental disturbances and begin to focus exclusively on more biological explanations for mental illness (Josephson, Larson & Juthani, 2000; Larson & Koenig, 2001; Thielman, 1998). During this time, some individuals living with mental illnesses were in the care of religious orders, though most were treated inhumanely (Koenig & Larson, 2001).

Despite scientific advances, early psychoanalysts including Freud continued to perceive religion as pathological and detrimental to mental health (Josephson, Larson & Juthani, 2000; Larson & Koening, 2001; Theilman, 1998). Contrary to some psychoanalytic perspectives, studies conducted in the past half-century consistently reported that religion and spirituality were associated with desirable mental health outcomes, thereby, challenging some of the earlier beliefs held by the psychiatric community (Ellison & Levin 1998; Larson & Koenig, 2001). A 1991 meta-analytic review by Gartner, Larson and Allen (1991) surveyed 200 studies completed between (1987-

1989). All of these studies were concerning the religious aspects of spirituality and psychopathology. Gartner, Larson, and Allen determined that no research supported the general presumption of a correlation between religion and psychosis.

Thielman (1998), however, explains, "medical explanations for madness have often coexisted with religious interpretations of madness in the world's great religions" (p. 4). Perspectives may be culturally based and may therefore have implications for treatment approaches (Nash & Stewart, 2002).

Greater cultural sensitivity toward religious and spiritual beliefs has been incorporated in the newest revision of the Diagnostic and Statistics Manual of Mental Disorders (DSM 4), which recognizes "religious or spiritual problems" as being distinct from those of psychopathology. Despite recent changes made in the DSM, some authors suggest that spiritual factors are often ignored in mental health practice (Grabovac & Ganesan, 2003; Josephson, Larson & Juthani, 2000; Larson & Koenig, 2001; Longo & Peterson, 2001; Post, 1998).

Spirituality and Psychopathology

Empirical research contradicts the depiction of spirituality as causing or associated with psychopathology (Zinnbauer, Pargament & Scott, 1999). Gartner, Larson and Allen (1991) conducted a meta analysis of 200 studies that were done during 1987-1989 on aspects of spirituality including religious commitment and mental health status. Findings from the authors' review of the studies showed that although causality could not be determined, the majority of studies indicated a positive association between improved mental health outcomes with religiousness. Improved mental health outcomes that were identified include, lower rates of hospitalization in schizophrenics who attended church, a decrease in psychiatric symptoms, improved psychosocial functioning and lower rates of depression.

Similar results where found in a Canadian study conducted by Baetz et al. (2002). The aims of this study were to determine whether or not religious commitment had an impact on outcome variables such as life satisfaction, severity of symptoms and to determine the level of religious interest amongst psychiatric inpatients of a tertiary care unit. In Baetz et al.'s sample of 88 patients, measures of mental health and life satisfaction were measured by using the Beck Depression Inventory (BDI) scale and Satisfaction with Life Scale (SWLS), religious beliefs and practices were also measured by using a 5 item Duke Religion Index and 3 questions from a Gallup Poll of Religious Beliefs.

Pearson correlations were used to determine the bivariate relationship between the measures of religious commitment and the 3 outcome variables. Baetz et al. (2002) confirmed high level of religious commitment amongst psychiatric inpatients with 59% believing in God who rewards and punishes, 27% who participated in worship attendance, and 35% of inpatients reported to pray once or more daily. Results from their study showed worship attendance having the most significant impact on mental health and illness than any other dimension of religious commitment. Inpatients that participated in worship attendance reported significantly lower scores on BDI and had fewer depressive symptoms, had shorter hospital stays and lower rates of alcohol abuse. Results of the study also showed that intrinsic religiousness i.e. silent prayer or private behaviors associated with one's spirituality and worship attendance can significantly impact rates of depression and alcohol use thereby increasing life satisfaction. Religious coping was the only factor to have a significant impact on length of psychiatric stay. From their study Baetz et al. provide support for incorporating aspects of spirituality such as religious commitment in caring for individuals with SMI because spirituality

may provide a significant coping resource and assists mental health professionals to address the person as a whole.

Barriers to Incorporating Spirituality

Issues Related to Professional Competency

Lack of conceptual clarity on what is meant by spirituality

The terms religion and spirituality are often used interchangeably in clinical practice settings and are poorly defined and understood by many health care professionals (Greasley, Chiu, & Gartland, 2001; Josephson, Larson & Juthani, 2000). This lack of conceptual clarity has made it difficult for many mental health professionals to incorporate spirituality into their practices. If mental health professionals do not understand what spirituality means for their clients, then they may find it difficult to incorporate this significant aspect of their clients' lives with their care. A review of the following studies shows that some disparity exists amongst practitioners and clients' views on how spirituality is conceptualized. This disparity is attributed to differing conceptual meanings attributed to spirituality as well as differences between the importance that spirituality has in the lives of care providers versus clients.

In Greasley, Chiu, and Gartland's (2001) study on The Concept of Spiritual Care in Mental Health Nursing, focus groups where used to explore the concept of spirituality amongst mental health clients and practitioners. Findings from this study showed that community mental health nurses and clients defined spirituality by the notion of God, religion and metaphysical beliefs. However, clients made distinctions between their spiritual needs versus their religious care needs. Clients suggested that their spiritual concerns may not be acknowledged if their care provider conceptualized religion and spirituality as synonymous. Therefore, those clients who do not identify themselves as

being religious may not have their spirituality addressed or incorporated with their care (Greasley, Chiu, & Gartland, 2001).

Similar client views were found in Lindgren and Coursey's (1995) two-part study on spirituality and mental illness. In their study, 30 mental health clients chose to use a narrower definition of religion, i.e., beliefs and practices associated with church attendance, while the researchers conceptualized spirituality as non-church set of beliefs and practices. Spirituality was the preferred term used by researchers because it was conceptualized broadly to include religion and religiousness. In this study there were no reasons given as to why clients chose to use the term religion, however, results from client interviews showed that over half of the clients attended church regularly and therefore may associate spirituality with church attendance.

Baetz et al.'s (2004) study compared psychiatrists' and psychiatric patients' practices, attitudes, and expectations regarding spirituality and religion. In this study 157 participants included individuals living with SMI. Of this sample, 71% of the clients reported spiritual and religious beliefs and practices as compared to only 54% of the psychiatrists. From the clients' perspectives, 53% felt it was important to have their beliefs addressed in treatment settings and 47% felt it was important to know the religious and spiritual orientation of their psychiatrists.

On the whole, the clients reported higher levels of religious and spiritual orientation than did the psychiatrists, and clients believed that their beliefs enabled them to cope and find meaning when faced with their illness. In this study, only 54% of the psychiatrists (n = 1,204) reported having a spiritual and/or religious orientation. The author's report that the use of quantitative approaches in their study limited psychiatrists from fully expressing their beliefs, attitudes, and values.

Focus on biological aspects of illness

Researchers have suggested that the psychiatric community has not been able to fully embrace the spiritual aspects of individuals because psychiatric care is predominantly based on the biological aspects of illness (Grabovac & Ganesan, 2003; Levin & Chatters, 1998). Emphasis on biological aspects is based on traditional psychiatric understanding of illnesses where by disease-oriented approaches are used to identify etiological factors, pathogenic mechanisms and risk factors associated with pathological states (Levin & Chatters, 1998). Levin and Chatters (1998) refer to this approach as pathogenesis. This type of approach fails to incorporate psychosocial aspects of individuals that are salutogenic, meaning those factors that may promote adaptation and coping instead of just diagnosable etiologic factors. Spirituality would therefore be included under those factors that are salutogenic and could potentially promote health.

Historically, however the care and treatment of persons living with SMI was bestowed to many religious orders primarily because mental illness was believed to be caused by supernatural forces (Josephson, Larson & Juthani, 2000; Larson & Koenig, 2001; Thielman, 1998). It was not until the Middle Ages that scientists suggested that biological mechanisms were responsible for mental illness and that religion was not capable of serving the mental health needs of individuals (Larson & Koenig, 2001). Conversely, early mental health reforms believed that a purely medical approach to mental illness would ultimately fail to produce cures, since insanity was a disruption of the mind and the spirit (Larson & Koenig, 1998). Today, mental health care calls for an integration of biomedical approaches with psychosocial aspects of the individual and involves the collaboration of multidisciplinary professionals to care for individuals that are living with SMI.

The World Health Organization (WHO) 2001 recommends that in order to decrease the growing burden of mental illnesses treatment, approaches must address both biological and psychosocial health determinants. Psychological and social health determinants include spirituality, which has an important role for improving mental health outcomes, and may provide alternative explanations for helping practitioners understand their clients. A biopsychosocial approach to mental health care would encompass all of these aspects.

Professional ethics

Individuals with SMI are faced with many barriers when it comes to being able to navigate their own health care and thus greatly rely on their relationship with their care provider. Trust is central to building a therapeutic relationship whereby clients' attitudes, beliefs and values are acknowledged. Post (1998) suggests that mental health professionals cannot fully succeed in establishing therapeutic empathy and efficacy without respecting and allowing a place for spirituality. Ethical considerations pertain to the professionals' ability to examine their own views and reactions to client's beliefs and value systems and a concern for the effect that spirituality has on the clients' lives (Post, 1998). Moreover, professionals who fail to examine their own spirituality run the risk of potentially being ineffective or harmful in addressing their client's spirituality (Sheridan et al., 1992).

Studies that have examined client perspectives on spirituality have found that client's felt devalued by professionals who ignored their spirituality and in some cases terminated their relationship with their care provider (Greasley, Chiu & Gartland, 2001). Clients also felt reluctant to disclose their beliefs for fear that their spirituality would be confused with symptoms of illness (Baetz et al., 2004; Greasley, Chiu & Gartland, 2001; Lindgren & Coursey, 1995). Lindgren and Coursey (1995) recommend that clinicians

need to understand clients' religious and spiritual views, even if their beliefs have a delusional component. This not only helps clinicians understand clients' beliefs, but also helps inform treatment approaches. Furthermore, some author's have suggested that professional avoidance to addressing and incorporating spirituality in clinical practice settings may be related to fears of negatively affecting patient outcomes (Baetz et al., 2004; Lindgren & Coursey, 1995).

Contrary to this view, investigators that have explored the nature and impact of interventions that focus on spirituality have shown that clients' value the ability to share their spiritual beliefs and have not experienced psychological disturbances by discussing their spirituality (Lindgren & Coursey, 1995; Phillips, Lankin & Pargament, 2002). In most cases clients have benefited from being able to explore an area that is often neglected in their mental health care and have usually thought a great deal about their spiritual beliefs (Lindgren & Coursey, 1995; Phillips, Lankin & Pargament, 2002). Wright (1998) applies principles of beneficence, nonmalifecence, autonomy and advocacy to all disciplines concerned with incorporating spirituality in their care. However, ethical practice goes hand in hand with a need for increased education in spirituality and mental health.

Education

The lack of academic training and education has also been a barrier to incorporating spirituality with mental health practice (Baetz et al., 2004; Gravbovac & Ganesan, 2003; Greasley, Chiu & Gartland, 2001; Sheridan et al., 1992). Prior to 1996, only a single report had been developed for providing mental health practitioners with guidelines for addressing and incorporating religious and spiritual beliefs with psychiatric practices (Bowman, 1998). These guidelines where developed by Larson, Lu and Swyers (as cited in Grabovac & Ganesan, 2003) and are referred to as the model

curriculum that has since been a template for most psychiatric residency programs. The American Psychiatric Association (APA) has also developed practice guidelines to assist practitioners to recognize their clients' spiritual backgrounds as part of the initial assessment. The APA guidelines stipulate that "important cultural and religious influences on the patient's life be collected as part of the initial evaluation of the psychiatric patient" (Koenig & Pritchett, 1998, p. 323). Despite these initiatives little is known about how CMHP utilize these guidelines in their practice. However, research on professional education in spirituality and mental health, continues to be lacking for many professionals that are involved in the care of individuals living with SMI.

A recent survey conducted by Grabovac and Ganesan (2003) on Spirituality and Religion in Canadian Psychiatric Residency Training programs found that of 14 programs only 4 had mandatory academic lectures concerning the interface of religion, spirituality and psychiatry. Although the 4 programs also provided case-based or clinical experience, only a maximum of 4 hours were devoted to didactic teaching. Only 43% of psychiatric residency programs offered case-based training to interested students. This recent survey clearly shows that although some attention has been given to the role of spirituality in mental health, the limited amount of training may present future practitioners with challenges when one considers the significance that spirituality has in the lives of people with SMI.

Sheridan et al. (1992) found similar results in their study that explored the professional attitudes and behaviors of social workers, psychologists and professional counselors toward religion and spirituality. Based on the sample (n = 259) 79% responded to have had no training in their graduate programs. Taken together all disciplines viewed spirituality and religion as meaningful aspects of their clients' lives as well as their own. The authors recommended that in order to incorporate spirituality in

their care, education should focus on how spirituality and religion can be applied in practice care settings, education on the diversity of meanings related to spirituality and religion, and education on the significance that spirituality and religion have on mental health (Sheridan et al., 1992).

Greasley, Chiu and Gartland's (2001) study on the concept of spiritual care in mental health nursing utilized focus groups (FG) to address: how practitioners and clients defined spirituality; their perspectives about the relationship between spirituality and health; and their views about the provision of spirituality in care. Perspectives of mental health nurses revealed that spirituality had not been formally integrated within nursing programs. Nurses brought forth their concerns related to professional competency stating that the quality of interpersonal care was directly affected by their limited amount of education and training about how to incorporate spirituality within community mental health care. Nurses recommended that incorporating spirituality with their care should go beyond the level of assessment in order to provide quality care.

Nurses who participated in the focus groups also suggested that education must be multidisciplinary in order to address the holistic needs of the client and that a spiritual model in mental health services needs to respond to a wide spectrum of spiritual needs that includes both religious and non-religious aspects of client beliefs. A caveat from one of the respondents specifically addresses this recommendation:

> For me it's about a multidisciplinary approach that takes into consideration the holistic needs of the patients despite having a very strong multidisciplinary team we still gear up our care towards the medical model and not a more holistic approach to care for each individual. (Greasley, Chiu, & Gartland, 2001, p. 635)

The above studies have addressed the need for education on spirituality and mental health based on the perspectives of mental health practitioners. Educational preparation

for mental health professionals should also include current theory development on the salutary effects of spirituality.

Salutary Effects of Spirituality

Current theory development on the salutary effects of spirituality pertains to specific religious and non-religious beliefs and practices that have been associated with positive mental health outcomes (George et al., 2000; Levin & Chatters, 1998; Mueller, Pleyak & Rummans, 2001; Oman & Thoresen, 2002). I will briefly discuss some of the main salutary effects of spirituality that pertain to three main mechanisms and include health behaviors, coping and support.

Spirituality and Health Behaviors

Health-promoting behaviors are encouraged by factors such as religious commitment and spiritual beliefs. George et al. (2000) state that "many religions encourage health promotion as a result of viewing the body as having spiritual as well as material significance" (p. 106). Based on this view, spirituality that includes religiousness is hypothesized to enhance resistance to disease through various life style practices that, in turn, protect against health stressors such as psychiatric symptoms (Levin & Chatters, 1998; Mueller, Pleyak & Rummans, 2001; Oman & Thoresen, 2002). Specific health behaviors may include meditation, prayer, and worship, as these practices are believed to engender positive emotions such as hope, thus, enabling individuals to transcend stressful illness experiences (Corrigan et al., 2003, Levin & Chatters, 1998; Longo & Peterson, 2002). Positive emotions also enhance resistance to disease through physiological and behavioral mechanisms that help individuals cope with stressors associated with illness (Baetz et al., 2002; Levin & Chatters, 1998; Mueller, Pleyak & Rummans, 2001).

Studies on the relationship between health behaviors and spirituality add convincing evidence for the salutary effects of spirituality in terms of preventing risk behaviors and in promoting healthier life style choices. Health behaviors that are particularly significant for those with SMI include avoidance of drug and alcohol use and suicide (Gartner, Larson & Allen, 1991; Mueller, Pleyak & Rummans, 2001). Many studies have demonstrated that religion and spiritual practices are inversely associated with psychoactive substance use, abuse, and dependence (Gartner, Larson & Allen, 1991; Larson & Koenig, 2001; Levin & Chatters, 1998; Mueller, Pleyak & Rummans, 2001). Work by Durkheim (1897-1951) has showed that individuals who prescribe to their spiritual beliefs and practices have a strong sense of attachment to a collective conscience, and are therefore less prone to suicide (Idler & George, 1998). Dukheim's theory was based on the fact that many religious communities provide rules for the preservation of an individual's life (Idler & George, 1998).

In Gartner, Larson and Allen's (1991) review on the relationship between religious commitment and mental health outcomes, 11 of 12 studies found a negative relationship between religious commitment and drug and alcohol use. Church attendance was more strongly associated with abstinence than with any other variable. All 12 studies showed a negative relationship between religiosity and suicide. In a more recent systematic review by Larson and Koenig (2001), 76 of the 86 (88%) studies examining the religion-alcohol relationship found lower alcohol abuse among participants who identified themselves as being more religious or spiritual. In Larson and Keonig's review, 57 of the 68 (84%) studies found lower rates of suicide among those having religious or spiritual affiliation. McCullough et al.'s (2000) meta-analysis of 41 research reports, including 126,000 participants with SMI, found that a decreased mortality was positively associated with participants who were religiously involved.

Spirituality and Coping

Spirituality as a coping resource for persons with SMI is particularly significant because individuals with SMI often experience hopelessness due to their suffering and illness. Spiritual coping is associated with positive health and mental health outcomes because of the stress buffering effects, which may be provided (Pargament & Brant, 1998). Lazarus and Folkman (as cited in Longo & Peterson, 2002) define coping as "a process for actively managing stressful events and accompanying emotional distress" (p. 337). Spirituality as a coping resource can be a powerful factor in preventing disease and hastening recovery from illness (Ellison & Levin, 1998). Coping theory is also explained by Pargament (as cited in Pargament & Brant, 1998), who suggests that "we cope in an effort to maximize what is of value or significance to us in difficult times, coping involves an attempt to maintain or transform those things that we care for in times of stress" (p. 116).

Spirituality also helps individuals cope with illness because it may provide a framework for understanding one's disabilities and purpose in life (Corrigan et al., 2003; George et al., 2000). Few studies have addressed spirituality, coping and its relationship with individuals with SMI. The following studies that have examined the relationship between spirituality and coping, have defined spirituality narrowly to include only religiousness. Nevertheless, these studies are significant to spirituality and its salutary mechanisms because spirituality, defined broadly, may include behaviors such as religious attendance, prayer, and meditation.

Baetz et al. (2002) looked at Canadian psychiatric inpatient religious commitment and its association with mental health. In their study, religious commitment was defined as "participation or endorsement of practices, beliefs, attitudes or sentiments that are associated with an organized faith community" (p. 3). Sample

characteristics in this study included 88 psychiatric male patients with high co-morbidity related to substance abuse and multiple hospitalizations. In the sample, 33% of the males indicated that their faith helped them cope with their mental illness. Worship attendance had the most significant impact on measures of mental health and illness, compared to other dimensions of religious commitment. Results from the study also showed that religious commitment was positively associated with decreased depressive symptoms, life satisfaction, and length of hospital stay. Religious commitment was negatively associated with alcohol abuse. Religious coping was the only factor found to have a significant impact on psychiatric length of stay (Baetz et al., 2002). The authors defined religious coping by worship attendance and suggest that this type of coping may have decreased the length of hospital stay because worship attendance promoted healthier life styles, enhance social and coping resources, and may provide patients with a sense of coherence or meaning to life (Baetz et al., 2002).

Tepper and colleges (2001) conducted a quantitative study, examining the prevalence of religious coping among persons with persistent mental illness. The researchers concluded that religious beliefs and activities are coping mechanisms that persons with a mental illness find beneficial in managing the stressors associated with their illness. In Tepper et al.'s study, 406 participants, who were diagnosed with mental illness and were, residing in mental health facilities, completed surveys that consisted of the Religious Coping Index, as well as the Global Assessment of Functioning Scale (GAF). Religious coping was defined as: religious activities that included prayer, and religious attendance and consultation with a spiritual leader. In the study, prayer was found to be the most common type of religious coping, followed by religious attendance and worship. Results from this study showed that more than 80% of the participants used their religious beliefs or activities to cope with their stress of illness and

frustrations. Participants who reported that their religious beliefs and practices were the most important thing that kept them going described the salutary effects of religious coping. The sample of participants experienced fewer hospitalizations. Tepper et al. (2001) discuss specific strategies, such as reading the bible and prayer, to be more likely used by participants who experience more severe symptoms. Furthermore, a correlation analysis showed that the number of years devoted to religious coping, and the percentage of time spent on religious coping, was positively associated with a decrease in severity of symptoms and better overall functioning on the GAF scale. Thus, Tepper et al. advocate for mental health providers to include and integrate individual resources such religious coping with psychiatric care, since they not only enhance the quality of life for those with mental illness but also provide clinicians with more meaningful coping strategies in their treatment of those with mental illness.

Spirituality and Social Support

Perhaps one of the most significant mechanisms associated with positive mental health outcomes includes the role of support. Individuals living with SMI continue to experience stigma and social isolation often leading to general life dissatisfaction and relapse of symptoms (Longo & Peterson, 2002). Religion and spirituality may act as resources in providing a broadened support network, as was demonstrated in protecting health and facilitating recovery from illness (Ellison & Levin 1998; George et al., 2000; Oman & Thoresen, 2002). Theoretical models that help to explain the relationship between spirituality and health are based on the understanding that religious and spiritual domains may have "stress buffering effects through association with 'other resources' such as social supports" (Kennedy, as cited in Koenig, 1998, p. 130).

A recent ethnographic study by Ranguram and colleagues (2002), addressed traditional community resources for people with SMI. In the study, traditional healing

temples were resources providing a source of refuge and support for people with SMI in India. The findings from this study also suggested that traditional resources may have a role in providing community mental health care.

Furthermore, social support need not be restricted to community resources or the external supports that spirituality might offer. Like spirituality, support is multidimensional and may include support received by health-related behaviors, perceived emotional support, and psychological states (Oman & Thoresen, 2002). A sense of support may also be obtained through a connection with sacred aspects of the divine (Longo & Peterson, 2002).

A recent study by Chiu et al. (2002) focused on the mental health care choices made by South and East Asian immigrant women living with SMI. The study qualitatively examined how the immigrant women were able to make choices about their care and how their religious and spiritual beliefs influenced their decision-making process. The findings of the study suggested that these women have scarce resources and limited choices in the current mental health system. When faced with these barriers, the women disclosed that they relied on their religious and spiritual practices, self-help, and connection with family and friends as sources for support. Spiritual connection (as a resource for support) also enhanced the participants' abilities to cope with their mental illness.

Tarko's (2002) qualitative study examined the experiences of spirituality among individuals living with schizophrenia. For the participants, spiritual support was defined by the participants' connection with their spiritual self, their community, and with significant others, as well as their connection with god or a higher power. A major conclusion of the study was that wellness and well-being was maintained by individuals

who were able to utilize these strategies of support, and the strategies provided their lives with meaning.

Summary

Currently societal and cultural trends conceptualize Spirituality as a broader concept that may or may not include religious aspects of an individual's culture or faith. Core themes that have been associated with the concept of spirituality include, existential experience that includes finding one's purpose and meaning in life and hope, connectedness and relationship with the self, or higher power, transcendence and one's ability to overcome suffering, and a motivational force that enables one to develop their spiritual selves.

According to research on clients' perspectives, spirituality is significant for people living with SMI in many ways. Spirituality may provide individuals living with SMI resources for coping with the stress of illness increase their resources of support and improve their health behaviors. Spirituality may also enable individuals living with SMI to find purpose and meaning through their connections with self, others or ultimate reality (Baetz, 2002; Chiu et al., 2002; Corrigan et al., 2003; Greasley, Chiu, & Gartland, 2001; Lindgren & Coursey, 1995; Tarko, 2002).

Spirituality has emerged as an important component of mental health treatment. A growing amount of empirical evidence and theoretical development on the salutary effects of spirituality has demonstrated that spirituality can be effectively used as a health resource that may facilitate positive mental health outcomes (Baetz et al., 2004; Ellison & Levin, 1998; Gartner, Larson & Allen, 1991; Larson & Koenig, 2001; McCollough et al., 2000; Mueller, Pleyak & Rummans, 2001).

In review of the studies that have addressed barriers to incorporating spirituality with mental health practice, it is evident that the professionals' need to understand how

their clients define spirituality and religion is imperative in order to provide accurate assessment and treatment. Studies have also shown that mental health professionals may not be addressing clients' spirituality due to personal barriers and beliefs that are related to ethical considerations and the lack of education in matters related to spirituality and mental health.

The majority of treatment and services for individuals who are living with SMI occurs within the community sector whereby mental health care and delivery is dependent upon the collaboration of multidisciplinary professionals. There is currently a paucity of research on the multidisciplinary perspectives of incorporating spirituality in caring for individuals living with SMI. Thus an exploration of the multidisciplinary perspectives on spirituality that is based on the collaboration of team members may have furthered our understanding of how professionals incorporate spirituality in their care of clients with SMI.

CHAPTER 3:

RESEARCH METHODS

In this chapter, I introduce the overall research design and research method followed by a discussion of the selection and characteristics of the research participants. I include a discussion of the recruitment of research participants and recruitment procedures under ethical considerations. Data collection and analysis that are congruent with the overall research design are also presented in this chapter.

I address issues of validity using Maxwell's (1992) three main types of understanding of validity threats (descriptive, interpretive, and theoretical), with researcher biases and reactivity as the key elements for addressing validity threats. This chapter concludes with a discussion of applicability, as it is applied to Maxwell's definitions of external and internal generalizability, strengths and limitations to the research design are also discussed.

Research Design

To best address the research question, I utilized a qualitative approach using an inductive, interpretive descriptive research design for this study. Interpretive approaches are naturalistic and are based on the researcher's attempts to uncover or gain insights into the subjective world of the participants (Denzin & Lincoln, 2000). Thus, the focus on meaning is central to the interpretive approach (Maxwell, 1996). In interpretive research designs, findings are obtained through an inductive process that are grounded in the data and are emergent rather than fixed, therefore, the results of qualitative research are unpredictable (Morse & Field, 1995).

The participants' perspectives on incorporating spirituality in their care of individuals living with SMI was inductively achieved by using focused interviews and a

constant comparative data analyzing technique using inductive content analysis. This method serves to gain understanding for a particular subgroup of the population (Hancock, 2002) and to provide descriptions that will sensitize other researchers and practitioners to their nature and meaning (Sandelowski, Davies & Harris, 1989). By using this method, I was able to describe how participants understand spirituality and how this understanding influences their practice.

In the interpretive process, the researcher has a unique relationship with the participants, the data, and the intended audience (Denzin & Lincoln, 1998). Thus, my years of experience as a community mental health professional and an interest in spirituality and its relationship to individuals living with serious mental illness, influenced the development of the research question, my relationship with the participants and knowledge of the data prior to implementing this study. Careful attention to these relationships will be further discussed in this chapter under researcher bias and reactivity.

Selection of Participants

The organizational structure of community mental health services in Vancouver includes multidisciplinary professionals who provide services through a team based approach to mental health management for individuals living with SMI in community. For this research study, participants were selected who provide community mental health service from 8 of the multidisciplinary mental health teams in Vancouver's Lower Mainland. Polit and Hungler (1999) refer to this technique as purposeful sampling or non-probability sampling. Purposely selecting participants this way, best represents the phenomena of interest and informs the research question.

Inclusion Criteria

The inclusion criteria for the selection of participants for this study included: community mental health professionals who had at least 2 years of experience working in community mental health; who came from various professional backgrounds, including nursing, social work, occupational therapy, medicine and psychiatry, drug and alcohol counselors and clinical counselors; and who provide case management, and or consultation services and resources for individuals living with SMI.

Exclusion Criteria

The following were excluded from this study: non professional groups who work within community mental health services but who do not provide clinical services such as peer support workers and consumers of mental health services; and professionals working in external agencies such as mental health emergency services, assertive community treatment services, dual diagnosis programs and acute inpatient services.

Participant selection was also influenced by the data collection method, focus groups (FG). In FG, participants are typically selected who share points of commonality (Bell Brown, 2000; Krueger, 1998). Points of commonality for participants in this study are defined by their joint mandate to provide psychiatric care and services to individuals with SMI under the multidisciplinary, team based approach. Morgan (1997) recommends that collecting data in this way facilitates free-flowing conversation among participants and may also facilitate analysis that examines differences in perspectives between and amongst focus groups. In order to represent the multidisciplinary perspectives of community mental health professionals, I mixed each of the FG to include a representative from different professional backgrounds. Selecting participants in this way provided a variety of different perspectives and experiences. This added to the richness of the data collected.

Characteristics of Research Participants

The professional discipline of nursing comprised of nine participants or (41%) and was the largest professional group that was represented in each of the FG. This might have been attributed to the fact that nursing comprises the largest professional group within Vancouver Community Mental Health Services. Within this discipline, the participants represented various sub specialty areas including, geriatric outreach mental health, and adult mental health case management. From the nursing discipline, two participants were masters prepared in counseling psychology and provided clinical psychotherapy. Four of the participants (18%) came from the profession of social work and specialized in adult case management, outreach, and trauma counseling and family child therapy.

Two multicultural liaison workers attended the focus groups. Three participants came from the discipline of medicine and included two psychiatrists and one medical doctor (14%). Both psychiatrists specialized in adult community psychiatry and provided consultative services for medication management, treatment and assessment for individuals living with SMI. The medical doctor provided culturally based treatment services for Indo Canadians living with mental illness. Community mental health rehabilitation services were represented (14%) by two recreational therapists and one occupational therapist. The professions of recreational therapy and occupational therapy provided assessment, life skills, rehabilitative supports and resources for mental health clients that were serviced by their community mental health team.

The Number of years of experience for the entire sample ranged from two to twenty-three years of experience in working in community mental health. The average years of work experience was 11.06 years. The majority of participants had over five years if experience working with individuals with SMI.

Sample Size

For an interpretive research design using inductive content analysis, analysis of the findings is done simultaneously with the data collection and therefore the total number of participants was dependent upon data saturation, i.e. the point at which no new information is forthcoming (Morgan, 1998). In this study, a total of 22 community mental health professionals were recruited and three focus groups were conducted. Data saturation had been achieved after the third focus group. Number of participants in each of the FG varied due to professional availability, professional time constraints and the need to provide variation amongst the professional backgrounds within each group. The multidisciplinary perspectives of community mental health professionals provided rich data and added to the conceptual development of the phenomena of interest.

FG (A) consisted of 7 participants and included one registered psychiatric nurse, one registered nurse who specializes in geriatric outreach services, and a master's prepared nurse who specialized in counseling psychology, one recreational therapist and one occupational therapist, one first Nations Mental Health Liaison worker who specialized in Drug and Alcohol counseling, and one social worker who works with adult populations.

Six participants where recruited for FG (B) and included one social worker, one counseling psychologist who specialize in grief counseling, one psychiatrist who works with adult mental health population, one medical doctor who works as a multicultural liaison worker and who provides mental health service to the Indo Canadian community, one registered psychiatric nurse working with the adult population, and one nurse psychologist who works with the adult population.

The final group, FG (C) included a total of 9 participants. In this FG the participants included one psychiatrist, one community mental health professional with a

PhD in psychology, two registered nurses who specialized in geriatric outreach services, one registered psychiatric nurse who specializes in drug and alcohol counseling, one recreational therapist, two social workers with specializations in trauma counseling and family and child therapy.

Ethical Considerations and Recruitment of Participants

I addressed the ethical considerations in this study by the following. First, ethical approval was obtained from the University of British Columbia Behavioral Ethics Review committee and the Vancouver Coastal Health Authority (Appendices F & G). After the research proposal received ethical approval from both authorities, I began recruiting participants through eight of the community mental health teams that operate under one of the Lower Mainland Health Authorities. Recruitment of participants was done by informing each of the mental health teams' senior mental health worker and team director by phone and in person. Once ethical approval was obtained, an information letter (Appendix C) and memo (Appendix A) were sent to all of the eight community mental health team directors. The information letter and memo included information about the purpose of the study, the data collection method and information on how participants could contact me.

The team directors posted the memos along with the information letter at the teams and also informed their staff of the study. Those professionals who were interested then contacted me through the number provided on the information letter and memo. Participants contacted me by phone and we discussed the purpose of the research and data collection methods. After obtaining verbal consent, I met with each of the participants to review the purpose of the research and obtained written consent. Consent was obtained in written form, indicating participants' understanding of the

research and consent to participate in the focus groups. All of the participants were given a copy of the consent form (Appendix B) and a copy of the information letter.

In meeting with the participants, I discussed with them issues of confidentiality, voluntary participation and participant anonymity. Specific issues of confidentiality that apply to FG were addressed in the consent form. In order to maintain confidentiality, participants were encouraged to refrain from disclosing the contents of the discussion outside of the FG during the consent process and at the beginning of each FG. Participants were informed of their right to withdraw from the study at any time both in the written consent and throughout the study. In order to ensure anonymity of all the participants' real names were not used or identified with the data collection procedures or findings.

The data, including transcripts and any information regarding the participants, were kept in a locked filling cabinet to which only I have access. Upon completion of the study, I will erase all audio taped material that were used and destroy all identifying information. Transcripts of the FG discussions will be held in a locked filling cabinet for 5 years as per UBC Behavioral Ethical Review Board protocol.

Data Collection

In this research design I incorporated focus group interviews and a constant comparative data analyzing technique to develop inductive understanding of how CMHP incorporated spirituality in their professional practice. The main goal of FG is "to provide qualitative data that gives insight into the attitudes, perceptions and opinions of participants" (Krueger, 1988, p. 30). Thus, focus groups (FG) were the main method chosen for data collection. Collecting data this way facilitated group interaction and reliance on the group to produce the data. This interactive process influenced participants to make comparisons of their experiences and allowed me to gain further

insights on CMHPs' perspectives on spirituality and how their perspectives influence their practice.

The FG were held in a meeting room at one of the community mental health teams that was centrally located in Vancouver's' Lower Mainland. A moderator with experience in conducting group interviews led three FG through a one hour interactive discussion that examined the questions developed in the interview guide (Appendix D).

Several focused questions were developed in consultation with the research supervisor, and the moderator who is an experienced mental health nurse. FG questions were refined during the process of constant comparative analysis in order to add further insights into the emerging themes. For example, the first trigger question asked the participants to describe their experience of how spirituality came up in their practice. Through the constant comparative method, the first trigger question was refined by asking probing questions such as; was it client initiated or professional initiated? In order to address the professionals' perspectives of incorporating spirituality, in their practice we also asked them to describe their experience of the process.

The FG were audio taped and digitally recorded using a boundary microphone. Once the data was recorded, a transcriptionist transcribed it verbatim. After receiving each transcription, I listened to the digital recording of each of the FG, comparing it to the transcript in order to ensure accuracy of the focus group discussions. I documented any changes on the transcribed text. Additionally, during each of the FG, I participated as an observer and made detailed field notes documenting the non-verbal behaviors of the participants, the environment of the setting and overall feeling of the groups. These field notes supplemented the findings and were used to interpret the research data.

The format used to structure the FG was referenced from Bell Brown (2000) and Dick (1998). The format included introduction and welcoming of participants followed

by a brief discussion of the purpose of the research and research question. Parameters of the FG were also discussed (i.e., length of time, audio-taping, and transcribing). Issues concerning participant confidentiality were emphasized and the role of the facilitator and observer were explained. The FG were structured using the prepared interview questions. Dick (1998) advises that it is sometimes common of participants in FG to conform to group consensus. We therefore emphasized that participants express their own views in order to obtain a broad span of opinion. At the end of the FG, participants were asked to comment on the interview questions and overall process. Participants were also given the opportunity to summarize any important points that were brought up during the discussions.

Data Analysis

Inductive constant comparative content analysis was used for data analysis. This type of analysis facilitates conceptual development and theory, furthering our understanding of human experience (Thorne, 2000). In the constant comparative method, the process of analysis begins during the data collection as the data already gathered are analyzed and shape the ongoing data collection (Pope, Ziebland & Mays, 2000). Constant comparison of the data is sequential and ongoing as the data is compared and contrasted with new data until no new information is forthcoming or until saturation has been achieved (Boeije, 2002). Content analysis is a systematic process that involves identifying, coding and classifying the data into primary patterns or categories (Dye et al., 2000; Graneheim & Lundman, 2004; Hancock, 2002).

For this study, I adhered to the following process of analysis. Content analysis can be described and analyzed on two levels, either at a descriptive or manifest level, or at an interpretive or latent level. Generally, the descriptive level pertains to what participants actually say, whereas, the interpretive level involves an interpretation of the

underlying meaning of the text (Graneheim & Lundman, 2004). In the descriptive level, I gathered the data inductively meaning that the codes and categories emerged out of the data rather than being imposed prior to data collection and analysis (Dye et al., 2000). To begin the process, I first reviewed the transcript(s) of the first focus group discussion and then coded the data by making notations on the right-hand column and highlighting statements that related to each of the interview questions. At the descriptive level, I searched for words or statements that were similar in meaning. For example, words or phrases such as "connecting to another, connected to family, being connected with other people" were codes that were later grouped under the category of spirituality as connection. The participants identified connection as a concept associated with their meaning of spirituality and how it was identified within client interactions. In addition to coding the transcripts, I re read my field notes and made analytic memos noting any insights that were relevant to the research questions. Constantly comparing the data prompted me to go back and refine the interview questions and pursue emerging avenues of inquiry in further depth.

Using the constant comparative method, the transcripts were coded and grouped or clustered into categories. Categories represent a constellation of codes that give conceptual structure to the data (Hancock, 2002). Comparison of the data within and between the categories allowed me to develop relationships amongst the data. Thus, categories are linked in some way and during the process of analysis; the researcher may see items fitting into other categories (Hancock, 2002). By constantly comparing the data I continually re examined which codes fit into which categories and linked the data with the interview questions. Categorization of codes was achieved by using a cut and paste method on a computer word program.

In the interpretive level of content analysis, I looked for relationship among different elements in the data by comparing differences and similarities amongst codes and their categories in order to identify potential themes or patterns. Through this process I began to identify themes emerging among the categories and properties of the categories. A total of 82 categories were developed and collapsed into two major categories, these include, CMHP perspectives on spirituality and the challenges to incorporating spirituality. Collapsing the categories was done by grouping categories that addressed the research questions for this study and thereby linking the categories to the overall purpose.

Theoretical analysis involved describing and examining what relationships existed between the two major categories. This method helped to link the data together in order to describe the two major categories of participants' perspectives and professional practice issues.

In summary, the process of content analysis involved continual revisiting of the data and the review of categories until the themes become saturated and no new meanings were derived from the data. I used analytic memos and a diagram showing the relationship amongst the categories to account for the developing themes. In order to verify the findings I consulted the moderator of the FG continuously during debriefing sessions at the end of each focus group. When all the data had been analyzed, a meeting was held with the research supervisor and moderator of the FG to verify the process of analysis.

Verification of the findings for each of the FG was also done with the research participants. All the participants were given a two-page summary of the content and interpretation of what was discussed in each of the FG. Participants were asked to reflect on the summary and provide feedback as to the accuracy of my interpretations. The

constant comparing of the data was done to ensure that the themes and categories that summarize the findings are truthful and accurate in reflecting the data. This process pertains to theoretical validity, which is addressed in other sections.

Data Verification

In this research study, I use the term validity in addressing the concept of rigor as the two concepts are not mutually exclusive. Validity refers to:

> the correctness or credibility of a description, conclusion, expectation, interpretation or other sort of account, and is not an inherent property of a particular method but pertains to the data, and accounts and conclusions reached by using a method in a particular context for a particular purpose. (Maxwell, 1992, p. 289)

To address issues of validity, Maxwell's (1992) conceptualization of validity was used. He describes three main types of validity threats, which include the ensuring of descriptive, interpretive and theoretical validity. I used the following strategies to address the three main types of validity threats.

Descriptive Validity

Descriptive validity, as defined by Maxwell (1992), concerns the accuracy of the data. In this study, the following techniques were applied to ensure accuracy. Focus group discussions were audio taped and transcribed verbatim. To ensure that the transcripts were accurately transcribed I listened to each audiotape and proofread all transcripts and checking them against the audiotapes to identify any missing or inaccurate portions. Any omissions or errors that were identified were rewritten on each of the transcripts. Participants were encouraged to reflect and summarize the content of each focus group in order to accurately convey their responses to the guiding questions at the end of each focus group. A summary of the content that was discussed, including the interview questions was also given to the participants in order to solicit their feedback on the accuracy of my interpretations.

Maxwell (1992) recommends that accurate recording of the data should include not only the non verbal behaviors and affect of the research participants but also their pitch and tone of voice as reflected in the transcripts. To address this validity threat, I made detailed field notes during each of the FG describing the participants' non-verbal behaviors and aspects of their speech that reflected the overall tone and feeling of each of the FG.

Interpretive Validity

The main threat to valid interpretation is imposing one's own framework or meaning, rather than understanding the perspectives of those being studied and the meanings they attach to their words and actions (Maxwell, 1996). This is the most significant aspect for this study since its purpose is to gain an understanding of how practitioners perceive spirituality and how their views might influence treatment approaches in caring for people with SMI. While gaining an understanding of the participants' points of view is important, it is equally important to understand and reflect on one's own influence on the research. The interpretive nature of qualitative studies includes the researcher's influence on the data and data collection procedures (Morgan, 1997). To address this issue, I used a reflexive process to acknowledge my own attitudes, beliefs, and behaviors, and how they might influence the data. Reflexivity is further discussed under researcher bias and reactivity.

Threats to interpretive validity also include participants' meanings that are not directly accessible, and which may apply to unconscious intentions, beliefs, and values of participants (Maxwell, 1992). Maxwell (1996) suggests that member checks are important for ruling out misinterpretations of the participants' words or their perspectives. Due to professional time constraints and commitments, the participants in each of the FG received a summary of the focused discussions via email. The

participants' feedback on my written summaries of what was discussed in each of the FG was included in the analysis and findings. Interpretation of the data and emerging themes was also discussed with the moderator throughout the process of data collection and analysis. Participants were also able to contact me directly to discuss any concerns or issues that they had with the summaries.

Theoretical Validity

Maxwell (1992) describes theoretical validity as pertaining to the theoretical constructs that the researcher develops during the study and how theoretical understanding explains some phenomenon. Understanding theoretical validity includes the validity of the concepts as they are applied to the study, the validity of the relationship among the concepts themselves and cases or accounts that may not fit with categorical codes.

Strategies that I used to address theoretical validity included constantly checking for descriptive codes against incoming data, and labeling which areas are similar and which stand out. Morse et al. (2003) describe this account as giving rise to new codes, which in turn, must be verified in the data that has been already collected. The development of theoretical concepts was done in consultation with the research supervisor in order to display the relationships amongst the codes, categories and the development of themes. An audit trail was kept and recorded on paper and included the coding of transcripts, categorization of codes and conceptual maps, field notes and analytic memos. Process notes were also kept that addressed any connections between the existing literature and the findings.

The theoretical validity may be seriously threatened if the researcher does not pay attention to discrepant data or consider alternative explanations for understanding a phenomenon (Maxwell, 1996). Participants were encouraged to provide their own points

of view and not conform to group consensus in the focus group discussions. To enhance theoretical sensitivity, I paid careful attention to the variation amongst the participant responses. This variation is reflected in the data analysis.

Researcher Bias and Reactivity

For interpretive research designs, two basic threats to validity include researcher bias and reactivity (Maxwell, 1996). Bias pertains to the researcher's values and how these might influence the conduct and conclusions of the study (Maxwell, 1996). Reflexivity is a process that pertains to all three aspects of validity threats and allows the researcher to acknowledge his/her beliefs, thoughts, and feelings about the phenomenon of interest (Carolan, 2003). In order to address my own bias, the process of reflexivity was used throughout this study. In this process I acknowledged how my beliefs might influence data collection, analysis, and interpretation of findings by journaling my thoughts and feelings and keeping analytic memos that reflected the data. Codes were developed inductively from the data, i.e. what participants actually said. The categories were developed from codes that were similar in meaning and addressed the guiding questions. Therefore, findings from this study were based on the perspectives of participants, not just those accounts that confirmed my assumptions, personal opinions, or expectations.

Reactivity refers to the researcher's influence on the setting or on the individuals studied, however, in qualitative research designs the participants' words are always a function of the interviewer and of the interview situation (Maxwell, 1996). Thus, an attempt to minimize the effects of the researcher's influence on the data and on the participants is not a meaningful goal (Maxwell, 1996). Nevertheless my influence on the data collection method and interpretation of the data are important questions for addressing descriptive, interpretive and theoretical validity threats.

FG have special considerations for reactivity and include:

1) the reluctance of participants to share issues of a deep or personal nature due to concerns of confidentiality and privacy (Bell Brown, 2002, p. 113).

2) issues of power imbalance amongst different professionals and lack of respect for differing opinions (Morgan, 1998).

3) in FG related to community organizations, discussions may lead to evaluating the agency's professionals and is particularly relevant for group members who have prior knowledge of each other or need to work together (Krueger, 1998).

4) participants in the FG may also be influenced by the facilitator and may want to answer questions correctly and may not want to "lose face" in front of others, for fear of being judged.

In this study, some participants had prior knowledge of one another and knowledge of the researcher. This familiarity was unavoidable due to the multidisciplinary and collaborative nature that defines community mental health services. To address issues of confidentiality participants were encouraged to refrain from disclosing the contents of the discussion outside of the FG, during the consent process and at the beginning of each focus group. Respect for participant's points of view was maintained by emphasizing that their various perspectives were important and relevant to the purpose of this study. In order to address issues related to researcher reactivity, a moderator conducted the FG discussions.

Applicability

The applicability of qualitative research depends on how the findings of the study fit the data from which they were derived (Sandelowski, Davies & Harris, 1989). This concept of applicability is defined by Maxwell (1996) as external generalizability. External generalizability is not the goal of qualitative research designs and would be more descriptive of quantitative approaches that include larger samples. In this study, however FG were not intended to reflect the perspectives of the entire population of

community mental health professionals, though the findings of this study may be applicable to other professionals who posses similar characteristics but are outside of the study (Krueger, 1988). The concept of fittingness is appropriately used to address validity of the findings in qualitative research. Fittingness is obtained when a specific audience views the findings as being meaningful and applicable in terms of its own experiences (Sandelowski, Davies & Harris, 1989). Strategies that I used to address fittingness of the findings included member validation and constant comparison of the categories in the data analysis.

Strengths and Limitations

I have identified a number of limitations for this study. The first limitation pertains to using FG for data collection. Although FG can facilitate dynamic discussions amongst participants, some participants might have been reluctant to share their attitudes, values and beliefs amongst their colleges. Participants might have withheld information or conformed to group consensus. The presence of certain group members will affect what participants have to say and how they say it. This is one of the limitations in using focus group discussions (Morgan, 1991). As a researcher for this study, my presence in the FG discussions might have also influence participant responses and willingness to participate.

The second limitation pertains to the fact that only those CMHP who where interested or wanted to discuss their experiences participated in the FG and therefore those perspectives influenced the findings. The small sample size of 22 participants may also not be representative of all CMHP perspectives working within community mental health settings. The lack of equal distribution of professionals may also not accurately reflect the perspectives of the various disciplines that operate under community mental

health services. The participants' views in this study may also not apply to mental health professionals who work in acute care settings or psychiatric emergency settings.

Despite these limitations, strengths of this study include the fact that professionals from various backgrounds were willing to come together in a group setting and talk about their experience of spirituality in how it relates to their professional work. The overall research design and qualitative approach facilitated the development of rich, descriptive data which provided valuable insights as to how mental health professionals incorporate spirituality and the challenges that exist. The data collection method allowed me to explore a number of professional perspectives on spirituality in a limited time frame.

Summary

In this chapter I have presented and described the research design as interpretive descriptive using constant comparative method. Content analysis was used to analyze the data. Purposeful sampling was used in selecting the total number of 22 research participants. Three FG were conducted as the main method for data collection. Maxwell's (1992) descriptive, interpretive and theoretical understanding of validity threats were used to address qualitative rigor and included researcher bias and reactivity. Finally, recruitment of participants was presented in context of ethical considerations. Strengths and limitations to the overall research design were also presented.

CHAPTER 4:

FINDINGS

The purpose of this study was to explore the perspectives of CMHP about incorporating spirituality in their care of individuals living with SMI. Two research questions guided this study and include; i) what are CMHP perspectives on spirituality in relation to their professional work with SMI clients? And ii) how do CMHP incorporate spirituality in their care of clients living with SMI?

A constant comparative method using content analysis was used to analyze the data as discussed in chapter three. A total of 82 categories were developed through this process of analysis (Appendix E). The categories were then collapsed into two major categories, which are participant's perspectives and professional practice issues. The three core categories that reflect participant perspectives were participants understanding of spirituality as connection, beliefs, meaning and purpose. I discuss the complexities associated with incorporating spirituality with community mental health practice under the major category of professional practice issues. Professional practice issues helped to explain the challenges that exist to incorporating spirituality and are described within five core categories of professional boundaries, practice environment, differences in conceptual frameworks, language and education.

A constant comparison of the relationship amongst the core categories helped to uncover the themes associated with how participants understand spirituality in the context of caring for their clients and the challenges that exist to incorporating spirituality. The central themes that evolved from the analysis were that spirituality has an important relationship with mental health. Participants viewed that spirituality positively or negatively affected their client's mental health. Although spirituality was

considered to be an important variable to understanding their client's mental health, incorporating spirituality into mental health treatment was a challenging process for participants.

I begin this chapter by presenting participant' perspectives on how they understand spirituality. This is followed by a discussion of professional practice issues that address the challenges that exist to incorporating spirituality within community mental health practice. I conclude this chapter by presenting a summary of the findings.

Participant Perspectives

For the participants there was no consensus on how they defined spirituality. Participants however commonly described some of the core attributes associated with spirituality as connection, beliefs, meaning and purpose. These attributes were also thought to have an important relationship with their client's mental health. I therefore discuss participants understanding of spirituality under the core categories of connection, beliefs, meaning and purpose. These concepts make up the participant perspectives and helped to explain the variation in how spirituality was included or raised with clients.

Connection

Connection was the first core category under participant perspectives. Although participants were not directly asked for their personal understanding of spirituality they described that they addressed spirituality with their clients in terms of how their clients make connections with others, family and their community. Participants reflected that these connections have an important relationship with their client's mental health. I discuss these relationships under the sub categories of belonging and comfort, support and spiritual coping.

The following quote demonstrated how a participant understood spirituality as connection:

> I kind of frame it for them – I can hear them talking about it but not really in those terms so then I'll try to encapsulate it for them and say, 'so what we're really talking about is, you know your ability to connect with the other people that you live with, or the other people in the community, or your inability to connect with other people.' So I'll sort of bring it around and talk about spirituality and how it's not necessarily talking about religion. So, more often then I'm the one that frames it that way.

Participants reflected that client's connections to others; community and family also affected their client's mental health. How these connections affected their client's mental health is described under the following sub categories.

Belonging and Comfort

Some participants stated that their clients benefited from their connection to others and community because of the sense of belonging and comfort that they received. The following participant described that having connections with community and or specific congregations, was important because it gave client's living with SMI a sense of belonging and comfort, which for some of their clients was difficulty to achieve in mainstream society:

> I don't know if it's anything that I have said or anything that I've said in discussions, but I know with several of my clients we spoke around religious or spiritual issues that they certainly derive a great deal of comfort from. I have one fellow who's a Jehovah's Witness and he likes to talk about it when he comes in – not so much about the religions aspect which is quite interesting, he likes to talk about the community of being a Jehovah's Witness and the sense of connection he gets from being a member of that congregation. For him that is the real benefit, the real plus and I can see that he likes being part of something, he feels very connected. He told me in quite frank terms that because he's schizophrenic he feels quite apart from all of the rest of society, this is an opportunity for him to feel a sense of belonging. So for me, that was the spiritual part, but he thought the spiritual part was actually the God that he believed in and stood on the corner and handing out flyers, which he does on a regular basis. It was that sense of connection he gets from being part of the congregation.

Other participants discussed that their clients are often disconnected from family and lack a sense of community. Thus a participant perceived a client's lack of connection as negatively contributing to her mental health and is described in the following example:

> Well, I have one example of a Jewish woman who feels really alienated from her – the group of people that she once as a young person connected with and she doesn't have that any more she feels that lack and that's part of a lack of family, too ... in this case this woman mentioned that the lack of spirituality was important, was part of why she couldn't move on in her life, get a feeling of being grounded enough to be healthy.

According to participants, one of the main benefits that clients receive from these connections was the support that they received from others and the feeling that they belonged. In some cases participants helped their clients to make connections. The following participant described an example of helping a client to make connections:

> I just reflect that your spirituality is very important to you, and this same client has recently met another person who's quite interested in Christianity and so I'm very encouraging of him to join with that other person as often as he can to have conversations because he's still got schizophrenia, he's still – he's extremely intelligent, the whole Christian spirituality is very important to him, and he gets a lot out of being able to talk about it.

Support

Participants discussed that another benefit that their clients received through their connections with others, members of their faith community and their families was the emotional support that they received. Participants viewed spirituality as an alternative resource that could provide additional supports to their clients. The following account describes how their clients' beliefs provide emotional support as well as increasing their social supports. This quotation illustrates the dual nature of support:

> I often ask it more in terms of when I think about supports and who are there for the client really...Well I often ask about- not necessarily – I don't word it spirituality, it often comes up for me in terms of support in the community and so I often ask that. Some people found it very useful and belonging to a group of people with the same beliefs and so on. I try to respect people's needs for that because, I mean, it's not about me really,

> but [laughing] I'm Agnostic, right so I try to understand what that means for them and how much strength they can get from their faith. I mean, it's a social support, you know you can use clergy very much for trying to sort things out and stuff like that. I try to be very open minded. I try and understand what that means for them and how much strength they can get from their faith. I mean it's a social support.

Spiritual Coping

Spiritual coping was described by participants as strategies that one can use to mobilize internal and external resources for support. Internal resources included mindfulness practice, meditation, prayer and scripture reading. External resources were described as supports that helped meet their clients' needs for shelter, food and detoxification. Some participants discussed that the support they received through their own spirituality provided an important resource to help them to cope with stress which helped them to care for their clients. The following participant explains,

> It's important to me, I've lived my life since my childhood in spirituality and religion, and I've found it to be these days very helpful to put my stress down and then dealing with the clients, their problems it effects us also to keep ourselves calm, I practice it regularly and almost all of my clients me in my interest they're always talking about it. It is very helpful for them, they will be psychotic, they will be depressive, they will be suicidal or they will be having family problems depending on the situation that we discuss those things.

Another participant describes her own spiritual coping as using internal spiritual practices such as meditation and mindfulness:

> I go to a lot of retreats, but I don't identify myself with any particular forum... Here I do a lot of retreats but they're kind of either meditation retreats or kind of non-denominational, maybe focused on presence or mindfulness practice ... which is compassionate or whatever so they're not – I don't see them as religious per se it's more of kind of like a personal kind of practice-type thing that helps you stay calm and have peace and be more loving and that kind of thing... I find it really helps me stay grounded in the job because we see a lot of very disturbing kinds of experiences.

Other participants described spiritual coping in terms of how their clients' spirituality helped them to cope with illness. Spiritual practices such as prayer, mindfulness and repeating scripture were experienced as practices that helped clients

cope with suicidal thoughts, hearing voices and coping with stress. The following participant describes the client's spiritual coping as the use of prayer:

> just this morning I sat down with one of my co-workers and ... she was away last week and I was looking after one of her clients and this particular client had been suicidal and told me he was praying and that's what brought him through this period of suicidality and we talked about how this was an important piece of his treatment in actual fact was supporting him and encouraging him.

Another participant described her account of a client who was experiencing hearing voices and how he coped by yelling out parts of scripture:

> Another sort of interesting example was a client was having such a hard time with voices and I was asking how he coped and one of the things that he says that he does is he has this quote from the Christian scripture and he just yelled it to them and it actually helped.

For other clients who did not necessarily have a spiritual belief or spiritual tradition, participants described incorporating alternative coping strategies such as mindfulness practice. This type of practice was available for clients to learn to manage stress within a group setting. In the following example a participant described spiritual coping as a kind of psychology in which clients can learn alternative ways of coping:

> I also do a Linehan, Dialectical Behaviour Therapy (DBT) group of which the core learning model is around mindfulness practice and this practice which is a Zen Buddhist practice, ...and I think our clients are like the world right now in the sense that there's a lot of interest in Eastern ..., and we practice it all the time, and then they kind of learn it in a context of psychology and developing coping skills and distress tolerance and this kind of thing. There just generally seems to be openness to this kind of learning.

Mobilizing external resources helped clients cope with meeting basic needs for housing and shelter. The following participant explained spiritual coping as including resources offered through a faith community:

> A lot of them only have their housing because the church would house them or their detox, because the program would take them and that's where there's kind of like a spiritual thing happening...that it's the Christian giving in them that is having them out there giving you the food and the hot chocolate at nine o'clock on a cold, windy night when- we need it, they give it to us. Visiting you if you're in hospital, helping you

> move if you have to pack up your apartment, taking care of you, checking in on you and that kind of thing...

Participants discussed that not all of their clients were able to mobilize internal or external resources for spiritual coping. This participant described how some clients are not able to use their spiritual or religious beliefs to support them during a health crisis:

> The funny thing I found is my more religious clients, when they come into crisis it hasn't exactly been the support that I would have liked to have seen, for somebody and I'm always shocked that they have like, for example, a client that goes to mass every day and was in a Catholic men's group and this sort of thing and then he got a serious cancer diagnosis and treatment and so on and there's just so much else consuming him that he can't ground himself in his faith and it surprised me...

Similarly, another participant discussed that during times of illness their clients felt abandoned and alone and in those situations were not able to incorporate internal or external spiritual resources for coping:

> My fellow who believes he's God also believes there is a God and he has this very personal relationship so God speaks to him, but he's chronically miserable. He's incredibly depressed and I kind of question, 'what about God? Doesn't he love you and look after you?' because he feels very abandoned and alone and it just doesn't transfer into his day-to-day coping.

Although most participants acknowledged that spiritual coping was important to help clients cope with stress, the experience of illness and provide alternative resources for support, some participants discussed that spirituality may be perceived as harmful if it does not support the overall well being of some of the more vulnerable clients.

> I've also had that situation where it is – the religiosity is too intense for some people to handle and it becomes difficult as to whether you see it as a support or see it as something that might lead them down a path where they might get more ill.

Participants noted that some of their clients have had past negative experiences with their spirituality and in those cases it was important to acknowledge how their client's spirituality did not provide resources for coping. Participants gave the following

examples of when an external resource such as one's faith community was not perceived to provide effective spiritual coping:

> I think it's really important. ... some of the other churches have a reputation for some bad sexual practices with children. We follow clients from residential schools, there's a lot of that. I've got a client that was part of the evangelical church that was exorcised. He was being sexually abused by his parents he was exorcised by the church for some of the behaviors that he had resulting from that so we know that the dark side is really also there.

Another participant added:

> I've seen one little kid where both parents were mentally ill and she's going to a church where she collapses playing by this spirit so I don't think that's appropriate for a little kid ... casting out demons. Many of my kids are stricken with demons.

Connection was a central concept that described participants understanding of spirituality. For participants connection included their client's connections with others, family and their faith communities. Understanding these connections was important to their client's mental health because it gave their clients a sense of belonging and comfort and provided alternative resources for coping. Spiritual coping was described as internal and external resources that could be used to help cope with stress, and symptoms of illness. In some cases spiritual coping was not beneficial to their clients because they were not able to incorporate their spiritual beliefs into day to day coping or had past negative experiences with their spirituality caused trauma. Overall participants viewed their client's connections to either positively or negatively contribute to their mental health.

Beliefs

Analysis of the data revealed beliefs as the second core category that described participants' perspectives on their understanding of spirituality. The sub categories that make up beliefs include religious beliefs, delusions and cultural beliefs. These types of beliefs were considered by participants to have an important influence on their client's

mental health in terms of suicide prevention and reducing other risk behaviors. In some cases participants also found that their client's religious beliefs negatively contributed to their client's mental health. These mental health outcomes are discussed within the sub categories.

Religious Beliefs

Participants stated that clients most commonly referred to spirituality in terms of their religious beliefs. The following illustrates the issue of spirituality as including religion:

> When that comes up with clients, mostly what I notice is that it comes in terms of religiosity as whatever religion that they are involved with. My own spirituality isn't like that, and so I kind of, I'm kind of wondering if there's something else. A lot of – mostly, that's how it comes up, is in terms of where it fits, under a name of a religious belief.

Some participant reflected that for some clients' religious beliefs and teachings positively affect their client's mental health because it helped them to reduce risk behaviors. In the following account a participant describes how a client uses his religious teachings to prevent him from seeking immediate gratification through drugs or causing harm to others:

> He's very immediate, he's a very immediate gratification kind of a person, he does a lot of drugs, doesn't do in his culture or in his family what he's supposed to be doing, and he uses religious teachings and their Roman Catholic teachings to put him on the right path, "I know I should be doing this, this is what I'm supposed to be doing because I've been told this all my life, this is what I've been shown to be, I'm supposed to be doing." So, he occasionally goes into that behaviour, that'll keep him from always seeking out immediate gratification, "I shouldn't do this, I shouldn't be doing that, I shouldn't pick a fight with that person or have someone chasing me down the street in Mexico because I've bought some pot." So, he'll say, "this is what I should be doing" because this is what he's been taught in religion, in his religious teaching that's how he was reared.

Many participants discussed that suicide prevention was a common health outcome associated with their client's religious beliefs. Thus participants often encouraged their clients to draw upon their religious beliefs and teachings during times

of crisis or illness. The following excerpts describe how religious beliefs can have a strong influence on suicide prevention:

> I think the most times that I hear about somebody's spirituality is to do with, they're thinking of suicide. That's – even with the elderly people, that's when they'll say, "oh no I couldn't do that." Even if they're not going to church they still have an affinity with the religion they grew up with or a belief in God that they don't usually talk about, but it would prevent them from ...

Another participant commented that a client's religious beliefs are encouraged when those beliefs are perceived to decrease risk for self harm or harm to others:

> It's easy to keep people alive by reminding them of the taboo that they have been culcated by their religious beliefs not to kill themselves, to encourage them to use that. I think we all do that at the drop of a hat. It works.

Client's religious beliefs were also described as prevention against suicide because it gave them a sense of hope, futuristic and afterlife:

> He's not supposed to kill himself because he's the chosen man in the Bible and he's got a certain – that's a hard job to do – but he's got that job to do so he can't kill himself but when he does die because he's having a hard life he has a sense of that he's going to merge with the Holy Spirit and go off in a space ship and be happy for ever more, right? So those are very, in a desperate light really this guy is, functions in a group home and is angry a lot of the time and hits walls sometimes and those beliefs are really – they're very – he's so happy when he's talking about it, you know, so I think it's deeply meaningful.

According to participants, the concept of God was part of their client's religious beliefs and described as some external phenomena that were guiding them through illness. Thus, some clients considered God to be responsible for their recovery as well as providing a sense of comfort. One participant described the client's acceptance of their illness as related to the belief in God:

> I mean, just the other day one client said, "I guess God gave me this situation for some reason" with a certain amount of frustration. I didn't pick up on a discussion of the spiritual in that particular situation. I have another client whose, her every move is being guided by God and sometimes I'll try to counterbalance that with helping her to see where things might come from her and her own things, but for her, God is a comfort but also kind of a defence against everything else.

Participants discussed that not all clients experienced positive mental health outcomes from their religious beliefs. Participants noted that in a few instances their client's religious beliefs could also cause them to feel guilty, ashamed and feel suffering. The following participant presented a case in which religious beliefs negatively contributed to the client's mental health:

> I think deep down regardless of what kind of religion I tell you I have clients who see themselves as practitioners of Eastern philosophy and religion and they get so paralyzed by their beliefs too. They're so superstitious; they cannot move one step without saying so many mantras.

In other instances participants described how their clients' spiritual beliefs could cause them to feel guilty or ashamed. Religious beliefs that did not support traditional approaches to psychiatric treatment were considered to negatively affect their client's mental health. The following example demonstrates how a client's religious beliefs could potentially result in negative mental health outcomes:

> It's not unusual that my clients bring up the topic of spirituality or religion automatically, I don't initiate it in discussion, but it's very spontaneous – sometimes it's even the focus of what they perceive as the issue. A lot of times their spirituality or religious beliefs are associated with guilty feelings. Sometimes so bad that they panic, sometimes this disbelief about medication or their church members or pastors will suggest them to stop medication because they believe they have enough faith you don't need the medication – that sort of negative act.

Delusional Beliefs

Most participants experienced the issue of spirituality in the context of their client's delusional belief system or psychotic episode. Participants described that their client's religious beliefs were often distorted during times of acute illness. The following participant stated that when clients become ill they often misinterpret their religious beliefs, which may be potentially harmful:

> I have a client who, his spiritual beliefs when he's ill become quite dangerous. He believes that he's the rebirth of Christ and to save the world he has to kill himself. He has made some major attempts at times but when he's well and he's taking his meds he doesn't talk anything

> about that even though he still has a spiritual community and is connected with some outreaches and various churches. There are some other clients that clearly as they become more ill there's a lot more intrusive symptomatology, religious based beliefs. Conversations have gone on where they're starting to interpret the Bible in a very bizarre way and extract different meanings out of it.

Some participants made the distinction that the client's delusional beliefs were the individual's misinterpretation or distortion of spirituality and therefore those beliefs (not spirituality per se) could cause distress or could be harmful to the individual's mental health, or could exacerbate existing mental health problems.

Cultural Beliefs

Participants also discussed that they work with clients from diverse cultural backgrounds and that it was important to consider how their client's cultural spiritual beliefs might influence their mental health. In the following example one of the participants described trying to assess how the clients' spiritual beliefs might be related to their cultural faith: "finding out, what does that mean in your culture and your religious belief or your community of faith?" The following participant expressed another example of how a client's spiritual belief is tied into their culture:

> With my clients spirituality and their religion is their belief – it's a really – life thing, you know. Belief that they live in their religion, their spirituality, and once I start talking in fact, they're very interested in knowing how they can be helped to view religion through their spirituality. And in fact what role their Sikh religion in fact has got – most of my clients are Indo Canadians and– most of them are Sikhs. Even Hindus, they are very much into their spirituality. I discuss a lot about Hindu and Sikhs with my clients.

Some participants discussed working with many diverse cultures and the need for cultural sensitivity and cultural competency in working with diverse population groups. One participant discussed these issues related to culture by facilitating a multi faith curriculum in order to meet the culturally diverse needs of clients:

> I work with kids up to about 19-start at about 5 so I think it's a really frequent topic, anything around spiritual sacredness and religion ... it's a

> very multicultural group of kids so there's a lot of different faiths and needs that I've been working with. The kids are learning, a lot of kids are learning about their faith, they're quite interested, they try to tie things together and I try to encourage their parents ... I have curriculum virtues that I try to work with parents around – and it's a sort of multifaith curriculum and it's drawn from a lot of different faiths and it's been tested by the Aboriginal drug and alcohol strategy ... I can give these materials to parents to work on some of these values with the kids, so that's quite useful actually.

Participants conceptualized spirituality to include their clients' religious beliefs. These beliefs were often experienced in the context of their clients' illnesses as well as their culture. Religious beliefs were discussed to positively influence their client's mental health through suicide prevention; comfort received through their belief in God, and decrease risk behaviors such as drug use. The client's spirituality was perceived as potentially harmful when clients misinterpreted their religious beliefs or when their faith community was not supporting their need for psychiatric treatment.

Meaning and Purpose

The concept of meaning and purpose was the third core category that evolved from the data. The four sub categories that describe meaning and purpose were; spirituality as meaning, meaning through illness experience, loss of faith and lack of meaning and purpose. Lack of meaning and purpose was discussed as having a negative influence on the client's mental health. I present participants perspectives on lack of meaning and purpose as promoting depression and suicide.

Spirituality as Meaning

As discussed earlier, the issue of spirituality came up in various ways in the context of caring for clients. For most participants, however their client's spirituality was something that ultimately provided meaning to their lives and may or may not be concerned with an individual's religious faith. The following example illustrates spirituality as what brings meaning to their client's lives:

> I tend to follow the client's lead with anything to do with spirituality, but I think it's really pervasive in all of the work really, that's how I see it. When you're talking about meaning and creativity and connection – I had one example. A client just wanted to show me the dress she had made – she had become a dress maker in Italy so she brought in three of her dresses and just to be able to go and to look at how the colours and the work and to be able to sort of celebrate that part of herself with her was very, very nice.

Meaning Through Illness Experience

Participants discussed that their client's spirituality often came into focus either during their illness or in the process of their recovery. Some participants described that their client's experience of illness will often make them question what spirituality means to them. These experiences were described by the following participants:

> ... often newly diagnosed people who are losing a lot, or they're being stigmatized now, and they've lost their job, they've lost their things. They're manic, they've gone out and spent a whole lot, so just grieving and their life is upside down and they don't know what it means. So, that's often come up.

Another participant added:

> We recently facilitated a recover group and it was in the context of recovery from mental illness and some addiction recovery..., but it was mostly about looking at the process of walking through your illness ... in the context of that, clients independently brought up lots about spiritual things. What does it mean? What's the purpose of my life? Why? They really wanted to talk about that, and in fact they wanted a group focused on that.

Loss of Faith

From participant points of view, client's experiences of illness meant that client's often experience loss of faith in their spirituality. Another participant describes a client's experience of loss and how that brings up questions about faith:

> Of late, in the last weeks I guess, two weeks three weeks, a gentleman is dying, he has cancer, and he's going through a huge loss of his faith and belief in his Catholic religion and he talks about – it's happening while he's dying. He has to talk about that.

Participants discussed that client's loss of faith involved a process of questioning their spirituality and questioning God. The process of client questioning is described here by one of the participants:

> She's really grieving and wondering what her faith is all about, what does it all mean, and it's incredibly central to her. In fact, it's part of what was identified as her illness was an overemphasis on Christian spirituality, so now she's trying to bring it back in line again, centered with it, but she's got all this grief and loss and questions "what does it mean, I've done all this for him, what's he doing for me." Crushed by it. Tearful, you know what's this woman about I don't understand.

Lack of Meaning and Purpose

Participants defined lack of spirituality as an inability to find meaning and purpose in their lives. Some participants understood client's lack of spirituality as an existential experience or spiritual crisis. This sense of lack of meaning and purpose is described in the following: "I work a lot with personality disorders, existential emptiness. My God that brings up huge issues ... really important things. So any kind of existential crisis seeing any person I think likely would affect that spiritual piece." One participant viewed their client's inability to find meaning and purpose as promoting depression:

> Maybe sometimes the lack of spirituality is sometimes really apparent and that sometimes is a problem. It's also our society is lack in that way too. We don't pay attention that much in society to it, and I think it's at our peril and clients sometimes if they are in some way have less resources or less in terms of skills then they have even more of a lapse in their lives. Not always, but I've noticed that that sometimes I mean – depression is so often lack of a sense of meaning and that may be what a lot of them are suffering from. I think it's important, but maybe because there isn't enough attention paid to it.

Other participants provided insights on how the lack of purpose and meaning contributed negatively toward their client's mental health. In this example a participant described how the client's inability to find meaning and purpose resulted in suicide:

> Last year I had a fellow that suicided ... I saw him every other week, and it was always around spirituality and the meaning of his existence and he just couldn't find- that's why I would always try to say "aren't you

> connected here and there?" is there any reason for living? Why are you here? He wasn't able to really make that connection why he was here and he was totally confused, I only had him a few months before he suicided but a lot of different approaches like that have been taught to try to get him more connected to the community ideally through a religious organization or other, but he was always in that kind of existential angst, you know why he was here, what his purpose and meaning was in life. For him, it was a huge issue and I was never able to ground him in it.

Some participants understood spirituality to include aspects of life that bring meaning and purpose. Participants felt that it was important to determine aspects of life that were meaningful for their clients because it gave them a sense of purpose and positively contributed to their overall well being. Participants discussed those clients who are newly diagnosed and in the process of recovery experienced a sense of loss and will begin to question their spirituality and what it means to them. Participant's perspectives on the lack of meaning and purpose were described through their client's experience of loss of faith and existential emptiness. In their experience, the client's loss of faith and sense of emptiness promoted depression and in some cases suicide.

Professional Practice Issues

Most participants discussed that spirituality was an important aspect of their client's lives and that the client frequently initiated the issue of spirituality. Spirituality was discussed as an important variable to understanding their client's mental health. Despite the significance of spirituality, incorporating spirituality into community mental health practice was described to be a challenging process that is influenced by several professional practice issues. In this section I discuss the major challenges to incorporating spirituality under the major category of professional practice issues. The five core categories that describe professional practice issues are the professional boundaries, practice environment, differences in conceptual frameworks, language and education.

Professional Boundaries

Participants discussed maintaining professional boundaries as a major challenge to incorporating spirituality. Professional boundaries concerned issues of participants' professional role and level of comfort in sharing their own beliefs about spirituality. I discuss these challenges under the sub categories of sharing and professional role.

Sharing

Participants discussed that their clients often inquire about and want to know the spiritual and or religious orientation of their care provider. The following participant described how client's question about the participants' spirituality was experienced: "I get asked quite a bit what my beliefs are and I'm very cagey about it. I just got asked about an hour ago, "do you go to church? How much do you go?" Most participants experienced the dilemma of not wanting to impose their personal beliefs because they were concerned about how their beliefs might influence their clients. A participant described this common experience, "I think we probably all have that dilemma at times, is how do you promote the client's spiritual beliefs without promoting your own." Participants being consciously aware of their authority demonstrated these concerns and how that might affect their clients. This issue was described in the following quote:

> I guess I worry about this idea. Yeah, right, because if you're in a position of authority in their minds ... then they're going to take it on... It's kind of like ...trying to get them to look at what's within them ... I think sometimes there has been a bit of a authority a top down way in this system, they're used to that, the hospitalizations, all of those things, there's a lot of structure so religion probably has a lot of structure, they have seen it that way often so trying not to participate in that I think for me is very important not to impose anything.

In some cases participants discussed that clients are reluctant to share their spiritual beliefs because they did not know how their care provider would perceive them. The following example illustrates how a client might hesitate to disclose their spiritual beliefs with a care provider who may not share their belief:

> I think that to say that spirituality is not important would be very- a big understatement, because in fact... some clients feel very comfortable with it, confident if they know for example they see someone who particularly is interested in religion and they want to talk about it they go, but I think it really depends where you're at intimately with them because I have had a lot of clients ask me, "do you believe in God? Are you Jewish? Are you Christian? Right? And that to me is a sign that they don't feel comfortable to bring it up unless they feel that it's o.k. with me ... you know that I'm not going to like them or that I will think less of them or vice versa, if they will think less of me-I mean I don't believe in God, if they know that right?

Other participants acknowledged the fact that some of their clients might be reluctant to discuss their spirituality because they fear they will be judged by their beliefs and possibly suffer negative consequences. This issue is illustrated in the following:

> I had a client recently who was – you know he couldn't talk about anything else that he was very pressured and all the rest of it so he was certified to hospital. He still learned to keep it under wraps and keep it mostly to himself so that he doesn't preach to everybody.

Participants discussed that their clients benefited from sharing their spiritual beliefs because it made their clients feel like they were individuals and not just their illness. This type of approach was important to making clients feel validated and is acknowledged by this participant:

> I think some of my clients, once we've had the talk that openly about spiritual beliefs that I do – and I may be projecting – but I sense that the client now has the belief that I see him with his spirit not as just a psychiatric patient, that his identity has been broadened by our discussion.

Participants commonly described that professional boundaries are challenged when clients might become more preoccupied with religious and or spiritual themes. In those situations participants might need to impose their level of authority. This participant described how maintaining professional boundaries included imposing some judgment about the client's beliefs:

> In fact, I just had very recently a woman who became more psychotic and more religious and it was a contentious issue because I tried to deal with it in gentle terms so she doesn't hit the roof, but kind of suggesting that perhaps it's a little more than she usually think of it. As she got better, I

> really think she appreciated the way we handled it, that it was o.k. to disagree and that you know you didn't send her to the hospital right away, you know we didn't. That we were able to deal with it together. So it helps the relationship and the trust in the sense that it doesn't have to be punitive, it's just a symptom really.

Other participants identified that one of the challenges to maintaining professional boundaries around spirituality was in situations where the client might share the same spiritual orientation as their care provider. This participant described how trying to meet all the spiritual needs of their clients could create a sense of dependency:

> This woman that I'm currently working with, she has a very strong Christian faith as do I, and it's been interesting because she's wanted to – because she feels this resonance with me – she'll say, "I'm so glad you're a Christian, now I can trust you" or whatever ... it felt good to be able to work with her as a whole person, ... but also trying to be careful that she's leading it , that I'm not pressing my own agenda...and trying to be wise in terms of what's best for her too because if I provide this really intimate connection around spirituality ... I'm afraid of the dependence ... I want her to be spiritually fed in her community and in her life ... I want them to become integrated in their community and not dependent on me or the team.

Although disclosing beliefs about spirituality posed challenges to maintaining professional boundaries, many participants stated that the benefits of self disclosure and incorporating client's spiritual beliefs helped to establish rapport, trust and strengthen the therapeutic alliance. A participant commented on how incorporating spirituality helped the therapeutic process:

> I think when you are on that level where you can talk about spirituality therapy is definitely deepening at that point, and your rapport is much more on the level of where, your not sharing in the sense, but the trust is there. They trust you and you trust them because you start to know more about them and so I think that process alone assists in their mental health and their connecting with another person.

For other participants incorporating spirituality involved sharing what was meaningful for their client and not necessarily sharing their own beliefs. This participant described how sharing affected their relationship:

> I think it gives a lot of meaning. I'm thinking of one schizophrenic guy that I have in his mid 40's who's always very delusional and his hopes. Occasionally he has given me prayers to save my soul so whenever he feels I'm going off track. It's very...it becomes more of a mutual relationship. He's saving my soul and I'm helping him with his mental health.

Throughout the FG participants discussed the need to maintain professional boundaries to incorporating spirituality but were challenged by how to do it. The following participant suggested the following solution to this common dilemma:

> I see this is as any other issue in psychiatry in fact, I don't think this is any different, and you invite a person to tell them about themselves and you don't necessarily reveal yourself, unless it is implicit, right? That's what you would do, right? So I think that maybe that's where you kind of get the boundaries which is correct. You don't want to preach or you don't want to show them what you expect because you don't.

Thus, some participants acknowledged that sharing beliefs with clients may not necessarily compromise professional boundaries as long as client safety is maintained. The following participant describes boundary issue as it relates to client safety:

> I think it is possible ...because of the treacherous territory I work in with severe personality disorders those boundary issues: who am I, who I am personally out of that therapy room is not the issue of why we're there ... it's about a shared idea not a shared life. Spiritual dimension is not licensed to cross boundaries, it's a difference...if we in our vigor to be spiritual allow people to be-cross a boundary that in therapy is not a healthy one for the relationship, then you're in a bit of trouble. So, I'm really mindful of that but that doesn't exclude the intention which is that this is a discussion...we don't talk about this a lot in medical model we don't develop the skill set to safely negotiate this territory for the clients.

Professional Role

Another major challenge to professional boundaries was participants' lack of clarity around their role. Few participants viewed incorporating spirituality as part of their professional role. For those participants who did not see it as part of their role questioned the appropriateness of incorporating spirituality with mental health treatment. The following participant described this assumption:

> I don't think personally I feel like it's a sort of approved treatment or practice that I think it would be- like someone mentioned before-people would say, "well, there's boundary issues, there's..." – is that really a role

> of psychiatry, is that part of ... their world that we have to go into or is that something we should leave well enough alone?

Some participants discussed that maintaining professional boundaries meant that it was not part of their professional responsibility to discuss spirituality with their clients. The following participant describes issues about professional responsibility: "I don't think that I do see it as a professional responsibility – if that means that I'm responsible for doing something with it. No, I think it comes from the client."

Another participant shared this view, and incorporated spirituality through other resources such as church or ministers: "I haven't initiated conversations about spirituality unless I feel like I'm at wits end and I'm sort of looking for other resources and I'll ask, 'don't you have a church or minister?' or if somebody goes to hospital then I ask if they want a visit from pastoral care.

For other participants however incorporating spirituality was viewed as part of their professional role because it could provide alternative resources for helping clients cope with illness. One participant explained that, "...our role is to help liberate them from this kind of disability...I think there is a potential for helping our clients if we use their spiritual beliefs..." Some participants expanded the professional boundaries by teaching spiritual practices such as prayer. The following participant discussed how incorporating spirituality was a teaching and learning process that may provide valuable resources to assist clients to cope with mental illness:

> I'm very comfortable with the idea of a teacher, and I'm there to teach them and show them how to pray and what the process is ... I have a group that happens every week and I run it every second Friday ... also twice a month I have a sweat lodge ... I feel very comfortable doing it, and I kind of feel like whole and I feel like I'm getting all possible options that they can for their treatment and whatever crisis they're in, why they're seeing us in the first place. We had an opportunity to help in alternate ways besides prescribing medication.

Other participants described learning to incorporate spirituality as part of their role through mentoring:

> I've had a number of co-workers who have expressed spirituality and I think that almost maybe in kind of an official mentor role, I've kind of learned from them. I'm thinking particularly of one of the multi-cultural workers that I've worked with sometimes who does see it as a part of what he does with his clients, and in some ways that's made it a little easier to kind of say if it's important with his clients it's probably also important with other clients and that we need to be more open to it.

Although not all participants viewed incorporating spirituality as part of their role, the common consensus was that participants felt more comfortable to discuss spirituality if the client initiated the discussion and or if they had known the client over a period of time. The following participant described this common view:

> I think you made a good point about the level of comfort and how long you know the client and what stage you're at with the client because it's not the sort of thing that would come up the first time I meet a client or until they get to know me fairly well or I get to know them fairly – if they're comfortable talking about issues as deep seeded as spirituality.

Practice Environment

Participants described that one of the major challenges to incorporating spirituality was the environment of their practice setting. The practice environment included the client care treatment setting and the unseen environment of participants' experiences in working with their colleagues. Participants described their practice environment as working within a septic, medical environment that is not conducive to incorporating spirituality. Some participants were challenged to incorporate spirituality in their office environment these challenges are described by the following participant:

> ... as many places as I have boarding homes I insist that at least every other serious med review we do at the home where these people live so that the doctor sees them in a normal environment, and not a septic environment of a medical office is really not good.

In order to incorporate spirituality some participants described creating an environment that would set an intention to incorporate spirituality:

> In my practice, because I believe spirit is so important, I mean not meaning particularly as religion, but my office is set with that intention. I have things in my office that I think lead to a sense that it's OK to talk about these things here and not in any particular denomination. ... I set the intention always in my office that this is a place where the wholeness of you, not just the symptoms of you ... I don't really have to ask a lot about religious questions per se but people will talk in this environment because there's permission to do that...my heartfelt belief is that if you're open to that and set the intention and provide the space that it will happen, because it's important to all ....

For other participants creating environment to incorporating spirituality into practice involved a displayed of spiritual symbols or pictures in their office and is described by the following participant:

> I have a signal on my wall which is a picture of a Buddha and if the client comments on it, I'll let them know that I've been involved in studying Buddhism for a long time, or if it comes up – if the client asks me my religion, I'll let them know that I was raised Jewish, and I'm still somewhat involved in that. By signalling who I am, I think it opens the door for them to be able to open up about spiritual issues just by these signals that you give.

By creating an environment participants viewed their office as an obvious place to incorporate spirituality with their clients:

> Also my office is a kind of obvious place because I've got Bodhisattva up on the wall and little pictures of Buddha around, and a copy of the yin yang symbol, it's hanging on a mobile from my window and stuff. If you come in there, there's also a statement I made of spirituality, a picture of – that has some totem poles and stuff, so when you come into the office it kind of invites the openness I think it's because my office is kind of an open office it's kind of an open thing to talk about and especially with clients that have been kind of traumatized and stuff.

Participants' perspectives on their practice environment also included their perceived lack of support from their colleagues. The lack of support was associated with whether or not participants felt able to either express their own spirituality or how they might be incorporating it in their own practices. Many participants did not feel supported to openly discuss how they were incorporating spirituality in their practice.

> I don't think it's encouraged, I don't think it would be supported. I certainly wouldn't sit down and say, 'well this is what I so and so has cancer and she's dying so is questioning their faith about this or that.' I

> certainly wouldn't sit down and say, '... well this is the discussion we had.' I'd make a note of it in the file but I wouldn't sort of bring it up at a meeting or something because I don't think it would be supported. I don't get the sense that it's and encouraged discussion in regards to treatment, or an area that you should even tread into with a client.

In some cases participants felt uncomfortable in discussing their own spirituality with their colleagues let alone discussing what they were doing with their clients. One participant in the following example described this finding,

> You can even be ridiculed by other staff members (exactly). That's a big fear of mine that I'll bring on to much. I've had staff joke or make fun of my spirituality and as a result I've had to pull back a bit and not share as much to them as I would to other clients.

Because they lacked support from colleagues some participants continued to struggle with incorporating spirituality. For this participant that the lack of support was experienced as an isolating experience:

> Here's another client that I just remembered who was a Jewish Holocaust survivor who talked a lot about spirituality and it was very difficult and he was one of the people ...There wasn't anyone else ... and I didn't know anybody, it's that isolation that's there for both of us, the client and myself. That's where the difficulty is ... That's what I've always thought ... and yet – I mean, it's doing me a lot of good just being here in a room with other people and I can talk about what is important to me because that's rare.

Although some participants indicated that they may not necessarily want to get all the diverse opinions of their colleagues about incorporating spirituality with their clients, they generally felt a lack of support. One participant noted that including team members may not always be necessary, however describes the process as a struggle:

> I don't think it's a situation where you want a lot of diverse opinions. You want to kind of concentrate on what that client believes and how they see it in their life, unless I have a problem with it. If I had a problem with it (a struggle), I struggle with it of course, but if I'm not struggling, I feel it's (there's no need), there's no need to.

The following quote demonstrates the lack of support amongst the various members of the multidisciplinary team on incorporating spirituality:

> I think it was an awful audit that we had at our team and this person had this very – in touch with God when he was psychotic unfortunately and he did horrible things to himself at the command of God and it was discussed in the audit, was he given the opportunity to talk about these beliefs and the sense was that he wasn't, that was a taboo subject because it was this psychosis and that conflict in that team in that audit was, do you talk about it or not...It wasn't accepted by the doctor and the care giver and then one of the psychiatrists was very adamant that that person's spirituality – was psychotic, delusional behavior and – but there was very positive experiences that he had through his spirituality that he really missed going on meds so that to me, that's where we really need to work with spirituality and mental illness when it creates a difficulty for a person to go on meds or feel whole or integrated."

Differences in Conceptual Frameworks

Participants were challenged to incorporate spirituality within multidisciplinary teams due to differences in conceptual frameworks. These differences included traditional psychiatric treatment approaches that focused on symptoms of illness versus holistic frameworks that focused on spirituality as part of normal, cultural, spiritual beliefs.

For some participants incorporating spirituality only came into focus if there was a dilemma concerning their clients: "Well one would suspect if there's some sort of dilemma arising through treatment or whatever then it would be brought up in the context of ... a team meeting type of thing ... usually it's not part of the formal treatment plan but there's no reason why it couldn't be..." Another participant discussed that incorporating spirituality this way reflected traditional approaches that were counterweight to a wellness model:

> I see them transformed by medical questioning, they're reminded of their illness, they're checked not about their wellness but, "are you sleeping, are you eating, are you hallucinating, are you taking your medications, are you constipated, is your mouth dry?" and I'm thinking and then they say "yeah he's pretty rigid" and I wonder why. I know that's their job, but clients dread sometimes coming to their medical reviews they're afraid that they're going to be judged on the scale of questions, not that the doctors aren't kind but that they're going to end up being told they're sick again or "you're not well" ... it's kind of counterweight to a wellness model...

Participants further described that a focus only on symptoms of illness creates challenges to incorporate spirituality, particularly in situations where it becomes difficult to figure out what is normal experience versus abnormal. Some participants described the experience of trying to incorporate traditional psychiatric model as a struggle:

> Another point which I struggle with at times is that often religiosity or spirituality becomes and mixed with the delusions and that is difficult, because then it's really difficult to find a point where you really consider that a delusion or is it still quite normal. Of course that can become a contentious issue ... more what I think of is when it becomes an issue, and people get into religious themes too much and I have to figure out is this still OK, or is this delusional.

Some participants viewed their client's spirituality as a normal process that may or may not be related to symptoms of illness. The following participant described that it was important to acknowledge their client's spirituality as a normal process:

> Also, whether people have religious or spiritual delusions or not I don't think that says that we shouldn't talk about God or spirituality. I think maybe even more so ... if it comes up as a natural thing to address it, it should be addressed. As people feel sometimes when they're psychotic that they're having a spiritual experience... I feel it's important ... I think it's also kind of a normalizing thing too that you can use it in – everybody has these feelings and trying to sometimes see what they are believing or what they find meaningful, it tends to make me sometimes see how maybe their thinking is a little off but really what they're trying to do is quite a very normal process so I find it kind of helps me in that way of seeing ... to try to fit it into being more normal than abnormal.

Another participant discussed spirituality as being strongly associated with culture and described how their client's spiritual cultural beliefs might be viewed as abnormal within the context of traditional psychiatric treatment approaches:

> A psychiatrist once asked me to come see a client who was kind of violent and noncompliant with his medication and kind of hostile...and psychosis of talking to spirits or talking to something and wrong numbers and stuff and when I went and talked to him, I was a little worried about it, he's a big Native guy, ... he started talking to me about his spirituality...where he was coming from, and all those things kind of made sense of what he was talking about. It made sense to me his spirituality...but the psychiatrist couldn't understand that and so he had to draw on my expertise what is

> psychosis and what actually it is. I mean the guy was definitely sick, and he needed medication, but some of the stuff he was doing-starving himself for 10-12 days at a time so he could connect with the spiritual kind of demon or something, but after communicating with me, a lot of stuff made sense, but not to the extreme of what he was doing.

For most participants it was important to include spirituality as part of their practice. Some participants, however, expressed that traditional psychiatric treatment approaches to caring for clients with SMI failed to integrate other aspects of the individual that were perceived to be important, such as spirituality. This view was expressed in the following excerpt:

> The distortion, the psychosis, it's not so much about the religiosity of whether or not these are accurate but there is a spiritual commentary going on ... There's a reason. That whole connection when we treat the brain and forget the soul we are in trouble.

In order to acknowledge the spiritual world that a person has some participants tried to use a biopsychosocial approach to caring for their clients. "I think it's fundamental to the model of a very holistic model and biopsychosocial model ... at least some acknowledgement of the spiritual world that a person has." Although participants tried to incorporate holistic approaches to caring for their clients, this study revealed that within the multidisciplinary team there was no standard way to address spirituality with clients. Amongst the focus group participants, only two participants out of twenty-two used a formal assessment tool that assessed their clients need for spirituality. Participants noted that not all clients identified a need for spirituality in their practice; however using Self Appraisal Living Skills (SALS) was one tool that helped participants to formally assess their client's need to incorporate spirituality with their care. The following participants described the (SALS) tool as helping clients to identify client needs:

> ... one of the forms that we use to sort of structure our initial interview is called the "Self Appraisal Living Skills." It's a very simple thing. It goes over all their aspects of day-to-day life and some touchy subjects are in

> there, like how is their sexuality, for example, do they have any issues with that, home management, etc. And, one of the questions is spirituality. Many will say its fine or choose not to really get into detail and many will say absolutely. I get them to rate areas on a scale of 1-10, with 10 being most important and I think right now 2 or 3 of my clients have rated that area 9 out of 10. So, just the idea of wanting to explore it and not being sure maybe what, in terms of meaning and purpose, some wanting to go back to their childhood spirituality and figure out if it's still relevant to them. So, I was really surprised, that when I was intentional about it, how many people were so focused on wanting to talk about it.

One of the main challenges of assessing spirituality was making it part of the multidisciplinary team approach. Although some participants inquired about their client's spirituality, participants discussed that spirituality was initiated on an individual basis, and in most cases, did not involve the other members of the multidisciplinary team. This excerpt illustrates an individual approach to incorporating spirituality:

> In my practice, because I believe spirit is so important ...I can categorically say that there's not one who's on my caseload that I haven't inquired about their spirituality. I think it is part of my initial assessment, not the assessment with the doctor, but I ask in the assessment as well if they are actively in formal religion and have spiritual beliefs and they kind of blow it off a little bit there, but as part of getting to know each other, not one client do I not say, "where is this for you? Is this an important part of your life and what do you make of this whole spiritual stuff?" People have a lot to say about that, I find.

Multidisciplinary teams were challenged to incorporate spirituality because of the differences in conceptual frameworks that exist and individual approaches to incorporating spirituality. Findings from this study revealed that most participants did not inquire about their client's spirituality unless it was in the context of a dilemma or problem. This type of approach was indicative of traditional psychiatric treatment approaches whereby issues such as spirituality were viewed in the context of abnormal experience. Although most participants viewed spirituality to be an important part of their client's lives and an important part of treatment few participants initiated conversations about spirituality with their clients and only two utilized assessment tools

to help identify the clients' need to have spirituality incorporated with their mental health care.

Language

Participants discussed language as another challenge to incorporating spirituality. Most participants did not use the word spirituality in their practice. This issue was reflected in participants' statements such as, or "I don't word it spirituality..." and "well I often ask but I don't word it spirituality." As discussed earlier, participants addressed spirituality by using words such as connection, support, religious beliefs, and purpose and meaning. The challenges to appropriate use of language are described by the following participant:

> I think having the language is important. I'm not usually always tongue-tied, but it's hard or challenging to talk about spirituality thinking I don't want to offend somebody else nor do I want to be offended and it's like almost walking on eggshells.

Most participants' personal view of spirituality did not include the concept of religion. Some participants, however, conceptualize religion as part of their client's spirituality and were described as their client's religious beliefs. The challenges included whether participants viewed spirituality as including religion or whether they viewed these as separate concepts. Some participants made distinctions about using the words religion and spirituality and is illustrated in this quote, "Spirituality is not necessarily talking about religion...".For this participant spirituality did not include religion:

> I think there's a division between spirituality and religion...I don't want to hear about somebody else's religion when I'm doing therapy but I certainly would like to get some of the spiritual...some of the ways to connect with a spiritual being or I think for me I want it to be more generic and more generic with a client.

Other participants did not use the word spirituality in their work with their clients because they felt that it was too abstract to define as described in the following,

"for those with the ability to think in the abstract some are so concrete that I'll bring up the subject just to see how concrete or their ability to think in the abstract."

Some participants did not feel comfortable to use the words spirituality and or religion because it was perceived as not part of the medical model. This participant gives the example of mindfulness:

> I work with clients with mindfulness, which is a positive, but these are all spiritual matters. And, they're all couched in the language that allows them to operate under the radar of the medical model. That's really too bad, but it's there.

In general participants reflected that they did not use the word spirituality because of the different meanings associated with this concept. Participants expressed that they felt more comfortable using words that convey the core attributes of spirituality such as connection, support, beliefs and meaning and purpose. Participants' experience of how spirituality was brought up by clients was often in the context of a religious belief. Because of the various understandings of spirituality that exist some participants wanted more time to reflect on the use of language around spirituality. This was conveyed by the by the following participant:

> When you try to define it in a way, I almost wanted to write down but didn't the things that we were talking about, what spirituality was? We all had different ideas – connections, creativity and all that stuff so it's something that you don't really know what you're talking about. Again, maybe more of a forum of talking about that to find out what other people think it is we're talking about.

Education

One of the major professional practice issues that affected participants' ability to incorporate spirituality was a lack of formal education and ongoing training in spirituality and mental health. In general participants did not feel adequately prepared to address spirituality in their clinical practice. Those participants who had educational preparation in spiritual aspects did not always implement it into their work with SMI clients or did not always remember to ask.

The following participant discussed how assessing aspects of their clients' lives are helpful to determine how they are functioning. Despite this information, however, spirituality was not always incorporated into the care of clients with SMI:

> I went to the Adler school for Counseling Psych. and we consider 4 tasks of life: relationship, social, work and spirituality. So, if I was in my private practice and I'm seeing people I would often cover these different areas, and it's very helpful for them to get a grounding of how they're functioning. What areas of life need a little work? And spirituality gets just as much as all the others. So, I have had that background, but I've not necessarily brought it into this work as much. I might now.

Similarly, another participant commented that despite having some formal training but they did not always inquire about the client's spirituality:

> Well it started to be and I trained quite a while ago, but I mean we are taught that, and it was known who was interested in – not necessarily spiritual issues but religious issues and all that. It was a more kind of keep it open for our patients that they can bring it to us if they wish to but I agree with you that there perhaps needs to be a little bit more on that...we were taught – not that I always remembered though to ask about religion in a non-threatening way, the same way as you ask whatever (basically you just ask about their support systems), home and stuff like.

The following participant provides a reason that spirituality is not incorporated into practice. Issues like spirituality and sexuality might be considered more challenging because they were considered to be private topics not only for the participants but also for the clients:

> It's a question in the nursing training they talk about the wheel, like the whole person, then there's sexuality and what they call health and community, however you want to divide that wheel and spirituality is in there and we had training on nutrition and sexuality and so on but not on spirituality and I would say it's actually a gap if I were to be working holistically ... but it is interesting that all of those formal, fill-out assessments for geriatrics, we don't actually ask about sexuality either, or "spirituality. They're both kind of [laughter] ... Even though we are supposed to be looking holistically. In the same way I probably wouldn't talk about it if it did come up – the client may initiate discussion about his sexuality I certainly wouldn't initiate with mine and I kind of feel the same way about spirituality that there's a privacy area there that is maybe why we don't go there.

Most participants discussed that although they had not received any formal training related to spirituality, were encouraged by the practical experiences that they received through their work. The following participant described how working with individuals from various cultures helped to incorporate spirituality:

> And I think certainly it came out of my training background feeling like, "oh you just don't talk about that," and yet what I find is that it is helpful for my clients to be able to discuss their beliefs and because I've worked with a few people who – from other cultures and other religions who do talk about it. It's something that I'm beginning to see that there's ways of doing it..."

In order to increase their education and training some participants attended regular conferences and workshops designed to integrate spirituality and health. The need for increased education on spirituality was presented in the following excerpt:

> Well, it certainly hasn't been any formal education [laughter] training but I think through various conferences that I've gone to, there's a particular conference that I attend fairly regularly that's more focused on community mental health issues and from time to time, more recently there's been spiritual presentations that have come up and so you go through that – you learn a little bit that way.

Findings from this study showed that spirituality has not been formally integrated within the system of community mental health practice. Participants acknowledged that in order to incorporate spirituality as part of formal treatment approaches more education is necessary. The following participant reflected this view:

> I've never been taught spirituality in my educational system [laughing]... It's sort of a system in which I've got research articles in which – from different countries, a number of clients have said that their spirituality have not been dealt with by mental health professionals, but still, this is not a part of the system to talk about the spirituality of the patient. It's not allowed. We are doing it individually because we are interested but it's not part of the system. And it should be part of the system.

Summary of the Findings

Currently there is a paucity of research that has explored mental health professional's perspectives on incorporating spirituality within a multidisciplinary setting (Baetz et al., 2004; Boston, Mount, Orenstein, & Freedman, 2001; Sheridan et

al., 1992). Thus, the purpose of this study was to explore the perspectives of CMHP about incorporating spirituality in their care of individuals living with SMI. An interpretive descriptive research design was used in order to gain an understanding for CMHP subjective experience of incorporating spirituality. This methodology helped to uncover the attitudes and behaviors currently held by mental health professionals concerning the spiritual dimension in practice.

The findings from this study revealed that several major challenges exist to incorporating spirituality within a multidisciplinary team environment. These challenges were described by participants as professional practice issues and included the professional boundaries, practice environment, differences in conceptual frameworks, language and education.

Participant perspectives on incorporating spirituality included how they conceptualized spirituality in their professional work with clients. The concepts of connection, beliefs, meaning and purpose were identified as core attributes of spirituality. These perspectives helped to identify how spirituality was incorporated into practice. The findings revealed that participants viewed spirituality as an important variable to mental health treatment because it helped to understand their client's mental health. Most of the participants viewed spirituality as positively influencing their client's health behavior; however participants also described that their client's spirituality might affect them negatively depending how their clients interpreted their own beliefs, and whether or not they had experienced trauma through their spirituality. The process of incorporating spirituality is a complex, interactive process influenced by diverse perspectives and professional practice issues.

CHAPTER 5:

DISCUSSION, IMPLICATIONS AND CONCLUSION

In this chapter I discuss the key findings that evolved from this study and how these findings support existing literature as well as provide new insights into the incorporation of spirituality in community mental health based practices. I begin this chapter by discussing participants understanding of spirituality; this is followed by a discussion about professionals' perspectives' on the challenges that exist to incorporating spirituality. The implications of participants' understanding of spirituality and participants' perspectives on the challenges that exist are also presented in terms of how it relates to practice and future research. In the final paragraphs I present the conclusions drawn form this study.

Discussion of the Findings

This study explored CMHP views on spirituality and how they incorporate spirituality with professional practice. Interpretations about the findings were achieved through the interpretive, descriptive research design and constant comparative method of analysis. Analysis of the findings revealed several layers of interpretation which included participants' perspectives of their personal understanding of spirituality, what spirituality means in the context of professional practice, as well as how spirituality was viewed within the larger context of the mental health team. This research design also included my own level of interpretation about the findings.

Through this process I was able to understand participants' points of view on spirituality as being significant aspect of life for themselves and their clients. The significance and meaning of spirituality is discussed under the perspectives of spirituality and include the three main attributes that participants associated with

spirituality, these include, connection, beliefs and meaning and purpose. This is followed by a discussion of the challenges that exist to incorporating spirituality in community mental health practice. For the purpose of clarity, I have reorganized the core categories, professional boundaries, practice environment, differences in conceptual frameworks, language and education, that were discussed under the challenges to incorporating spirituality in chapter four, in three main topic areas, in order to encapsulate the main challenges; these include boundaries of professional role, team support and biomedical frameworks.

Participants' Understanding of Spirituality

Participants' understanding of spirituality was described as an important aspect of life. The importance of spirituality was described in participants' comments such as "I think to say spirituality is not important would be a very big understatement..." and "It's important to me..." Religious beliefs and client's religiousness were conceptualized as part of spirituality, however for most participants; religious beliefs were not included in participants' personal spirituality. These differences were revealed in comments such as the following "My own spirituality isn't like that..." or "Spirit is so important, not meaning particularly as religion...", and "I'll bring it around and talk about spirituality and how it's not necessarily taking about religion..." Some participants however, described their understanding of the client's spirituality as including religiousness, meaning formal religious practices such as worship and church attendance, and the concept of God. Thus participants acknowledged that for many of their clients spirituality included traditional conceptualizations of religion. One participant expressed this difference, as "this is an opportunity for him to feel a sense of belonging So for me, that was the spiritual part, but he thought the spiritual part was actually the God that he believed in and stood on the corner and handing out flyers."

Other participants referred to themselves as agnostic. For those participants who did not identify their personal spirituality with a particular faith or belief in God, did not mean that they were not spiritual or believe that spirituality was not important either for themselves or for their clients. One explanation for the conceptual differences between how participants understood spirituality versus their clients could be accounted for by the difficulty in establishing appropriate language about spirituality and religion. In some instances participants felt spirituality was an abstract concept that meant different things to different people. This finding underscores the complex and multidimensional aspects of spirituality.

These distinctions, support current trends in the literature that view religion as associated with religiousness, and only one of the variety of ways for understanding spirituality (Hill et al., 2000). The multidisciplinary perspectives that were found in this study however, addressed participants' subjective experience and understanding of spirituality and therefore depart from previous studies that suggested mental health professionals tend to be less religious than their patients (Baetz et al., 2004; Corrigan et al., 2003; Hill et al., 2000; Lindgren & Coursey, 1995; Longo & Peterson, 2002; Sheridan et al., 1992; Zinnbauer, Pargament & Scott, 1999).

Perspectives on Spirituality as Connection

Participants in this study understood spirituality to include connections that one has with others, family and with their community. Thus participants conceptualized spirituality broadly to include connections that clients made within or outside of their faith community. Findings from this study showed that the concept of connection was important to understanding spirituality and is consistent with other reviews that have examined the concept of connection as important aspect of spirituality for both care providers and clients (Chiu et al., 2004; Faver, 2004; Tanyi, 2002; Tarko, 2002).

The findings showed that participants assessed their clients' ability or inability to connect as associated with their client's mental health. This reflected the substantial knowledge that participants had in working with clients living with SMI, as many participants recognized that clients often feel alienated and isolated by their communities, others and family. Participants viewed connection as positively contributing to their client's mental health because it enhanced their sense of belonging and comfort that they received, increased their client's social support systems, and provided clients with alternative strategies for coping. In this way spirituality as connection influenced positive mental health outcomes for their clients. Participants therefore encouraged clients to develop adaptive ways for coping either through establishing relationships with others or incorporating other spiritual resources that would foster connections. Participants identified spiritual coping as internal and external resources that provided both clients and participants with alternative resources. They therefore, felt it was important to incorporate both internal and external resources that would foster connections.

For clients, external resources for spiritual coping were often associated with increased social supports received through their spiritual fellowships and faith communities as well as the supports that they received to obtain basic living resources such as food, and shelter and in some cases treatment for drugs and alcohol. These findings are consistent with theory on the salutary effects of how spirituality positively affects health by increased social supports (Ellison & Levin, 1998; George et al., 2000; Longo & Peterson, 2002; Oman & Thoresen, 2002).

Internal resources were viewed as spiritual practices that clients could draw upon in order to manage their symptoms of illness. Participants in this study described that when they asked their clients how they coped, clients disclosed incorporating practices

such as prayer, scripture reading aloud, and mindfulness practice as some spiritual coping methods. These spiritual practices are not new to ancient spiritual traditions; however they have recently been understood as potential therapeutic techniques available for clinicians working with general and low functioning populations (Oman & Driskill, 2003). This study revealed that individuals living with SMI are able to utilize spiritual practices to help them cope with their illness. A salient example of spiritual coping was described by one participant whose client actually yelled out part of a scripture from a Bible in order to cope with hearing disturbing voices.

There is recent theoretical evidence to suggest that incorporating spiritual coping strategies such as prayer and aloud scripture reading not only endorses adaptive ways of coping, provide individuals with internal resources of support and foster higher ideals but helps individuals cope with adversity by allowing them to shift their attention away from the troublesome stimuli or problems (Oman & Driskill, 2003). Although some theorists and scientists are now discovering the salutary effects of or mechanisms associated with positive health outcomes on members of the general population and those living with other chronic illness, spiritual coping as a resource for clients living with mental illness has had little attention in the scientific literature (Chiu, 2000; Corrigan et al., 2003; Levin & Chatters, 1998; Mueller, Pleyak & Rummans, 2001; Tepper et al., 2001). The findings from this study identified that clients use practices such as prayer, scripture reading and meditation in order to deal with symptoms of illness. The effects of spiritual coping on SMI remain poorly understood by most health care professionals. For a long time it was believed that such practices were actually associated with their illness, or even symptoms of their illness, and not seen as potential resources. The findings from this study, however, supports a growing body of literature

that suggests clients that are living with SMI may also potentially benefit from certain spiritual and religious practices such as prayer, meditation and repeating scriptures.

Perspectives on Beliefs

For participants in this study the concept of beliefs was discussed as an important concept associated with an individual's spirituality, mental health, illness and culture. Delusional beliefs were distinguished by their association with symptoms of psychopathology. Participants' raised some very important issues, however concerning the relationship between spirituality and psychopathology and its effect on the notion of beliefs. The first issue relates to the fine line that exists between what constitutes abnormal versus normal experience and how one makes the distinction between the two. This difficulty was expressed as "...people get into religious themes too much and I have to figure out is this still O.K., or is this delusional..." and "... maybe their thinking is a bit off but really what they're trying to do is quite a normal process...it kind of helps me in that way of seeing ... to try to fit into being more normal than abnormal." These perspectives support psychological theories that have called attention to the complex relationship between psychoticism and spirituality (Clarke, 2001). This study also underscores that it is important to distinguish between healthy beliefs and delusional beliefs, which, simultaneously, is a challenge as well.

The second, related, issue was expressed by one participant who stated, "... the distortion the psychosis ... there's a spiritual commentary going on. I don't really understand it... its dicey when someone's psychotic, but at the same time why this dialogue..." This question concerns the issue of why some clients who experience psychosis often incorporate spirituality into their illness. These findings suggest that individuals who experience psychosis may have an increased need for spirituality and therefore incorporate their spiritual and or religious beliefs in order to cope with

symptoms of mental illness. This relationship might also provide further insights into the link between stress and coping as discussed by some researchers (Pargament & Brant, 1998; Tepper et al., 2001).

Although the psychiatric community has had a long history of associating spirituality, religion with psychopathology, participants' perspectives on spirituality in this study contradict recent reports that mental health care providers tend to pathologize their clients spirituality with illness (Hill et el., 2000; Longo & Peterson, 2002; Thielman, 1988). This emerging, alternative perspective that spiritual practices can actually be a resource and are integral to the clients' culture and view of life is in line with recent amendments to the DSM IV. It now includes a focus and greater sensitivity toward the important cultural and religious influences on the individual (Koenig & Pritchett, 1998). An increased acceptance of cultural diversity may help to broaden the perspectives about how culture might influence understanding of mental illness for some individuals.

Despite the increased awareness and sensitivity toward addressing important aspects such as culture and religion, participants were ambivalent about incorporating spirituality due to potential harmful effects their client's spirituality might also have. A feeling of ambivalence was expressed by one participant who suggests:

> It is helpful, and my answer is yes and no. When spirituality is interpreted or translated to them in a meaningful way and in a way that they can comprehend and is helpful but [if] it is interpreted or translated or mistaken then it could be harmful. I have seen clients who are really suffering from the misinterpretation of their own spirituality...

Thus, many participants were sensitive to how their client's spiritual beliefs either positively or negatively influenced their mental health. Some of the findings suggest that client religious beliefs included the concept of God as an external phenomenon that provided clients with a sense of hope, comfort and defense against

illness. Suicide prevention, harm to others and decreased drug and alcohol use were perceived to have an important relationship with prevention of risk behaviors. This finding is congruent with other studies that suggest that religious commitment may influence mental health through encouraging health related behavior, such as adopting healthy life styles that discourage behaviors such as, alcohol use, drug use and physical health risks in general (George et al., 2000; Levin & Chatters, 1998; Mueller, Pleyak & Rummans, 2001).

Although participants acknowledged the potential health benefits that spirituality may provide, they also discussed that some clients experienced trauma and suffering from their spirituality. Client religious beliefs were viewed to negatively affect client's mental health if they had experienced abuse from specific faith communities. This was described by one participant whose client experienced abuse in the context of residential schools. Other participants noted that some clients' religious beliefs caused them to experienced increased anxiety about their illness, feelings of abandonment, shame and guilt. Thus the relationship between religion, spirituality and health is complex.

Participants found that some of their clients who experienced feelings of guilt consequently avoided medical treatment. Some authors have suggested that religiosity may worsen the course of psychiatric disability and undermine recovery by encouraging clients to avoid or discontinue traditional treatments (Corrigan et al., 2003; George et al., 2000). Similarly, others have also suggested that in some cases religious beliefs may adversely affect people's health by encouraging religious abuse, or persons within a religious group may not accept SMI as illness leading to isolation, stress, anxiety or may alienate others who do not share their beliefs (Mueller, Pleyak & Rummans, 2001).

In some cases client's spiritual beliefs manifested as religious delusions or incorporated with psychotic experiences. This resulted in the client's misinterpretation

of their spirituality and could be potentially harmful. These experiences were described by one participant who noted, "when he's ill ... he believes he's the rebirth of Christ and to save the world he has to kill himself." In this study participants were aware of how their client's religious beliefs could undermine health or increase mental health by avoiding risk behaviors such as suicide and self harm. It should be noted, however, that, there are limited studies that have explored the area of negative aspects of spirituality on members of the general population and even fewer have explored the potentially negative influences on vulnerable groups and sub groups of the population such as those living with SMI. Most of the empirical research on spirituality and health has shown religious involvement to have either no effect or a positive effect on health (George et al., 2000; Koenig & Larson, 2001; Mueller, Pleyak & Rummans, 2001).

In this study participants viewed cultural beliefs as another aspect of their client's spirituality. The concept of religion and spirituality are multidimential with overlap of attributes and are influenced by individual culture (Post, 1998). Emergence of cultural diversity was described in this study by participants in their efforts to provide culturally appropriate psychiatric treatment. As a result the notion of what constitutes spiritual beliefs and practices is taking on different meanings according to one's cultural background and personal beliefs. These findings emphasize the issue of cultural competency and have been discussed in the literature as challenging mental health professionals to take on new interpretations and explanations of human behavior (Alarcon, Westermeyer, Foulks, & Ruiz, 1999).

As discussed above, culture has a strong influence on beliefs, attitudes and behaviors and has been defined by social scientists as amongst the most important factors that give structure and meaning to human values, behaviors and experiences (Nash & Stewart, 2002). Participants noted the growth of multiculturalism in

Vancouver's Lower Mainland and discussed the need to provide cultural sensitivity and culturally appropriate mental health care to diverse population groups. This study included the perspectives of two multicultural liaison workers who provided community mental health care to both First Nations peoples as well as East and South Asian clients. These as well as other participants expressed that spirituality played a significant role in their client's lives and affected the way in which engaged with traditional psychiatric treatment approaches. In order to integrate clients need for culturally appropriate care with traditional psychiatric treatment approaches, participants implemented alternative resources for clients within the community of the mental health teams. These resources were community run groups that provided a place for clients to express and incorporate their cultural and spirituality. An example of the community run groups that were implemented by participants included, sweat lodges, talking circles, prayer groups and the Linehan (DBT) group based on mindfulness practice and Zen Buddhist philosophy. Other participants also incorporated a multi faith curriculum in order to meet the culturally diverse needs of families and children.

Few studies have examined the cultural, spiritual needs of clients living with SMI. My study challenges other mental health care providers to understand how culture might impact client's use of traditional psychiatric treatment approaches. This finding supplements recent social science literature that has suggested consumer identification of a need to integrate spirituality and religious practices with traditional psychiatric treatment that fit their cultural world view (Chiu et al., 2004; Sirois & Gick, 2000; Smye, 2004). Others have also suggested that incorporating indigenous local resources that offer a place of refuge and worship might influence policymaking and planning for community mental health care (Raguram et al., 2002).

Perspectives on Meaning and Purpose

Findings in this study have shown that participants understood spirituality as something that gave their clients a sense of meaning and purpose. Meaning and purpose was discussed as those experiences that give meaning and may or may not include an individual's religious faith or belief, rather meaning and purpose was perceived as a universal experience. The universal aspects of their client's search for meaning and purpose where described when clients began to ask existential questions such as "What's the purpose of my life? Why?" and "what does it all mean..." The concepts of meaning and purpose are consistent with other researchers and mental health professionals who define spirituality as a personal sense of meaning and purpose which may or may not be expressed through traditional religious beliefs and practices (Greasley, Chiu, & Gartland, 2001; Tanyi, 2002).

Participants found that client's search for meaning was more acute during a health crisis and psychotic experiences. These experiences often resulted in clients experiencing multiple losses, questioning their faith and or distorting their spirituality. This finding is similar to other studies that suggest individual experiences of illness may evoke the need for spiritual pursuits (Cavendish et al., 2000; Chiu et al., 2004; Corrigan et al., 2003; Lindgren & Coursey, 1995; Mueller, Pleyak & Rummans, 2001; Murphy, 2000; Narayanasamy, 2004; Pargament & Brant 1998; Tepper et al., Tulbolt, 1996).

In some cases clients were able to incorporate their spiritual resources in order to find meaning in their experience of illness. This was expressed in the examples whereby client's religious beliefs in God often gave them a sense of comfort and hope for the future. Thus clients' ability to find meaning in their lives also gave them a sense of purpose. As one participant noted, " they have an affinity with the religion they grew up with or a belief in God..." and " He's not supposed to kill himself because he's the chosen

man in the Bible ... he has a sense that he's going to merge with the Holy Spirit ... and be happy for ever more."

Although participants were encouraging of incorporating spiritual resources that might aid in relieving clients suffering, participants found that in some cases they were not able to help their clients in their search for meaning and purpose. This experience was described by participants as negative health outcomes and included, a sense of existential emptiness, depression, the lack of spirituality and suicide. These findings suggest that mental illness may prevent or enable clients to incorporate spiritual practices and beliefs that provide meaning. Similar views were found by Phillips, Lankin and Pargament (2002) who make the point that clients who experience high levels of symptoms may experience barriers to incorporating spirituality. Therefore, identifying what gives meaning and purpose has important health implications.

In this study participants incorporated what was meaningful for clients by asking about their faith in God or other cultural spiritual beliefs, and encouraged clients to develop relationships that gave them connection and support either through their faith community or other social resources. Participants also celebrated their clients' creative pursuits in order to promote what was meaningful to them. Clients' ability to find meaning and purpose in some cases centered on the connections and supports that clients received through their mental health team.

Although clients may experience greater need for spirituality during illness, and therefore incorporate the search for meaning and purpose as providing a framework for coping, the opposite was also evident as participants found that in some cases the lack of meaning can result in clients experiencing existential emptiness, which can precipitate negative health outcomes such as depression and even suicide. This finding is congruent with theorists who advise that spirituality can give some individuals a sense of meaning

and purpose because it allows people to understand their role in the universe, the purpose of life, and develop the courage to endure suffering. They caution, however, that there is no assumption that the meaning fostered by religious faith is exclusively positive, and that individuals can only minimize the risk of suffering if they find meaning in that suffering (George et al., 2000). This finding is supported by classic findings from sociological theorist Durkheim (1897/1951) who suggested that individuals were less prone to commit suicide who had a strong sense of attachment to the collective conscience (as cited in Koening, 1998). Nevertheless, participants noted that client's spirituality as defined by what gives meaning and purpose to their lives has a strong influence on suicide prevention.

Challenges to Incorporating Spirituality

Although participants viewed spirituality as an important aspect to providing mental health care, the findings revealed several challenges to incorporating spirituality that were consistent with the literature. Other new insights were also discovered that address the challenges to incorporating spirituality within the context of a multidisciplinary team. I discuss these new insights and challenges under the sections of boundaries of the professional role, team approach and biomedical frameworks.

Boundaries of the Professional Role

Participants reflected that not all clients might want or need to have their spirituality addressed within the context of their mental health care. Nevertheless the findings revealed that their clients often asked participants about their spiritual and religious orientation. This finding is consistent with other studies that suggest most clients want their spiritual needs met and discussed by their health care professional (Beatz et al., 2004; Greasley, Chiu & Gartland, 2001, Josephson, Larson & Juthani,

2000; Koenig & Pritchett, 1998; Lindgren & Coursey, 1995; Mueller, Pleyak & Rummans, 2001).

For most participants sharing belief systems and personal points of view of spirituality challenged the boundaries of their professional role and the therapeutic relationship with their clients. Participants perceived their professional role to provide client safety and therefore felt uncomfortable to disclose their own beliefs that were viewed as deeply personal and intimate. Participants stated that in order to incorporate spirituality they required skills to "safely negotiate" this territory with clients. Participants did not want to impose their own views on spirituality for fear that they might misuse their level of authority and thereby judge their client's religious and or spiritual beliefs. In addition some participants, who did share the same religious and spiritual orientation, feared that their clients would become dependant on them to meet all of their spiritual needs. In other cases participants avoided discussing spirituality due conflicts and differences between their beliefs and their clients. Participants perceived these differences as a potential threat to the therapeutic relationship. Wanting to avoid conflict was stressed by a participant who commented, "I've had to put some stops in place and be really firm ... about the differences between ... my idea of what the differences where and hers ... so it doesn't overflow into all the other stuff we do all year."

Despite these challenges, self disclosure was also perceived by some participants as important to developing trust and rapport with their clients. Participants' ability to disclose their own spirituality was another way in which spirituality was incorporated into care. From some participants view, clients were reluctant to express their spiritual and or religious beliefs to their mental health professional if they feared that they would be judged and that their beliefs would be seen as associated with their illness. These

findings addressed the issue of trust as important to developing the therapeutic relationship and substantiate other studies that have examined consumer perspectives (Fitchett, Burton & Sivan, 1997; Greasley, Chiu & Gartland, 2001; Lindgren & Coursey, 1995). Some researchers have also suggested that it is particularly relevant that mental health care providers acknowledge their client's spirituality even when those beliefs manifest within the context of illness in order to maintain trust. Thus participants emphasized that for clients who expressed or wished to express their spirituality it was important to understand what spirituality meant to them and to not dismiss this important aspect of their life.

In this study participants acknowledged that connection to health care professionals is a significant aspect of the therapeutic relationship and is congruent with Tarko's (2002) study where mental health clients identified connection to their community mental health team as being important aspect of their spirituality. As one participant stated that "you can talk about spirituality therapy is definitely deepening at that point, and your rapport is much more ... I think this process alone assists in their mental health and their connecting with another person." In this study participants acknowledged that many clients living with SMI are disconnected from their communities, family and others. Connection was perceived by participants to have an important relationship with their client's mental health because it helped clients gain a sense of belonging and comfort. Participants also experienced their client's lack of connection or inability to connect has been associated with negative health outcomes such as depression, alienation and isolation.

Therapeutic connections in some instances involved participants being able to share their own spiritual beliefs, feeling comfortable to do so, as well as acknowledging the role spirituality plays in their clients' lives. One of the insights gained from this study

was that participants also felt that they benefited from incorporating spirituality because it provided meaning to their relationships with their clients and helped them to provide care. One participant commented, "it gives a lot of meaning." Another disclosed that simply being with the client and sharing experiences was a type of spiritual experience in itself. The meaning and sense of connection that participants and clients received from being able to incorporate spirituality, supports theoretical development on relational spirituality, and suggests that care providers also receive an increased sense of spirituality through their connectedness with their clients and their work (Favor, 2004).

Participants described how their own spiritual practices helped them increase their ability to provide care to their clients. Practices such as mindfulness helped participants deal with their own stresses related to their work and helped them to stay calm. Mindfulness was used by one participant who stated, "I find it really helps me stay grounded in the job." Another added that regular practice of spirituality is "important ... and helpful to put my stress down in dealing with clients, their problems effects us also." Few studies have explored how spirituality might help care providers in their practice and whether or not incorporating spiritual practices like prayer or mindfulness might enhance care giver efficacy. Although research on care giver efficacy remains in its infancy some authors have suggested that implementing spirituality in this way could supply many health care professionals with tools that enhanced their confidence and ability to deal effectively with psychosocial and relational care giving tasks, manage personal relationships, boundaries, and deal with ultimate concerns (Oman, Hedberg, Downs, & Parsons, 2003).

The dilemma of professional boundaries and roles of mental health professionals as they are related to spirituality has been a long debate within the psychiatric community. This dilemma originates within the various theoretical perspectives that

that exist about causes and treatment of mental illness. One the one hand mental health professionals view issues of spirituality as out of their realm of expertise and believe that such matters should be dealt with by clergy. However as Koenig and Pritchett (1998) suggest that regardless of any biological explanations for mental illness, psychological issues often overlap with spirituality and are difficult to separate thus both of which need addressing to allow for the total healing of the person. Thus incorporating spirituality at the vary least, helps us to understand our clients cultural and spiritual needs better and may offer alternative resources that may potentially improve mental health. These interventions challenge roles while at the same time offer interventions that are not limited to purely medical approaches.

Team Support

In many respects participant experiences of the challenges to incorporating spirituality parallel their clients' experience. Most participants described incorporating spirituality as an individual practice that was done on a one to one basis with their clients or in groups that were designed to incorporate spiritual and cultural needs of the clients. Participants, however did not tend to share these experiences with their colleagues because they feared being judged or ridiculed by other staff members. One participant described this sense of isolation, as "there sometimes isn't anyone to talk to it's that isolation that's there for the both of us, the client and myself." Another participant was reluctant to share because they felt they would be judged: "I've had staff joke and make fun of my spirituality." Findings form this study revealed that participants overall perceived a lack of support from other members of the team to incorporate spirituality.

The words that participants used to describe their experience of the lack of support were "it's a difficult job" and "we have to struggle." Participants did not feel that

openly discussing topics such as spirituality would be accepted. Participants only involved other members of the multidisciplinary team if there was a dilemma or problem associated with the client's spirituality, i.e. a health crisis or complex psychotic and delusional behavior. By incorporating spirituality this way, a professional might have a tendency to overlook the potential positive health outcomes associated with spirituality. If spirituality has important relationship with mental health status either positively or negatively then both aspects should be acknowledged equally. To only address spirituality in the context of problems undermines the potential health benefits that spirituality could provide and may create barriers to addressing clients' spiritual needs.

In order to overcome some of these challenges participants tried to set an intention for incorporating spirituality by changed their physical environment and by creating language that addressed their client's spirituality. Participants set an intention for incorporating spirituality by displaying a religious and or spiritual symbol in their office that had personal significance. By doing this participants felt that they had created a safe environment for clients to express their spirituality.

Some participants stated that they felt uncomfortable using words such as spirituality and religion because of the different meanings associated with each concept, and because they felt that it was not part of the medical model. The issue of language and conceptual clarity around the meaning of spirituality and religion were found to be consistent with other researchers that have addressed the main challenges to incorporating spirituality as the lack of conceptual clarity (Baetz et al., 2004; Hill et al., 2000; Longo & Person, 2002; Miller & Thoresen, 2003; Sheridan et al., 1992). Thus clinicians were challenged to find appropriate language that meets the spiritual and cultural needs of their clients as well as incorporating language that could be accepted by all members of the team. Participants were more comfortable using words that described

the core attributes of spirituality, such as connection, beliefs and what gives purpose and meaning.

Although participants generally felt that there was an overall lack of support from colleagues in being able to incorporate spirituality or discuss it as part of their practice, many participants stated that they appreciated being able to discuss their ideas, opinions and experiences about spirituality in the focus groups of this study. These impressions were revealed in comments such as, "Again, maybe more of a forum of talking about that to find out what other people think it is we're talking about. It's good." Other participants wanted more time to be able to discuss their ideas; this need was expressed by one participant who stated, "I think you could probably have had a little more time on this. I think this is a very interesting topic that I'm fond of and I'd love to spend two hours here..." Participants felt supported within the focus group setting by being able to discuss their experiences of the challenges. This format also helped participants to draw upon the similarities in their experiences and share their knowledge about the affects that spirituality had with their clients. The focus groups provided an opportunity for participants learning and encouraged participants to address spiritual issues with their clients.

Biomedical Frameworks

This study focused on the multidisciplinary points of view on incorporating spirituality and therefore included professionals from various fields that make up the community mental health teams. It is therefore not surprising to find many different points of view regarding spirituality. The variation in perspectives and conceptualizetions of spirituality is consistent with recent reviews that have shown that no single perspective on spirituality dominates post modern culture rather multiple perspectives exist simultaneously (Hill et al., 2000; Zinnbauer et al., 1997).

Despite the various perspectives, in this study there was a general consensus that viewed biomedical approaches to client care as a major challenge to incorporating spirituality. This study informed the underlying assumption that biological frameworks i.e. the medical model as the dominant approach to psychiatric treatment prevents the ability of clinicians to fully incorporate other important psychosocial aspects of the individual such as spirituality. As one participant put it, "it's kind of counterweight to a wellness model." This finding supports other researchers that have suggested that psychiatry continues to be strongly influenced by biomedical traditions (Baetz et al., 2004; Greasley, Chiu & Gartland, 2001; Hill et al., 2000; Levin & Chatters, 1998; Longo & Peterson, 2002; Mueller, Pleyak & Rummans, 2001; Smye, 2004).

By using biomedical approaches clinicians focus on pathological states of disease. This is in fact is "counterweight to a wellness model", as one participant stated. New frameworks are needed in order to address the psychosocial aspects of the individual that influence health. The literature on mental health policy development suggests that in order to decrease the increased prevalence and morbidity associated with SMI, clinicians adopt strategies that promote health and prevent mental illness (Canadian Alliance on Mental Illness and Mental Health, 2000; Magyary, 2002; WHO, 2001;). These new perspectives have been described by Magyary (2002) who recommends that a broader positive mental health orientation encompass not only the treatment of mental disorders but also the prevention of mental health disorders by enhancing positive qualities of daily functioning, which include incorporating psychosocial aspects of the individual such as spirituality. Thus, it has been well documented that the salutary effects of spirituality may prevent risk behaviors such as suicide and drug and alcohol use, and promotes health behaviors, improving the quality of life for individuals living with SMI.

The findings from this study also showed that despite recent amendments to the DSM IV and APA guidelines that help clinicians to address their client's spirituality as part of their initial assessment, very few participants addressed spirituality in their initial interview. As one participant stated, "it's not part of the formal treatment plan but there's not reason why it couldn't be." The findings showed that most participants viewed issues of spirituality as intimate and personal and therefore preferred to address spirituality once they got to a certain level of comfort with their client. Participants however, did address the core attributes of spirituality with their clients during the initial phases of their relationships as well as in the long term. This finding underscores the issue of language around spirituality, and not wanting to impose their views. These issues may account for the fact that most participants preferred that the client initiate the discussion about spirituality.

Participants in this study discussed that incorporating biomedical frameworks made it difficult for some participants to distinguish between delusion and what was part of normal experience. As a participant in the FG pointed out that fasting to ward off demons was considered normal practice within the client's Native spirituality. In order to provide culturally competent care, it is necessary that all members of the multidisciplinary team be able to address their client's spirituality and what it means to them separate from symptomatology. A failure to do so may have negative implications for the therapeutic process and wrongly inform treatment approaches.

Implications

The findings from this research study gives rise to several implications for community mental health practice and insights for future research. I delineate these implications under how participants understood spirituality, this includes, the meaning of spirituality as including connection, beliefs, meaning and purpose. I discuss the

implications of the major challenges to incorporating spirituality, under boundaries of professional role, team support and biomedical frameworks.

Perspectives on Spirituality as Connection

Implications for practice

Spiritual connections are an important concept that has many implications for positive and negative mental health outcomes. CMHP can help clients to identify and apply both internal and external spiritual resources in order to help clients increase their supports and provide alternatives for coping. It is very important that CMHP seek to understand what spirituality means to the client, and address spirituality based on their clients' needs and point of view. In order to increase clients coping, CMHP can incorporate the use of internal resources such as prayer, scripture reading and meditations by encouraging their clients to make use of these practices. Implementing external resources such as the use of church or temple and development of spiritual relations may also provide clients with increased supports.

Implications for research

Very few studies have examined the use of spiritual practices by individuals with SMI. If clients express a strong need for spirituality it becomes clinically relevant to identify how these practices might help cope and the benefits that they receive. How do individuals living with SMI incorporate their spirituality as a source for healing? What are their spiritual needs and how do they compare with those living with physical illness? These questions may encourage other researchers to explore the relationship between spirituality, health and mental illness.

Participants' Perspectives on Beliefs

Implications for practice

Although the terms religion and spirituality were often used interchangeably by participants, the findings revealed conceptual differences on the construct meanings of spirituality and religion, amongst participants as well as clients. The concept of religion in most cases was used to describe their client's spirituality. These conceptual differences are clinically relevant and have important implications for incorporating spirituality in practice. CMHP who strongly favor spirituality over religion may exclude or devalue their client's beliefs that represent more traditional religious beliefs and practices, such as church attendance and the belief in God. Initial assessment of client's beliefs about spirituality could help CMHP to understand what client belief systems are, whether or not clients have a spiritual and or religious belief system, and help identify relationships between spiritual, religious beliefs and client behaviors. Early assessment of client belief systems could also help clinicians to recognize the importance of spirituality as part of normal experience and the important cultural aspects of their beliefs. A failure to assess the client's cultural and spiritual belief systems may wrongly inform treatment approaches and undermine the importance of the relationship between spirituality, religion and health.

Implications for research

The current standards of psychiatric practice encourage the use of APA guidelines to address the important cultural and spiritual influences on an individual's life; however this study showed that they are underutilized. Future studies are needed to identify how mental health professionals assess their client's need for spirituality, what other guidelines exist and whether or not the existing guidelines are suitable for the needs of the community mental health teams.

Perspectives on Clients' Beliefs and Culture

Implications for practice

Clients' spiritual beliefs are often associated with culture and therefore have important implications for CMHP in the practice setting. Clients often use their cultural world view to access therapies and treatments that fit with their spiritual and cultural belief systems. CMHP assessment of their client's culture can help to inform treatment approaches and help professionals to understand client cultural norms. Examples of how participants in this study incorporated their client's spirituality in a multicultural context included offering groups focused on native spirituality. CMHP can also offer other culturally appropriate services through community networking with other agencies and spiritual organizations in order to integrate their client's spiritual, cultural needs.

Implications for research

Research in the area of culture and mental health remains limited. This study supports new research that suggests individuals living with SMI benefit from being able to incorporate resources that fit with their cultural worldview. More studies are needed to help mental health professionals understand the cultural implications of how mental illness is understood in various cultures and how their understanding affects treatment approaches. Furthermore, a paucity of research exists on, how do mental health professionals incorporate spirituality in a multicultural context? More studies in this field can help to address the need for cultural competency amongst mental health professionals.

Perspectives on Meaning and purpose

Implications for practice

It is important for CMHP to understand what brings meaning and purpose to their clients' lives in order to prevent and promote health. This study showed that CMHP

can incorporate client spiritual cultural beliefs in order to prevent client's risk to self harm or others. CMHP who incorporates what brings meaning to clients' lives can foster hope and sense of self. This includes incorporating what clients identify as significant and what gives meaning to their lives that may not be directly associated with a client's religious belief or faith tradition. CMHP can have an important role in helping clients to identify what brings meaning and purpose in their lives, whether it is through connections with others, their religious beliefs and faith or other aspects of life that are meaningful. Helping clients to identify what brings meaning has been strongly associated with suicide prevention. Similarly, spirituality can also encourage positive health behaviors and discourage health risk behaviors such as drug and alcohol use. Clients who experience high levels of symptoms may have greater spiritual needs and or may be unable to incorporate their spiritual beliefs that once provided a source of strength and comfort, it is therefore important to assess what spirituality means in the context of illness and whether or not it should be used as a resource.

Implications for research

Participants in this study incorporated spirituality as a strategy for preventing clients from committing suicide. How effective is incorporating spirituality as a technique for preventing clients from suicide and other forms of self harm such as drug and alcohol use? Future studies are needed to explore the effects of spirituality on suicide prevention and prevention of other high risk behaviors in clients living with SMI.

Boundaries of Professional Role

Implications for practice

The issue of maintaining professional boundaries posed a major challenge to incorporating spirituality and had important implications for the development of therapeutic relationships. CMHP who do not feel that it is their place to discuss spiritual

matters with their clients may be undermining their ability to develop a therapeutic alliance with their clients. Failure to acknowledge client's spirituality or associate their client's religious and or spiritual beliefs with their illness may create a sense of distance and separation between themselves and their clients. Similarly, research has shown that clients are reluctant to disclose their spirituality because they fear that they will be wrongfully judged, and further alienated from their mental health team. Findings from this study suggest that clients and participants benefited from sharing beliefs about spirituality because it helped to develop, meaningful relationships, important connections and sense of trust.

Based on this study, it can be argued that mentoring might be an important educational strategy for CMHP to develop skills in order to be able to safely discuss the issue of spirituality with their clients without imposing one's own beliefs. Mentoring might help other mental health professionals to feel comfortable to discuss the issues of spirituality with their clients. CMHP need to identify what their client spiritual needs are and perhaps expand their working relationships outside of the multidisciplinary team in order to help meet their clients' need for spirituality. Developing collaborative relationships with professionals from the spiritual disciplines can assist CMHP to incorporate spiritual resources for clients who identify a need for spirituality.

Implications for research

This study showed that those participants who examined the issue of spirituality in their lives helped them to provide care for their clients and may also have influenced their ability to address this issue with their clients. There are currently very few studies that have examined how spirituality influences care giver efficacy. Future studies are needed to respond to the following research questions. How does spirituality impact on the lives of mental health professionals and how does this affect their ability to care?

How do professionals incorporate their own spirituality in their care of clients with SMI, and how do professional's spiritual practices influence their relationship with their clients?

Team Support

Implications for practice

CMHP are less likely to incorporate spirituality if they do not have the support of their colleagues. Furthermore, if incorporating spirituality is only done on a one to one basis it could lead some professionals to experience isolation as one participant described in this study. The failure to share professional experiences also creates tension and difficulty around spirituality. To only present spiritual issues in the context of a crisis or dilemma undermines the potential positive health outcomes associated with spirituality and may create barriers to addressing client's spiritual needs. Although most participants in this study did not feel supported they stated that they had greatly benefited from being able to discuss their points of view and experiences within the context of the focus groups. If spirituality is going to be incorporated, CMHP need to feel comfortable when discussing their experiences. This not only informs treatment approaches but enhances professional knowledge and education about spirituality and mental health. Therefore, one important educational strategy to incorporate spirituality into professional practice might be the organization of occasional team discussions or seminars on topics related to spirituality and religion in community mental health practice.

Implications for research

It is not known if the lack of support from colleagues is a common phenomenon to other multidisciplinary teams in other practice settings, such as hospital based psychiatry or how other multidisciplinary teams in other settings i.e. palliative care

incorporate spirituality differently and whether similar challenges exist. Future studies are needed to determine how multidisciplinary professionals in other health care settings incorporating spirituality and whether or not similar challenges exist.

Biomedical Frameworks

Implications for practice

Biomedical approaches to the care and treatment of those living with SMI has greatly improved the lives of many individuals. Psychiatric practices are largely influenced by biomedical frameworks and oriented toward the cause of disease and treatment with pharmacotherapy. These approaches however make it difficult for CMHP to integrate other aspects of the individual that might prevent health risks and promote health behaviors, such as spirituality. CMHP have an opportunity to incorporate other frameworks that encompass psychosocial aspects of the individual such as culture and spirituality in order to provide holistic care. Furthermore, the biomedical approach to care and treatment of those suffering from SMI impedes the ability of CMHP to include cultural and spiritual explanations for illness and may wrongfully inform treatment approaches.

Many experienced CMHP feel inadequately trained to deal with spiritual issues. The relationship between spirituality, religion and health is starting to be addressed in many health fields, and may eventually influence community and policy development about how to incorporating other frameworks. The use of multidisciplinary focus groups as an educational strategy could provide professionals with an opportunity to share knowledge about other frameworks used to explain and understand health and illness. As stated above, the use of multidisciplinary FG may decrease some of the challenges that exist to incorporating spirituality.

Implications for research

Future studies are needed that address how other frameworks address the issue of spirituality in community mental health practice, such as psychosocial rehabilitation models.

Conclusion

This research study has made an important contribution to understanding how CMHP understand and incorporate spirituality in their care of individuals living with SMI. The meaning of spirituality was associated with core attributes of spirituality and included connections, religious and cultural beliefs and meaning and purpose. CMHP acknowledged that the core attributes of spirituality played an important role in understanding their client's mental health and illness and were identified as either positively or negatively contributing to mental health.

This study supports that CMHP need to understand spirituality from the client's point of view. Most participants described their client's spirituality as providing an important source of connection, support, comfort and belonging. Client's spiritual and cultural beliefs also provided a source of strength and source of meaning in the context of their illness experience. Participants were also aware that clients were reluctant to discuss their spiritual and or religious beliefs because they feared that those beliefs might be misunderstood as part of illness. Most participants who where able to incorporate spirituality also benefited from the experience, it deepened the therapeutic alliance, increased rapport and provided meaningful relationships.

Despite the significance of spirituality for practice, this study revealed the main challenges to incorporating spirituality as, boundaries of professional roles, lack of team support and biomedical frameworks. Conceptual differences in understandings of spirituality did not pose as major impediment to incorporating spirituality in the context

of community mental health practice, however difficulty in using appropriate language about spirituality and or religion were associated with the tensions between biomedical approaches and holistic frameworks. The failure to address spirituality may undermine the significance of client cultural beliefs and worldviews and wrongly inform treatment approaches.

CMHP benefited from being able to participate in FG because it allowed them to discuss their clinical experiences and points of view with their colleagues in a supportive environment. The process of focused group discussions helped to raise awareness of the issue of spirituality within clinical practice settings. Using this approach might serve as a model for education and discussion and might assist in making CMHP feel more comfortable in incorporating spirituality as an important component of mental health and practice.

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APPENDIX A:

INVITATION MEMO

COMMUNITY MENTAL HEALTH PROFESSIONAL'S PERSPECTIVES ON INCORPORATING SPIRITUALITY IN THEIR CARE OF CLIENTS LIVING WITH SERIOUS MENTAL ILLNESS: A QUALITATIVE INQUIRY

If you currently provide case-management and/or consultation services and have been working within Vancouver Community Mental Health Services for at least two years, you are invited to participate in a focus group discussion about incorporating spirituality in caring for your clients. Focus group discussions will take place at one of the mental health teams located near your work, or at the place of your work. The focus group discussions will take up to 1-2 hours and you will be given time to participate in the focus group at a convenient time during your work day. You may be invited to validate the findings of your discussions several weeks after your participation in the initial focus group; this will take up to a maximum of 1 hour. Dr. Anne Dewar is the principal investigator for this study. This project is research for a graduate thesis.

For more information, please contact the co-investigator, Nancy Clark, master's student, School of Nursing at UBC (604) xxx-xxxx

All calls will be kept confidential

APPENDIX B:

PARTICIPANT CONSENT FORM

Project Title:

Community Mental Health Practitioner's Perspectives on incorporating Spirituality in their care of Clients with Serious Mental Illness: A Qualitative Inquiry

Principal Investigator:

Dr. Anne L. Dewar: Nursing Department, UBC, Phone: 604-xxx-xxxx

Co Investigator:

Nancy Clark: MSN student: School of Nursing, UBC, Phone: 604-xxx-xxxx

Purpose:

This thesis project will be conducted by me, Nancy Clark. I am a master's student in the department of nursing at UBC. The purpose of this study is to hear and document how community mental health practitioners conceptualize spirituality and how their views are incorporated in caring for clients living with serious mental illness.

Procedure:

If you agree to take part in this study you will be asked to participate in a focus group discussion which will take up to 1-2 hours of your time. The focus groups will be conducted at one of the various mental health teams situated in the Lower Mainland in Vancouver. The focus groups will be conducted by a facilitator and an observer. The role of the facilitator is to focus the group discussions by asking 4-5 questions that have been designed to gain your perspectives on spirituality. The observer may ask questions but will primarily be involved with taking detailed field notes on the focus group discussions. You may be invited to participate in a second focus group where you will be asked to comment on the accuracy of my interpretations of the findings of previous focus group discussions. Any concerns or disagreements you have regarding the material will be amended to my previous interpretations in order to accurately convey your perspectives. You may be invited to participate in the second focus group discussion that will occur approximately 7 weeks after the initial focus group discussion. The second focus group will take up to a maximum of 1 hour. The focus group discussions will be audio- taped.

Confidentiality:

The information that you provide will be kept confidential throughout the study and you will only be identified by a code number. This information is kept in a locked filling cabinet to which no one will have access to except the researcher. All audio-tapes will be destroyed following the completion of this research and at no time will any identifying information be made available to anyone other than me and my research supervisor(s).

However, only limited confidentiality can be offered in focus groups as we cannot control for what other participants involved in focus group do with the information discussed. We therefore encourage all participants to refrain from disclosing the contents of the discussion outside of the focus groups.

Compensation:

You will not receive any direct benefits from your participation. If you are interested in obtaining the research results you may access the thesis through the UBC library. For practitioners who are interested in obtaining a summary of the focus group discussions an in service will be provided. If you agree to participate in the study, your contributions will help to further our knowledge and understanding of spirituality as it relates to caring for individuals with serious mental illness.

Consent:

For this study there are no identified risks to you as a participant. Your participation is entirely voluntary. You may withdraw from the research study at anytime without prejudice. You have been invited to participate in this study because of your experience and expertise in working with clients with serious mental illness in the community mental health setting and you are interested in discussing your own perception and experience of spirituality and how this relates to caring for your clients.

If you have any questions regarding the study please feel free to contact either myself at 604-xxx-xxxx, or you may call my supervisor Dr. Anne Dewar at the School of Nursing, UBC at 604-xxx-xxxx. If you have any concerns regarding your rights as a research participant in this study, you may contact the Research Subject Information Line in the UBC office of Research Services at 604-xxx-xxxx

Your signature below indicates that you have read this consent and have agreed to participate in this study. Your signature also indicates that you have received a copy of this form for your own records.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Researcher	Date

APPENDIX C:

INFORMATION LETTER

[UBC letterhead]

Date

Project title:
Community Mental Health Practitioner's Perspectives on Incorporating Spirituality in their care of Clients with Serious Mental Illness: A Qualitative Inquiry

Principal Investigator:
Dr. Anne L. Dewar: Nursing Department, UBC, Phone: 604-xxx-xxxx

Co-Investigator:
Nancy Clark: MSN student: School of Nursing, UBC, Phone: 604-xxx-xxxx

Dear participant:

I am a graduate student in the school of nursing at the University of British Columbia. For my master's thesis I am conducting a study which explores the perspectives of community mental health practitioner's on incorporating spirituality in their care for clients living with serious mental illness.

The purpose of this research study is to understand how community mental health practitioners conceptualize spirituality and how their views are incorporated in caring for individuals who are living with serious mental illness. In using the word spirituality, I am interested in your own personal understanding of spirituality and how your own experiences and perspectives inform your practice.

In order to carry out this research I will need 24 participants who meet the following criteria: (1) who have had a minimum of 2-5 years experience in working in community mental health; (2) who provide case management and or consultation services for clients with serious mental illnesses and (3) who come from differing professional practices and educational backgrounds including, social work, nursing or psychiatric nursing, medicine and psychiatry, clinical counseling and or addictions counselors, occupational therapy and mental health recreational or rehabilitation therapy.

If you agree to participate in this study you will be asked to take part in a focus group discussion. The goal of the focus group discussion will be to draw upon your experiences and perceptions on spirituality in caring for your clients with serious mental illness. The focus group will be centered on a few questions to help focus the discussion. This discussion group will take up to a maximum of 1-2 hours. You may be asked to

participate in a secondary discussion group that will take up to a maximum of 1 hour several weeks after the first focus group. The purpose of the secondary focus group is to share my interpretation of the findings with you and to give you an opportunity to validate or expand on some of your answers. The focus groups will be audio- taped and transcribed for research purposes only and will be kept strictly confidential. Your name will not appear on any of the transcripts or report of this study. You will identified only by a code number in order to maintain your confidentiality.

In order to maintain confidentiality throughout the focus group discussions it is requested that you refrain from disclosing the contents of the discussion outside of the focus group. The findings from this study may be submitted for publication however your identity will be kept confidential in any published and unpublished material.

Your participation in this study is greatly appreciated. If you are interested in participating in this study, you may contact me at 604-xxx-xxxx. Should you have any questions or concerns regarding this research project I would be happy to discuss them with you either over the phone or in person.

Thank you for your attention to this matter,

Sincerely,

Nancy Clark, Masters Student
UBC, School of Nursing

APPENDIX D:

INTERVIEW GUIDE FOR FG DISCUSSION

1. In your work, have client's ever discussed their spirituality with you?

Probe: Can you recall the last time a client brought up their spirituality with you?

2. What where the circumstances and/or events that might have prompted your client to discuss their spirituality?

Probe: Can you think of any specific client examples?

3. Have you found spirituality to be an important issue for your client's?

Probe: If so, how is spirituality important, and how do you think it affects your client's mental health?

4. From your experiences, how were you able to incorporate your client's spirituality with their care?

Probe: What was this process like for you?

5. Have you ever shared your experiences with other team members?

Probe: Where there any instances where you formally presented issues related to your client's spirituality either in a case conference or audit?

6. What kinds of things helped you to incorporate your client's spirituality with their care?

Probe: What personal, professional or educational factors assist you in incorporating your client's spirituality with their care?

7. Is there anything that prevents you from being able to incorporate your client's spirituality with their care?

Probe: What personal, professional or educational factors prevent you from being able to incorporate your client's spirituality with their care?

APPENDIX E:

CATEGORIES DEVELOPED FOR FG 1,2,3

1. DEATH AND DYING
2. GROUP
3. ASSESSMENT
4. SPIRITUALITY AS CONNECTION
5. SPIRITUALITY AS SUPPORT
6. SPIRITUALITY AS COMMUNITY
7. WHOLE
8. LANGUAGE
9. SPIRITUAL RESOURCES
10. CULTURE
11. DRUG AND ALCOHOL
12. SPIRITUALITY DISTINCT FROM RELIGION
13. SPIRITUALITY INCLUDING RELIGION
14. TRAUMAN/ILLNESS
15. SPIRITUALITY AS PURPOSE AND MEANING
16. SPIRITUALITY AS PSYCHOLOGY
17. FAITH
18. VALUES
19. EXPERIENCE
20. PRACTICE
21. PROCESS
22. GIVING
23. LOSS
24. LACK/EMPTINESS
25. NEED
26. DELUSION/PSYCHOSIS
27. QUESTIONING
28. BELIEFS
29. SUICIDE

30. PROFESSIONAL'S BELIEFS
31. FEAR
32. SAFETY
33. APPROPRIATE PRACTICE
34. ROLE
35. AUTHORITY
36. RESPONSIBILITY
37. RELATIONSHIP
38. COMFORT
39. NORMAL EXPERIENCE
40. SHARING
41. OPEN
42. IMPORTANCE
43. DIFFICULT
44. PRIVATE/SECRET
45. LANGUAGE
46. BOUNDARIES
47. DIFFICULT PROCESS
48. BELIEF
49. INTEREST/SIGNIFICANCE/IMPORTANCE
50. NEED
51. CULTURE
52. SUPPORT
53. SPIRITUAL RESOURCES
54. CONNECTION
55. SERVICE/DOING FOR OTHERS
56. MEANING/PURPOSE
57. HEALTH OUTCOME
58. IDENTITY
59. RECOVERY
60. SUICIDALITY
61. TEACHING/LEARNING
62. SIGNIFICANCE OF GOD(BELIEF)
63. NEGATIVE EXPERIENCE/HEALTH OUTCOME

64. SPIRITUAL CRISIS
65. NOT FOR EVERYBODY
66. PRACTICE ENVIRONMENT
67. NEGATIVE EXPERIENCE WITH COLLEAGUES
68. ROLE
69. ENVIRONMENT
70. UNIVERSALITY
71. RELIGIOUS/SPIRITUAL BACKGROUND
72. PERSONAL PRACTICE
73. IMPORTANCE
74. HEALTH BENEFIT
75. EDUCATION
76. CLIENT INITIATED
77. PROFESSIONAL INITIATED
78. TEAM EXPERIENCE
79. PRACTICE
80. FRAMEWORK/MODEL
81. SOCIETY
82. INTEGRATION