

PSYCHIATRIC NURSES' UNDERSTANDING OF THE SPIRITUAL DIMENSION OF HOLISTIC PSYCHIATRIC NURSING PRACTICE IN SOUTH AFRICA: A PHENOMENOLOGICAL STUDY

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ABSTRACT

The purpose of this study was to explore psychiatric nurses' understanding and practice of the spiritual dimension of holistic psychiatric nursing practice in South Africa by using a descriptive phenomenology design. By means of purposeful sampling, seven psychiatric nurses with knowledge and experience about "spirituality" were selected.

Data were collected through in-depth interviews. Colaizzi's Method of data analysis and representation was utilised. Four themes emerged from the data:

- The higher power of spirituality, religion and their relationship with each other
- Spirituality is central to but forgotten in psychiatric nursing practice
- Spiritual aspect of psychiatric nursing: enabling and limiting factors
- Holistic nursing practice: educating for spiritual psychiatric nursing care

These themes illuminate psychiatric nurses' understanding of the spiritual dimension of holistic psychiatric nursing practice in South Africa.

Psychiatric nurses should acknowledge the spiritual dimension in the assessment process; integrate concepts of spirituality, religion and mental health into curricula and in-service education in an open or spiritually sensitive manner. This might improve psychiatric nurses' understanding of how consumers of healthcare services, family members and other team members experience

this dimension and its impact on mental health. Policy should be developed that clearly defines the content and scope of spiritual care assessment intervention options and the qualifications of and support for persons providing such care.

KEYWORDS: forgotten care, higher power, holistic care, psychiatric nursing, religion and spirituality, spiritual aspects of nursing care, spiritual aspects of psychiatric nursing

INTRODUCTION AND BACKGROUND INFORMATION

Psychiatric nursing is defined as a holistic activity concerned with bio-psychosocial-spiritual dimensions of the individual and his/her experience of mental health and illness (Middleton & Uys, 2009:577). From this perspective, all dimensions, including the spiritual dimension, have equal value and importance in psychiatric care. The nursing literature reviewed differentiates between spirituality and religion, and regards spirituality, rather than religion, as the main focus for the spiritual dimension of the nursing model (Koslander & Arvidsson, 2007:597; O'Reilly, 2004:46; Paley, 2008:175; Pesut, 2008:100). Spirituality is an essential dimension of human experience and a relevant factor in psychiatric nursing practice (O'Reilly, 2004:46).

Although there is no consensus definition of spirituality in psychiatric nursing literature, most authors agree that it is concerned with a person's search for meaning and purpose in life (Koslander & Arvidsson, 2005:559; O'Reilly, 2004:46; Pesut, 2008:100), a belief system that offers life-sustaining meaning which influences and is influenced by daily life experiences (Wilding, Muir-Cochrane, & May, 2006:146), experienced as a journey or process that extends throughout life (Wilding et al., 2006:147), and related to religion, but religion is not synonymous with spirituality. Religion, on the other hand, is viewed as an organised set of beliefs contained within particular sacred texts, rituals, and practices upon which some individuals draw during the process of meaning-making (Koslander & Arvidsson, 2007:598). Examples of religions in South Africa include different forms of Christianity, Hinduism, Islam, and Buddhism. In short, spirituality is the internal experience of one's connection to God or higher being and religion is the outward expression of a connection to God or a higher being.

Nursing authors suggest that if psychiatric nursing is to be holistic, it must account for the spiritual as well as the physical, social, and psychological needs and health experiences of clients (Awara & Fasey, 2008:183; Koslander & Arvidsson, 2007:598; Mohr, 2006:174). The bio-psycho-social model of care in mental health traditionally focuses on the biological, social, and psychological determinants of wellness and illness. The physical dimension generally involves the complex biological functions of the body, enabling individuals to live, move, and exist in the world. The psychological dimension refers to the individual's abilities to reason, think, know, experience and make sense of situations arising in life. The social dimension is concerned with interpersonal social interactions, but also with interactions between the person and his/her social

environment, and factors that impact on the individual's social wellbeing (McSherry, 2006:912; Ray & McGee, 2006:334).

Although some psychiatric nurses integrate spiritual care into their practice, some nurses frequently avoid this dimension (Awara & Fasey, 2008:183; Koslander & Arvidsson, 2007:564). Nurses report not having enough knowledge about this dimension to adequately address it; being unfamiliar with the diverse cultural and spiritual practices in contemporary society; fearing that spirituality might trigger psychiatric symptoms (Awara & Fasey, 2008:189); not having the tools of this dimension to discuss it with clients, and not seeing it as part of their job (Koslander & Arvidsson, 2005:559).

Problem statement

There seems to be a limited body of knowledge about how psychiatric nurses in the South African context understand and practise the spiritual dimension of holistic psychiatric nursing practice. Two nursing studies situated in the South African context explored the issue of spirituality among people living with HIV/AIDS (Dolo, 2006: 2-6; Mahlangu & Uys, 2004:15).

Integrating spiritual and psychiatric care is an important contemporary issue for psychiatric nursing if the profession is to continue to define itself as a holistic and client-centered activity (Mohr, 2006:174). Local data, about how nurses understand and practice spirituality in their working encounters with clients, would be an important first step towards enhancing holistic, quality patient-centered psychiatric nursing care in the South African context.

Significance of the study

Research has shown that mentally ill patients have spiritual needs that might remain unmet (Foreman, 2007:1). It is anticipated that this study's findings are relevant for clinical practice, nursing education, and further research. The findings are useful to clinicians as they strive to incorporate spiritual care within their practice; for nurse educators in developing education curricular content for teaching nurses about spirituality in psychiatric nursing; as a basis for further research for developing a knowledge base of spirituality in psychiatric nursing and for patients and their families as they benefit from more holistic care that includes the spiritual dimension.

Purpose of the study

The purpose of this study was to explore and describe psychiatric nurses' understanding and practice of the spiritual dimension of holistic psychiatric nursing practice in South Africa

Objectives of the study

The study objectives were to:

- explore and describe how psychiatric nurses, caring for persons with mental illness, conceptualised the spiritual dimension of holistic psychiatric nursing care
- describe how psychiatric nurses assessed the spiritual needs of persons with mental illness
- identify the strategies or interventions that psychiatric nurses used to address the spiritual needs of people with mental illness
- describe psychiatric nurses' perceptions of the forces enabling or limiting their ability to provide spiritual care to psychiatric clients.

Methodology and data analysis

This study is based on the four principles of descriptive phenomenology, namely:

- bracketing, where the researcher attempts to set aside his/her usual and natural assumptions about the phenomena and to suspend his/her beliefs in the existence or nonexistence of the phenomena
- intuiting, which involves immersing oneself in the data and being attuned to the meanings given to the phenomena by those who have experienced it
- analysing and
- describing as outlined in Colaizzi's method of qualitative data analysis (Creswell, 2007:270)

Purposeful sampling was used to select participants who had knowledge and experience of the phenomenon of interest. Participants were therefore selected from the 2008/2009 and 2009/2010 advanced psychiatric nursing classes of the School of Nursing, University of KwaZulu-Natal. All were registered psychiatric nurses working in psychiatric units of hospitals and psychiatric clinics situated in primary health care (PHC) centers of the EThekweni District in the KwaZulu Natal Province of South Africa. These nurses (five females and two males) were targeted for their many years of rich experience in psychiatric nursing and thus, for their knowledge and experience of spirituality in the psychiatric nursing practice context. Interviews were conducted in English because the participants were all studying at the University of KwaZulu-Natal where English is the language of instruction and all the nurses were competent to communicate in

English. Four of the females and both males identified their religion as Christian while one described herself as a Hindu.

Data collection began immediately after ethical clearance had been granted by the University of KwaZulu-Natal's Ethics Review Committee. The researcher telephoned each of the 15 potential volunteers. Seven in-depth interviews, each lasting 45-60 minutes, were conducted over a period of eight weeks. The purpose and nature of this study was discussed with each participant and consent to participate was obtained. Interviews were audio-taped and later transcribed verbatim to facilitate analysis. A series of probing questions related to the research objectives was on hand to guide the interview, if necessary. Biographical data such as gender, age, place of work, psychiatric nursing working experience in years were collected in order to describe the characteristics of the sample for meaningful contextualisation of the qualitative data.

The data were analysed using Colaizzi's six-stage (Creswell, 2007:270) method of data analysis and representation:

- acquiring a sense of each transcript; each verbatim description was closely read and re-read with the aim of developing an understanding of the meaning of the data
- extracting significant statements and phrases from the transcripts of the participants' understanding of spirituality in their work places
- the formulation of meanings from the extracted significant statements
- organising the formulated meanings into clusters of themes and categories
- providing an exhaustive description of the phenomena, integrating the textual and structural descriptions into a coherent and holistic picture of the experience of spirituality in psychiatric nursing practice
- returning to the participants to validate the exhaustive descriptions with the participants by comparing the exhaustive descriptions with the audio-taped interviews

Three methods were used to validate the findings and determine the trustworthiness of this qualitative study:

- transferability which is the extent to which the findings of this study can be transferred to other similar settings or groups; the researchers utilised the services of a variety of participants providing care to psychiatric patients in psychiatric clinics and hospitals
- dependability, implying that the entire process of data collection, analysis and interpretation was closely examined, monitored and evaluated by the research supervisor as an expert in the field
- credibility, focusing on how interpretations were grounded in the data and whether they were formulated in ways consistent with the available data

- confirmability was attained because the researcher continuously listened to the interviews and compared them to the verbatim transcripts to ensure that both were conveying the same meaning

FINDINGS

Forty-eight significant statements and phrases relating to the participants’ understanding of spirituality in their psychiatric nursing practice were identified and extracted. These significant statements were grouped into larger units of information by the association of significant statements. The formulated meanings obtained from significant statements were arranged into clusters of themes. These clusters brought together a series of clearly related other themes. Four themes (or formulated meanings) from forty associated significant meanings were identified.

Table 1: Major themes

Theme numbers	Major themes
Theme 1	The higher power of spirituality, religion, and their relationship to each other
Theme II	Spirituality is central to but forgotten in psychiatric nursing practice
Theme III	Spiritual aspects of psychiatric nursing: enabling and limiting factors
Theme IV	Holistic nursing practice: educating for spiritual psychiatric nursing care

The higher power of spirituality, religion, and their relationship to each other

All participants linked spirituality to a higher power, and to the phenomenon of being human and connected with each other through our humanity, as indicated by the following statements:

“Spirituality is Higher Being in terms of human being”:

“I think that [spirituality] is what makes a person human...”

“I think if I didn’t have my own spirituality, I don’t think I could be able to be human to my patients”

“To me, spirituality is the lining of the globe that holds persons together”

“Spirituality may be a way of ancestors, is a way of linking with the supernatural world, as without mental health there is no health, so without spiritual health there is no health”.

Spirituality is central to but forgotten in psychiatric nursing practice

This theme centered on the relationship between spirituality and psychiatric nursing care. All participants alluded to a relationship between spirituality and psychiatric nursing care and identified spiritual care as part of the holistic focus of nursing, which might be neglected, by stating:

“We do not look at especially in the spiritual part, which has equal importance like any other area of the body, mentally, physically, etc. So we need to look at that area, how we fortify that area to come equal to others in terms of caring so that we give the patient a holistic approach, because if one aspect is neglected, then it is not holistic anymore”.

“Also their prognosis and their compliance with treatment will improve”

“You see that a person will not get better because their spirituality is not being fulfilled”

“Spirituality is very important for psychiatric patients and a tool in their repertoire of general clinical skills.

“There is a gap, a gap in that we don't really offer spiritual care for these patients”

“Spirituality should be one area which should be visited, explored, and tested in our daily care of our clients”

“I would say it is an area that is actually lacked, and not attended to and lacking in psychiatric nursing practice: “Spirituality is lacked in psychiatric-giving care”

“Spirituality is even forgotten among policy-makers dealing with mental health services.”

Spiritual aspects of psychiatric nursing: enabling and limiting factors

The third theme focuses on the factors psychiatric nurses regarded as influencing their provision of spiritual care. These factors can be classified as factors limiting or enabling their ability to provide spiritual care to their patients. In considering factors that limit their provision of spiritual care, they mentioned a lack of training, knowledge, and understanding about other people's cultures and religions, as reflected by the following statement:

“lack of training and understanding about other spiritual beliefs, lack of spiritual assessment area on patient's admission record as well as lack of knowledge”

One psychiatric nurse listed personal, patient-related and institutional factors that limited her ability to provide spiritual care. Providing spiritual care suggests that one has a spiritual or religious point of view on which to base spiritual intervention and thus “Not being religious” is a limiting factor. The patient’s condition and the nurses’ workload in general were related to providing spiritual care, which in this case, the more aggressive the patient and the greater the work load in general, the lower became the priority of spiritual care in the daily provision of care.

“Well, I think being busy with my work, also the condition of the patient, like the patient is really aggressive, also if I am not a religious person I won’t offer any spiritual help.”

As well as not being religious, being of a different religion to the client was seen as being a limiting factor:

“and if the patient is of different belief, it will be difficult to go into the patient’s belief”.

Institutional policy also prevented or limited spiritual care providing opportunities, as one participant said:

“Management, because where I work, we are not allowed to offer spiritual care. Management prohibits that because we are a multicultural community of many religions.”

Factors that psychiatric nurses considered to be enablers for providing spiritual care included their own spiritual orientation and knowledge about spirituality, as indicated by the following explanations:

“In short, knowledge, your own spiritual orientation”

“It takes special people to nurse psychiatric patients, you got to have God-given skills to handle psychiatric patients”

“I think if I didn’t have my own spirituality, I don’t think I could be able to be human to my patients. Spirituality helps me look at my clients as spiritual beings based on my own spiritual belief. I think it is part of me, without spirituality I am incomplete”.

“My own moral relationship with my Creator, which enables me to be where I am today. My own spiritual belief as well, my love for my Creator also, I also think my own need to be touched with my Creator helps me to see the needs of other people to be in touch with their gods”

“If I am of the same faith of the patient, my own spirituality as a Christian and if the patient is of different belief, it will be difficult to go into the patient’s beliefs”.

Holistic nursing practice: educating for spiritual psychiatric nursing care

Theme four reveals how important education could be for providing spiritual care within the holistic model of nursing. This is important for the development of the psychiatric nurse's own spirituality and for her provision of spiritual care. It provides strength, knowledge and moral conscience to psychiatric nurses for providing spiritual care to their patients. These nurses commented that the introduction of spiritual education in the psychiatric nursing curriculum would enable them to detect patients' spiritual needs and offer the required spiritual care needed to augment care to a holistic level:

"That is why I say it takes a person to have spiritual understanding through training to be able to know when a person is expressing a spiritual need."

Psychiatric nurses providing some level of spiritual care to their patients recommended that spirituality should be included in nursing training programmes for student psychiatric nurses to adequately prepare them to provide different forms of spiritual care based upon their patients' needs. Ongoing education for already practising psychiatric nurses was also suggested:

"I will recommend that spiritual care form part of the patient's care and that it should be in the training of nurses so that people can be open-minded and be aware of other people's religions and cultures"

"Workshops, in-service training on spirituality and what it means to different people and how we can help to meet those needs in times of crisis".

DISCUSSION

The participants conceptualised spirituality in a variety of unique ways, linking spirituality to religion and to personal and hence cultural values, as well as to daily moral and interpersonal experiences with self and others that provide direction and meaning in life. Spirituality was conceived of as "the glue that brings people together and as a primary source of belonging and of joy, hope, and comfort in both difficult and happy times". Participants described spirituality as a personal belief as well as an emotion which links them in a relationship with their God or Higher Being and enables them to provide compassionate care in the face of their patients' distress and suffering.

Spirituality was portrayed as an important component of holistic psychiatric nursing care with direct benefits, not only for the patients but also for the nurses. The participants revealed that spirituality brings improvements in the overall health of mentally ill people by improving their prognosis and compliance with treatment."Also their prognosis and their compliance with treatment will improve". This prevents relapses and brings

about positive changes in patients' behaviours. Such changes include that patients are calmer and more responsible, enabling them to think more logically and to have a source of joy, hope, and comfort and healing power for their illnesses. These findings are consistent with the literature review regarding spirituality as helping to manage depressive symptoms and to live successfully with others (Nasser & Overholser, 2005:125), providing hope and thus helping to prevent suicide, and managing anxiety and substance abuse (O'Reilly, 2004:47).

For these participants spirituality and religion were interwoven. The idea of spirituality, being related to and different from religion, is a central theme in the nursing literature reviewed (Pesut, 2008:103; Wilding et al 2006:144). This study highlighted similar notions of spirituality and uses of the idea of religion as the outward expression of a connection to God and spirituality as the internal experience of this connection to differentiate the terms (Mohr, 2006:175). These participants, on the other hand, emphasised the connections (such as providing meaning in life, connecting to a higher power, finding sources of hope and joy) rather than the differences between the two. (Koslander & Arvidsson, 2005:559; Wilding et al., 2006:146). These authors concurred with the participants' views regarding the difference between spirituality and religion. Although there is a difference between spirituality and religion, they both focus on a relationship with a higher being upon which individuals depend for hope, joy and meaning in life "Spirituality is Higher Being in terms of human being": (Koslander & Arvidsson, 2007:598; Wilding et al., 2006:146).

Nurses' own beliefs about whether spiritual care should be routinely provided in this context, who should provide it and how it should be provided and under what circumstances, as well as institutional policies about equity of religious activity, influenced the extent to which these nurses engaged with this dimension of providing holistic nursing care.

Although these nurses had received no formal education in spirituality, it seems that they combined the principles of the nursing process, their knowledge of psychiatric nursing and their own understanding of spirituality in responding to the more obvious spiritual needs of their patients. Nurses were thus able to recognise that patients commonly expressed their desires for assistance to meet their spiritual needs through specific behaviours, direct requests and statements about their intended spiritual actions. Common behaviours included praying, chanting and singing religious songs. Patients' spirituality was also evident in their direct requests for some form of assistance to meet their spiritual needs, such as asking for a Bible, time to be alone to pray and permission for their pastor to visit them. Statements about their intended spiritual actions included informing the staff that they would be going to church or that they were planning to fast on specific days in order to "be closer to my God." Although some nurses offered direct spiritual assistance by praying with patients, the nurses mainly enabled clients to express

their spirituality. Enabling took the form of arranging rooms for them to pray, organising for pastors or religious leaders to come and pray with patients, advocating with doctors for leave of absence for patients to go home and perform cultural and religious rituals and speaking directly to patients and family members about their religious needs.

The nurses reported on a number of personal, institutional and patient forces that enabled or limited their abilities to provide spiritual care. Nurses perceived that their lack of training in spiritual care and their limited knowledge of and understanding about other people's cultures and religions affected their abilities to respond effectively to their patients' expressed spiritual needs. This knowledge limitation was more pronounced when the patient and nurse were from different religions. "If the patient is of different belief, it will be difficult to go into the patient's belief". Limiting patient forces included the patients' mental conditions and behavioural disorders. Nurses experienced greater difficulty relating to the spiritual needs of patients who were actively psychotic or aggressive. Institutional forces limiting nurses' ability to engage with the spiritual needs of their patients, included the large number of patients in the clinics and the wards and in some cases, lack of permission from management to engage with this dimension because of the multicultural and multi-religious nature of the institutions and the possibility that one religion might be emphasised at the expense of others.

"Management, because where I work, we are not allowed to offer spiritual care. Management prohibits that because we are a multicultural community of many religions."

With respect to enabling forces, the nurses' own spiritual orientations and knowledge about spirituality enabled them to provide spiritual care. Nurses' love for their Creator and their relationship with Him has motivated them, and having the same religious beliefs as patients, could motivate them to provide spiritual care. The participants recommended that nursing training programmes, especially those dealing with mental health provision, should incorporate spiritual care.

"I will recommend that spiritual care form part of the patient's care and that it should be in the training of nurses so that people can be open-minded and be aware of other people's religions and cultures."

"Workshops, in-service training on spirituality and what it means to different people and how we can help to meet those needs in times of crisis".

For many participants, these notions of spirituality provided a bridge of understanding between their own religious system and the cultural and traditional beliefs of others, particularly if their beliefs differed from those of their patients.

The nurses' perspectives of spirituality enabled them to understand that a spiritual dimension underpinned their expressed need and behaviours even if they had no

knowledge of the religion or the meaning of the traditional practices for a specific patient.

CONCLUSION

The essence of spirituality gathered from this study concurred with the views reported in the reviewed nursing literature (Pesut, 2008; 103; Wilding et al 2006:144). Both the results of this study and the literature reviewed considered spirituality and religion to be related although not the same, but considered spirituality as an important dimension if psychiatric nursing care is to be holistic. Spirituality is considered to be an individual understanding of having a relationship with God or a higher power whereas religion is an organised set of beliefs, sacred texts, rituals and practices with which individuals involve themselves as they associate with their God or with a higher power (Koslander & Arvidsson, 2007:598).

RECOMMENDATIONS

It is an understanding that human beings are spiritual beings and have physical, social, psychological and spiritual dimensions which combine to motivate humans to search for meaning and purpose in life. Although the physical, social and psychological dimensions are adequately attended to during the provision of psychiatric nursing care, the spiritual dimension might remain unattended. The following recommendations could promote total patient care, including spiritual care:

Nursing practice

Psychiatric nurses caring for psychiatric patients should acknowledge the spiritual dimension in the assessment process and include the patient's religion, degree of observance and meaningful religious practices in the nursing care plan. Spiritual and religious counselors should be acknowledged as being important partners of the multidisciplinary team and their participation could provide comfort and solace for patients during times of spiritual distress.

Nursing education

Integrating concepts of spirituality, religion and mental health into curricula and voluntary in-service education programmes in an open and spiritually sensitive manner will enhance psychiatric nurses' understanding of and respect for the unique meaning spirituality has for each patient, its role in the caring process and its relationship to holistic psychiatric nursing care.

Nursing research

Understanding how psychiatric patients, their family members and other team members experience the spiritual dimension and its impact on mental health, coping, family wellbeing and psychiatric nursing practice, including evidence about how nurses might avoid bias or prejudice when assessing this dimension and planning care, would promote psychiatric nursing's holistic mandate.

Policy makers

The South African Nursing Council, dealing with the scope of practice for nurses, could consider developing policies pertaining to the spiritual dimension of psychiatric nursing care. Nursing managers and nursing education forums should strive to clearly define the content and scope of spiritual nursing care assessment and intervention options, specifying the qualifications of and support for nurses providing spiritual care. These aspects could provide psychiatric nurses and other team members with resources to facilitate the planning and implementation of comprehensive holistic care, including spiritual care.

LIMITATIONS

The first author is not a South African citizen and is unfamiliar with the nursing system and the people's customs, rendering this in-depth study challenging. While reviewing the transcripts, it became apparent that the interview style might not have been as open-ended as phenomenology requires.

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