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Elliott, Ruth

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Spirituality, mental health nursing & assessment

Ruth Elliott critically examines the literature regarding mental health nursing assessment and spiritual beliefs and considers whether a person's spiritual belief influences the outcome of a mental health nursing assessment and to identify possible strategies to overcome assessment bias or prejudice.

Key words

Literature review

Spirituality

Mental health nursing and assessment

Ruth Elliott. University of Huddersfield. Senior Lecturer Mental Health Nursing. RMN, Bsc
Nursing Studies M/h, MSc HPE

Exploration through research has identified that constructive approaches to spirituality can have a positive effect on health. The Office of National Statistics (ONS)(2001), has produced figures from the census and shows that here in the United Kingdom (UK) we have a more diverse community than any other country in Europe, contributing to the richness of spiritual understanding.

The National Institute for Mental Health in England (NIMHE) and the Mental Health Foundation launched a two year partnership to review current ideas in how nursing practice approaches the area of spirituality and mental health. The results identified that people with mental health needs are increasingly identifying spirituality as a vital part of their recovery. The NIMHE (2003) proposed that the partnership between NIMHE and the Mental Health Foundation would promote the merits of spirituality in achieving good mental health. The Nursing and Midwifery Council (NMC, 2004) identified in their standards of care, that it requires a nurse engage in a holistic approach to care, therefore, the dimension of spirituality must be provided. It clearly states that the nurse must:

'Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients/clients/communities'

Figures from the Census show that over 70 per cent of people claim to have a religious or spiritual affiliation (ONS, 2001). That is despite the decline in the church attendance of mainstream faiths like Christianity (ONS, 2001), It is important for the nurse to be able to define a persons' individual resource in coping when assessing their needs (Forster, 2001). In order to fully assess holistically, the practitioner needs to understand an

individual and respond to their identified needs. Nurses are often put in an uncomfortable or almost certainly unprepared position to assess spiritual needs without bias (Barker, 2004). Traditionally, the focus has been on the '*mechanics*' of '*treating*' a person's illness by allegedly using a holistic approach and ultimately addressing the dimension of spirituality inadequately. It is, therefore, easier to ask a person's religious belief and document it in their notes whilst ordering their '*special diet*'. Practitioners may feel that by using this strategy they are showing how they have evidenced their commitment to facilitating a person's right to express their spirituality.

To the individual who has a spiritual belief, it is as important as the dimension of physical or psychological (Barker, 2004).

To omit or not fully address one of the dimensions identified in an holistic assessment is to fail to care for the individual as a whole. The NIMHE (2003) identified spirituality as being vital to the recovery of a person experiencing mental ill health. It was furthered by identifying that the concept of spirituality is becoming more diverse and increasing along with the different cultures in Britain. Whilst there is extensive research and discussion surrounding well being and the significance of a persons spirituality, there are fewer studies undertaken on how the attitude of the nurse towards spirituality and their spiritual beliefs affects the outcome of a mental health assessment. Spirituality is a deeply personal matter and each individual has their own perception on what emphasis this has on their day to day life. The Chief Nursing Officers Review (2006) recommendation 10, directed mental health nurses to act in response to the identified spiritual or religious needs of the individual.

Search methods

This article describes a systematic critical review, the relevant studies that were identified were appraised and analysed for methodological quality and rigor. The reviewer was independent and the qualitative studies that were used were categorised by using an evaluation tool adapted for the review by Cormack (2000). Levels of evidence for qualitative research were categorised by using a tool adapted from the Joanna Briggs Institute (2004) (*Table 1*).

In order to critically examine the literature regarding mental health nursing assessment and spiritual beliefs and consider whether a person's spiritual belief influences the outcome of a mental health nursing assessment searches were conducted using MetaSearch that included CINAHL, British National Formulary, Cochrane Library, PubMed and other data bases from the period 2000-2009.

The initial part of the search strategy was a search that was limited to the MEDLINE and CINAHL databases in order to set the benchmark parameters for a more in depth review of the literature. The search terms used were related to words in the title of the proposed review.

In order to review the current relevant literature it is important to refine the search area and use a carefully defined inclusion criterion. An initial broad search exercise helped to refine and identify the key points to include when searching the literature (Polit & Beck, 2006)

The second part of the search involved a more comprehensive search of the following databases, British National Formulary, Cochrane Library, Electronic Journals Service

(EBSCO), PubMed, Science Direct. The search terms that were used were spirituality, mental health nursing and assessment. The search was restricted to articles in the years 2000-2009 to ensure currency of the papers retrieved. The third phase was conducted by searching the material manually from the bibliographies or reference lists used in the articles that had been previously retrieved from the search process. Papers were included if they were reports from qualitative research that employed methods like case studies, questionnaires, focus groups or individual interviews. All settings were considered, ranging from inpatient services, nursing or continuing care homes and community based care facilities. Participants included mental health nurses patients or service users and or their carers and families. They involved service users both in the recovery or florid phase of their mental health and did not exclude people with a diagnosis of a psychotic or manic illness. There were no restrictions on age or gender. Studies published prior to 2000 were excluded with the exception of seminal works. Non English speaking and non-British articles were excluded.

Table 1: Based on the criteria set by the Joanna Briggs Institute shows Levels of Evidence for Qualitative studies.

Level of Evidence	Description
A	Evidence which may include Findings that are matter of fact, directly reported/observed and not open to challenge.
B	Findings that are, interpretations, plausible in light of data They can be logically inferred. The findings may be challenged.
C	Findings not supported by the data

Search outcome

There were a total of 666 articles retrieved that were potentially relevant. The numbers of articles retrieved from each individual database were as follows: British National Formulary and MetaLib could not retrieve the number of hits from this target, Cochrane Library = 339 hits, Electronic Journals Service (EBSCO) = 2 hits, PubMed = 23 hits and Science Direct (Elsevier) = 302 hits. Articles that were duplicated within the search were identified and eliminated. For the final review, a sample total of six articles which met the criteria were included. Others may have been suitable, however, these were either unavailable electronically or restrictions for access were applied. The literature surrounding this often contentious subject is non-exhaustive. Due to the constraints of this literature review the sum of the review articles collected was 'capped' at six to make the data manageable and, therefore, offering a depth of understanding of the data.

It must be acknowledged, however, that literature that was omitted through the exclusion criteria, unavailability or '*capped*' selection may have been wholly relevant and valuable to the review but was not considered in this instance.

Synthesis

All the studies critically analysed were qualitative in nature. There were no randomised controlled trials (RCT's) in the review. The findings of the review were synthesised using a narrative format. The articles were critiqued against the specified criteria and comparisons were made with each other.

Results

The importance of spiritual care in nursing as a whole was identified just as spirituality was recognised as an important factor in people's relationship with each other and themselves. There are recognised assessment methods to assess someone's spiritual beliefs, however this is limited to what a person believes and how it may be expressed.

Conclusions and Recommendations

There appears to be little empirical research in how the nurse can avoid bias or prejudice when assessing someone's mental health. Further study of comprehensive and contemporary literature in the first instance may offer some indication on how to develop the formulation of an assessment tool for the future.

Results

Table 2 presents the six studies that were included in the review. They are graded according to criteria adapted from the Joanna Briggs Institute (2004) (*Table 1*) that

identified levels of evidence for qualitative research. It must be noted that the results are limited due to the non-exhaustive literature available. Further to this the evidence may be generalised to other populations because of the culturally diverse nature of spirituality and the same principles may be applied across culture and beliefs.

Literature review

The article titles by Greasley *et al.* (2008) Ledger (2005), Eeles *et al.* (2003), Coyle (2001) and Narayanasamy and Owen (2001) gave a good indication of what the research was about, however, only titles by Greasley *et al.* (2008), Eeles *et al.* (2003) Coyle (2001) and Narayanasamy and Owen (2001) offered an indication on what type of research or review was to be commented on. Four of the titles suggested the paradigm and all of them identified the concept. All the titles suggested a phenomena, however, the title by Dein (2004) did not identify who was working with what type of people.

Abstract : All of the articles offered an abstract prior to the main findings of their papers however three of the articles abstracts were a comprehensive review of the main paper and concisely summarise the main points of the report. Narayanasamy and Owen (2001) Greasley *et al.* (2008) Coyle (2001), and Eeles *et al.* (2003) specify the background, aims, method's findings and conclusions. The papers by Dein (2004) and Ledger (2005) were scant and offered little or no indication on the methodologies or main findings. Only three identified the sample used.

Introduction: The six papers all introduced their topic and identified the phenomenon of interest, however, only three stated the focus unambiguously and were therefore easily identified. Narayanasamy and Owen (2001) viewed that spiritual care in nursing has scope for improvement but indicated that there is little evidence in nursing literature. This view is

supported by Eeles *et al.* (2003) who goes on to say the evidence available proves to be inconclusive. All showed the significance to nursing, however, three generalised the issue to all nursing disciplines whilst only Eeles *et al.* (2003), Greasley *et al.* (2008) and Dein (2004) specified mental health nursing. The subject matter was appropriate and approached the research by using qualitative methods of enquiry that matched the paradigm. Only Narayanasamy and Owen (2001) specifically addressed the limitations by saying that caution is needed when generalisation is being considered, given the relatively small sample size.

Literature review: The studies all considered the theoretical underpinning of their work that at least in part summarise the body of knowledge and background that surrounded their studies. Four of the studies use up-to-date and relevant supporting material as well as acknowledging seminal works, however, Greasley *et al.* (2008), Eeles *et al.* (2003) and Dein (2004) rely on some works that are outdated or have sufficient bias to make the review questionable. The Narayanasamy and Owen (2001) and Coyle (2001) critiques show sufficient evaluation of balanced material that suggests the focus both supports and challenges the position proposed. They also identify the need for further empirical research, whilst the other four articles merely allude to the need, rather than offer specific recommendations. All of the studies show comprehensive references, however, the subject matter is so vast and difficult to refine and define, it was challenging to regard which works should be included or excluded. It is with this in mind that it is acknowledged that the six articles used appropriate references and therefore important ones did not appear to be omitted. That said it must also be acknowledged that Narayanasamy and Owens (2001) referenced several of their own works which would suggest bias. It may be then considered that the findings of this work and recommendations may be questionable. Their work was also referenced in other papers that were reviewed, giving rise to the

acknowledgement of their expertise. Dein (2004) did not present a review of the literature however showed that the literature had been considered as this was presented in the introduction part of the paper.

Research questions: Five of the articles retrieved state the research question or statements. Dein (2004) made a broad statement and then proceeded to present case studies that appear to support the title. Narayanasamy and Owen (2001) and Greasley *et al.* (2008) had a very clear remit of the questions or statements that are addressed and are consistent with the philosophical basis and theoretical underpinning considered in their introduction and literature reviews. Dein (2004) and Ledger (2005) show weakness in this area compared with the other articles and against the critique criteria.

Method: Four of the research articles followed a different methodology. This included focus groups, questionnaires, semi- structured interviews and case studies. Ledger (2005) and Coyle (2001) chose to review the literature for their findings although they chose a different approach. Ledger chose to concentrate on the statistics obtained from the literature collected and Coyle (2001) chose to use a concept view indicator to extract the data required. The semi-structured interview was used in order to extract rich information and not limit the responses that may have been elicited with a more structured methodology, for example questionnaires or critical incident questionnaires. Case studies offered the value of the richness of information, however, may not be structured enough to offer specific information that may be needed to answer the question, statement or hypothesis stated in the aims (Cormack, 2000).

Samples selection: Four of the six articles reviewed stated the sample very clearly. Ledger (2005) and Coyle (2001) made no reference at all. It could be considered that

because the two relied heavily on documented literature for their findings that their research would not formally need to state sample size, however, it would have been interesting and useful to know the breadth of the literature used in order to analyse whether the result were reliable, valid and rigorous (Polit & Beck, 2006). Four of the articles that conducted formal qualitative research used samples that were convenient to them. Narayanasamy and Owen (2001) sample of 130 was relatively large compared to the other articles reviewed. The sample chosen in all examples were congruent to the methods chosen.

Data collection:The chosen review articles used a different method of data collection. All could be considered suitable for the aims and objectives of the individual research aims. Three of the studies discussed the validity and reliability of their chosen methods of data collection. Dein (2004), Ledger (2005) and Coyle (2001) made no reference to rigor within their data collection methods. Dein (2004) did not propose a method so it was unclear until the rest of the paper was reviewed. The reader had to conclude the method based on the material presented. Ledger (2005) used statistical analysis as the method of data collection, however as the article was qualitative in nature the findings, conclusion and recommendations were presented in a narrative format. Narayanasamy and Owen (2001) and Greasley *et al.* (2008) showed sufficient analysis that determined any significant differences that were not attributable to other variation. Greasley *et al.* (2008) considered that there could be a paradigm shift that could affect changes whilst Narayanasamy and Owen (2001) showed that there was a danger of bias based on the beliefs of the experts interpreting the data. Coyle (2002) and Eeles *et al.* (2003) showed sufficient analysis however differences in variables that may have affected the findings were not fully

acknowledged. Of the remaining two, little or no reference was made to any variables that may have impacted on the results of their findings.

Only Coyle (2001) considered two other collection methods to achieve triangulation and therefore increase the rigor of the findings. Eeles *et al.* (2003) and Narayanasamy & Owen (2001) used questionnaires for their method both discussed their subjects questions and recorded the findings appropriately.

For the basis of the articles aims, four of the six articles showed that a sufficient amount of data collected was to be used in the first instance. Only Narayanasamy & Owen (2001) and Greasley *et al.* (2008) showed sufficient depth and richness, however, it could be considered that as the subjects were students of the review the material may have been distorted by the behaviour of the subjects (Polit & Beck, 2006).

Rigor: Four of the six showed that the methods used would have enhanced the trustworthiness of the data and the presentation of those methods was adequate for the studies. The documentation of the research process and findings were sufficient that the material could be audited and therefore able to be confirmed. Ledger (2005) and Dein (2004) made little or no acknowledgement of those considerations which makes the findings in the reports lack validity and reliability (Cormack, 2000; Polit & Beck, 2006)

Ethical considerations: Ethical considerations were only confirmed in the articles by Narayanasamy & Owen (2001) and Greasley *et al.* (2008) and these methods were approved and confirmed by the NHS ethical committee. The two literature review articles did not need formal ethical approval as the material used was readily available to the public at large. Of the remaining two one made no reference to ethical considerations at all

whilst the last discussed potential considerations however viewed the method of data collection as voluntary so the ethical considerations were viewed a satisfactory by the researcher.

Data analysis: Management and coding of the data was clearly sufficient in four of the articles. Work done by Ledger (2005) and Dein (2004) unearthed relevant material however it was unclear where this had been derived from the data presented. Dein (2004) relied on the literature reviewed in the first instance as opposed to the results of the material studied in the research. The tables and graphs that were presented in the three where this method was appropriate were clear and adequate. Greasley *et al.* (2008) and Narayanasamy and Owen (2001) tables were more in depth and offered further explanation in the narrative.

The issue of possible bias or weakness of the methodology was discussed in Narayanasamy and Owen (2001) and acknowledges that this may suggest the findings may in part be viewed as questionable, however, this notion was later addressed in the recommendations. The analytical procedures in the five remaining studies showed that there may be analytical bias towards the studies findings (Cormack, 2000).

Discussion: Overall, all six of the articles interpreted their findings appropriately within the social context. With four of the studies the major findings were discussed and in line with previous studies. Interpretation of studies done by Dien (2004) did not acknowledge the studies limitations and recognise this weakness in the interpretation.

Narayanasamy and Owen (2001) and Greasley *et al.* (2008) addressed the issue of transferability and acknowledged that the same issues may apply to other countries and indeed cultures.

The presentation of five of the studies were well-written, organized and had sufficient detail for the critical analysis. The weaker study by Dein (2004) although considered to be weaker based on the tool developed for the purpose of this review, presented good points for recognition and gave sufficient implications for the necessity of further study.

Conclusions/Recommendations: Greasley *et al.* (2008), Narayanasamy and Owen (2001) and Coyle (2001) recommended further study. Coyle (2001) furthered this and recommended that the framework developed be tested empirically in the future. The three studies acknowledge that the study that had been already embarked upon raise new questions and highlighted the need for further testing or review based on their findings. The recommendations appeared reasonable based on the findings of their research. The remaining studies only made recommendations for the behaviour of nurses within the paradigm but offered no suggestions on how those recommendations may be achieved. These issues may be considered by another researcher who feels it necessary to explore the findings further (Polit & Beck, 2006)

Findings: All of the articles afforded definitions of the term spirituality and separated it at least in part from the term religion. Clarification of the term ranged from a deep rooted need to worship a deity or deities and follow a 'religion' that had its own doctrine or laws to abide by, to just a basic acknowledgement of an individuals role with in the world or universe. Their spirituality may be expressed in the wonder of nature, music, art, literature or their ability to love or be loved (Greasley *et al.*, 2008). Eeles *et al.* (2003) advanced this by considering that what is considered a hallucination in one culture is evidence of divinity in another.

Spiritual care provision

Historically, nursing has strived to establish itself as a profession based on scientific evidence. The term '*evidence based practice*' is often used in relation to care. Quantitative research particularly Randomised Control Trials (RCT's) provide the benchmark for quality research (Cormack, 2000). Qualitative research is less valued as control of the findings, paradigms and variables are not easily controlled (Holloway, 2005). To the purist qualitative research relies too heavily on subjectivity and opinion rather than the cold hard fact that is offered from an RCT (Polit & Beck 2006). Unfortunately, this gives rise to qualitative research having less emphasis and seems the poor relation in research terms. (Cormack, 2000). In real terms qualitative research is the way forward when considering topics like spirituality (Holloway, 2005) and with the emphasis from NICE guidelines and Department of Health objectives, qualitative research results should be given more recognition and respect. By utilising this approach it may serve to address some of the cognitive dissonance that may be felt by the nurse struggling to care for an individual and support their spiritual beliefs.

Nurse attitude consideration

As previously stated the UK Census (ONS, 2001), has identified the culturally rich society we live in with people from a wide range of culture, religions and spiritual persuasions including the rise of neo-paganism in the western world.

The evidence has shown that nurses do not always recognise the spiritual needs of their patients and if they do they are often unable or ill equipped to assess and provide for the individuals needs. However, as the NMC (2004) instructs, the nurses duty is to ensure that the spiritual needs of of the individual are addressed. The practitioner must learn to use

the persons '*lived experience*' and incorporate this into the persons' toolkit for recovery (Barker, 2004).

The review identified that not all nurses feel able to meet the needs of their patients particularly if the beliefs conflict with that of their own whether the nurse is spiritually aware or atheist. Narayanasamy & Owen (2004) considers that if the nurse is not in touch with their own spirituality or has strong beliefs that conflict with that of the patient then they are unlikely to be sensitive or able to offer the individual support in expressing their spirituality. This viewpoint supported by Greasley *et al.* (2008) who identified two distinct opinions within nursing staff, those of the '*believer*' and those of the '*non-believer*'. NICE (2005) identifies simple and practical ways often address some of those needs. The most simple could be allocating a quiet, private place for the individual reflect or pray and equally importantly, time to do it.

In times of crisis, which would include mental ill health, patients often try to make sense of their suffering in terms of their spirituality. They turn to their beliefs for support doubt their faith in times of such pressure. These doubts could in turn cause distress and impact on the mental well being of the individual (Barker, 2004).

Assessment methods

The current available literature mainly addresses the need to facilitate a persons right to express their spirituality, but gives little consideration to the impact of a nurses judgement when assessing someone's mental health who is expressing their spiritual beliefs (Eeles *et al.*, 2003). What is one persons' belief is another person's delusion (Dein 2004). If that person is physically unwell then their beliefs at best may be respected and worst dismissed, but when a person is mentally ill then the judgement of those beliefs become the assessment criteria for delusional beliefs. In extreme cases, a person may lose their

liberty by being admitted to hospital. Coyle (2001) suggested that it is impossible to define spiritual self, as this aspect is often obscure and symbolic in nature. Spirituality may not simply mean an individual's relationship with the divine or whatever deity is to be worshipped, spirituality is multi-faceted and may be the individual's concept of love, peace, compassion and their role within the universe (Greasley *et al.*, 2008).

Most people use metaphoric descriptions when expressing their spiritual thoughts and require a certain amount of subjective interpretation to put it into context within the mental health assessment (Dein, 2004). Interpreting these clues may leave the assessment open ended or ambiguous which may lead to misunderstanding and a biased assessment. Narayanasamy and Owen (2001) warns against eliciting thoughts from the person that may transform a positive interview into an inquisition and that may have what could be perceived by the person as punitive consequences. This thought is echoed by Ledger (2005) who considers that an interview or assessment is rarely without bias and cannot be accepted that the nurse's judgement is not value free. Dein (2004) purports that certain thought or behaviours have different emphasis in different cultures. For example, if a person hears voices or experiences hallucinations it is considered that the person has a serious psychotic illness. In other cultures visual hallucinations may be considered a vision and hearing voices communicating with the dead or God. Even in British culture it is accepted in certain social settings or churches to speak in tongues or commune with the dead through spiritualist mediums.

There are recognised assessment methods to assess someone's spiritual beliefs; however, this is limited to what a person believes and how it may be expressed. The method may even go as far as to offer guidance to nurses in how to support the individual within that expression. The feeling of well being that this support may offer will no doubt

assist in helping the individual to '*feel better*'. These assessment methods may be transferable across the nursing and indeed any health professional discipline.

Unfortunately, the assessment falls short when the assessment is in conjunction with assessment of mental health needs, particularly when the individual is experiencing florid symptoms of psychosis or mania. (Eeles *et al.*, 2003). With these concepts in mind the nurse who strives to implement evidence based practice must experience a certain cognitive dissonance when trying to marry the world of science and the realm of spirituality.

Recommendations

The questions still remain, where does spirituality stop and mental illness start? How can the nurse be sure that the assessment is not biased because of the nurses' influence if their belief differs from that of the person being assessed?

Whilst there seems to be no accurate consistency when assessing someone's mental health and supporting their spiritual belief it is recommended that further research and trials be embarked upon to redress this. There appears to be little empirical research as to how the nurse can avoid bias or prejudice when assessing someone's mental health in conjunction with their spirituality, however, there is an abundance of literature that discusses some of the main issues. Further study of comprehensive and contemporary literature in the first instance may offer some indication on how to develop the formulation of an assessment tool for the future.

