EXPLORING HOW PSYCHIATRIC NURSES WORKING WITH PSYCHIATRIC CLIENTS IN THE ETHEKWINI DISTRICT UNDERSTAND THE SPIRITUAL DIMENSION OF HOLISTIC PSYCHIATRIC NURSING PRACTICE

A DESCRIPTIVE PHENOMENOLOGICAL STUDY

A Dissertation Submitted To

The School of Nursing

The Faculty of Health Sciences

College of Health Sciences

University of KwaZulu-Natal, Durban

In Partial Fulfillment of the Requirements for the

COURSE WORK MASTERS DEGREE IN NURSING

(MENTAL HEALTH NURSING)

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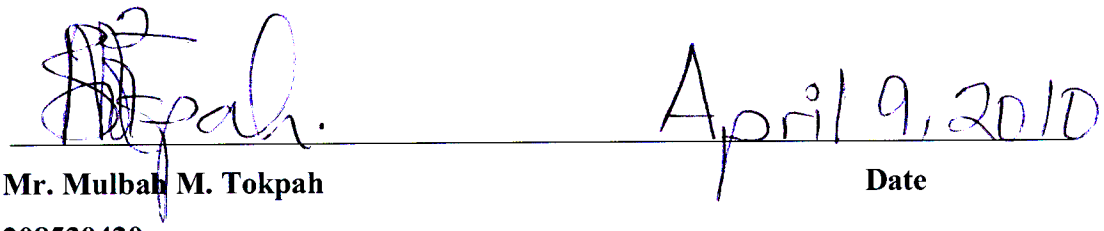
Date: April 2010

Declaration

I, Mulbah Massaquoi Tokpah, honestly declare that this dissertation entitled "Exploring how psychiatric nurses working with psychiatric clients in the EThekwini District understand the spiritual dimension of holistic psychiatric nursing practice" is my original work. It has not been submitted for any other degree or academic qualification at this or any other University. I also declare that sources of information utilized in this work have been acknowledged in the reference list.



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Dedication

This dissertation is dedicated to my wife, Reddie L.Tokpah for her continuous support in managing the affairs of the home while I was studying and to my children, Marion, Barcolleh, Paul, Kabeh and David for their love, understanding and cooperation while I was away from the home.

Acknowledgments

I would like to express my sincere thanks and appreciation to the following personalities and institutions for their guidance and support I received for this study. This dissertation would not have been completed without this support. I would therefore like to extend a special and big thank you to:

1. Dr. Lyn Middleton, my research supervisor for being patient with me and offering constructive criticism to my work. Her parental encouragement and guidance made me confident in conducting this study.
2. The academic and support staffs of the School of Nursing, University of KwaZulu-Natal for creating an atmosphere conducive for learning.
3. Ms. Amanda Smith for helping me to gain access to the sample population.
4. Ms. Shannie Maharaj for her motherly support given me during the course of my study.
5. My research participants for their willingness, understanding and cooperation during the course of this research study.
6. My best friends and classmates, Benoite and Genesis for helping me with their advanced computer knowledge.
7 My mother, sisters and brothers for their blessing and continuous prayers for me.
8. Dr. Henrique F. Tokpa, President, Cuttington University, Republic of Liberia and the Cuttington University Family for granting me study leave and for all their moral and financial contribution to study.
8 Dr. Walter T. Gweinegale, Minister of Health & Social Welfare, Republic of Liberia and the Ministry of Health & Social Welfare Family for providing me the opportunity to undertake this study.
10. Dr. Nestor Ndayimirije and the World Health Organization Family of Liberia for provision of funds for this study.
11. Dr. Stella Anyangwe and the World Health Organization Family of South Africa for their support regarding my safety and well-being.

Abstract

The purpose of this qualitative study was to explore how psychiatric nurses working with psychiatric clients in the EThekwini District understand the spiritual dimension of holistic psychiatric nursing practice. Descriptive phenomenology informed the study design, data collection and analysis. 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 and to provide socially responsive care (Greasley et al 2001; Mohr, 2006). Local data about how nurses understand and practice spirituality in their working encounters with clients would be an important first step in enhancing holistic, patient-centered psychiatric nursing care in the South African context.

Purposeful sampling was used to select the seven psychiatric nurses working in psychiatric settings in the EThekwini District. These participants were selected from the advanced psychiatric nursing classes of the School of Nursing of the University of KwaZulu-Natal for 2008/2009 and 2009/2010.

Data were collected through in-depth interviews lasting for 45minutes to 1hour and were audio-taped and later transcribed to facilitate easy analysis. The Colaizzi Method of data analysis and representation was utilized.

The following four themes emerged during the analysis of the data. Each theme had between three and twenty one associated significant statements. Theme 1 revolved around the higher power of spirituality, religion and their relationship. The participants conceptualized spirituality in a variety of ways, linking spirituality to religion and to cultural values, 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 meaning making in daily life that provides people, nurses and patients with a sense of belonging and of joy, hope, and comfort in both difficult and happy times.

The second theme "Central to but forgotten in psychiatric nursing practice" concurs with the literature view that spirituality and psychiatric nursing care are related, although spirituality is often forgotten in psychiatric nursing practice. Participants linked spirituality specifically to Maslow's Hierarchy of needs.

The third theme entitled "Psychiatric nursing for the spirit: Enabling and limiting factors identifies a number of factors which influence how psychiatric nurses engage with this dimension of holistic psychiatric nursing practice. This theme focuses on factors which influence psychiatric nurses in providing spiritual care for their patients. Enabling factors include psychiatric' nurses own spiritual orientation and knowledge about spiritual care enables them to provide spiritual care whereas limiting factors include the lack of spiritual education and spiritual knowledge in providing this care. The final theme highlights what these nurses see as important for developing their ability to provide spiritual assistance and includes education in method of spiritual assessment and intervention as the basis for providing holistic psychiatric nursing practice.

A number of recommendations for psychiatric nursing practice, education, research and policy-making based on the data from the study were made to relevant stakeholders. If accepted and implemented will go a long way in augmenting psychiatric nursing intervention to be holistic wherein psychiatric nursing care will include not only the biological, psychological and social care but also the spiritual care.

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CHAPTER ONE

1 INTRODUCTION TO THE STUDY

This chapter presents the background to the study and the problem statement, describes the purpose of the research study and then details the research objectives and questions. It also briefly explains the significance of the study in nursing.

1.1 Background to study

Spirituality is an essential dimension of human experience and thus, a relevant factor in holistic nursing and psychiatric nursing practice (O'Reilly, 2004). Psychiatric nursing defines itself as a holistic activity concerned with the bio-psychosocial-spiritual dimensions of the individual and his/her experience of mental health and illness (Middleton & Uys, 2009). From this perspective, all the dimensions, including the spiritual dimension have equal value and importance in the process of care.

The nursing literature differentiates between spirituality and religion and regards spirituality, rather than religion, as an appropriate focus for the spiritual dimension of the nursing model (Cornah, 2006; O'Reilly, 2004; Pesut, 2008). Spirituality has been variously defined in the psychiatric nursing literature. Although there is no consensus definition, most authors agreed that it refers to a person's search for meaning and purpose in life (Cornah, 2006; O'Reilly, 2004; Pesut, 2008); to a belief system that offers life-sustaining meaning which influences and is influenced by daily life experiences and is therefore, unique to each person (Thompson & MacNeil, 2006; Wilding, Muir-Cochrane & May, 2006); is experienced as a journey or process that extends throughout life (Ameling & Povilonis, 2001; Wilding, Muir-Cochrane & May, 2006); involves an awareness of a greater being with whom the person communicates in thought or word (Kristen & Schmidt, 2003); and finally, that spirituality is related to religion but that religion is not synonymous with spirituality (Ameling & Povilonis, 2001). Spirituality has an important cultural component since individuals draw on specific world views in the process of meaning making (Campinha-Bacote, 2003).

Religion on the other hand, is viewed as an organized set of beliefs contained within particular sacred texts, rituals and practices that some individuals draw upon in the process

of meaning making (O'Reilly, 2004). Examples of religions in the South African context include different forms of Christianity, Judaism, Hinduism, Islam and Buddhism. Although acknowledging religious diversity is an important aspect of holistic and spiritual care, many nurses find this difficult to do (Mohr, 2006).

Nursing authors are beginning to 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 (Koslander & Arvidsson, 2007; Mohr, 2006; O' Reilly, 2004). The bio-psycho-social model of care in mental health traditionally focuses on the biological, social and psychological determinants of wellness and illness. The bio-psycho-social dimensions of this model and the nursing activities within each dimension have been well-described (McSherry, 2006). The physical dimension generally involves the complex biological functions of the body which enable individuals to live, move, and exist in the world (Kristen & Schmidt, 2003). 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 interaction and the interaction between person and social environment and the factors that impact the individual's social well-being (Kristen & Schmidt, 2003; McSherry, 2006; Ray & McGee, 2006).

Although spirituality and religion are acknowledged as an important aspect of human experience, this model has not traditionally emphasized the nurse's role in this dimension of everyday care (Ameling & Povilonis, 2001; O'Reilly, 2004). The North American Nursing Diagnosis Association recognizes spiritual distress in its classification system but unlike the other dimensions it does not provide any spiritual interventions (Mohr, 2006). The spiritual dimension is most frequently associated with end-of life care and featured quite strongly in palliative nursing, gerontology nursing and substance abuse care (Lawrence, Head, Christodoulou, Andonovska, Karamat, Duggal, Hillam & Eagger 2008; Lin & Bauer-Wu, 2003; Miller, Chibnall, Videen & Duckro, 2005; Neff & MacMaster, 2005; Salib & Youakim, 2001).

Kristen and Schmidt (2003) argue that for a person to be in a state of wellness, the person's physical, psychological, social, and spiritual dimensions must work together as a system in

order to achieve a meaningful balance and hence, existence. These authors suggest that the spiritual dimension encompasses the whole person including the other three dimensions and that it is within this dimension that people find meaning, take courage and gain insights for living meaningful lives in the presence of others (Kristen & Schmidt, 2003).

Psychiatric nurses do to some extent, understand and integrate spirituality in different ways into their practice. For example, McSherry (2006) in his grounded theory study of a spiritual model for nursing argues that many nurses practice spiritual care –sharing the person's lived-experience of illness and supporting their search for meaning without necessarily being aware of doing so. From this point of view, the interpersonal psychiatric nursing skills of empathy (ability to enter into the life-world of another) and unconditional positive regard (ability to be with and appreciate another in their fullness and without judgment) are integral to the process of spiritual nursing (Mohr, 2006). There are benefits for nurses in providing spiritual care. For example, Kaldjian (2005) and Kristen and Schmidt (2003) found that providing spiritual care enabled nurses to enter into mutually satisfying but therapeutic relationships with their clients which increased their sense of competence and self-worth as nurses.

Although some psychiatric nurses do integrate spiritual care into their practice, nurses more frequently avoid this dimension (Koslander & Arvidsson, 2005 & McSherry, 2006). Nurses report not having enough knowledge about this dimension to adequately address it; not being familiar with the diverse cultural and spiritual practices in contemporary society; of fearing that spirituality might trigger psychiatric symptoms (Awara & Fasey, 2008); not having the vocabulary of this dimension or the tools to discuss it with clients and not seeing it as their job (Koslander & Arvidsson, 2005; McSherry, 2006; Mohr, 2006; Weaver, Flannelly, Koenig, Larson, 1998). Mohr (2006) suggests that some of the difficulties nurses have in dealing with this dimension are related to their personal awareness and understanding of the concept and the ways in which it differs from religion. Nurses who understand spirituality as a process, as unique, as a search for personal meaning to life' s questions and as distinct from the doctrine of a specific religion are more able to actively support clients as they try to make sense of the suffering associated with their particular illness (Koslander & Arvidsson, 2005; Mohr, 2006).

Many psychiatric clients report that spirituality is central to their overall wellbeing. Ameling and Povilonis (2001) describe spirituality as a source of hope, joy, comfort and guidance in the lives of individuals who are suffering with mental illness. More specifically, spirituality is regarded as an important strategy for managing depressive symptoms; improving coping and living successfully with others (Nasser & Overholser 2005); enabling them to resist suicide (Wilding, 2002); for building hope and meaning in life as they learn to live with and recover from chronic mental illnesses (Fallot, 2001); for understanding and dealing with psychotic symptoms (Murphy, 2000); for reducing levels of anxiety and managing substance abuse (O'Reilly, 2004). Psychiatric clients want to be able to discuss their spiritual needs but many feel that their background spiritual beliefs are not taken into account and in some cases, are negatively judged when their views differ from those of staff (Awara & Fasey, 2008; Wilding, Muir-Cochrane & May, 2006).

Two nursing studies that focused on spirituality in the South African context were identified. Both are concerned with spirituality and HIV/AIDS. Mahlungulu and Uys (2004) explored the perceptions of people living with HIV/AIDS, their relatives and nurses and found that the concept spirituality was unique to each individual, and was helpful in establishing a relationship with the self, others or God Almighty or supernatural beings. They identified hope, inner peace, finding meaning and purpose in life, illness and death as outcomes of spirituality in people living with and alongside HIV/AIDS. These authors identified spirituality as an important but neglected dimension of nursing in South Africa. Dolo (2006) explored the role of spirituality in people living with HIV/AIDS. Her study found that spiritual care is important for people living with HIV/AIDS and she stressed the need for nurses and other care-givers to develop an awareness of integrating spiritual care into the overall care of people living with the disease.

Spirituality is becoming an increasingly important component of the bio- psychosocial model of health in recent practice and research (Mohr, 2006; O'Reilly, 2004; Ray & McGee, 2006). Most authors writing in this area believe that spirituality lies within the heart of nursing and consider spirituality as an integral part of holistic nursing care (Barnum, 1996; Duffy, 2006; Wilding, Muir-Cochrane & May, 2006). Mohr (2006) does raise a number of ethical concerns that need to be considered when integrating spirituality and nursing. These include obtaining

consent from patient or relatives before administering spiritual intervention and being morally obliged to respect all patients for who they are as well as for their views. These ethical concerns are discussed more fully in the literature review.

1.2 Problem statement

A number of authors have argued that psychiatric nurses have a moral obligation to integrate spiritual care with psychiatric nursing care since the mandate of spiritual care and psychiatric care is similar (Wilding et al, 2006). Both are aimed at assisting the client to explore and to understand their lived-experiences of health and to implement appropriate bio-psychosocial-spiritual health enhancing strategies.

This similarity would suggest that psychiatric nurses practicing from a holistic psychiatric nursing perspective are likely to address directly or indirectly the spiritual dimension in their interactions with clients (Koslander & Arvidsson, 2005; Wilding et al, 2006). However, many psychiatric nursing studies are beginning to show that observed psychiatric nursing practice is heavily influenced by the medical paradigm which focuses more on the presentation and management of symptoms than on lived-experience and psycho-social-spiritual care (Middleton & Uys, 2009).

Although spirituality is discussed as a dimension of the holistic model of psychiatric nursing practice, spiritual needs frequently go unmet in practice (Foreman 2007; Greasley, Chiu, & Gartland, 2001; O'Reilly, 2004; Salmasy, 2002). A number of reasons have been given for why this is the case, all of which relate to the limited knowledge base of spirituality in psychiatric nursing (Koslander & Arvidsson, 2005; Wilding, Muir-Cochrane & May, 2006). Specifically, knowledge about how spirituality is defined, how nurses understand the concept of spirituality, whether and how nurses should focus on this dimension in daily practice and in nursing education contexts and to the understanding of the relationship between spirituality, mental illness and psychiatric nursing intervention (Koslander & Arvidsson, 2005; Wilding, Muir-Cochrane & May, 2006).

There seems to be a limited body of knowledge about how psychiatric nurses in the South African context understand the spiritual dimension of holistic psychiatric nursing practice in

their encounters with clients. No local studies to this effect were found although two nursing studies situated in the South African context have explored the issue of spirituality among people living with HIV/AIDS (Dolo, 2006; Mahlungulu & Uys, 2004).

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 and to provide socially responsive care (Greasley et al 2001; Mohr, 2006). Local data about how nurses understand and practice spirituality in their working encounters with clients would be an important first step in enhancing holistic, patient-centered psychiatric nursing care in the South African context.

1.3 Purpose of the study

The purpose of this study was to explore how psychiatric nurses working with psychiatric clients in the EThekwini District understand the spiritual dimension of holistic psychiatric nursing practice.

1.4 Objectives of the study

The objectives of this study were four -fold.

1.4.1 To describe how psychiatric nurses caring for persons with mental illness conceptualized the spiritual dimension of holistic psychiatric nursing care.

1.4.2 To describe how psychiatric nurses assessed the spiritual needs of persons with mental illness.

1.4.3 To identify the strategies or interventions that psychiatric nurses used to address the spiritual needs of people with mental illness.

1.4.4 To describe the factors that psychiatric nurses perceived as enabling and limiting their ability to provide spiritual care to psychiatric clients.

1.5 Research questions

1.5.1 How do psychiatric nurses caring for persons with mental illness conceptualize the spiritual dimension of holistic psychiatric nursing care?

1.5.2 How do psychiatric nurses' assess the spiritual needs of persons with mental illness?

1.5.3 What strategies or interventions do psychiatric nurses use to address the spiritual needs of people with mental illness?

1.5.4 What factors do psychiatric nurses perceive as enabling and limiting their ability to provide spiritual care to psychiatric clients?

1.6 Significance of the study

Research has shown that mentally ill patients have spiritual needs, but very often, these needs go unmet (Foreman, 2007). Foreman (2007) suggested that this may be due to the lack of knowledge mental health care providers have about how to address these needs.

It is anticipated that the findings from this study are relevant for clinical practice, nursing education, patient care and further research. The findings are useful to clinicians as they strive to incorporate spiritual care within their practice; for nurse educators in developing educational strategies and curricula content for teaching nurses about spirituality in psychiatric nursing; as the basis for further research in developing a knowledge base of spirituality in psychiatric nursing and for patients and their family who will benefit from care that is more holistic in addressing their deepest interests and needs.

1.7 Summary

This chapter discussed the background to the study, including the purpose of the study, the research objectives and the significance of the study for psychiatric nursing in one local South African context. Spirituality is considered an important dimension of human experience and thus necessary in the provision of holistic psychiatric nursing care for psychiatric patients. This next chapter provides a more detailed theoretical context for spirituality in psychiatric nursing.

CHAPTER TWO

2 LITERATURE REVIEW

2.1 Introduction

This chapter reviews some of the literature in the area of spirituality and psychiatric nursing. The following search terms were entered in the data bases of BioMed Central, Medline-Ebscohost, CINAHL, Cochrane Library, Pubmed, Science Direct, LWW Journals @OVID full Text, Md Consult Core Collection, Health Source: Consumer Edition: "spirituality and psychiatric nursing"; "religion and spirituality and mental health"; "religion and spirituality and mental illness"; "psychiatric nursing spiritual practice"; "the bio-psycho-spiritual model of nursing and psychiatric nursing"; "spirituality and the mentally ill client"; "spiritual dimension of the mentally ill." Approximately 175 articles were retrieved and 128 were found to be relevant to the study.

2.2 Contemporary understandings of psychiatric nursing

Psychiatric nursing defines itself as an interpersonal, person-oriented holistic activity. It delivers care through a process which is frequently described in the psychiatric nursing literature as "the nurse – patient relationship" (Middleton & Uys, 2009). It provides a climate in which care providers consider their patients unique individuals with capabilities and strengths, not merely diseased persons; and assists psychiatric patients with emotional comfort which in turn increases their chances for healing and recovery (Middleton, 2007). Studies also reveal that this relationship provides an opportunity for developing trust, bringing about effective change in the client's behavior and attitude; engaging the client in health promoting activities; teaching, identifying and working toward goals which are achieved through the establishment of the relationship (Schultz & Videbeck, 2007). The authors consider trust, genuine interest, acceptance, positive regard, and self-awareness as basic components for the establishment of this relationship. They further charge the nurses with the responsibility of developing these components to promote and enhance a successful working atmosphere between them and their clients.

The nurse-patient relationship has benefits to both the mental health care providers and the mental health care users. According to Dearing (2004), it provides a safe working environment for the nurse and the patient; allows the nurse and patient to see each other as partners of a therapeutic relationship; allows the nurse to "be open" and not judgmental of patient behaviour; provides an opportunity for nurses to carry on assessment of patients' mental status; allows nurses to identify specific symptoms of their patients' illnesses and be able to properly intervene; enables nurses to detect problems by carefully observing patients; allows patients to get responses from nurses; allows patients to share personal experiences and information and get feedback from nurses.

Although the nurse-patient relationship is important to all fields of study in nursing, its importance is very practical and visible in psychiatric nursing, as it is the central core for treatment compliance and serves as the foundation for achieving treatment outcomes (Middleton & Uys, 2009; Videbeck, 2007). Dearing (2004) reports on a study conducted on how the nurse-patient relationship influences the treatment compliance of a mental health care user diagnosed with schizophrenia. Findings reveal that the nurse-patient relationship is a therapeutic and rewarding relationship which provides an opportunity for the total enhancement of psychiatric patient compliance with treatment.

McCann and Baker (2001) and O'Brien (2001) consider the nurse-patient relationship an important tool in all phases of patient recovery from mental illness; a relationship that brings about the enhancement of hope for people living with mental illness especially when their conditions seem critical; a tool that enables mental health care providers to understand their patients' illnesses and consider them partners in a relationship that deserves confidentiality during and after interaction; and a space to elicit first-hand and in-depth subjective and objective data about a patient's illness.

2.3 Psychiatric care in the South African context

The purpose of this section is to provide a description of the context within which the nurses in this study work. Psychiatric services in South Africa are delivered through a network of community-based public health clinics and hospitals. This network emphasis is on universal primary health care delivered through a decentralized process of mental health services at

district level, based on the new Mental Health Act No.17, of 2002, and the 1977 White Paper on the Transformation of the Mental Health System (Petersen et al. 2008; WHO,2001).

In South Africa, the idea of integrating mental health service into primary health service for mental health care consumers has made some gains and positive impact on the lives of people living with mental illnesses (WHO, 2008). In 2002, half of the community clinics were providing mental health service (WHO, 2008). In early 2007, more than 80% of the clinics were promoting mental health services. General primary health care nurses provide basic mental health services in primary health clinics, and trained psychiatric nurses visit the clinics to manage serious cases and provide supervision to primary care nurses (WHO, 2008).

As patients move from the psychiatric hospital to begin a community-based life involving the integration of primary health care in their treatment scheme, there is a need for these patients to be fully rehabilitated to make their transition successful (Barbato, 2006; Farkas, Cohen, McNamara, Nemec & Cohen, 2000). Psychosocial rehabilitation, according to Barbato (2006), is a process that provides an opportunity to a person with psychiatric disability to function fully and independently in the community of his choice. Middleton and Uys (2009), state that about two thirds of mental health care services are provided to mental health patients at the clinic level in communities while about one third is provided to patients at institutional level. The understanding and appreciation of the integration of mental health services with primary health care is crucial to the overall treatment strategy for people living with mental illness in South Africa.

2.4 The phenomenology of spirituality and human experience

Victor Frankl's Theory of Existentialism provides an understanding of spirituality and spiritual wellbeing. This theory is chosen because "spirituality has existential underpinning that involves finding meaning and making sense of one's life with the notion of being connected to something or someone greater than oneself. "(Bauer-Wu & Farran 2005, p.175). Frankl's Theory of Existentialism is centered on the "meaning of human existence". Frankl (1963, p. 121) states that the primary motivation of humankind is his /her search for meaning in life. He adds that it is the search for meaning and purpose that helps to endure and overcome stressful situations and suffering.

In people's quest to find meaning, Frankl mentions three broad approaches which help. In the first approach which he refers to as experiential values, he names love as a cardinal element of cohesion that a human develops for another human. He classifies love as the ultimate and highest goal humans can aspire to (Ibid, 1963, p. 58- 59); through love humans tend to help the people they love to develop meaning, and in return they themselves develop meaning. Frankl further considers love as humankind's ability to recognise the uniqueness of the other person as human, and the acceptance that others possess potential which can be utilised to enhance their chances for finding meaning.

The second way of finding meaning is through creative values or by "doing a deed". This could be involvement in art, writing, music and the invention of a person's own life through the many encounters with situations which provide them the opportunity to fully understand and make meaning from life's situations. Frankl's third approach of finding meaning is through attitudinal values. These values are composed of virtues like compassion, bravery, and a good sense of humour. He notes that through making meaning from life's situations, suffering can be endured with dignity, optimism, and happiness (Ibid, 1963, pp. 70- 120). In his books entitled "Man's Search for Meaning", and "The Unconscious God: Psychotherapy and Theology", Frankl concludes with the following statements:

"Everything can be taken away from man, but one thing: the last of the human freedoms- to choose one's attitude in any given set of circumstances, to choose one's own way"

(Ibid, 1963, p. 104). "Without suffering and death human life cannot be complete" (Ibid 1963, p.106). "Meaning must be found and cannot be given" (Frankl, 1975, p.112).

Meaning is like laughter, he says; you cannot force someone to laugh, you must tell him a joke. The same applies to faith, hope and love; they cannot be brought forth by an act of will, our own or someone else's. *"Men must be equipped with the capacity to listen to and obey the ten thousand demands and commandments hidden in the ten thousand situations with which life is confronting him"* (Ibid, 1975, p.120). Frankl (1975) believes that it is the work of physicians, therapists, and educators to assist people in developing their individual consciences and finding and fulfilling their unique meanings.

2.5 The holistic model of psychiatric nursing practice

The traditional definition of health seems to narrow our understanding of wellbeing, treatment efforts and methods of preventing diseases (Lakhan, 2006). The nursing literature clearly mentions the difficulty in giving a contemporary definition of holism (Clark, 2003). There is no concrete definition of holism; rather a belief which brings together the physical, spiritual, psychological and social needs of individuals. Holism derives from the Greek word – "holos" meaning being whole or complete and holistic nursing recognises that health proceeds from a balance of the physical, spiritual, social and biological dimensions (Clark, 2003; Davies & Janosik, 1991).

The nursing profession has committed to offering nursing services to patients through a multidimensional approach based on the concept of holism (Davies & Janosik, 1991). Holism takes into account the physical, psychological and social experiences of the clients, their family members, and their communities (Davies & Janosik, 1991). Although holism is bio-psychosocial in its context, it is also concerned with the integration and wholeness of the individual's life experiences which enables mental health care providers to understand a client's attitudes and behaviours as well as their own attitudes and behaviours in their professional duties (Davies & Janosik, 1991).

The practice of psychiatric nursing is based on many theories with viewpoints deriving from biology, psychology, and social sciences (Boyd, 2007; Koslander and Arvidsson, 2005; Mohr, 2006; O'Reily, 2004). This holistic approach of care, known as the bio-psychosocial model with three separate but interdependent dimensions considers biologic, psychological and social factors as important elements in determining the overall health status of a person. A comprehensive and holistic approach to mental disorders is the foundation for effective psychiatric nursing practice in which the combination of all three dimensions, not only the biologic, determines the individual's overall health status (Lakhan, 2006). The bio-psychosocial model places greater emphasis on recognising that psychological factors (beliefs, relationships, stress) greatly affect an individual's chance of recovery from illness and disease (Boyd, 2007; Koslander & Ardvisson, 2005; Mohr, 2006; O'Reily, 2004). Lakhan (2006) argues that in order for this model to provide a basis for understanding the

cause and hence, management of health and disease, it must consider the spiritual context of the patient and not only the biological, psychological, and social contexts.

2.5.1 The biological dimension

The biological dimension of the bio-psychosocial model consists of the biological theories related to mental disorders and all biological activities related to other health problems (Boyd, 2007). It involves complex functions like exercise, sleep, and adequate nutrition which enable individuals to live, move, and exist in the world (Boyd, 2007). The biological dimension helps the psychiatric nurse to understand how the cause of illness is related to the functions of the body and how appropriate pharmacological agents can be administered to deal with the illness (Boyd, 2007; Lakhan, 2006).

2.5.2 The psychological dimension

The psychological dimension looks at the psychological causes of the health problem, e.g., lack of self-control, emotional turmoil, and negative thinking (Boyd, 2007). It also looks at the individual's abilities to reason, think, know, experience, and make sense of situations arising in life. This dimension requires an understanding of the patient's emotions, thinking, and behaviour through an interpersonal communication technique that enables the nurse to view, understand, and create awareness of her own internal feelings and behaviour and that of the patient (Boyd, 2007; Lakhan, 2006).

2.5.3 The social dimension

The social dimension is concerned with interpersonal social interaction and the interaction between a person and his/ her social environment and the factors that impact on the individual's social wellbeing (McSherry, 2006; Ray & McGee, 2006). This dimension gives an explanation of the connections of all the various activities of the patient in the family structure that tends to affect his mental health and treatment protocol (Boyd, 2007; McSherry, 2006). Although psychiatric disorders are not caused by social factors affecting the individual, the individual treatment outcome is greatly affected by the community in which he/she lives, especially the level of support received from the family (Boyd, 2007; Lakhan, 2006).

2.6 The spiritual dimension

Given the focus of this study, the spiritual dimension will be discussed in greater detail in this section.

2.6.1 Introduction

This next sub-section will describe the terms and differentiate between them, briefly outline the major religions represented in the sample of this study and highlight the spiritual practices common to these religions.

2.6.2 Spirituality and religion

The concepts of spirituality and religion are important elements of the holistic model of psychiatric mental health nursing, particularly with respect to holistic assessment and intervention. However, these concepts are often neglected by psychiatric nurses in the process of care-giving (Mohr, 2006). Despite the debate among nursing researchers about the meaning of these terms both deal with human uniqueness and are often used interchangeably while differences exist between them (Ameling & Povilonis, 2001; Cornah, 2006; Koslander & Arvidsson, 2005; Mohr, 2006; O'Reilly, 2004; Pesut, 2008).

2.6.2.1 Spirituality

Spirituality is described as the process used by individuals in an attempt to find answers to life's questions. Problems and suffering are examples of life's questions that tend to go beyond normal individual human imagination (Ameling & Povilonis, 2001; Stoll, 2007). The spiritual dimension of holism is essential and unique to all human beings; it comprises of four distinct components which portray the total make-up of people (Oermann & Heinrich, 2004). Firstly, it comprises the individual personal values. Values are principles which the individual considers important to his/her survival and to some extent tell how an individual deals with life experiences which determine his/her attitude and behaviour (Mohr, 2006). These include the recognition of the self, body, and life plus the ability to care for family, friends, and the community (Mohr, 2006).

The second component of spirituality is meaning making. This deals with the various happenings in the lives of individuals which provide strength and hope as they initiate and experience those happenings. The third component is concerned with relationship to God Divine or a higher power. Mohr (2006) further describes spirituality as a person's understanding of their relationship and/or connectedness with their God, Divine Being or a powerful force. This relationship encompasses all the beliefs and activities in which a person attempts to be related or connected to that God or force. It also concerns the individuals' personal relationship with people whom they consider important in their lives and with whom they interact on a daily basis. Finally, the fourth component deals with the individual's goals or mission in life. It involves the individual's call to duty in life; how possible it is to achieve their life's goals or whether special skills are needed to do so (Oermann & Heinrich, 2004; Van Wormer, Besthorn & Keefe, 2007).

According to Ameling and Povilonis, (2001); Greasley, Chiu and Gartland (2001), O'Reilly (2004), spirituality is a source of hope, joy, comfort and guidance in the lives of individuals who are suffering from mental illness; it improves individuals' self- control, self-esteem and confidence and brings about faster and easier recovery; improves relationships with self, with others, and with God or Nature and enables people to accept and live with problems not yet resolved. Stoll (2007) argues that spirituality is helpful in times of emotional distress, physical and mental un-wellness, loss, bereavement and death (Stoll, 2007). Spirituality is thus identified with experience and a sense of deep-seated meaning, belonging and purpose in life, and builds and works on the principles of acceptance, integration, and wholeness (Awara & Fasey, 2008).

2.6.2.2 Religion

Religion is most frequently defined as the outward or publically visible expression of one's relationship to God or a higher being (Speck, 1998). Religion is generally defined as an organized set of beliefs contained within particular sacred texts, rituals and practices that some individuals draw upon in the process of meaning-making (O'Reilly, 2004). This means that knowing an individual's religion does not necessarily reveal his/her spiritual orientation (Ameling & Povilonis, 2001).

Religion has been shown to be an important coping mechanism during periods of acute illness and to reduce the onset, intensity and severity of depression in persons with chronic, debilitating illnesses. (Koenig, Cohen, Blazer, Pieper, Meador, Shelp, et al.1992). Religious practices have also been associated with a lower incidence of substance abuse and improved self-esteem (Black, 1991). Ameling and Povilonis (2001) state that individuals who report high levels of religiousness report lower levels of depression, higher levels of positive affect, less emotional distress and greater life satisfaction. Wilding, Muir-Cochrane, and May (2006), hypothesized that many of these favorable outcomes may also be accounted for in part, by the material and emotional support that religious individuals receive from members of their religions-social network.

2.6.2.3 Common religions

The religions of Christianity, Hinduism and Islam will be briefly discussed since these are the religions of the respondents in this current study. Although none of the participants reported being of the Islamic faith or indeed, of practicing a traditional indigenous African religion, these are briefly outlined since the nurses referred to some of their patients as being of this faith. The population of KwaZulu-Natal is predominantly classified as Christian (40%), 22.5% as African/Traditional faith, 4.8% as Hindu and 1.5% as Islam (http://www.statssa.gov.za). These figures are open to scrutiny but their use is simply to illustrate the presence and to some extent, the broad distribution of these religions in the province.

2.6.2.3.1 Traditional indigenous African religions

In South Africa, members of the Traditional African Religions are stakeholders in the delivery of health services to the population. These people are very instrumental in treating illnesses where the sufferers and the healers strongly believed that the cause of the illness has some supernatural origin and can only be treated through the intervention of supernatural force as practiced by these traditional healers (Reuther, 2001; Thornton, 2002).

Members of the African traditional faith make up 22.5% of the total population of KwaZulu-Natal Province. There are two broad types of African healers in South Africa: faith healers and traditional healers (Walker, Reid & Cornell 2004). South Africa also has *sangomas*,

people who are possessed by spirits and have been initiated into a healing cult. These people are different from the *inyanga* because the *sangoma* believe that an individual is possessed by one or several spirits, and they experienced some life –threatening illness that had been cured through their apprenticeship to a senior Sangoma. There are also the *inyenga*, herbalists who are considered to be knowledgeable about African herbs. According to Pretorius (1999), there are about 150,000 - 200,000 traditional healers in South Africa who treat people for different illnesses. Thornton (2002) estimates that 80% of people living in and around South Africa consult these traditional healers on a daily basis even in areas where there are health facilities. These people who consult the traditional healers believed that traditional healers provide "psychological" and physical diagnoses which, combined, relate to the complaint and the social environment of the patient. Traditional healers usually give a holistic approach when treating their patients. They explain the cause and time of the illness and its relationship to the social and supernatural world in a culturally familiar way (Reuther, 2001).

2.6.2.3.2 Spirituality, the Christian religion and mental illness

Religious beliefs, specifically those of Christianity, dominated the concepts of mental illness in the Middle Ages to the extent that priests were looked up to for treating the mentally ill (Videbeck,2007). The church which is considered a spiritual entity of God or a community of believers and children of God, functions in accordance with the mandate of Jesus Christ when He said to His disciples " proclaim the Kingdom of God and heal"(Luke 9:2). It is made up of human beings who are created in the image and likeness of God (Genesis 1:26-27). According to Genesis 2:7 and Videbeck, (2007), human life is sacred; therefore it is the duty and obligation of every Christian to protect and save it. This statement clearly demonstrates the meaningful role the church as a people of God has always played in the treatment of people with mental illness. The church has helped to treat mental illness with prayers, recreational measures like attending theaters, taking a ride, walking and music. These measures provided motivation to psychiatric patients who were depressed. In the Middle Ages, according to Alexander and Salesnicks (1966) the clergy (priests) in monasteries used prayers, holy water, sanctified ointments, breath, and visits to holy places to offer services to the mentally ill; consoled the mentally ill with the words of God; organised healing services; supported patients with the administration of sacraments when possible; and

instilled hope in patients with a variety of sicknesses, and even in their families. The church members' prayers were based on faith in order to yield fruitful results.

The Bible mentions three important benefits that the spirit provides to those who are spiritual: firstly, the spirit produces a Christ-like character; a life-style that resembles the life that was lived by the Lord when He was on earth; a life- style that portrays the goodness of Jesus Christ to others; a life- style that shows trust in Christ; and a life- style that acknowledges relations with Christ whom believers look to for support and strength in times of difficulties (Galatians 5:22-23: Luke 4: 1-6). Secondly, the spirit produces Christ- like service. This form of service deals with service to God and then to humanity and requires dedication and commitment to render this service (Acts 2: 4; 4:8, 31; Ephesians 2: 10). Thirdly, the spirit produces praise and thanksgiving for God the Creator for all of life circumstances that believers experience, be they good or bad (Ephesians 5: 19).

2.6.2.3.3 Spirituality, the Islamic religion and mental Illness

Within the Islamic religion or tradition it is stated in the Qur'an "... sends down from the Qur'an that which is a healing and a mercy to those who believed" (Qur'an 17:82). From this quotation it is clear that the mosque played an important role in the treatment of people with mental illness. According to Alexander and Salesnick (1966), during medieval times, the practice of scientific aspects of Greek medicine flourished in Islamic countries. Synchronising classical with Islamic tradition and thought, Islamic scholars taught the Greek medical system and developed it into what is now called Islamic Medicine. In the 10th century Islamic religion established sections of hospitals to treat mentally ill patients. Today the mosque is active in the treatment of people with mental illness based on Islamic spiritual doctrine, the Qur'an (Alexander & Salesnick, 1966).

2.6.2.3.4 Spirituality, Hinduism and mental illness

The members of the Hindu's faith make up 4.8% of the total population of the province of KwaZulu-Natal. It is believed that the roots of Hinduism can be traced and linked to the traditions of the people of the Indus Valley as far back as 2500BC-1500BC. People of Hindu faith consider spirituality as an essential value for mental health and believe people are mentally healthy when there is harmony between self and their environment (Wig, 1999).

The religious beliefs of Hinduism are quite different from the beliefs of other religions of the world, like Islam, Christianity and Judaism (Wig, 1999). The author mentioned that Hinduism believes in one God (Brahman) who is worshipped in many different forms (avatars) and it is these that give the faith a polytheistic perspective.

Understanding mental health requires one to understand the basic beliefs of Hinduism (Francis, Robbins, Santosh & Bhanot, 2008; Juthani, 2001). Although the concept of holism in psychiatric nursing intervention is accepted in Hinduism where there is a balance with in the person and the environment, the dimensions of holism in Hinduism differ (Wig, 1999). These dimensions include: Dharma, Kama, Artha, and Moksha. Dharma focuses on the individual value of righteousness or religiousness, selflessness, and goodness of purpose. Kama deals with the fulfillment of the biological and sensory drives and the consequences thereof; Artha is the fulfillment of the social needs and includes acquiring wealth and gaining social recognition. Moksha refers to the individual liberation from world bondage and being connected with God (Juthani, 2001; Wig, 1999).

In Hinduism, these four dimensions of life are believed to be the source of harmony and represent healthy spirituality which involves loves for self and others, courage, and an open mind. An imbalance in these four dimensions may result in unhealthy religious practices which in turn, lead to intense fear, lack of prudence, self-centeredness, self-hate, hate of others, ignorance and madness (Juthani, 2001;Wig, 1999).

2.6.3 Differences and commonalities between spirituality and religion

Spirituality and religion have some common features (Mahlungulu, 2001). They both deal with values in the lives of individuals and meaning making from difficult life situations confronting the individuals. According to the author, the individuals' ability to deal with situations confronting them thus making meaning and purpose from them depends on their ability to know what situation is confronting them; trust in the environment in which they find themselves and hope for possible results. She revealed that individual's ability to search for meaning and purpose in life is increased by illness, suffering and bereavement.

There are a number of practices that occur across religions and that are tools for spiritual healing. These practices are possibly what links spirituality and religion (Mohr, 2006).

2.6.3.1 Common religious practices

2.6.3.1.1 Prayer

Prayer has been researched for decades and found to be useful in clinical practice in the treatment of variety of illnesses (Aldridge, 2001). It is a kind of conversation or communication with God Divine, or a powerful force that one recognises as being supreme. Mohr (2006) mentions that this form of religious expression is practised by all Western believers who acknowledge a relationship with God or a supreme being and by some Eastern traditions (e.g. Buddhism, Hinduism, Shintoism, Taoism). The use of prayer is related to a specific health outcome and accepted within medical practice. Recent studies from a broader medical perspective have shown that intercessory prayer benefits patients (King, Speck & Thomas, 1999; Mageletta & Dukro, 1996).

Prayer provides an individual with coping mechanisms before and after a major surgery (Saudia, Kinney, Brown, & Ward, 1991). In a study recently conducted with 96 patients who were scheduled for surgery, seventy patients reported that prayer is the highest and most important tool to use in critical times such as going for surgery. Although prayer is practised by both western and eastern religious believers, it differs in terms of form and content from one religion to another (Mohr, 2006). It may be offered by individuals or in a group and may have different effects on the individual's well- being and satisfaction. Group prayer is believed to generate a great and intense sense of well- being and happy living, and solitary prayer seems to be linked to individuals feeling depressed and lonely.

2.6.3.1.2 Bibliotheca and sacred writings

Bibliotheca is the use of religious literature and tracts which provide solace and inspire patients. These tracts and literature are owned and used by all major world religions. Although they seem to help patients gain insight into their feelings and behaviour, develop new coping skills, wisdom, and guidance (Alpers, 1995; Burkhardt, & Nathaniel, 1998); Mohr (2006), stresses that mental health care providers must at all time consult the treatment team, patient, and family members before recommending any literature for a patient's use.

2.6.3.1.3 Worship and ritual services

Worship and rituals are services that people of major religions are motivated to practice. These services may be performed privately and or publicly (Mohr, 2006; Tan, 1994). Worship expresses devotion to God or a supreme being whereas rituals are ceremonial activities which give recognition to an individual's relationship to God or a powerful force. Both worship and rituals sanctify people's devotion to their religious beliefs; reinforce individual commitment to God or a Supreme Being; and provide opportunity to live peacefully with others. Examples of rituals include prayer, singing hymns, fasting from food, water, sexual relations, and sacred emblems and sacred activities like baptism and hajj undertaken by followers of Christianity and Islam respectively (Mohr, 2006; Richards & Bergin, 1997).

2.7 The role of spirituality in health and illness

Recent surveys reveal that spirituality is very important in the lives of all human beings (Myers & William, 2003). According to Ameling and Povilonis, (2001) and O'Reilly, (2004), the "Theory of Human Becoming" provides a nursing framework that understands clients as related to a higher being (God) that client could depend on for equilibrium of health involving the body, mind, and spirit. As a person's health status changes, so does the individual's relationship with self, with others, and the universal. The attainment of spiritual health in mental illness is possible because spirituality provides us with a sense of direction and order (Mascaro & Rosen, 2005).

Charton (2005) reports on a study conducted in a community where the population was not religious but had clear spiritual beliefs. The findings of the study reveal that 71% of the people who were admitted in hospital for an acute stay had important spiritual beliefs even though some of them failed to express this in a religious way. More specifically, spirituality was regarded as an important strategy for managing symptoms of depression, improving coping and living successfully with others.

Research shows that spiritual distress commonly occurs in people suffering from both physical and mental illnesses. Chronically ill people are likely to suffer emotionally as well as physically because of a lack of spiritual care (Brown, 2001). Up to the present little has

been known about the concept of spiritual suffering or spiritual distress (Aldridge, 2001). The findings of a study conducted among religious and non-religious patients, who were emotionally and physically ill, revealed that people who attended regular religious services may live a longer and healthier life (Koenig, 2005).

On the other hand, spiritual distress was found to shorten the lives of certain categories of patients who did not attend religious services or have an active spiritual life. For example, Aldridge (2001) describes how a patient with a colostomy felt disappointed and lost all hope. He was often lonely and depressed and died despite receiving the proper physical treatment (Aldridge, 2001). Another study involving elderly hospitalised patients found that spiritual struggle such as a feeling of being abandoned by God increases the risk of dying by 28% (Gallagher, 2008).

Brown (2001), reports similar results conducted among religious and non-religious patients who were emotionally and physically ill. These findings revealed that patients who attended regular religious services lived longer and healthier lives than patients who did not. Patients' involvement in religious activities gives strength to the patients to develop the necessary coping skills which are needed by them in finding meaning and purpose in their illnesses. This helps patients to develop hope which leads to improved health and well-being; maintains inner peace and emotional control which decreases the incidence of depression in one's life and recognition of individual dignity not as psychiatric patients, but as a unique person (Koslander and Arvidsson, 2005). These reports demonstrate the benefit of spiritual care in the lives of patients, and how, when this is lacking, feelings of being unwanted and unaccepted arise, and spiritual distress takes over (Gallagher, 2008).

Spirituality also plays a very important role in the lives of people diagnosed with mental illness (Barnum, 2006; Coyle, 2002; Fallot, 2001). These authors report on research studies conducted on clients with mental illness. In all of their findings, the clients state that spirituality helped them cope with everyday stress and kept them grounded; brought them a feeling of being connected to something bigger than them; shaped their life's journey; and helped them to discover purpose, meaning, and inner strength. Greasley et al. (2001), also report on a study which showed that religious people with psychiatric symptoms felt that their spirituality, e.g. participating in a spiritual event, could be helpful in dealing with symptoms

of depression. They considered spirituality as a source of comfort and support in time of health crises, which lead to a desirable health outcome such as peace of mind, ability to engage in a task and be successful, emotional stability, good relationships with self, others and God or the higher power and a lower tendency towards heart attack.

The importance of spirituality in this population of people is further emphasized in a study reported upon by Foreman (2007). This study was conducted at Duke University Medical Center in New York with patients diagnosed with various mental illnesses. The findings reveal that 90% of patients rely on spiritual beliefs to help them cope with the stress of illness, experience less pain and anxiety, and maintain hope. These findings clearly demonstrate a relationship between spirituality and mental illness and how psychiatric clients seem to benefit from spiritual beliefs. Koenig (2005) reported on a study conducted to determine the role of faith on the mental health of 724 respondents. The findings revealed that 428 (66%) of the respondents admitted positive effects of faith on mental health. It also revealed that people who believe strongly in religious activities tend to experience less heart attacks (disease); have lower blood pressure; attempt suicide less often; recover from illness faster; are able to cope with stress more successfully; and finally, live longer.

In a similar manner, two separate studies were conducted in Australia to determine how faith protects individuals from wanting to commit suicide or cause harm to themselves. The findings revealed that there is a positive relationship between faith, wellness, and improved life satisfaction in people with mental illness. Individuals who are greatly involved in religious activities tend to depend on their faith for hope and purpose in life and will not think of doing harm to themselves. People more frequently commit suicide when they lack purpose in life and become hopeless (Koenig, 2005; Maurer, 2007). According to Keyes and Reitzes (2007) in a study involving older workers and retirees, religious identity is linked with decreased depression and better self esteem; helps individuals to see problems as belonging to God and not them, meaning only God has control over problems and able to best solve them; enables people to live satisfying and successful lives; influences how people view their God, themselves, their roles in the faith community and how well they live up to their beliefs (Maurer, 2007).

2.8 Spirituality and psychiatric nursing

Spirituality, though often overlooked in the assessment and intervention of psychiatric mental health, remains an integral domain of human existence. Spirituality requires recognition, validation and intervention for mental health care providers to support their patients' quests for wholeness in health (O'Reilly, 2004). Although nurses generally acknowledge that religious diversity is an important aspect of holistic and spiritual care, they have great difficulty in addressing the issue of religion with patients whose religion differs from their own (Mohr, 2006). The positive benefit of the role of faith in mental health is not always acknowledged by mental health professionals despite findings that show faith positively influences mental health (Maurer, 2007). The manner in which religious faith is used determines whether or not it will make a positive impact on people lives.

Some nursing researchers have differentiated spirituality from religion based on the type of intervention the nurses engage in their practice (Richard & Bergin, 1997). These authors considered spiritual interventions as being more internalised, personal, affective, ecumenical and transcendent whereas religious interventions are more organised, structured, externally expressed, denominational and ritualistic. Even though there are modern medicines which are very effective in the treatment of diseases, the human spirit with faith cannot be separated from the treatment of diseases and other illnesses (Berry, 1995; Pargament, 2007; Swinton, 2001). Frankl (1984) and Swinton (2001), suggest that faith should be considered a strong force to reckon with during the process of rendering care to the ill. This is because most patients rely on their religious faith for comfort and hope leading to faster recovery from their illnesses.

2.8.1 Psychiatric nurses' perceptions of spirituality and its role in practice

Over the years, the nursing literature mentions clients' perceptions of spirituality and their spiritual roles (Charton, 2004; Foreman, 2007; Greasley et al, 2001), yet very little is known about nurses' perception of spirituality and their spiritual needs and how these needs can be met in their places of work (Ray & McGee, 2006). Greasley et al (2001), report of a study that solicited nurses' perceptions about spirituality. The findings reveal that nurses associate spirituality with God, religion, and a strong belief that could be linked with reality; they

reported that spirituality helps them find meaning and purpose in life and in times of illness; enables them express their personal values like love, caring, and compassion in the performance of their duties; and provides peace and hope in dealing with depression and stressful situations at work and home.

Ray and McGee (2006), also report on a study conducted with psychiatric nurses at two regional mental health facilities. The findings reveal that the nurses consider spirituality as providing hope which strengthens them during difficult situations, like catering to critical patients, death, or divorce; enables them create a sense of relationship and belief in God or a higher being that helps them live a moral and just life with others; and is a source of comfort which helps them to be more concerned for themselves and others through prayer.

2.8.2 The psychiatric nurses' dilemma: spirituality or psychiatric symptoms?

Psychiatric nurses are often faced with the dilemma of distinguishing between psychiatric symptoms and the religious practices of their clients. This is important when it comes to spirituality and the provision of individualised holistic care (McLaughlin, 2004). The provision of holistic care requires that the psychiatric nurses take care of the clients' spiritual needs. However, psychiatric nurses are sometimes faced with the dilemma of encouraging or discouraging some religious practices which might appear delusional in nature. According to McLaughlin (2004), nurses must allow clients spiritual practices, but at the same time, must discourage overt harmful religious practices and at the same time promote relevant non-harmful practices which offer relief and comfort to clients. This is where the psychiatric nurses' dilemma comes in.

Sometimes the nurses are not sure whether their client is experiencing mental health problems or if he/she is experiencing some form of spiritual distress. Inasmuch as psychiatric nurses are faced with such dilemmas, they must carefully evaluate each case so that they can achieve positive client outcomes. It is suggested that psychiatric nurses need to take an open approach to care if they are going to fully address the spiritual needs of their clients (McLaughlin, 2004).

2.9 Psychiatric nursing assessment and intervention in spiritual care

The nursing literature is divided about the extent to which nurses should engage with spiritual assessment and intervention as a part of their daily practice (Mohr, 2006; O' Reilly, 2004). In the West, especially in the United Kingdom (UK), spiritual care is largely offered by mental health care providers in the mental health setting whereas in the United States of America, surrogate chaplains are employed by hospital administrators to render spiritual care to these patients (Koslander & Arvidsson, 2005; Paley, 2008). The debate about who and if the nurse should be responsible for spiritual care is as on-going as the debates about spirituality, religion and the similarities and differences between them (Paley, 2008). However, most nursing studies support the idea that the nurse should be involved to some extent, in the spiritual lives of their patients, particularly if they endorse the holistic model of nursing (Koslander & Arvidsson, 2005; Mohr, 2006; Paley, 2008; Wilding, Muir, Cochrane & May, 2006).

Spiritual assessment of a psychiatric client is a sensitive issue. This is particularly so for those clients who have had past experience of their religious beliefs being judged and interpreted negatively by others (O'Reilly, 2004; Wilding, Muir, Cochrane & May, 2006). Spiritual assessment and intervention is only possible within the context of a mutually respectful, non-judgmental and affirming nurse-patient relationship and is based on the client's own understanding of spirituality (O'Reilly, 2004).

Self-awareness on the part of the nurse is an important component of offering non-judgmental, patient-centered spiritual care. Mohr (2006) and O'Reilly (2004) suggest that the mental health nurses first consider their own spiritual beliefs, values, and feelings before doing a client's spiritual assessment. This allows the nurse to remain client-focused and not to project preconceived notions about spirituality or religion, onto the client. In this respect, the function of the nurse is thus to evoke the client's personal experience about spirituality; to remain with the client and observe him/her for outward signs of spirituality; to enter into empathy with the client's illness; and to respect and honour client's spiritual belief (Mohr, 2006; O'Reilly, 2004).

Psychiatric assessment is the first phase of interaction between the psychiatric nurse and the patient. It involves the systematic collection of both subjective (patient's view of his/her own story) and objective (nurse's view of patient's story) data to determine the patient's present spiritual history (Mahlungulu, 2001). The spiritual history, although a relevant factor in determining a patient's spiritual status, is not applicable to every patient. Its inapplicability can be observed in cases where the patient is psychotic and has delusional beliefs about him/herself and the world; where the patient expresses the desire not to participate; and with minors whose parents believe that such intervention may interfere with their religious doctrines (Mohr, 2006).

According to Mahlungulu (2001) and O'Reilly (2004) nursing practitioners apply several methods to assess patients' spiritual needs. These methods include: observation, collaboration with a nursing team, family members and religious leaders, and the use of simple open-ended questions that allow patients to tell the nurse about their experience and coping skills in the past. Mohr (2006) and O'Reilly (2004) also allude to the use of open-ended questions in determining a patient's spiritual status and give the following examples (Mohr, 2006, p.179).

Is faith (religion, spirituality) important to you in this illness?

Has faith been important to you at other times in your life?

Do you have someone to talk to about religious matters?

Would you like to explore religious matters with someone?

According to Pulchalski (2003, p.152), spiritual assessment should be based on the acronyms called FICA which involves the use of four open-ended questions that allow patients to explain to the nurse about their spiritual experiences both in the past and the present (Burkhardt & Nathaniel, 1998). FICA is similar to the spiritual strategy used in Mohr (2006, p179), as seen below:

F Faith "What do you believe in that gives meaning to your life?"

I Importance and influence, "How important is your faith (religion or spirituality) to you?

C Community "Are you a part of a religious or spiritual community?"

A Address or Application "How would you like for me to address this issue in your health care"?

Patients and families feel better when permission is given them to share and discuss beliefs (Pulchalski, 2003). Pulchalski (2003) and Rumbold (2007) assert that although spiritual assessment can generate a great deal of information about patients' spirituality or religious beliefs, the nurse needs to be sensitive, cautious and aware of patients and families preferences. These authors advocate a number of precautious measures when performing spiritual assessment. These include allowing the patient's view to prevail; involving all the team members in collecting spiritual data, and not just one person; keeping clear records of patient's responses to the assessment, spiritual needs intervention strategies; ensuring that there is continuity in spiritual care; and finally, providing a place for religious activities and care to take place (Pulchalski, 2003; Rumbold, 2007).

There are a few studies that have explored how the spiritual dimension of patients was addressed by the nurses. For example, Koslander and Arvidsson (2005) interviewed twelve nurses working in mental health settings. Their analysis grouped how nurses dealt with the spiritual dimension into three categories. In the first category, mental health care providers dealt with the patient's spiritual dimension by behaving as good carers. They were active participants in the patient–nurse relationship providing strength, encouragement, confidence, trust, understanding, and showed a willingness to help. In the second category the nurses were actively aware of patients' spiritual needs and dealt with these needs in different ways. In this category nurses described their thoughts about how they recognized the spiritual dimension of patients through their patient-nurse relationship. They also said that it requires courage to enter a patient's inner world, to ask questions about client's spiritual needs and to be prepared to address them when these spiritual needs surface. In the third category, the

group of nurses regarded the spiritual dimension of the patients as difficult to deal with. This demonstrates the difficulties nurses have in recognising the spiritual dimensions of the patients in the patient-nurse relationship.

Although the following two studies are not directly about spirituality in psychiatric nursing practice, they do address the issue of spirituality in nursing and are especially important since they are developed from the local context. These studies will therefore be briefly described here and their major findings about spirituality summarized.

Mahlungulu (2001) in her grounded theory study of spiritual care in nursing, conceptualizes spirituality as a unique individual quest for establishing and maintaining a relationship with the self, others, God or higher being based on the individual belief, faith or trust. The author emphasizes the important role spirituality plays in the lives of the sick and argues that hope, inner peace, finding meaning and purpose in life's situations like illness and death are some of the patient outcomes of this process. She regards the therapeutic patient- nurse relationship as the vehicle for this care and which allows the nurse to regard the patient as a unique and productive person and not merely as a suffering or sick person.

In the second study, Dolo (2006) explored the role spirituality plays in the lives of people living with the HIV/AIDS. In this study, spirituality is described as an individual's personal relationship with God or higher power which manifests love, forgiveness and connectedness, and respect for others. She identified inner peace, physical and mental wellness as some of the outcomes of spiritual engagement. Specifically, she noted that spirituality provided strength to patients living with HIV/AIDS to live successfully with the stigma and discrimination; provided hope and enhanced the quality of their relationships with self, others and the higher power.

In conclusion, the spiritual dimension of patients is of particular importance in caring relationships in the psychiatric setting. However, nurses lack knowledge about the meaning of the spiritual dimension in their patients and therefore, these needs continue to go unmet. Addressing the psychiatric clients' spiritual needs is a cardinal responsibility of the psychiatric nurse. Hence, it must be done with caution to avoid causing harm to the clients.

2.10 Spiritual education curricula for psychiatric nursing

Nursing institutions and educational programmes are continuously being challenged to integrate spirituality and spiritual care into their curricula. Such integration will help nurses and all concerned to provide spiritual knowledge which prepares nurses for the task of providing spiritual care to their patients, thus treating the patients holistically (Pesut, 2008). The nursing literature clearly mentions that due to the lack of instruction and the poor preparation of nurse educators in this regard, nurses are unable to adequately provide spiritual care to their patients (Koslander & Arvidsson, 2005; McSherry, 2006; Rogers, 2004). Foreman (2007) confirms the above statement with reference to a group of radiologists who conducted a study at the Harvard Radiation Oncology Program. This study found that 72% of advanced cancer patients felt their spiritual needs were not addressed by the medical system. Rogers (2004) further stresses that until the spiritual aspect of nursing care is adequately handled by nurses themselves, nursing educators, and policy makers, total patient care will not be realised and care will not be holistic.

Nurses are generally not educated on how to provide spiritual care during their education (Greasley et al., 2001). They therefore recommend that nursing educational programmes incorporate this aspect in nursing curricula to fulfill the profession's definition of itself as holistic and client-centered pride in both its art and science (Ameling & Povilonis (2001).

According to Pesut (2008) and Tholen (2009), the contents of this spiritual curriculum should include the following seven topics:

Relationship building skills that include developing the nurse's capacity for self-awareness and understanding what spirituality is and its functions in the lives of those for who care is intended.

Spiritual assessment skills e.g. FICA.

Skills to distinguish spiritual needs from psychiatric symptoms.

Skills for the implementation and evaluation of the spiritual dimension.

Professional confidentiality.

Knowledge and skills in the integration of spirituality in the management of mental disorders in general.

Knowledge and skills in dealing with ethical issues concerned with the provision of spiritual care.

The Royal College of Psychiatrists advocates a holistic approach when dealing with psychiatric patients. This includes biological, psychological, social and spiritual dimensions (Awara & Fasey, 2008). The authors state that ignoring patients' religious and spiritual needs can be termed a form of discrimination on the basis of race, religion, and ethnicity and could inhibit the psychological healing process of the patient.

2.11 Ethical cautions in integrating spirituality into psychiatric Nursing Practice

While spirituality is an essential part of psychiatric nursing practice, the discipline of psychiatry in general poses the greatest level of legal and ethical concern than any other branch of medicine (Norman& Ryrie, 1991; Ryrie &Norman, 2004).

Mohr (2006) outlines a number of ethical concerns or issues which nurses should consider in providing spiritual care. The first is that no health practitioner should refuse to treat a patient with mental illness because the patient's preoccupation with his/her religious beliefs interferes with day-to-day functioning. Furthermore, all psychiatric nursing professionals are under obligation to respect the patient's views especially in those circumstances where the patient and nurse hold different views. Thus, nurses and health practitioners should not impose their personal or religious values or beliefs upon patients. Giving religious literature or leaflets professing the nurse's beliefs, faith, or doctrine to patients is therefore unethical. Most importantly, care must continue to be holistic and spiritual intervention should not be substituted for other needed forms of physical, emotional, social and biological care. Finally, no health practitioner should hold a religious conversation or ceremony (devotion, prayers or reading scriptures with patients, handing out bibliotheca literature) without the informed

consent of the patient and in the case of children or adolescents, without the written consent of parents or legal guardians.

These are important cautions upon which to end this exploration of spirituality in the psychiatric nursing context.

2.12 Summary of the chapter

This chapter very briefly outlined how psychiatric services delivered in the South African context and worldwide and explored how spirituality is understood in psychiatric nursing and related to the psychiatric nursing mandate for the provision of holistic, patient-oriented care. The dimensions of the holistic model of psychiatric nursing were discussed, and how the spiritual dimension fits within this model. With respect to this dimension, the issues of spirituality and religion were explored and studies related to the relevance of this dimension to health, were presented. This next chapter presents the methodology used in this study.

CHAPTER THREE:

3 PHENOMENOLOGY AS THE THEORETICAL FRAMEWORK AND METHODOLOGY

3.1 Introduction

This study draws on the philosophical and methodological roots of descriptive phenomenology to understand how psychiatric nurses experience the spiritual dimension of the holistic model of psychiatric nursing in their work with psychiatric clients. A phenomenon is defined as an appearance or immediate object of awareness in experience. A phenomenon may be objective (external to the person aware of it) or subjective (for example, a thought or feeling) (Creswell, 2007). This study describes how psychiatric nurses experience the phenomenon spirituality (Creswell, 2007).

The basic purpose of this approach is to "reduce individual experiences with a phenomenon" to a composite description of its essence and in so doing, to describe in detail, what they experience and how they experience it (Creswell, 2007 p. 58). Although there are a number of different procedures for how phenomenology can be accomplished, most procedures share similar philosophical roots. These roots are briefly outlined and then followed by a description of the procedure used in this study.

3.2 Philosophical assumptions of phenomenology

Phenomenology is the study of phenomena, their nature and meaning (Finlay, 2005). Most phenomenological approaches emphasize three philosophical principles in the study of phenomena (Creswell, 2007; Polit & Beck, 2008). The first principle is that people's experiences are the source of wisdom in phenomenological study. This perspective implies that people and their experiences are the source of knowledge about a specific reality or phenomena. This idea is connected to the second principle which says that consciousness is always directed towards an object and that what can be known about the object is intertwined with the person's consciousness of it. The third principle is that the reality of phenomena is

appreciated as both object and subject as it appears in consciousness within the meaning of the experience of an individual (Creswell, 2007; Polit & Beck, 2008).

Creswell (2007) highlights two types of phenomenology commonly used in health care research. The first is hermeneutical phenomenology and the second, transcendental or psychological phenomenology. Whereas both traditions focus on developing descriptions of the understanding of phenomena, the hermeneutic approach focuses more on the researcher's interpretations of the different meanings of the expressed understandings (Silverman, 2001). The transcendental approach on the other hand, is concerned with building clear descriptions of phenomena and bracketing out as far as possible, the researcher's interpretations.

3.3 Phenomenological approach for this study

Stubblefield and Murray (2002) argue that phenomenology involves building knowledge of social reality from the view points of individuals living within a particular phenomenon or situation. These authors point out the similarity between the focus of psychiatric nursing practice and phenomenology; both are concerned with understanding the lived experience of individuals. O'Brien (2001) regards phenomenology as a useful methodological framework for understanding the experiences of nurses and patients in different contexts and thus, for beginning the process of knowledge building for different aspects of psychiatric nursing practice.

3.3.1 Steps in the descriptive phenomenological approach

This study is based on the principles of descriptive phenomenology. Polit and Beck (2008) identify four steps in the descriptive phenomenological process, namely bracketing, intuiting, analyzing and describing.

3.3.1.1 Bracketing

The first is bracketing where the researcher attempts to set aside his usual and natural assumptions about the phenomena and to suspend his/her beliefs in the existence or non-existence of the phenomenon (Finlay, 2005; Polit & Beck, 2008). Bracketing (alternatively known as epoche), continues throughout the research process. Terr Blanche, Durrheim & Painter (2006) suggest that the researcher clearly states his personal interest in the topic and

position with respect to the phenomenon at some point in the research report. In line with this principle of researcher reflexivity, section 5.3 of this report describes this process and specifically, some of the problems the researcher experienced in applying a phenomenological method in the interview process.

3.3.1.2 Intuiting

This step involves immersing oneself in the data and being attuned to the meanings given to the phenomenon by those who have experienced it (Polit & Beck, 2008). Intuiting is a form of openness; of being open to the diverse potential of meanings and being willing to listen, see, and understand with sensitivity, respect and humility for the experiences of others (Finlay, 2005). To some extent, intuiting is an aspect of bracketing.

3.3.1.3 Analyzing and describing

The final two steps are analyzing and describing. This study has drawn largely upon the procedures outlined in Colaizzi's method for qualitative data analysis (Creswell, 2007; Polit & Beck, 2008). These are outlined in section 3.6 of the study.

3.4 Selecting participants for the study

Purposeful sampling was used to select participants who had knowledge and experience of the phenomena of interest (Polit & Hungler, 1999). 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 of these nurses are registered psychiatric nurses working in the main psychiatric units of district hospitals and psychiatric clinics situated in primary health care centers of the EThekwini District. These nurses 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.

These participants were first approached with the assistance of their lecturer and in consultation with the research supervisor, to consider volunteering to participate in the study. Periods of class time were negotiated with the lecturer wherein the researcher outlined and discussed the study and its purpose with the psychiatric nurses. Concerns relating to the study were discussed e.g. confidentiality of data and protection of anonymity in disseminating

results, and addressed in order to facilitate their participation. A list of names, addresses and contact numbers of those who provisionally agreed to share their experiences was drawn up. Provisionally, fifteen nurses agreed to participate in the study, pending ethical approval. Thereafter, a letter was sent to each potential participant, through the class lecturer, thanking them for their participation pending ethical approval and again explaining the purpose of the study, describing how privacy and confidentiality would be protected, how data would be collected, stored and managed and how the researcher would contact the person to arrange a date and time for the interview.

Terr Blanche, Durrheim and Painter (2006) suggest that 6-10 participants are sufficient for a phenomenological study. Seven participants were interviewed for the study. Although data saturation occurred at the 5th interview, an additional two interviews were conducted to confirm that no new meanings were emerging from the data.

3.5 Procedure for collecting and recording data

Data collection began immediately ethical clearance was received from the University of KwaZulu-Natal's ethics review committee. The researcher telephoned each of the fifteen potential volunteers. Five potential participants consented to be interviewed and provided the researcher with suitable interview dates and times. Two potential participants asked that the researcher write a letter to their manager requesting permission of the manager for them to participate in the interviews. This request was complied with to facilitate their participation although the manager's permission was not ethically required. However, neither of these potential participants was available to participate in the interviews.

Five in-depth interviews, each lasting from 45 minutes to one hour, were first conducted with volunteers from the 2008/2009 advanced psychiatric nursing class. These five transcripts were reviewed by the researcher and supervisor for evidence of data saturation. Although data saturation was evident, an additional two interviews were conducted to increase the supervisor's and researcher's confidence in data saturation. Participants for these additional two interviews were drawn from the four volunteers from the 2009/2010 advanced psychiatric nursing class.

These seven interviews took place over a period of eight weeks and were conducted in a private office on campus. The purpose of the study was discussed with each participant and consent to participate obtained. Participants were also given a research study information sheet with detailed information about the research study purpose, contact details for the researcher and supervisor, how privacy was to be ensured, how data would be collected and stored and how confidentially was to be maintained. Interviews were then audio-taped and later transcribed to facilitate analysis. A series of probe questions related to the research objectives was on hand to guide the interview, if necessary (please see Appendix 1 section B). Biographical data such as gender, age, current place of work, psychiatric nursing working experience in year were collected in order to describe the characteristics of the sample. Interviews were done in English because the researcher was aware that the participants are all studying at the University of KwaZulu-Natal where English is the language of instruction and all the nurses are competent in English. There was therefore no need for the probe questions to be translated.

The section on ethical issues describes what information participants were given, how the data were managed and how ethical concerns of anonymity, privacy and confidentiality were observed.

3.6 Colaizzi's method of data analysis and data representation

According to Polit and Hungler (1999), data analysis is a way of transforming data through interpretation. It involves clustering together related types of narrative information. Data from this study were analyzed using Colaizzi's (1978) method. According to Creswell (2007), Polit and Beck (2008) & Sanders (2003), there are six stages in this process of data analysis. Each stage is described below.

3.6.1 Acquiring a sense of each transcript

In this stage, all the participants' oral descriptions were closely read and re-read, with the overall aim of immersing oneself in the data and developing a preliminary understanding of the meaning of the data. This was the beginning of the process of prolonged engagement with the data which continued until the point at which the report was considered as complete as possible. The researcher listened to each interview six times and read and re-read the

transcripts on eight different occasions in order to gain a sense of each participant's understanding of spirituality in their practice and of the organizing principles that might 'naturally' underlie these understandings (Terre Blanche, Durrheim & Painter, 2006). The researcher made notes of his impressions, thoughts and responses in the margins of each transcript on each occasion of reading and re-reading. These notes were discussed with the supervisor and formed the basis for the next step, extracting significant statements.

3.6.2 Extracting significant statements

Forty eight significant statements and phrases from the transcripts of the participants' understanding of spirituality in their work places were identified, highlighted and extracted. In the early phase of this step, all the statements were regarded as having equal or horizontal worth (Terre Blanche, Durrheim & Painter, 2006). Thereafter, similar statements were combined, repetitions were eliminated and a list of non-overlapping non-repetitive statements was developed (Creswell, 2007). The researcher manually extracted the significant statements in order to facilitate his on-going emersion in the data (Terre Blanche, Durrheim & Painter, 2006). A table with significant statements and their locations in each transcript by line number was developed. This stage of the data analysis is elaborated upon in Chapter 4 section 4.

3.6.3 Formulating meanings

In this stage, the significant statements were grouped into larger units of meaning or themes. The terms 'meaning units', 'themes', and 'emergent themes' are used interchangeably with the phrase 'formulating meanings' (Creswell, 2007; Smith, Flowers & Larkin, 2009; Terre Blanche, Durrheim & Painter, 2006). Again, a table with the formulated meanings and their associated significant statements was developed to facilitate this stage of the analysis. This stage is also further elaborated upon in Chapter 4, section 6.

3.6.4 Organizing formulated meanings into cluster of themes

Formulated meanings (themes) were then organised into clusters of themes or as Smith, Flowers and Larkin (2009) describe, into super-ordinate themes. The principles of texture and structure in phenomenological analysis were used as an aid to clustering these meanings (Creswell, 2007). Texture refers to the "what" of the phenomena and structure refers to the

"how" or the contexts and situations in which the specific experiences (that what) occurred. The texture cluster was then broken down further into different aspects of the "what" of the experience including the feelings, thoughts and behaviours that formed part of the texture of the experience of spirituality.

3.6.5 Exhaustively describing the investigated phenomenon

The final stage of the data analysis involved developing an exhaustive description of the phenomena, integrating the textural and structural descriptions into a coherent and holistic picture of the experience of spirituality in psychiatric nursing practice.

3.6.6 Returning to the participants

This step is one of the strategies that are used to validate the exhaustive descriptions with the participants. The exhaustive description was compared to the participants' audio taped interviews. Both the exhaustive description and the audio taped interviews were compatible and represented the participants' lived experience of the spiritual dimension in psychiatric nursing care. Furthermore, the researcher managed to have cell phone conservations with three of the participants on the exhaustive description. All of the three participants agreed with the exhaustive description and thought it represented their experiences of spirituality. Returning to the participants is explored further in section 5.3, researcher reflexivity.

3.7 Strategies for validating findings

The potential strength of a qualitative research may be undermined if appropriate and necessary verification strategies are not applied during the process of research as well as at the point of report writing (Khalifa, 1993). Trustworthiness refers to the extent to which the findings are an authentic reflection of the personal or lived experiences of the phenomenon under investigation (Lincoln & Guba, 1985). Three methods were used in this study to determine the trustworthiness of a qualitative data namely transferability, dependability and credibility,

3.7.1 Transferability

This is the extent to which the findings of a qualitative study can be transferred to other settings or groups (Polit & Hungler, 1999). In qualitative research, transferability is a matter of reader interpretation. The potential for transferability is increased if the study context from which the findings emerged is richly described, if all the methodological decisions are clearly outlined in the report and if the findings are substantiated with narrative examples. The presence of these factors will enable the reader to decide what insights might best be applied to his/her context. Thus, as Sanders (2003) indicated, this study should be believable, accurate and right and useful to people beyond those who have participated in the study.

To ensure transferability in this study, the researcher utilized the services of a variety of participants providing care to psychiatric patients in psychiatric clinics and hospitals. These participants differ in age, sex, educational background, working experiences, cultural background, and religious affiliation. Also, the researcher provided a detailed but simple description of research findings so that the reader will evaluate the applicability of these findings to other settings.

3.7.2 Dependability

This is the second method that was used to enhance trustworthiness. This method is concerned with the stability of data in the study (Polit & Beck, 2008). To ensure the dependability of the data, the researcher's work, the entire process of data collection, analysis and interpretation was closely examined, monitored and evaluated by the research supervisor as expert in the field. An electronic copy of a step by step data collection, analysis and interpretation of data was sent to the research supervisor for scrutiny and relevant feedback sent to researcher.

3.7.3 Credibility and confirmability

These are the final methods in determining the trustworthiness of a qualitative study. According to Graneheim and Lundman (2004), credibility focuses on how interpretations are grounded in the data and whether they are formulated in ways consistent with the available data. To ensure credibility and confirmability of the data, the researcher continuously listened to the interviews and compared them to the verbatim transcripts to ensure that the both were

saying and meaning the same (prolonged engagement). Also, the researcher through peer debriefing (structured group research supervision sessions facilitated by the research supervisor and another member of staff of the School of Nursing) discussed the process of data analysis at regular intervals.

Colaizzi's method of data representation and analysis is in itself, a strategy for determining and maintaining the rigour of the study.

3.8 Ethical considerations

The ethical considerations with respect to ethical research, participant privacy and confidentiality were maintained in the following ways. The proposal was submitted to the School of Nursing Ethics Committee for expert scrutiny, and thereafter, to the Ethics Research Committee of the University of KwaZulu-Natal for ethical review and approval.

Participants were given a sheet of important information about the study to keep and this was discussed with them before they were asked to sign the consent form. This sheet indicated the purpose of the study, how the findings were to be disseminated and assured them that they have the freedom to withdraw at any point from the study and to request to have their data removed from the study. Further, they were not disadvantaged in any way if they requested to withdraw, nor were there any benefits for participating in the study. They were given contact details of both the researcher and the supervisor and they were invited to contact either at any point to discuss their responses or the study. At the end of the interview, they were each given the opportunity to discuss and give their personal opinions on the interview conducted. The researcher also offered them the opportunity to listen to a part of the recording before they left. None of them wanted to do this.

3.9 Data management

Hard copy biographical data and transcribed interviews were stored in a locked cupboard in the researcher's place of residence. This data will remain stored for five years. The researcher made use of a private computer to which only he had access. Identified names and places were removed from transcribed transcripts. The audio-cassettes were stored in a locked cupboard and will continue to be stored in a locked cupboard in the supervisor's office for

two years if the result of the study is published and for five years if no publication results from this study before being destroyed.

3.10 Data dissemination

The examined and corrected report will be bound and submitted to the library of the University of KwaZulu-Natal. The completed study will be prepared with the supervisor, for publication in an accredited nursing journal.

3.11 Conclusion

This chapter outlined the methodology of the study. The descriptive phenomenology which gave the understanding of how psychiatric nurses experience the spiritual dimension of the holistic model of psychiatric nursing in their work places with psychiatric patients was utilized. The participants for this study were recruited from the 2008/2009 and 2009/2010 classes of the advanced psychiatric nursing classes of the School of Nursing, University of KwaZulu-Natal. These nurses have vast knowledge and experiences in psychiatric nursing care. The Colaizzi method of data analysis and interpretation which involved six steps was utilized to analyze the data for this study. Transferability, dependability, and credibility and confirmability were strategies applied to validate the findings of this study. Ethical consideration for research study, participants' privacy and confidentially were maintained.

CHAPTER FOUR:

4 DATA ANALYSIS

4.1 Introduction

The purpose of this chapter is to present the qualitative data regarding how psychiatric nurses working with psychiatric clients in the EThekwini District understand the spiritual dimension of holistic practice.

4.2 Description of the participants and their work settings

Seven psychiatric nurses participated in this study. These nurses are presently working in various psychiatric hospitals and clinics in the EThekwini District in South Africa and between them have a wealth of psychiatric nursing experience ranging from three years to twenty seven years. One nurse is involved in rendering psychiatric services to out-patients at clinics and six nurses to in-patients in hospital settings. Nurses working in psychiatric hospitals and clinics are involved in many different activities. The nurses working in hospital settings admit patients who are referred from psychiatric clinics; administer medications and calm patients who are aggressive; make contact with relatives who may have refused to take their family member home; teach and supervise psychiatric students from various nursing institutions; arrange for religious leaders of different denominations to come and conduct prayers with their patients; liaise with social workers to assist in locating patients' relatives who have refused to take their patients home; counsel relatives to accept patients back into the home and to take an active part in care giving. The nurses working in the psychiatric clinics receive and calm psychotic patients who are referred from general hospitals; arrange for patients to see psychiatrists; provide follow-up consultations to patients that come in regularly every month or bi-monthly for treatment and do one- on- one counseling about a range of different emotional, social and psychiatric problems.

The nurses who participated in this study are predominantly female which is consistent with the class gender distribution where over seventy-five percent of the class members of this psychiatric class are female and a very small proportion, male. Among the seven nurses, five (71.4%) are women and two (28.6%) are male. Four of the women and both men identified

their religion as" Christian" while one of the female respondents described her religion as Hindu. All of these nurses are registered general nurses with an additional psychiatric nursing qualification. Two of the female nurses have a Bachelor of Science Degree in nursing as their first degree in nursing. The demographic characteristics of the participants are presented in the below table (Table 4.1).

Table 4.1 Demographic characteristics of participants

Participant	Age in years	Gender	Education	Religion	Psychiatric working experience(years)
1	43	F	Diploma/First degree in nursing	Hindu	19 years,7months
2	51	F	Diploma	Christian	23 years
3	51	F	Diploma	Christian	27 years
4	49	M	Diploma	Christian	22 years
5	43	M	Diploma	Christian	13 years,3 months
6	35	F	Diploma/First degree in nursing	Christian	4 years
7	27	F	Diploma	Christian	3 years, 4 months

4.3 Extracting significant statements

The researcher engaged himself with reading and re-reading each transcript to identify statements and phrases which expressed the participants' experiences of the phenomenon. These statements were highlighted on each page of the transcription and later copied and pasted on a separate page with the page and line numbers attached. The copying and pasting of statements enabled the researcher to re-read the pasted statements and thus to focus on identifying emerging themes.

Forty-eight significant statements and phrases relating to the participants' understanding of spirituality in their practice were identified, highlighted and extracted. Six significant

statements were extracted from both the first and last transcriptions, seven were extracted from the second, third, fifth and sixth transcriptions while eight significant statements were extracted from the fourth transcription. These significant statements and their locations in each transcript are presented in Table 4.4 in Appendix 6. An example of this table is provided here in Table 4.2.

Table 4.2: Example of significant statements and their locations in text

Significant statements	Location in transcript
Spirituality means more ideas, beliefs sometimes even emotional concern with connection with a higher being	Transcript 1 lines 56-57
Spirituality is connected to religious beliefs and practices	Transcript 1 line 57
Spirituality is related to personal belief, that is my personal belief	Transcript 1 lines 58,64

4.4 Formulating and clustering meanings

These significant statements were then grouped into larger units of information called association of significant statements. The researcher read and re-read the statements and in so doing, asked himself two basic questions about the "what" and the "how" of the meaning of the experience embedded within the statements. The researcher asked himself: What is this statement telling me about how the participant experienced spirituality and how did this experience happen in this context? Creswell (2007) suggests that these questions are useful for novice qualitative researchers in formulating meanings. The formulated meanings obtained from significant statements were arranged into clusters of themes. These clusters brought together a series of clearly related other themes.

A decision was taken with the research supervisor that a theme should have at least three meanings associated with it and that these meanings should if possible, illustrate both similarity and difference. For example, while the following two themes are different in their

experience, both are related to the theme, 'The higher power of spirituality, religion and their relationship". The first quote shows how ancestor worship as a personal belief is linked to spirituality for that person while the second quote shows more broadly how religion as a personal belief is linked to spirituality, as stated here: *"Spirituality may be a way of ancestors, is a way of linking with the supernatural world."* (Transcript 5, lines1146- 1147).

"*Spirituality means a system of belief that you have whether a Christian or not; it is associated with your religion.*" (Transcript 6, lines 1307- 1308).

In this way, four themes or formulated meanings with forty associated significant meanings were identified. These themes are discussed below with illustrative examples from the transcripts. All the themes with their associated formulated meanings are presented in Table 4.5 in Appendix 7. An example of the first theme and associated significant meanings is provided in Table 4.3.

Table 4.3 Example of theme with associated significant meanings

Theme	Associated significant meanings
The higher power of spirituality, religion and their relationship	A person's own spiritual orientation enhances his/her ability to offer spiritual care to psychiatric patients. (Transcript 2, lines 361-362) Psychiatric' nurses own spiritual orientation enhance their abilities to offer spiritual care (Transcript 3, lines 755-756) Psychiatric nurses own spiritual orientations provide them support in offering spiritual care to their patients. (Transcript 5, lines 1184-1185)

Theme 1: The higher power of spirituality, religion and their relationship

Ten statements were used to develop this theme about spirituality and its relationship to religion. Although vivid and sometimes different definitions were put forward by the participants, all participants linked spirituality to a higher power *"Spirituality is Higher Being in term of human being"* (Transcript 1, line 82); and to the phenomenon of being human and connected with each other through our humanity: *"I think that [spirituality] is what makes a person human..."*(Transcript 3, line 655); *"I think if I didn't have my own spirituality, I don't think I could be able to be human to my patients."*(Transcript 3, lines 754-755; *"To me, spirituality is the lining of the globe that holds a person together"* (Transcript 3, lines 782-783). The participants emphasized the importance of spirituality in moral decision-making and knowing right from wrong: "*Spirituality is a sense of being, is a sense of belonging, knowing the right from the wrong"* (Transcript 2, lines 510-511).

Some defined spirituality as a very personal experience based on that person's own beliefs and values: "*Spirituality is personal; it is a personal belief, very individual; often based on your own personal need"* (Transcript 3, lines 653,716)", frequently experienced through a connection to religious beliefs and/or to a higher force or being such as God, a Super-being and Ancestors. *"Spirituality means a system of belief that you have whether a Christian or not, it is associated with your religion"* (Transcript 6, lines 1307-1308); *"Spirituality means more ideas, beliefs, sometimes even emotional concern with connection with a higher being"* (Transcript 1, lines 56-58); *"Spirituality may be a way of ancestors, is a way of linking with the supernatural world."* (Transcript 5, lines 1146-1147; 1151-1152).

"*One of the needs of the person is one of the basic needs as compared to Maslow's hierarchy of needs. Spirituality is one of the bottom needs, very important for everybody; definitely, I will recommend spiritual care for my patients. As without mental health there is no health, so without spiritual health there is no health. Whatever your spirituality is, it needs to be healthy*." (Transcript 3, lines 784- 788).

Thus spirituality and religion are interwoven with participants emphasizing different characteristics or facets of their connection such as communication: "*Spirituality means those things that deal with religion, belief, or those things that have to do with a person's*

understanding or his communication with his God. We as humans were made in God's image, is also our connection to God." (Transcript 4, lines 867-870); ideas, beliefs and emotions: "*For me it means more ideas, beliefs, sometimes even emotional concern with connection with a higher being, specifically religious belief and practices. And it is related to personal belief."* (Transcript 1, lines 56-58); "source *of meaning, comfort and hope"* Transcript 6, lines 1327-1328).

Theme 2: Spirituality: Central to but forgotten in psychiatric nursing practice

Twenty-one statements were used to develop this theme. 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: "*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 do we fortify that area to come equal to others in term of caring so that we gave the patient a holistically approach, because if one aspect is neglected, then it is not holistic any more..."* (Transcript 5, lines 1262-1267), *"The system itself because there is no traditional healers as part of the management team, our negative attitudes, lacked of training and understanding about other spiritual beliefs, lacked of spiritual assessment area on patient's admission record as well as lacked of knowledge*."(Transcript 1, lines 184- 187).

Linked specifically to Maslow's Hierarchy of Needs: "[*spirituality] is one of the needs of the person, is one of the basic needs as compared to Maslow's hierarchy of needs. Spirituality is one of the bottom needs, very important for everybody*" (Transcription 3, lines 784-786) and an essential element of mental health: " *without spirituality, you can't have mental health, you can't be compassionate*". (Transcript 3, lines 783-784) and therefore, as a dimension that needs to be nurtured as one of the sources of human strength: "*A part that needs to be always nurture as human beings, because there where our strengths come from.*" (Transcript 2, lines 317-318).

One nurse described how her own spirituality is an essential element of her being as a person and a psychiatric nurse: "*Without spirituality, I will be incomplete and my work will also be incomplete. It 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." (Transcript 3, lines 755-757). While another commented upon the central role spirituality plays in her being human within the context of the nurse-client relationship: *"I think if I didn't have my own spirituality, I don't think I could be able to be human to my patients."(*Transcript 3, lines *754-755).*

Spirituality is not only an important element of the identity of these nurses as psychiatric nurses but also, a paradigm for understanding mental health and illness: *"Spirituality can improve their health and mental illness in the sense that we should not undermine their spirituality. Also their prognosis and their compliance with treatment will improve." (Transcript 7, lines 1405-1407)"; "You see that a person will not get better because their spirituality is not being fulfilled". Spirituality is very important for the psychiatric patients."* (Transcript 7 lines 1399-1400, 1409*);* and a tool in their repertoire of general clinical skills: "*Spirituality is part of life and is an area that needs to be attended to for every psychiatric client and need to be included in the psychiatric client care, the total care". (*Transcript 1, lines 201-203*; "Instead of us saying psychosocial rehabilitation, we should say psychosocial spiritual rehabilitation."(*Transcript 4, lines 870-872*);* and for managing difficult psychiatric situations: *"It takes special people to nurse psychiatric patients; you got to have God giving skills to handle psychiatric patients." (*Transcript 2 lines 361-362*);* and for offering support and solace to clients: " *In our setting, we pray even with the patients, sometimes they actually remind us we have to pray and thank God for giving us life*" *(*Transcript 2, lines 406-408.

Although spirituality is seen as an important aspect of care, it is frequently neglected " *There is a gap, a gap in that we don't really offer spiritual care for these patients*"(Transcript 4, lines 930-931); " *Spirituality should be one area which should be visited, explored and tested in our daily care of our clients*" (Transcript 4, lines 1052-1053). "*Spirituality is part of life and it is an area that needs to be attended to and included in the psychiatric client care.*" (Transcript 1, lines 201-203); invisible "*I would say it is an area that is actually lacking, and not attended to*" (Transcript 3, line 671) and lacking in psychiatric nursing practice "*Spirituality is lacking in psychiatric-giving care* (Transcript 4, lines 930-931), and in policy as well: "*Spirituality is even forgotten among policy makers dealing with mental health services.*" (Transcript 5, lines 1166-1167).

Six of these nurses revealed that they are engaged in the provision of some level of spiritual care for their patients through praying with them, allowing them to go to church, allowing their religious leaders to come and pray with them and negotiating with the doctors for them to go home and perform religious rituals. One nurse revealed that management prohibits the provision of spiritual care of any kind because as she said, management feels *"we are living in a diversified society, a multicultural community of many religions"* (Transcript 7, lines 1418-1419).

Psychiatric nurses have revealed ways of knowing that their patients are expressing spiritual needs. They admitted that their patients are often observed expressing spiritual needs of various kinds through chanting, singing of the gospel and religious songs, asking permission to attend church services, fasting on Tuesdays and Thursdays, requesting their religious leaders to come and see them, and asking for pass outs to go home and perform religious rituals, as mentioned by these participants:

"*I can know, there are those who will be singing religious songs, chanting their prayers if they are Hindus and sometimes I get to the family and ask them if this is an ongoing thing. Some of them come out and tell you*" (Transcript 2, lines 455- 457).

"*If patients express the spiritual need and if we cannot manage it, we invite a spiritual leader to deal with that.*" (Transcript 3, lines 697- 699).

"*As I said before, some of them actually asked to go to church, some of them will asked why not ask the pastor to come and pray for us inside, some of them when they are admitted, will ask us to go home and perform some ritual activities with their gods in order to get connected to their ancestors and they believed when that is done, it helps them be relieved, so they go home to come back later. They believed if this is done it will relieved them of the evil spirit.*" (Transcript 4, lines 925-930).

"*Some will say I miss my pastor, some will asked don't you have Bible in this hospital? Some will be singing gospel songs.*" (Transcript 6, lines 1334-1335).

"*You will see those that are Christian will say today I will be going to church, today is a church day, you see the Indian community will be fasting on Tuesday and Thursday and will*

tell you that they are not going to have anything today because they are fasting today." (Transcript 7, lines 1414-1417).

"*Either we give them the pass out or if they asked for a room I can give them a room to pray, if relatives come and they want to pray with client, I can give them a separate room to pray.*" (Transcript 7, lines 1446-1448).

Although psychiatric nurses have admitted not receiving spiritual education during their basic and psychiatric training, these nurses on many occasions have rely on their own spirituality to provide spiritual care to their patients and to treat their patients as humans. They admitted that their spirituality put them under moral obligation to treat them rightly despite them being ill, as stated by this participant; "*spirituality is a sense of being, is a sense of belonging, knowing the right from wrong and an eye opener" (*Transcript 2, lines 510-511).

Theme 3: Psychiatric nursing for the spirit: Enabling and limiting factors

The third theme is developed from six statements and focuses on the factors psychiatric nurses see as influencing their provision of spiritual care. These factors can be classified as factors limiting and enabling their ability to provide spiritual care to their patients.

In considering those factors that limit them from providing spiritual care, they mentioned the lacked of training, knowledge and understanding about other people cultures and religions; " *lack of training and understanding about other spiritual beliefs, lacked of spiritual assessment area on patient's admission record as well as lack of knowledge"(*Transcript 1, lines 185-187*)* prevent us from providing spiritual care; " *also lack of training in that area will make it difficult for me*" (Transcript 2, lines 495).

One psychiatric nurse listed personal, patient-related and institutional factors that limited her ability to provide care. Providing spiritual care suggests that one has a spiritual or religions point of view to base spiritual intervention upon 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 less of a priority is 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" (Transcript 6, lines 1345-1347*)*. As well as not being religious, being of a different religion to the client was seen as limiting" *and if the patient is of different belief, it will be difficult to go into the patient belief; the availability of the Bible and having insight of the patient spiritual belief"* (Transcript 6, lines 1351-1353).

Institutional policy also prevented or limited spiritual care-giving opportunities because as one respondent said "*Management, only management because where I work, we are not allowed to offer spiritual care. Management prohibits that because we are multicultural community of many religions*" (Transcript 7, lines 1452-1453).

In determining what psychiatric nurses considered enabling them to provide spiritual care, these participants revealed that their own spiritual orientation and knowledge about spirituality enable them to provide spiritual care: "*In long and short, knowledge, your own spiritual orientation"* (Transcript 5, line 1252*)*; *" it takes special people to nurse psychiatric patients, you got to have God giving skills to handle psychiatric patients*"(Transcript 2, lines361-362*) ; " I think if I didn't have my own spirituality, I don't think I could be able to be human to my patients. Without spirituality, I will be incomplete and my work will also be incomplete. It 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"* (Transcript 3, lines 754-757*);* their love for their Creator and their relationship with Him: *"My own moral relationship with my Creator, that enable 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 in touch with my Creator helps me to see the needs of other people to be in touch with their gods"* (Transcript 3, lines 762-765*)* and having the same religious beliefs as patients have motivated them in the provision of spiritual care to their patients: *"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 belief; the availability of the Bible and having insight of the patient spiritual belief"* (Transcript 6, lines 1351-1353).

Theme 4: Holistic nursing practice: Educating for spiritual care

Three statements were used to develop this theme. Theme four reveals how education in providing spiritual care within the holistic model of nursing is important for the development of the psychiatric nurse's own spirituality and her provision of spiritual care. It provides strength, knowledge and moral conscience to psychiatric nurses in their provision of spiritual care to their 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."(*Transcript 3, lines 754-755). These nurses commented that the introduction of spiritual education in the psychiatric nursing curriculum will 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."*(Transcript 5, lines 1219-1221).

Psychiatric nurses providing some level of spiritual care to their patients therefore recommend that spirituality be included in nursing educational programs for psychiatric student nurses to adequately prepare them to provide different forms of spiritual care based upon the needs of their patients: *"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 religions and cultures"'(*Transcript 3, lines 742-744). Further on-going education for already practicing psychiatric nurses was also suggested: "*workshops, in- service training on spirituality and what it means to different people and how we can help to meet those needs in time of crisis*" (Transcript 3, lines 748-749).

4.5 Exhaustive description of the phenomenon

In this stage of data analysis the researcher incorporated all the resulting ideas into an exhaustive description with verbatim examples of the spiritual dimension in psychiatric nursing practice of participants working with psychiatric patients in the EThekwini District.

Psychiatric nurses have revealed that indeed spirituality, although often forgotten in the provision of care for psychiatric nursing practice, is an important domain in the provision of care for psychiatric patients. They revealed that spirituality is related to their personal

religious beliefs and enhances their abilities to provide spiritual care for their patients; is perceived as an integral part of their humanity and their identity as psychiatric nurses and includes their behavior, feelings, beliefs, values and responses to events, as revealed by these participants:

"*For me it means more ideas, beliefs, sometimes even emotional concern with connection with a higher being, specifically religious belief and practices. And it is related to personal belief.*" (Transcript 1, lines 56-58).

"*Yes, I think that might help a lot because we always looked at other areas, not spiritual area, it is neglected, if it is offer, we will see great changes in the people involved by helping in their recovery.*"(Transcript 5, lines 1176- 1178).

"*One thing that I can say from the interview is it has enlightened me on certain thing that 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 do we fortify that area to come equal to others in term of caring so that we gave the patient a holistically approach, because if one aspect is neglected, then it is not holistic any more. So it should be integrated into training and workshops be held to help even doctors and nurses in that direction.*" (Transcript 5, lines 1261- 1267).

Spirituality is a person's interconnection to the higher world and the world in which the person dwells; has a close link with religion, enhances human to human relations and is a personal belief and part of a person's total make-up, as revealed by this participant:

"*To me, spirituality is the lining of the globe that holds a person together, is a code of every person, without spirituality, you can't have mental health, you can't be compassionate*" (Transcript 3, lines 782-784).

Participants also mentioned that spirituality has significant benefits to both psychiatric nurses and patients. For the psychiatric nurses, spirituality enables them to be united and linked to God or a Higher Being which in turn, helps them to live a moral life and to care for their patients; provides them with inner strength and confidence to develop meaning from life

circumstances whereas for the psychiatric patients, it serves as a source of hope and relief in times of illness and unforeseen life circumstances, as stated by these participants:

"*Spirituality is a sense of being, is a sense of belonging, knowing the right from the wrong, and an eye opener.*" (Transcript 2, lines 510-511).

"*A part that needs to be always nurture as human beings because there where our strengths come from.*" (Transcript 2, lines 317-318).

Psychiatric nurses' experiences with the patients have also helped their patients to make sense of their illnesses and to gain hope by depending on their own spiritual beliefs and values: *"It does give hope; a person can get hope through spirituality".* (Transcript 4, line 870, 909).

Psychiatric nurses most often strived to fulfill their patients' demands for spiritual care. Creating an awareness of their own spirituality coupled with the wealth of experience in the nursing profession has led to nurses being able to respond to these needs to some extent:

"*It takes special people to nurse psychiatric patients; you got to have God giving skills to handle psychiatric patients.*" (Transcript 2, lines 361-362).

"*Without spirituality, I will be incomplete and my work will also be incomplete.*" (Transcript 3 lines 755-756).

With the involvement of these patients in these various religious activities, these nurses revealed that their patients were seen behaving more responsibly, calmly, and orderly "*For those who asked to go home to perform religious rituals, they usually come back improved and calm."* (Transcript 6, lines 1329-1330).

The holding of consultative meetings with patients and their families for patients to go home to perform religious and cultural rituals has created a trust working relationship between the psychiatric nurses and the patients and their families. This relationship has enabled psychiatric nurses to pick up signals of spiritual concern and subsequently offer spiritual support which brings comfort and hope to patients in finding meaning and strength in their

experiences. Psychiatric nurses' respect for patients' religious beliefs is considered important to the provision of spiritual care. This respect is evident in the way prayers are facilitated in the psychiatric wards and at the clinical settings, allowing patients go to church, allowing religious leaders to visit and pray with patients and in negotiating for patients to go home to perform religious rituals.

"*Those that are allowed to go home for pass out, most of them will come back much calmly and very understanding. I have not seen a case where patient will come back worse than before.*" (Transcript 7, lines 1428-1430).

This behavior on the part of the patients further emphasized for these nurses that spiritual care is necessary for the psychiatric patients and should be incorporated in their care as an aspect of holistic psychiatric nursing care. These participants also mentioned factors which seem to limit them in providing psychiatric care for their patients. They mentioned the lack of spiritual knowledge during training, having a different spiritual orientation to that of patient, their heavy workload and the patient's condition as some hindrances in the provision of spiritual care, as was revealed by these participants:

"*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.*" (Transcript 6, lines 1345- 1347).

The ability to provide spiritual care is increased if the nurse and patient share a similar religious orientation and if the nurse has the capacity to think outside of her own 'spiritual box' in dealing with people of different faiths and spiritual values: *"My own spiritual belief enables me to recognize and offer patient spiritual care. The problem is when people becomes rigid they don't attend to other people religious belief*" (Transcript 1, lines 194-196).

"*To me, spirituality is the lining of the globe that holds a person together, is a code of every person, without spirituality, you can't have mental health, you can't be compassionate ... Spirituality is one of the bottom needs, very important for everybody; definitely, I will recommend spiritual care for my patients. As without mental health there is no health, so*

without spiritual health there is no health. Whatever your spirituality is, it needs to be healthy." (Transcript 3, lines 762- 768).

These psychiatric nurses providing some level of spiritual care to their patients therefore recommend that spiritual care forms part of psychiatric training curriculum and on-going education if psychiatric nurses are to be successful in providing holistic care for their patients.

"*It will be very useful if spirituality is incorporated in our care for the patients and in our training, curriculum which will make a lot of goods.*" (Transcript 4, lines 974-975).

"*It should be integrated into training and workshops to help even doctors and nurses in that direction.*" (Transcript 5, lines 1266-1267).

4.6 Conclusion

The Colaizzi method of data analysis and interpretation which comprised of six stages was adapted and used in this analysis of the data. The understanding of these psychiatric nurses concerning spirituality in psychiatric nursing care was made known. They mentioned that creating an awareness of their own spiritual beliefs or values enables them to offer spiritual care for their patients. They considered spirituality as an important domain of the holistic model of psychiatric nursing care and stressed that this domain be attended to as long as the patient lives. They further mentioned that they are incapacitated in meeting the spiritual needs of their patients because they lacked spiritual education. The discussion of findings follows in subsequent chapter.

CHAPTER FIVE:

5 DISCUSSION OF THE RESULTS, RESEARCHER REFLEXIVITY, STUDY LIMITATIONS, RECOMMENDATIONS, SUMMARY AND CONCLUSION

5.1 Introduction

This chapter first summarizes the essential experience of spirituality developed from the analysis and then discusses aspects of this experience with respect to the literature. Thereafter, some of the issues encountered by the researcher in the process of bracketing are discussed in the section entitled "researcher reflexivity". Finally the chapter turns to the limitations of the study and recommendations for psychiatric nursing practice, education, research and policy-making and then summary and conclusion.

5.2 Discussion of the essential experience of spirituality

The participants conceptualized 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 meaning-making in daily life that provides people – nurses and patients with a sense of belonging and of joy, hope, and comfort in both difficult and happy times. Participants described spirituality as a personal belief as well an emotion, which links them in relationship to their God or Higher Being and enables their compassion in the face of their patients' distress and suffering.

These understandings of spirituality are similar to those reported upon in studies by Ameling and Pavilions (2001); Cornah (2006); Greasley et al., (2001); Koslander and Arvidsson (2005); Mohr (2006); O'Reilly (2004) and Pesut (2008). These authors describe spirituality as a process individuals use to find meaning in life, particularly in difficult situations. For these authors, as for the respondents of this study, spirituality is described as the individual's understanding of their connection to their God or Higher Being and from which meaning in life and the capacity for love, hope, joy and comfort can be realized.

Spirituality helped the respondents to look for the unique humanness in both themselves and their patients and to accept a range of different behaviours, as expressions of this humanity, rather than solely expressions of psychiatric disorder. Thus, nurses own spiritual beliefs or orientations are a vehicle for the expression of their own humanity in the nurse-client relationship and for understanding the humanity and behaviour of their patients. The literature reviewed emphasizes that sharing the patient's lived experience of illness, supporting his/her search for meaning and relating to the patient's past in an empathic, non-judgmental and affirming manner are the central activities of psychiatric nursing as well as for spiritual intervention (McSherry, 2006; Mohr, 2006).

Spirituality is perceived as an important component of holistic psychiatric nursing care with direct benefits not only for the nurses but also for their patients. The nurses revealed that spirituality brings improvements in the overall health of people with mental illness by improving their prognosis and compliance with treatment which prevents relapses; brings about positive change in patients' behavior, making patients behave calmly, responsibly and think logically and serves as a source of hope, joy and comfort and healing power for their illnesses. These findings are consistent with the literature reviewed regarding spirituality as a source of hope, joy and comfort for people with mental illness (Ameling & Povilonis, 2001); as helping to manage depressive symptoms and to live successfully with others (Nasser & Overholser, 2005); as providing hope and thus, helping to prevent suicide (Wilding, 2002) and for managing anxiety and substance abuse (O'Reilly, 2004).

For these respondents, spirituality and religion are interwoven. The idea of spirituality being related to and different from religion is a central theme in the nursing literature reviewed (Cornah, 2006; Pesut, 2008). These studies highlight similar notions of spirituality and use 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 (Greasley et al 2001; Wig, 1999; Wilding et al.2006) These respondents on the other hand, emphasized the connections (e.g. providing meaning in life, connect to a higher power, source of hope and joy) rather than the differences between the two (Ameling & Povilonis 2001; Koslander & Arvidsson, 2005; Wilding et al.2006). These authors concur with the participants' views regarding the difference between spirituality and religion. Although there is a difference between

spirituality and religion, the both focus on a relationship with a higher being upon which individuals depend for hope, joy and meaning making in life.

Spirituality was especially important in situations where moral judgments about right and wrong were required. This was particularly evident in trying nurse-patient encounters where nurses drew upon their own spirituality to remind themselves of the principle of "doing to others as unto self" which thus prevented them from being "nasty and unkind to others". A similar theme was reported by Ray & McGee (2006) whose nurse-respondents believed that their spirituality helped them to live a moral, just and ethical life in relation to others. Frankl's (1963) notion that the ability to recognize the humanness of another and to accept expressions of humanness for their uniqueness is a form of love provides support for the deep love and compassion.

The 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 in what patient circumstances, as well as institutional policy about equity of religious activity, influence the extent to which these nurses engaged with this dimension of holistic nursing care. The literature presents two opposing points of view about who is responsible for the spiritual care of psychiatric patients. A number of authors support the view that spiritual care should be offered by psychiatric nurses. The nursing literature emanating from the United Kingdom regards spiritual care – assessment and intervention as the responsibility of the nurse (Koslander & Arvidsson, 2005; Paley, 2008). These authors argue that the assessment of this need and the provision of spiritual care are provided through a therapeutic working relationship between the patient and the nurse based on love and understanding. In this respect, psychiatric nursing assessment is the first point of interaction and hence, potential for spiritual care, between the patient and the nurse (Mahlungulu, 2001). This view is shared by these nurses as well as by the authors of the few studies in spirituality in nursing in South Africa (Dolo, 2006; Mahlungulu, 2001). A second body of opinion emanating from the United States of America and which differs to that held by these nurses from the UK, is that the spiritual needs of psychiatric patients should be assessed and provided for by the hired services of chaplains, pastors and other religious leaders and not by nurses (Koslander & Arvidsson, 2005; Paley, 2008).

Thus, while spirituality is an essential feature of holistic care, the decision to provide spiritual care is often a personal one and unlike the biological or social dimensions of this model, is seldom informed by a coherent body of disciplinary knowledge and skills about spirituality. Although these nurses had received no formal education in spirituality, it seems that they drew together the principles of the nursing process, their knowledge in psychiatry and their own understandings of spirituality in responding to the more obvious spiritual needs of their patients. Nurses were thus able to recognize that patients commonly expressed their desire for assistance in meeting their spiritual needs through specific behaviours, direct requests and statements about their intended spiritual actions. Specific behaviours most commonly included praying, chanting and singing religious songs. Patients' spirituality was also evident in their direct requests for some form of assistance in meeting their spiritual needs e.g. asking for a Bible, time to be alone to pray and permission for their pastor to visit. Statements about their intended spiritual actions included informing the staff that they will 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 in, organizing 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 with patients and family members about their religious needs.

These methods of assessment and intervention are similar to those encountered in the literature and reported upon by (Aldridge, 2001; King et al, 1999; Mageletta & Dukro, 1996; Mohr, 2006). These authors considered prayer as being useful in the treatment of many illnesses including mental illness. They argued that prayer is the most important tool that patients have when faced with difficult life circumstances. Worship and the performing of religious rituals which include prayer, singing religious songs, fasting from food, water and sexual relations and sacred emblems as interventions of addressing the spiritual needs of people with mental illness. The methods used by these nurses in this study are also similar to those identified by Mahlungulu, (2001) and O' Reilly, (2004). These authors mentioned the use of psychiatric assessment through the collection of both subjective and objective data; observation and collaboration with care providers, patients' relatives and their religious

leaders and the use of open ended questions which allow patients to make known spiritual needs. Mohr (2006) alluded to the use of open ended questions as means of detecting patient spiritual status.

There is consensus agreement between the research finding and the literature concerning strategies and interventions that psychiatric nurses use in addressing the spiritual needs of people with mental illness. In this study there is evidence that psychiatric nurses rely on observing patient's behavior, asking patients and relatives open-ended questions and collaborating with the nursing team, patients' relatives and religious leaders as a way of soliciting information about the patient's spiritual status (Mahlungulu, 2001). Mohr (2006) and O'Reilly (2004) both supported the use of open-ended questions to assess the patient's spiritual status. Although these nurses regarded spiritual assessment and intervention as integral to holistic psychiatric nursing, spiritual care is not a visible or even consistent feature of holistic nursing care, with consequences for both the patient and the nurse. The nursing literature has mentioned that psychiatric patients have openly reported that their spiritual needs were not being attended to by psychiatric nurses caring for them (Greasley et al., 2001). Foreman (2007) alluded to this statement when he reported that 72% of advanced cancer patients admitted that their spiritual needs were going unaddressed by health care providers. The nursing literature reviewed is clear that although spiritual care is essential in the lives of people living with mental illness, it is often neglected by psychiatric nurses as an aspect of holistic care (Koslander & Arvidsson, 2005; McSherry, 2006; Mohr, 2006).

The nurses reported on a number of personal, institutional and patient factors that both enabled and limited their ability to provide spiritual care. Nurses perceived that their lack of education in spiritual care and their limited knowledge and understanding about other people's cultures and religions affected their ability to respond to their patients expressed spiritual needs. This knowledge limitation was more pronounced when the patient and nurse were of a different religion. Limiting patient factors included the mental condition of the patient and behavioural disorders. Nurses experienced more difficulty in relating to the spiritual needs of patients who were actively psychotic and or aggressive. These nurses admitted that these aggressive patients exhibited behaviours that were violent and life-threatening to themselves and even the nurses caring for them. Nurses had to use medications

to calm their aggression before assessing their spiritual needs and subsequent provision of spiritual care. Institutional factors limiting their ability to engage with the spiritual needs of their patients were the increased volume 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 multi-cultural, multi-religious nature of the institutions and the possibility for one religion to be emphasized at the expense of others.

Some of these limiting factors have been reported on by Foreman, (2007); Koslander & Arvidsson, (2005); McSherry, (2006); Mohr (2006); Weaver, Flannelly, Koenig and Larson, (1998). These authors have discussed how lack of knowledge on the part of the mental health care providers about spirituality and the different ways in which it can be provided, their unfamiliarity with the different spiritual practices in modern day society limit the nurses' ability to provide holistic spiritual care. These authors have mentioned that because psychiatric nurses have no spiritual education in their training, they lacked spiritual knowledge to adequately address patients' spiritual needs. Because of that, they looked at themselves as being incompetent and unprepared to provide such service. Also the fact that they were never exposed to the various religious doctrines and principles, they fear that attempting to provide spiritual care will only further increase patients' conditions. A limiting factor which is mentioned in the literature is the personal fear that attending to the spiritual needs of patients who are psychotic or aggressive might exacerbate or worsen their condition to the extent that the patient is uncontrollable (Awara & Fasey, 2008). Although this fear was not directly expressed by these nurses, they did indicate that the patient's condition was a limitation in providing spiritual care. The researcher acknowledges that he could have asked for more clarity about this issue during the interview as it is very possible that a similar fear might have been uncovered. This is especially important since a number of studies have reported that nurses experience difficulty in differentiating between spiritual needs and psychotic symptoms in patients who are psychotic (Awara & Fasey, 2008; McLaughlin, 2004).

These findings are a clear manifestation that spiritual education which enables psychiatric nurses to address the spiritual needs of their patients has not been included in nurses training curriculum. It might probably also be that the use of the traditional biomedical model of

medicine which only dealt with health in terms of the absent of pathogens, abnormality and injury and which did not view the spiritual dimension as an important domain in the provision of holistic care for the psychiatric patients, might have blocked the views of nursing management from looking at the spiritual dimension during the training sessions of psychiatric nurses (Boyd, 2007; Koslander & Ardvisson, 2005; Mohr, 2006;O'Reily, 2004). Based on the above information, it is evident for one to believe that both the nursing literature and the research finding on what psychiatric nurses considered as limiting their abilities of providing spiritual care for their patients are in consensus agreement with each other.

With respect to enabling factors, the nurses own spiritual orientation and knowledge about spirituality enabled them provide spiritual care. Nurses' love for their Creator and their relationship with Him as motivating them and having the same religious beliefs as patients could motivate them in providing spiritual care. The nursing literature did not agree nor disagree with the research finding but alluded to the recommendation put forth by this finding. The finding recommended that nursing training institutions especially those dealing with mental health care provision incorporate spiritual care into nursing curriculum (Greasley et al, 2001). These authors believe that by doing so psychiatric nurses will be able to acquire knowledge to adequately be in the position to address the spiritual needs of those patients with mental illness. The literature also mentioned about the establishing and maintaining of the therapeutic relationship with the patients. This relationship enables the nurse to consider her patient as unique individual with strength and capability and not just a person who is sick (Mc Cann & Baker, 2001 & O'Brien, 2001).

Finally, for many respondents, 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 needs and behaviours even if they had no knowledge of the religion or the meaning of the traditional practices for the person. These nurses were able to understand that requests for leave and space to perform traditional religious practices had spiritual significance for their patients and thus, were culturally important. In this respect, spirituality for these nurses has enabled what Campinha-Bacote (2003) calls a cultural balance between

their own culture and the cultures of their patients. Attending to the spiritual dimension is perhaps, a vehicle for providing culturally competent care, one component of which is the nurses' willingness to work within their own culture as well as that of their patients to promote helpful cultural practices (Campinha-Bacote, 2003).

5.3 Researcher reflexivity and limitations

Researcher reflexivity is an important aspect of qualitative research. "Reflexivity in qualitative research requires that the researcher engage with the intellectual process of research while retaining some degree of awareness of how the researcher's point of view - personal experience, values, interests, knowledge, beliefs, moral qualities are brought to bear in shaping the form, content and outcome of the research process." (Middleton, 2007, p.122).

Some of these points of reflection also reveal the limitations of the study.

I as the researcher elected to study this topic in a qualitative way because a qualitative approach could broaden my understanding about how nurses perceive spirituality in caring for people with mental illness. This research has enlightened my own understanding of psychiatric nurses' experience with this phenomenon and has broadened my thinking about how important this dimension is for holistic psychiatric nursing intervention and thus an important part of what nurses should do.

Prior to conducting this research study, I did not have the view that even psychiatric patients themselves could acknowledge the presence of God or some higher power in their lives that they could relate to and rely upon for hope, comfort and relief in times of their illnesses. Moreover, my limited knowledge acquired in psychiatric nursing during my basic nursing training program made me believe that the provision of spiritual care for psychiatric patients was the duty of religious people and not psychiatric nurses. I believed that nurses did not have the requisite spiritual knowledge and skills to help people with mental disorders. My belief at the time is consistent with the literature emanating from the United States that chaplain should provide spiritual care and not psychiatric nurses. My belief has changed, and I think nurses can and do offer spiritual support to those patients who directly request it, if they feel able to do so.

I am not from South Africa so I found doing this kind of in-depth study in a situation I am not familiar with, very challenging. I am not familiar with the system of nursing here or the people and their customs and they are not familiar with me. This might have prevented them from speaking freely.

In reviewing the transcripts with my supervisor, it became clear to me that my style of interviewing was not as open-ended as phenomenology requires. I attempted to change this in the 4th and 5th interview but I found it difficult to rid myself of my directive approach. Questions which allow participants to freely express their experiences with the phenomenon were most often not asked as a result participants answers to some of these questions were "YES and NO". These answers to some extent did not give a detail of participants' narrations on those questions asked (Smith, Flowers, & Larkin, 2009).

The process of transcription was time-consuming and exhausting. I chose to do the analysis manually because there were not too many transcripts and I wanted to immerse myself with the data and not get distracted by a computer programme. Again, this was difficult and time-consuming although it did allow me to get to know the data.

An exhaustive description is defined by Sanders (2003) as the integration of all the resulting ideas (textural and structural) into a lengthy description of the phenomenon. The researcher had intended to separate this description into its structural and textural components but a decision was taken, in consultation with the research supervisor, to integrate the two descriptions. One of the weaknesses of the separated-out descriptions was their repetitiveness and this might have something to do with having limited data about certain aspects of the phenomena e.g. the different situations in which psychiatric nurses engaged with spiritual care in the clinic and hospital contexts. Although the data reached saturation of new ideas, it is possible that my own interviewing style has something to do with the limited data.

I was not able to return to the participants with a synthesis summary of their experience of spirituality, as I planned and as the method suggests. Nevertheless, the exhaustive description was compared to the participants' audio taped interviews and they both seem compatible. Also, the researcher managed to have cell phone conservations with three of the participants

about the exhaustive description. All of the three participants agreed with the exhaustive description and thought it represented their experiences of spirituality.

A number of recommendations were made, drawing upon the data from this study.

5.4 Recommendations

It is an understanding that human beings are spiritual beings and have physical, social, psychological and spiritual dimensions which work together to motivate human to search for meaning and purpose in life. Although the physical, social and psychological dimensions are adequately attended to during the provision of psychiatric care to the people with mental illness, the spiritual dimension most often goes unattended. The nursing literature and findings from this study relate one of the reasons to psychiatric nurses' lack of knowledge to provide spiritual care because they were never taught how to attend to the spiritual dimension of psychiatric patients during their entire education. Cognizant of this information, the researcher recommends the following to the nursing organizations, relevant authorities, stakeholders and all concerned with the provision of psychiatric nursing care.

5.4.1 Nursing Practice

Those psychiatric nurses caring for psychiatric patients should include in their care plan for every patient seeking psychiatric intervention with them the assessment of patients' spiritual needs. This will help psychiatric nurses to easily detect those patients expressing spiritual needs from patients exhibiting a psychotic symptom which is a dilemma for them. Also they should include in their care plan the habit of taking their patients to church, mosques and other religious centers of patients' choice to worship and to acquire spiritual care. For example, those patients who are Christians and worship on Sundays could be accompanied by nurses to their places of worship on Sundays, whereas for the Moslems, the same on Fridays and the Hindus on Tuesdays and Thursdays. This action on the part of the nurses helps the psychiatric patients to socially interact with other members of their faith and thus realize their uniqueness as human being other than people with mental illnesses. This could be done once a week and the day of worship depends on the patient day of religious worship.

That an interdisciplinary team consisting of psychiatric nurses with religious knowledge and religious counselors with psychiatric knowledge be formed to augment the level of spiritual care psychiatric patients are receiving. These religious counselors will to some extent be referred cases of spiritual concern which are not easily handled by psychiatric nurses. This will enable psychiatric nurses to be more grounded and in better position to offer spiritual care to their patients.

5.4.2 Nursing Education

That the South African Nursing Council and other institutions of government involved with educating of psychiatric nurses integrate spirituality into psychiatric nurses training curriculum which will enable them to acquire knowledge and skills and be prepared to adequately address the spiritual need of their psychiatric patients by providing holistic psychiatric nursing care. Such training should include educating would –be psychiatric nurses to the concept of holism and various doctrines and practices of the various religions especially those commonly practice in South Africa.

That in- service training and workshops on spirituality is conducted for already practicing psychiatric nurses. These workshops and training should be made compulsory for all psychiatric nurses working at psychiatric institutions. Schedule could be made in such a way that it does not interfere with nurses' working hours. This helps to broaden their knowledge and skills on spiritual care and its provision for their psychiatric patients.

5.4.3 Nursing Research

These research findings from this phenomenon on spirituality in psychiatric nursing are most applicable to the setting which the study was conducted. It is therefore expedient that other nurses explore the concept of spirituality in their areas of specialties. This exploration of spirituality should be done through nursing research which will then help to broaden the importance of spiritual care to a wide range of nursing specialties needing spiritual care to make its interventions holistic for their patients. Other studies could also be conducted to solicit the patient's own experience with spirituality in their care provision.

5.4.4 Nursing policy markers

As reported by participant in this study, one of the limiting factors for the provision of spiritual care to psychiatric patients in the hospital was the lack of policy allowing psychiatric nurses to provide spiritual care to their patients at all level of mental institutions. It is therefore recommended that policy makers and hospital administrators develop policy which will allow nurses to provide spiritual care to their patients as part of intervention gear towards providing holistic care.

5.5 Summary

The purpose of this study was to explore how psychiatric nurses working with psychiatric clients in the EThekwini District understand the spiritual dimension of holistic psychiatric nursing practice. The objectives of the research were four-fold. They are:

To describe how psychiatric nurses caring for persons with mental illness conceptualize the spiritual dimension of holistic psychiatric nursing care

To describe how psychiatric nurses' asses the spiritual needs of persons with mental illness

To identify the strategies or interventions that psychiatric nurses use to address the spiritual needs of persons with mental illness

To describe the factors that psychiatric nurses perceive as enabling and limiting their ability to provide spiritual care to psychiatric clients

The literature review considered spirituality an important dimension in the provision of holistic care for the psychiatric patients but stated that this dimension is often neglected by psychiatric nurses. It also shows that there is a common consensus among most researchers and participants of the study on the definition of spirituality. The common hallmark is a relationship between individuals and their God or Higher Being upon which they depend for hope, joy and comfort in term of life difficult situations. The literature review differentiates between spirituality and religion and prioritizes spirituality over religion as the focus for the provision of spiritual care. It views spirituality as individuals' relationships to God or Higher Being whereas religion is viewed as individuals' outward expressions of their relationship to

God or Higher Being. The literature acknowledges the importance of spiritual care in the lives of people with mental illness, but reports that spiritual care is most often avoided by psychiatric nurses. It was quick to point out that psychiatric nurse's report that they lacked enough knowledge to provide this care; not seeing the provision of spiritual care as their job and fear that while attempting to provide spiritual care it may trigger psychiatric symptoms.

Descriptive phenomenology which gives detail understanding of how psychiatric nurses working with psychiatric patients experience the spiritual dimension of the holistic model of psychiatric nursing in their work places was utilized for this study. Purposeful sampling was used to select participants who have knowledge and experience about the phenomenon. Seven nurses were selected from the advanced psychiatric nursing class of the School of Nursing, University of KwaZulu-Natal and are registered psychiatric nurses currently working in main psychiatric clinics and hospital in the EThekwini District in the KwaZulu-Natal Province. The Colaizzi Method of data analysis and data representation which involves six steps was adapted for this study.

All steps contained in the Colaizzi Method of data analysis and representation were fully adapted and utilized. Four themes were realized from the research findings. The first theme, "The higher power of spirituality, religion and their relationship" is centered on the concept of spirituality and how it is related to religion. In this theme, participants defined spirituality as God Divine or higher being and that spirituality is unique to everybody based on that person's beliefs. They further revealed that spirituality and religion are related in the provision of spiritual care. Spirituality is the individual recognition of a higher being and religion manifest that individual's relationship to that higher being.

The second theme "Central to but forgotten in psychiatric nursing practice" linked spirituality to psychiatric nursing practice and mentioned how spirituality, though an important domain in psychiatric nursing practice is forgotten in the provision of holistic psychiatric nursing care.

The third theme "psychiatric nursing for the spirit: Enabling and limiting factors" mentioned those factors psychiatric nurses considered as preventing and motivating them in providing spiritual care. They named their own spiritual orientation being the same as patients which

manifest their relationship to their Creator or higher being as enabling factor in the provision of spiritual care. The lack of spiritual knowledge and training coupled with patient "aggressive behaviour" and heavy work load as factors preventing them from providing spiritual care.

Finally, the fourth theme "Holistic nursing practice: Educating for spiritual care" revealed the importance of spiritual education to psychiatric nurses' ability to provide spiritual care to their patients. Although psychiatric nurses were providing some level of spiritual care to their patients, they admitted that they have never received spiritual education both during their basic nursing and psychiatric education. They therefore recommend that spiritual education form part of both basic nursing and psychiatric curricula. The education in these disciplines will help psychiatric nurses to become knowledgeable about spirituality and equipped in providing spiritual care to their patients.

5.6 Conclusion

The essence of spirituality gathered from this study concurred with those reported in nursing literature. Both the result of the study and the nursing literature considered spirituality and religion as being related although not the same, but considered spirituality as an important dimension if psychiatric nursing care is to be holistic. Spirituality is considered as an individual's understanding of having a relationship with God or a higher power whereas religion is an organized set of beliefs, sacred texts, rituals and practices that individuals involved themselves as they associate with their God or higher power.

Recommendations which are based on the findings of the study were made to relevant stakeholders. These recommendations mainly focused on nursing practice, nursing education, nursing research and nursing policy.

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APPENDICES

APPENDIX 1

INTERVIEW GUIDE

Section A: Demographic Characteristics

Age in years ☐

Gender male ☐ female ☐

Nursing qualifications ☐

Diploma in nursing ☐

Bachelors of Science in nursing ☐

Masters in Nursing ☐

Other, specify: _____

Religion

Christianity ☐

Islam ☐

Buddhism ☐

Other, specify: _____

Place of work (please tick as many as apply)

Psychiatric clinic ☐

Psychiatric unit in a general hospital ☐

Psychiatric hospital ☐

Primary health care clinic ☐

Other, specify: _____

How long have you been working as a psychiatric nurse: Years: Months:

What is your official position at work?

Nurse in charge ☐

Registered nurse ☐

Other: _____

Psychiatric nursing working experiences in years ☐

Section B:Interview Questions

Follow-up probing questions – what, when, who, what, where and how - might be needed to clarify aspects of each answer.

Please briefly tell me what your current job involves?

What does the term "spirituality" mean to you?

Please describe your understanding of the relationship or connection, if any, between spirituality and psychiatric nursing care?

How do you know when the client is expressing a spiritual need? Can you give an example from your clinical practice of this?

What sort of things do you do to meet these needs? Can you give an example of this from your practice?

What sort of thing prevents you from giving spiritual care? Can you give an example of this from your practice?

What sort of thing enables you to give spiritual care? Can you give an example of this from your practice?

APPENDIX 2

RESEARCH STUDY INFORMATION SHEET

Ethical Approval Number: HSS/0372/09M

Title: Mr.

Student Investigator: Mulbah M.Tokpah

Contact number/s: 0725799908/ +2316566849

Student No: 208530420

Position: Post-graduate nursing student studying mental health/psychiatric nursing in the School of Nursing, University of KwaZulu-Natal.

Research Supervisor: Dr. Lyn Middleton

Contact number/s: +27 31 2601655

Institution: School of Nursing, Desmond Clarence Building, Faculty of Health Sciences, University of KwaZulu-Natal, Durban, South Africa.

I am a student at the School of Nursing, University of KwaZulu-Natal, pursuing a Masters Degree in Mental Health nursing programme. I am conducting this research study in partial fulfilment of this programme.

The purpose of this study is to better understand how psychiatric nurses perceive the spiritual dimension of psychiatric nursing in their management of psychiatric clients.

You are invited to participate in this research. 6 – 10 psychiatric nurses will be asked to volunteer to be interviewed and to share their experiences with us. Your opinions as a practicing psychiatric nurse are therefore very important to the study.

Your participation in this study is voluntary and your participation does not involve any physical risk or emotional risk to you. There are also no benefits for you in participating in this study.

If you agree to participate in the study you will be interviewed on an individual basis in a private space on Howard College Campus. Interviews will take about 45-60 minutes of your time. I will first ask for general information about yourself and then ask questions that are focused on your understanding of the spiritual dimension of psychiatric nursing care.

There are no penalties for declining to participate and should you decide to volunteer, you are free at any point during the study to withdraw from the study and to ask for your data to be removed from the study. Your request will be respected without question.

The records of this study will be kept confidential. In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. Research records will be stored securely and only researchers will have access to the records. Results of this study may be used for publications in scientific journals and presentations at scientific meetings.

If you have any questions about this study, or would like additional information to assist you in reaching a decision about participation, please feel free to contact either me or my supervisor on the telephone numbers given above.

This study has been reviewed and received ethics clearance through the University of KwaZulu-Natal.

If after reading this information sheet you are willing to share your perceptions of this topic, please complete the consent statement. By participating in this study you will help us gain an insight in the role of spirituality in the treatment of mental illness. It is our hope that this information will help us to incorporate spiritual care in psychiatric nursing practice.

I thank you for your time.

Signed Consent

I hereby consent to take part in the study:

.....	.....
Participant Signature	Witness Signature
Date.....	Date.....

APPENDIX 3

School of Nursing

University of Kwazulu – Natal

Durban

April 28, 2009

Psychiatric Nurses undertaking the advanced mental health nursing programme

School of Nursing

University of KwaZulu-Natal

Durban

REF: REQUEST FOR SUPPORT AND PARTICIPATION IN A NURSING RESEARCH STUDY

I am a student at the School of Nursing, University of KwaZulu-Natal. I am pursuing a Masters Degree in Mental Health Nursing. I am conducting this research study in partial fulfilment of the requirements of this programme. My research supervisor is Dr. Lyn Middleton (telephone number 031 2601655).

I am writing to you as practicing psychiatric nurses to request your individual participation in this study.

The purpose of the study is to better understand how psychiatric nurses perceive the spiritual dimension of psychiatric nursing in the management of psychiatric clients.

Your participation will involve individual interviews. Each interview will be tape recorded and will last for about 45 minutes to 1 hour. A second interview may be requested in case of any eventuality. Your participation is voluntary and you will be required to sign a written

consent to that effect. It is important to clarify that you have the right to withdraw from the study at any time.

If you have any questions about this study, or would like additional information to assist you in reaching a decision about participation, please feel free to contact either me or my supervisor on the telephone numbers given.

The result of this study will be accessed at the Malherbe Library on the main campus of the University of Kwazulu- Natal.

I hope this request receives your favorable consideration.

Yours faithfully,

Mulbah M.Tokpah

Contact No. 0725799908

APPENDIX 3.1: Participants' declaration of intent to participate in the study

To: Mr. M.M. Tokpah

MN (mental health) student

UKZN

From: Ms. A. A. H. Smith

Mental health nurse

Date: 18.7.2009

RE: Request to advanced mental health nurses to participate in your research study

Dear Mr. Tokpah

Thank you for your correspondence to the advanced mental health nurses group.

Your request was read out to members of the group and several are interested in participating in your study. They have your details and will contact you directly.

Sincerely

Mandy smith

Ms. A. A. H. Smith

UKZN School of Nursing

5th Floor Desmond Clarence Building

Coordinator Decentralized mental health programs (Acting)

Email: **smitha1@ukzn.ac.za**

APPENDIX 4: Ethical clearance to conduct a research study

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

03 JULY 2009

MR. MM TOKPAH (208530420)
SCHOOL OF NURSING

Dear Mr. Tokpah

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0372/09M

I wish to confirm that ethical clearance has been approved for the following project:

"Exploring how psychiatric nurses' working with psychiatric clients in the eThekwini district understand the spiritual dimension of holistic psychiatric nursing practice"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

PX Imba
.....

MS. PHUMELELE XIMBA
ADMINISTRATOR
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Supervisor (Dr. L Middleton)
cc. Mr. S Reddy

Transcriptions of Interviews held with participants

Interview 1

Gender: female Age: 43years APPENDIX 5

Length of experience in psychiatric nursing: 19years and 7months

Interviewer: Please briefly tell me what your current job involves?

Participant: I am presently working in the closed male psychiatric unit, acute and involved with clinical work for the patients, and quite bit of teaching, it is an appropriate teaching hospital with diploma as well as degree psychiatric students and supervision of the ward but most of the work is usually clinical.

Interviewer: Does it mean that you only deal with male patients?

Participant: Currently, Right now yes, purely it is an acute male that involves involuntary male patients according to the mental health Act, with in those 72hrs if they come directly from our clinic or patients that get post 72hrs, basically patients who are en danger to themselves.

Interviewer: Do they have other units in the hospital that deal with female clients as well?

Participant: Yes, the ward I am currently working in is just for the rarely aggressive and difficult patients, also another male ward that deals with acute psychosis and then there is a female ward that currently keeps all the female patients; adolescent's clinic, and then we have the psychiatric clinic. Currently I am in the male closed unit, prior to this about 6months ago; I was in the psychiatric clinic.

Interviewer: Does it mean that you will work there for 6months and there after you are transfer to another ward?

Participant: It is rotational, not a specific period, not really being transfer. Basically there are five units and you rotate in all five units.

Interviewer: Have you had the chance to work in all of the units?

Participant: I worked in the female and male step-down, but the adolescent unit is newly opened, so I have not worked there. Prior to the establishment of the adolescent's unit, the adolescents were mixed with the adults, and I worked with them.

Interviewer: What is your feeling like in working with male clients especially being of the opposite sex?

Participant: Personally, I prefer working with the male patients, there is some how certain respect between male and female when we interact with one another,; male

patients, no matter how aggressive or psychotic they are, they still seem to respect female, especially female nurses; still tern to have that social and closed interaction; open to female nurses, and respond more positively to female. For me it may be due to the fact that the way I view and respond to male with more tolerance between myself and them make them to respect me more, that is why I haven't ever been assaulted by male patients during my many years of working experience. If I had the choice to make, I will prefer working with the male patients.

Interviewer: What does the term "spirituality" means to you?

Participant: For me it means more ideas, beliefs, sometimes even emotional concern with connection with a higher being, specifically religious belief and practices. And it is related to personal belief.

Interviewer: Excluding your understanding of spirituality to be connected to a higher being, is there any other idea that could come from spirituality to means something to you order than being connected to higher being?

Participant: That is my personal belief, but of course with patient, spirituality is related to religion, the beliefs, the ideas, and emotions.

Interviewer: For your own belief, is there a connection between spirituality and religion?

Participant: Yes, there is a connection but I feel that often there are beliefs and practices in religion and spirituality but often the practices and belief in religion super see that of spirituality .All the religions have the same basic values, but the practices are different. For me the values are there and they are the ones that connect spirituality to religion.

Interviewer: If you were ask if these two are the same, what will you say?

Participant: No, I don't think so, I think there is certain element that they shared, that is higher being, but they are not the same.

Interviewer: Higher being in terms of what?

Participant: Higher being in term of human being. For example I am a Hindus and believed that there is a higher being, God, but with other Hindus, there are lots of religious practices that they carried out which I personally do not believe in but there is something more than just human being and that is God, which is my belief.

Interviewer: Please describe your understanding of the relationship or connection, if any, between spirituality and psychiatric nursing care?

Participant: There is a huge connection which needs to be taken into consideration. Often our clients come to us, we are the last after going to people who they think could

help them spiritually, some one that understands their cultures and religions they believed, . .This happen in all cultures, like the Zulu, they first go to the Sangoma if they are hearing their ancestors' voices in their ears, but if it is physical illness they prefer to go to the Inyanga, so they know the difference, even with the Hindus, they go to the Hindus priest. There is a connection which is spiritual need, but I don't think mental health care providers really pay attention to that connection.

Interviewer: Do you think that spiritual care is really needed for psychiatric clients?

Participant: It has to be because it is part of life, it is important to us and need to be taken into consideration. I personally have recommended to my consultant that we should have someone on hand like the Sagoma or priest that would help to provide this care when need be,

Interviewer: What are some benefits of spiritual care to the psychiatric clients?

Participant: Well it prevents relapses of patients especially those with psychoses when they seek early help from these faith healers .Spirituality affects all areas of our lives, therefore it must be offered for the psychiatric clients.

Interviewer: Do all of our psychiatric clients need spiritual care?

Participant: I think it depends on the client himself if he expresses the need. Like all of us if we express a need we should be attended to and spiritual care should be attended to when expressed by these clients.

Interviewer: Who do you think should be responsible for offering the patient's spiritual care?

Participant: I think all mental health care practitioners across the board especially when the patients are acutely ill. Doctors or psychiatrists should also be concerned about this, but it should be mostly the nurses because they spent more times with the patients which make them to be more open to them.

Interviewer: At your work area, do you offer spiritual care to patients?

Participant: No, we don't offer any spiritual care formally, but what we do is that we are aware of certain practices that are done based on culture that help in that direction. When the need arises, we explain to them that these practices can not be performed in the hospital. What we do here is to talk to them. If family members see the need to take client home to perform such ritual practice, then they are allowed to take the patient home to perform that ritual practice and then come back and most often when they come back, the client is much better. Also the same goes with the Hindus and the Christian patients. When they want a priest to come, we do arrange for that and he comes and a room is provided for that. These people and patients are told not to pray louder to disturb the other patients' peace.

Interviewer: As you said previously, that spiritual care is essential for the patient and this area of care is often neglected, what do you think can be done to meet this need of the patient?

Participant: we need to change our attitudes, because we all come from different religions, definitely we have different beliefs ,different ideas, values, but as nurses we are there to care for patients, so I think by changing our attitudes and our exposure and being familiar with the different types of religious practices, and our own attitudes towards the patients will help greatly Also integrating it into the nursing curriculum will help to a greater extent, and workshops to change our attitude toward the mentally ill,

Interviewer: What could be your suggestion as it relates to the curriculum and spiritual care?

Participant: Spiritual care should be included in the curriculum and for already nurses there should be in service training and workshops constantly so as to create awareness regarding spiritual care for the patients. It should also be made a priority when rendering services to all patients not only psychiatric patients.

Interviewer: What is your view on spiritual care being offer by a surrogate chaplain order than a nurse?

Participant: For me I think that is a good idea as long it is respectable to patients, I think it is a good idea if these people come to help give this care not only nurses although we spent more time with the patients. But I think 80% of patients spiritual care should be offered by nurses.

Interviewer: How do you know when a client is expressing spiritual need? Can you give an example from your clinical practice of this?

Participant: You have to be very observant, be vigilant and check on behavior and inquire what they are doing to differentiate between psychiatric symptoms, like hallucinating, chanting and spiritual need whether they are like praying. Sometimes you ask the client and also be direct, ask him about spiritual belief or need.

Interviewer: What sort of things do you do to meet these needs? Can you give an example of your clinical practice of this?

Participant: Speak to the patient, be open to patient and observe the patient and acknowledge that his spiritual need is important.

Interviewer: What sort of things prevents you from giving spiritual care? Can you give an example of this from your practice?

Participant: The system itself because there is no traditional healers as part of the management team, our negative attitudes, 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.

Interviewer: What sort of things enables you to give spiritual care? Can you give an example of this from your practice?

Participant: My own spiritual belief enables me to recognize and offer patient spiritual care. The problem is when people becomes rigid they don't attend to other people religious belief.

Interviewer: What is your concluding statement on spirituality and the psychiatric patients?

Participant: Concluding statement on spirituality could be that Spirituality is part of life and is an area that needs to be attended to for every psychiatric client and need to be included in the psychiatric client care, the total care.

Interviewer: **If you were to make any recommendation to the South African Nursing Council regarding spirituality, what will you recommend?**

Participant: Recommendation could be it should be part of all training, part of the basic curriculum and should be included in the total assessment process of the client

Interviewer: IS Spirituality a right or a privilege for the psychiatric clients?

Participant: It is a right and every one needs it.

Interviewer: Any special think you have to say about the interview?

Participant: No, but one question**, what is it? When you finished with your study can we not get a copy**?

Interviewer: Two copies will be placed in the Malherbe Library on the main campus; you may have access to them.

THANK YOU FOR COMING.

Interview two

Gender: female Age: 51 years

Length of experience in psychiatric nursing: 23 years

Interviewer: Please briefly tell me what your current job involves as a psychiatric nurse involves?

Participant:: My current job involves taking care of psychiatric patients, also to be able to see whether there is somebody with severe side effects and intervene to get the doctor, also give information to patient relatives relating to their care and also for religious leaders coming and they want to see them and pray for them and give them privacy with in the setting, also to phone relatives for those who want to see their relatives and haven't been visited and to inform them that the patient is admitted, to contact the social worker, whether there is a social problem. For example, if the patient is brought in by a police because he is destructive in the community and nobody is at home, it is nice for us to take the details of the police station number so that I can if nobody follow up and visit so that I can contact those police that brought the patient in to make a follow up and to see the family and inform them that the patient is admitted in care of the contact number to correspond with the family.

Interviewer: Do you take care of a specific unit with clients coming in with or admitted for acute illnesses?

Participant: We are working at admission ward, those who are acute, we nurse them in 72 hours, and the... .. If they are not acute, if with in 72 hrs there is no improvement, patient gets transfer to a general hospital or better management.

Interviewer: At present are you working at the hospital or at the clinic?

Participant: I am at the hospital

Interviewer: Have you had the chance to work at the various units of the psychiatric hospital?

Participant: Yes, yes

Interviewer: Have you interacted with both male and female clients?

Participant: Yes, yes

Interviewer: If I should ask you who do you prefer working with, the male client or the female client? and why?

Participant: To be honest with you, I actually prefer to work with the male clients. Because the reason why I say I prefer working with the male client is that with the male client they really opened, there is no hidden agenda, if they fear any thing they speak out easier and you can actually have him interview and get him on the role of recovery quicker whereas the female, you see them leaving the ward and you will find out that there are other information coming in from relatives after two or three weeks, rather than the male with in few days, they will also tell you the recent faith ,they even guaranteed you the collateral that they have given you to check with their relatives that have come to ensure that it is true.... unlike the female.

Interviewer: How long have you work with the male clients?

Participant: Oh oh, well the same amount because we can rotate, the same amount as the ladies.

Interviewer: Have you ever experience being assaulted by any male client?

Participant: I have never been assaulted but one of my clients actually made a sexual gauzure and that it was a time, and... Assault no no.....

Interviewer: And what was it like?

Participant: What actually happened was it was a week end and there was only me, a pastor and a male nurse and what happen it was during the 2 o'clock medication and this gentleman noticed that he was like almost the last standing and he waited till everybody leaves treatment room even the male nurse was gone, and the pastor was gone , he just stir at me and started looking down at his pubic areas and I noticed that he had actually opened up his pajama pent and you know, got an erection and I said that, well , what's happening and realized that he could grasp me right there because there was no one but fortunately for me one of the busy patient , we always get a busy patient, one of my busy patients was around and then I say to him remove this gentleman on the wheel chair because I need to get out and he helped and pulled the wheelchair out of the way he had actually blocked the door.

Interviewer: Is this attitude a frequent one carried out by these male clients against the female psychiatric nurses?

Participant: Yes, is frequent, but it never happened to me but they do have some sexual connotations sometimes even in their speech toward female if they like you.

Interviewer: What does the term spirituality means to you?

Participant: Spirituality, to me, it means connecting with God, on a daily basis, any way, any time and for me I feel it is a part that needs to be always nurture as human beings, because there where our strengths come from.

Interviewer: Does it only mean being connected to God because there are some people who do not believe in God but yet they expressed spiritual need?

Participant: Yes as you are saying that there are some people who don't believe in God, but they have some sort of gods of their own they are connected to, their gods. It means some kind of god of their own; you are connected to your kind of god.

Interviewer: Does it only refer to the Almighty God?

Participant: No No, but for me it is the Almighty God because I am a Christian.

Interviewer: Have you experience some benefits of spirituality?

Participant: For one, for me before I act to do something harmful or to say something harmful, or to affect somebody, I will ask myself what did Jesus do if He was in my shoes, and then it is my guideline, so, it prevents me from being nasty, it prevents me from being unkind to others , it reminds me that there are those that are more unfortunate or in unfortunate situation than me and where I can extend a hand, I do,and where I can, even those that are and sometimes it is not material thing people need, they just need somebody to talk to and for me even at the history of nursing, Jesus started the healing long before I was even contemplated .

Interviewer: Do you think spirituality or spiritual care is essential for the psychiatric clients? Why?

Participant: Definitely, because some of the patients that I have known in psychiatry have ask that family members take that person to their religious leader for some religious rituals to be done, and when the person had come back, we noticed that definitely they are more calmer, more reasonable, but sometimes it is the extreme, not always, that way, the other way they come back more aggressive and more psychotic; and you will really see some of the patients with the religious needs and they sing gospel songs through out the day, they quote the Bible, I also think for some of them it is their lifestyle, is like an in born thing that they have to go to church, what ever religious believed they believed in, I think it is important to them.

Interviewer: Please describe your understanding of the relationship or connection if any between spirituality and psychiatric nursing care.

Participant: spirituality and psychiatric nursing….. There should be, because really speaking most people fear psychiatric patients, even some of the professional nurses don't even want to be affected with psychiatric patient. If you look at it we don't nurse them who are going to nurse them so it takes special people to nurse psychiatric patients, you got to have God giving skills to handle psychiatric patients, not everyone that can nurse psychiatric patient. The first thing you need to have is you have to be a listener, you got to be someone that listens, you also have to be somebody that is empathy, and sympathy. Those are the three elements you need to be a psychiatric nurse. And those

things only come from being in the spiritual or a person that is spiritually grounded. Those are the things that will happen, not always being empathetic, not that the patient is acting out. You see that this person probably needs spiritual intervention

Interviewer: If I got you clear, are you saying that not everybody should take care of psychiatric patients?

Participant: Yes, you must have special qualities to take care of psychiatric patient.

Interviewer: Are there times that you have projected your own spiritual belief or feeling into that of the client?

Participant: Never, I don't do that, not at all it demoralizes.

Interviewer: Do you think that all psychiatric clients need spiritual care?

Participant: It is individual thing, I wouldn't say so, it is an individual thing, I think in that sense not everybody that is religious is psychiatrically ill, I wouldn't say so and it is a personal thing.

Interviewer: Do you really offer spiritual care to your patients?

Participant: If they are spiritually inclined I will offer it. Is like we have pastor coming in to pray for their members, we allow them a quiet time with their pastor, people have requested or call and as part and parcel of who a person is, we say psychiatric care is holistic, that is part of holistic nursing.

Interviewer: As you have mentioned that spiritual care is part of the holistic care, do you think that in the absent of spiritual care, is the client receiving a holistic care?

Participant: They will because … **NO, no.** I think what ever they believe in. Like a Christian, you call a pastor and if it is an ancestral thing they believed in, you have to get their ancestral.....whatever, I think there is a need.

Interviewer: Who do you think should bear the responsibility to offer spiritual care for the patient, the nurse or the religious leader or a surrogate chaplain?

Participant: Who do I think should offer spiritual care**…** In our setting, we pray even with the patients, sometimes they actually remind us we have to pray and thank God for given us the life, but I will leave it to the relatives, I think they will inform you and you can discuss, I think it could be the nurse…….

Interviewer: How do you offer spiritual care for your patients?

Participant: We pray with them in the morning, we also phone their pastors if they have to see a pastor, they give us the numbers and we phone the pastors to pray with them, where I am is not much of psychiatric patients, but when I was at King George some times we allow them to visit the church on Sundays.

Interviewer: Do you seek permission from the clients before offering prayers for them?

Participant: Most of the religious leaders write letter to offer their services, yes, yes, I do. Sometimes I invite them, those that are Christians will come and those who are not Christians will just lie in their beds and stay away.

Interviewer: Don't you think that those who are not Christians may feel that if they stay away you may have different feeling for them?

Participant: No, No

Interviewer: Do you offer spiritual care to minors or clients less than 18 years of age?

Participant: NO, we normally admit people over 18; we do not deal with client less than 18years.

Interviewer: Does it mean that children do not suffer from mental illness?

Participant: They do, we have a child clinic and we transfer them to their area.

Interviewer: During your training program as a nurse or psychiatric nurse, were you ever trained to offer spiritual care?

Participant: Yes, during my training, we used to pray every morning and sing two or three choruses but it did not form part of my training.....no, no

Interviewer: What do you think could be done to integrate spiritual care to the nursing curriculum?

Participant: Well, I think, I will recommend that they make it inclusive into the curriculum because if it is inclusive there is no way somebody will avoid it.

Interviewer: How do you know when a client is expressing a spiritual need, can you give an example from your clinical practice of this?

Participant: How do I know..... I can know, there are those who will be singing religious songs, chanting their prayers if they are Hindus and sometimes I get to the family and asked them if this is an on going thing. Some of them come out and tell you

and for some their actions will tell you. For those that do not tell me, their behaviors will tell, as I said if a Christian, they sing Christian religious songs, if Hindus they will be chanting, if Muslim, they will be using the bees and then you inquire from the family if this is a normal behavior or it is a new development with admission, then you will realize that an intervention is needed and you inform the family and they will get the appropriate person to come and see the patient if need be.

Interviewer: How about those clients whose behaviors do not show signs of spirituality, like No praying, no chanting?

Participant: **I** have never met one like that in my entire nursing career.

Interviewer: So it means all of your clients have expressed spiritual needs?

Participant: Yes, sometimes they even come to me and asked to pray.

Interviewer: What do you do to meet those spiritual needs?

Participant: As I said earlier, what I will do, I will check with the relatives if this is a new development, if new then I will know and if not new I will know and bring it to the attention of the family that this is how the person behaved.? Then from there you know whether there is a collectra needed or intervention.

Interviewer: What are those factors that motivate you in giving spiritual care?

Participant: Well, the factors that motivate me, you see the need because they tell you, and sometimes they come to you and tell you they are telling me to kill myself, you know that is not from God, then you pray with the patient and sometimes my own spiritual belief as well, also if the client is of your own faith,

Interviewer: What are those factors that prevent you from offering spiritual care?

Participant: If it is going to bombard the person personal faith, then I wouldn't think is something I need to do, also hostility, because if the person is hostiled, there is nothing you can do. Also lack of training in that area will make it difficult for me.

Interviewer: What could be your concluding statement on the interview dealing with spirituality and the psychiatric clients?

Participant: I would say it is an area that is actually lackened, and not attended to.

Interviewer: What do you recommended?

Participant: I recommend that training in that area will help, and it should be included in the training for would- be nurses, and refresher courses for psychiatric nurses who were not trained to that, workshops and so on to help them to be empowered in that area.

Interviewer: What is your personal view on spirituality?

Participant: My personal view on spirituality is that spirituality is a sense of being, is a sense of belonging, knowing the right from wrong and an eye opener.

Interviewer: Is spirituality really important to you as a psychiatric nurse?

Participant: Oh yes, it is my life; it makes me to be committed to my God. It makes me to be with my patients at all times and to behave rightly to all- treat all my clients the same.

Interviewer: What is your closing statement on the interview?

Participant: It is quite an intense interview, and it actually makes you to think, have I done enough for my patients.

THANK YOU FOR COMING

Interview 3

Gender: female **Age: 51years**

Length of experience in psychiatric nursing: 27years

Interviewer: Please briefly tell me what your current job involves?

Participant: I worked in the psychiatric community clinic in Weinberg. Lot of our patients are referred to us, they have to be referred to us, we do their basic assessment first when they arrived to us, once we have done the referral, we will ask that the patient sees doctor, or do the counseling if need be. We follow up patients that come in regularly every month for the follow up treatment, we do group work not often enough, but we do group work. We do one to one counseling, we do cross examination. Our patients are basically patients with schizophrenia, bipolar, major depression, suicidal patients, borderline personality like, IDHT, psychotic group and that they come in monthly, some of them are two weekly, and yes that's the work I do and now I am an operational manager.

Interviewer: At present are you only working at a psychiatric hospital or a psychiatric clinic?

Participant: I work at a psychiatric community services clinic, but I am attached to a hospital. Before then I was working at Tenlorg clinic up to 2007, but come 2008, I have been in the clinic Before we became part of the hospital, we do more home visits often, I mean the load has changed, We do up to 20-30 home visits and with the new mental health act they go now to INH to be admitted.

Interviewer: Do you rotate in the various units?

Participant: No, no most often we are permanently in the clinic.

Interviewer: Do you admit in the clinic?

Participant: No, we don't admit patient because we are out patient, we are primary health care, psychiatric primary health clinic, so it is an out patient clinic totally, we don't admit patient.

Interviewer: Are there specific types of patients that you deal with?

Participant: We deal with any psychiatric patient. We see schizophrenia patients, bipolar, what ever illnesses that come, it doesn't matter whether they are grown or under grown, as long as they are in our catchment area, we deal with them., male, female all age group. We have children as young as 3-4years coming to the clinic and we see them, I think all of our patients are 92 in number today.

Interviewer: If I should ask you, which group of patients you prefer working with, the male, female or the children?

Participant: You know I enjoyed working with all whether they are male or female; I enjoyed the both of them, **WHY?** I enjoyed psychiatry, as long as the patient is a psychiatric patient, it touched my heart. At times children are more difficult, more challenging, because their diagnoses are more guided, their symptoms are spontaneous and their behaviors are almost difficult to handle. Male patients, female patients, I love my patients.

Interviewer: How do they relate to you?

Participant: Well, they have got very accustomed to me, I been with them with the last 20years, lots of them know me from Town Hill days; most of them are really really closed to me in a lot of ways. Most of them I know their families, but they don't trust people easily.

Interviewer: Are there times that you have been assaulted by these patients?

Participant: I think psychiatry is some thing that to say no assault is difficult, or very rare, but I have been put against the ward, but not to really be assaulted sexually. You

need to read your patient as a person and not be judgmental. I have had a cordial relationship with them.

Interviewer: What are basically your functions at the clinic?

Participant: My function,…I am the Operational manager of the clinic, that means I need to coordinate the running of the clinic, the supervision of staff, position of staff, do interviews, I do get involved in crisis intervention, do supervision, often go to meetings, and do other things outside the clinic, but I try to keep it at minimum and handle problems with staff issue.

Interviewer: At the clinic level what is the job like for the psychiatric nurse?

Participant: Sometimes the load gets heavy; we see lots of students at the moment, we have students from varsity, student from Ellington, and it is a lot of training on our staffs. With the interviews, we let the students get the experience of managing the various types of patients like the suicidal, get involved with interviews so they get use to the way of doing interviews. We are small group of sisters, we two chief nurses, one very junior nurse and then myself .we see something like a 100 to 150 patients a day and some days it is more. I think today we have seen up to 120.

Interviewer: What specific job you do at the clinic level unlike the hospital level?

Participant: We work very closely with the other primary health clinics. We don't refer our patient to the other primary health clinics, patient that are not stable will remain with us, the patients that are stable will go to the near by clinic and are referred back to us for doctor to see. We personally do the interviews in between the doctor visit, so doctor will see the patient every 6 months we see them in between. All of the staffs do the interview, we advise the patients or do counseling, and we also refer patients.

Interviewer: Do you also serve medication at the clinic?

Participant: Yes, the medications get ordered from the hospital not ordered at the clinic, our medications come pre dispensed.

Interviewer: Are you also involved with psychosocial rehabilitation at the community level?

Participant: We do involved most of our students with that. We try with our interview and get the students involved with the psychosocial rehabilitation. Over the last few months, it been very difficult, most of them will come and say that they have financial difficulties, no jobs, we have the social worker with us in the clinic, we try to motivate the patients on social skills but when it comes to psychosocial rehabilitation, it is not what people will expect it to be as an advanced psychiatric nurse I learned a lot about it, when I do my interview I practice it., I assist them to find out if there is job available. It is

always not practical with three when they have to see 100 patients. But we have done a lot already in a moment toward that. It is very difficult to do psychosocial rehabilitation with many patients. Practically, if you do it with one you have to do it for all of them.

Interviewer: What does the term spirituality means to you?

Participant: It actually had to do with religion and your relationship with God. If a patient in the clinic has a spiritual need and if the need arises, one needs to look at that need. We see a big variety of patients, we have Christians, Muslims, Hindus and Buddhist, to me it is the relationship between me and God and to other it may be their higher power, it is also the way of living. We should not be discriminating other religions, only God knows. Spirituality is personal; it is a personal belief, very individual. We look at the physical side, we look at the social side, very important we also need to look at the spiritual as well, because I think that is what makes a person human, if any of those areas are not looked at, and then you are not looking at the person holistically.

Interviewer: Who do you think should bear the responsibility to offer spiritual care to our psychiatric clients?

Participant: I think the individual who interviews the patient; because if you are not comfortable with your religion, you don't feel comfortable to talk about other people religions and finding out more about them. Definitely, it is the nurse responsibility. It is my responsibility to allow the patients to talk about his religion, or ancestral belief based from the cultural context. If the need arises, whether a Muslim, Hindus or Christian or so on, Also for me, is it my responsibility as Christians and not only as a nurse.

Interviewer: Please describe your understanding of the relationship or connection if any, between spirituality and psychiatric nursing care?

Participant: There is a big gap in psychiatric care when it comes to spirituality. We have lots of patients that come with religious feelings and one need to be aware of these feelings; we also need to know the patients well enough and to know who you can speak to about this, sometimes we fall short to discuss patient spiritual need, to be able to handle these feelings or needs.

Interviewer: Are there benefits of spirituality for the psychiatric clients?

Participant: Part of it is for the holistic well- being, because we are spiritual beings. We got a body, we got a spirit, we got a mind, all come together .It also worked as a support system for the clients and also for mental stability, it is part of us as human, it is part of the culture.

Interviewer: Do you think all of our psychiatric patients need spiritual care?

Participant: I feel if the need arises , like some patients will be physically well, we don't need to look at the physical side, but if you see the needs arise, then you need to attend to that need and you should think of the culture aspect. So I think it is very important to work with the person as a whole.

Interviewer: How do you know when a client is expressing a spiritual need? Could you give an example?

Participant: 90% of our clients directly connect to God. For example if a client wants to commit suicide, they tell you I love to be with God, already they believed in God, sometimes they ask me directly to pray for them, because they are having a difficult time. For me that time I will pray for them if they asked me to pray for them. If patients expressed the spiritual need and if we can not manage it, we invite a spiritual leader to deal with that.

Interviewer: What do you do with those clients that do not come to you to pray for them?

Participant: If the patient does not need spiritual assistance, they won't come to us. For example, I don't expect my GP (general practitioner) to discuss my religion with me. Sometimes I ask them openly about their spiritual relationship with God, because when it comes to spiritual care, it is not included in our curriculum, is often neglected.

Interviewer: What do you do to meet these needs when expressed by these patients?

Participant: I normally speak out openly and I try to be careful not to push my belief on to patient, but listen to their needs and how they think. Teach them basic counseling skills and allow the patient to bring the need. I won't push my belief into the patient. Spirituality is often based on your own personal need and as a counselor you can't push your own personal belief on to patient. I will discuss their own spiritual needs, I will allow them to verbalize what their needs are, we often helped them go to people who they think could help them meet their spiritual needs, sometimes we have contact with their ministers that come to the clinic to pray with them, sometimes we contact these ministers to come over and we discuss the patient medication with them prior to the patient going home to attend to their spiritual beliefs.

Interviewer: What sort of things prevents you from offering spiritual care? Can you give an example of this from your practice?

Participant: Ignorance, ignorance of other people's cultures and religions. There is a big gap, like a language gap there , if one is not spiritually strong in your own religion , it is

hard to understand another person belief, if you are not secure in yourself, I think that is a major gap,

Through out your training as a nurse and even as a psychiatric nurse, is there time you were train to offer spiritual care?

Participant: It has never been included in any of my training

Interviewer: What could you recommend to the South African Nursing Council (SANC) concerning spirituality and psychiatric nursing training?

Participant: 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 religions and cultures.

Interviewer: What will you also recommend for already practicing nurses?

Participant: I will recommend workshops, in- service training on spirituality and what it means to different people and how we can help to meet those needs in time of crisis. What are those resources out there; basically it should be in the curriculum for nurses.

Interviewer: What benefit is spirituality to you as a psychiatric nurse?

Participant: I think if I didn't have my own spirituality, I don't think I could be able to be human to my patients. With out spirituality, I will be incomplete and my work will also be incomplete. It 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.

Interviewer: What sort of things enables you to offer spiritual care? Can you give an example of this at your practice?

Participant: My own moral relationship with my Creator, that enable 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 in touch with my Creator helps me to see the needs of other people to be in touch with their gods. I think everybody have got the right to be in touch with their creator or some how their higher being, if a person should be well, you need to look at all aspects concerning the person health, that includes all what is important to them as well, which includes their spiritual belief.

Interviewer: Are there special attributes that a psychiatric nurse should posses to enable him/ her offer spiritual care?

Participant: I think everybody needs to be developing in their own spirituality. , develop in their needs; if a person is not developed in something, he will not be aware of that thing. Spirituality is very deep between a person and the client, also tolerance in understanding other people beliefs and cultures, beware of others needs. Yes, people need

to be compassionate, if they haven't got it, they need to learn what other people needs are even if I don't believe in it.

Interviewer: What will be your concluding statement on spirituality?

Participant: To me ,spirituality is the lining of the globe that holds persons together, is a code of every person, with out spirituality, you can't have mental health, you can't be compassionate, is one of the needs of the person, is one of the basic need as compared to Maslow's hierarchy of needs. Spirituality is one of the bottom needs, very important for everybody; definitely, I will recommend spiritual care for my patients. As without mental health there is no health, so without spiritual health there is no health. What ever your spirituality is, it needs to be healthy.

Interviewer: Anything you want to say about the interview?

Participant: I will say not enough researches are being done on spirituality. You are the first person I have met that interested in spirituality, and I often thought of why you doing that? Whether are you a spiritual healer, I think it is a wonderful research you are doing.

THANK YOU FOR COMING

Interview 4

Gender: male Age: 49years

Length of experience in psychiatric nursing: 22years

Interviewer: Please briefly tell me what your current job involves

Participant: I am currently working as a psychiatric nurse in the acute psychiatric ward of the hospital, there where I am being placed at the movement.

Interviewer: Can you further elaborate on your functions in the acute psychiatric ward?

Participant: In the acute ward, we usually calm patients who come directly from the general hospital psychotic, the aim of the unit is to stabilize those patients because when they are coming most of them are acute psychotic, we stabilize them and when they are stable, and then transfer them to the psychotherapy ward where they get psychotherapy which will enable them or assist them to cope when they are discharged back to the communities where they are coming from. Basically what we do in acute ward is to stabilize them and take them to the psychotherapy ward. But some of them when they come on the acute ward, they are not that psychotic.

Interviewer: **Beside the acute ward in the psychiatric hospital, are there other wards in the hospital?**

Participant: Yes, there are other ward for geriatric, some of the patients when they come they have a special problem when they have been stabilized and psychotherapy given to them, they have a problem with staying because some of them have no accommodation, we also have the out patient and a special area connected to the out patient where patients from the communities come for psychotherapy daily; recently child - adolescents unit has been opened but not more than month old yet.

Interviewer: **Have you had the opportunity to rotate in all of those other wards?**

Participant: Yes, I have worked in the acute psychiatric ward and the ward for those patients who are waiting to be reintegrated back to the community, yes; basically, I am mostly in the acute psychiatric ward.

Interviewer: **In the acute psychiatric ward, what type of patient you deal with mostly?**

Participant: I deal with only male patients and not female. There are other wards for females but they are separated, I have not worked there. I only deal with male.

Interviewer: I also interacted with some female nurses and they told me that they have been working in both the male and female wards of the psychiatric hospital, what will you say about that?

Participant: Yes, the female nurses are in majority and the male there are very few, that could be one of the reasons why the male nurses are always assigned on the male ward and it is the policy that the male psychiatric nurses work on the male ward.

Interviewer: **What is your experience like in working with the male clients?**

Participant: You know there is something very interesting. Over the years, aggression from the patients has subsided, patients who are coming now for treatment are not that aggressive as they used to be some years ago , because some years we used to deal with very very aggressive patients, but somehow it has subsided. I am not sure whether it is the different treatment or what, I don't really know.

Interviewer: **Are there times you have been assaulted by your clients?**

Participant: EH EH, not necessary assault but attempted assaulted--- to fight me.

Interviewer: **What does the term spirituality means to you?**

Participant: The word spirituality to me, spirituality means those things that deal with religion, belief, or those things that have to do with a person's understanding or his communication with his God. We as humans were made in God's image, is also our connection to God. It does give hope. I think it should be part of our care. Instead of us saying psychosocial rehabilitation, I think we should say psychosocial spiritual rehabilitation.

Interviewer: **Does it only mean to be connected to God because there are some people who don't believed in God?**

Participant: Yes, they might not believed in God, but they believed in ancestors, they are connected to their ancestors and when there is a need for ritual, they go to their ancestors and do various activities, some of them, they talk to their ancestors as if they are talking to someone who can hear.

Interviewer: Do you think spirituality is important for the psychiatric clients?

Participant: It is important yes, because it serves as hope for some of them. Some of them come in less psychotic and they believed in prayers and after praying, the patient sometimes recovered faster. And spirituality is good for the client. It is not only important for the psychiatric clients, but also for us especially when you have problem and after praying you observed that the problem will be taken care of after sometimes. It provides hope for recovery for the psychiatric patients as well.

Interviewer: **What benefit is spirituality to you as a psychiatric nurse?**

Participant: I will say at the moment, we do not have any spirituality in our training, but we take the patient to church which is inside the hospital, some of them really asked us, so we sent them to church and that can help them to change their behavior.

Interviewer: **What do you do with patients who do not believed in spirituality or God?**

Participant: For those who do not believed,…..… but the majority of them do believed, even those who do not attend the church when they are inside the hospital, they also asked for pastors or their religious leader to come and spend some times with them.

Interviewer: Please describe your understanding of the relationship or connection, if any, between spirituality and psychiatric nursing care?

Participant: I think with mental health you are dealing with the mind, and the belief that you have will take you to spirituality or prayers, it will definitely help a person who has no hope, because if a person can get hope through spirituality, then why not assist or implement then. There is a connection and is therefore important for the psychiatric patients.

Interviewer: Do you think all of our patients deserve spiritual care?

Participant: All of them, yes, all of them need spiritual healing and even all of us as psychiatric nurses.

Interviewer: How do you know when a client is expressing a spiritual need? Can you give an example of this from your clinical practice of this?

Participant: There are instances where patients believed that their illness is related to them being attacked by demons and they believed that only what they need is prayer to help them. Some of them go to the extent of not wanting to accept medication because they believed that they only have to reconcile with God through prayers and that can heal them. As I said before, some of them actually ask to go to church, some of them will ask why not ask the pastor to come and pray for us inside, some of them when they are admitted, will ask us to go home and perform some ritual activities with their gods in order to get connected to their ancestors and they believed when that is done, it helps them be relieved, so they go home to come back later. They believed if this is done it will relieved them of the evil spirit. You observed that there is a gap, a gap in that we don't really offer spiritual care for these patients.

Interviewer: **What do you do to recognize patient who do not express their spiritual need to you?**

Participant: People who provide spiritual care to patients, some of them do not believe in spirituality, but for some of us we go to the extent of praying, but for those patients that stay away, we interview them and even asked them about their religion. In fact our admission record tells us that all of them belong to a religion somehow.

Interviewer: **What do you do to meet those needs?**

Participant: As I have said previously, for those who will like to attend church services on Sundays, we take them to church, the hospital has a pastor who comes only when he asked to come especially where a patient asked to see a pastor, but this is very rare for someone to ask to see a pastor.

Interviewer: **Are there times that you the nurse have made the request for a pastor to come and see a patient?**

Participant: Not me, certain time, they come on Sunday, but there is one who volunteer to assist whenever we want his service but is very rare except on Sunday.

Interviewer: **Do you really offer spiritual care to patients in the acute ward?**

Participant: Not that I know of, we do not have any special program related to spiritual care like that. Where I work, we deal with medication and psychotherapy which does not

involved spirituality, nothing is done in term of spirituality. As I have indicated there is a gap in our care.

Interviewer: **Are you saying that through out your training as a nurse and a psychiatric nurse, you have never received training in spiritual care?**

Participant: NO, not at all, even my basic training as a nurse and as a psychiatric nurse, nothing at all.

Interviewer: **If you had the chance to make a recommendation to the South African Nursing Council concerning spirituality and nursing training, what could you recommend?**

Participant: I believe that some how spirituality has to be integrated into training of all nurses, but is something that some people will accept and some people won't accept because some people don't believe in God. I don't know how it will be set up; but I think it will be very useful if spirituality is incorporated in our care for the patients and in our training, curriculum which will make a lot of goods. You see some years back people used to really be attached to God, doctors used to pray for patients , but now some how they believed in themselves to do everything,

Interviewer: Do you think in the absent of spiritual care, our care to our patients will be holistic or complete?

Participant: No, definitely not. As I indicated we are also spiritual beings, all of us and yes it will be very useful for spirituality to be incorporated in our care. I remember when attending a workshop one of the facilitators, a psychologist who was travelling through the country, she said to us a story that she had seen a client who had totally recovered from mental illness just from prayer. **Spirituality is very important to everyone-mentally ill or physically ill, all of us.**

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Interviewer: **Who do you think should be responsible to offer spiritual care for our patients?**

Participant: The nurses and the pastors, you can invite the pastor but you know most of the time the patient is with us, you can not expect the pastor to provide the care and always be there with the patients, but the nurses are there.

Interviewer: If spirituality is incorporated into nursing curriculum, who do you think should take the responsibility in offering spiritual care?

Participant: The nurses, definitely the nurses, some of us are spiritual, we belong to different denominations, and we will be quite available to provide that care. As I stated before doctors and nurses used to believe in God mostly than now. As time goes on, they believed in themselves.

Interviewer: As you said in those days' doctors and nurses were more religious than doctors and nurses of today, what do you think is responsible for that?

Participant: We tend to believe that we are able to provide everything that the patients need; we tend to believed in ourselves and depend on our own skills and knowledge; the development in science make us to believe that we can do everything which is not quite true.

Interviewer: What sort of thing prevents you from offering spiritual care to your patients?

Participant: As an individual, nothing, there is absolutely nothing that can prevent me from giving spiritual care. Sometimes we provide psychotherapy but there is nothing that would prevent me from offering spiritual care, but as I have said, it is not part of our training, it is an individual thing, and we only do it if we want to. I can do it if I want to, but if it was part of our program and appropriate training provided for that, we could be able to offer it always.

Interviewer: **Do you need special skills to enable you offer spiritual care?**

Participant: You need special skills like love and knowledge about other religions to enable you provide spiritual care; it should be included in training to help those people who are hopeless.

Interviewer: What sort of things enables you to offer spiritual care?

Participant: I think the starting point will be to arrange for or to run workshops, and then invite people who are knowledgeable on the subject spirituality; to help equip nurses with skills to be able to provide the type of care needed, also having those shills which could assist you as a psychiatric nurse, and really to find people who can assist us to offer this care to our patients, that is through training.

Interviewer: Are there time that your own spiritual belief has served as a motivating factor for offering spiritual care?

Participant: Yes, to some extent yes, before you talk to the client you need to know the client, his religion and assist him with spiritual care but that aspect of care has been neglected, but it forms a greater portion of our care for the psychiatric patients.

Interviewer: **Are there times where in you have projected your own spiritual belief into patient?**

Participant; No, in fact I don't talk about Christianity, but only God the creator, not Christianity that will help , but God. We all believed in God and that there is god that we can go to, not necessary God divine, but it may be their ancestors who they believed in.

Interviewer: What could your concluding statement on spirituality be?

Participant: I believed spirituality should be one area which should be visited, explored and tested in our daily care of our clients and should be part of our care. Workshops should be held to conscioustie us as to the importance of spiritual care for the psychiatric patients and even ourselves.

Interviewer: **Do you have anything to say about the interview?**

Participant: Well I think the research on spirituality is very good but I think the result should be communicated to nursing colleges, universities and the broader thing to help the mental health care providers to be apt to provide their input on this important subject and the recommendation is to include spirituality in our program and in our institutions.

THANK YOU FOR COMING

Interview # 5

Gender: Male **Age**: 43years

Length of experience as a psychiatric nurse: 13years, 3months

Interviewer: Please briefly tell me what your current job involves?

Participant: Firstly, nursing is..... I am doing nursing in psychiatric institution whereby people have got different presentation in term of their illness and mostly it involved feeling whereby you see that the person is out of touch or might need care in term of himself or herself and if now the person becomes a child in terms of thinking and other things, at times you need to be the mother, you need to be the father or you need to be a guidance, there is a lot that is involved currently when you deal with it. That is my job currently.

Interviewer: At present where are you working?

Participant: In a psychiatric hospital

Interviewer: What is your function like working in the psychiatric hospital?

Participant: Firstly, is to make sure that people or try to make sure that people understand what is psychiatric illness and second point is to try and prevent its occurrence and minimize it , then another point is to help those who have psychiatric ill problems; nursing them, giving them the guidance that they have to live with, or they have to understand their sickness, they have to know what they have to do since they got

sickness, helping them to accept it if they haven't accept it and try to make living in term of recovery, or rehabilitation, those are things I am involved mostly .

Interviewer: At present, what type of patient are you dealing with?

Participant: Presently, I got one that I am dealing with, although I still have difficulty in recognizing him because his relatives can not be contacted, no contact number. What make me to be interested in following his case is the fact that every time you talk to him, you find out that there is a relationship that is not good between he and the family, when you talk to him he say the family do this ,do that. My intervention is that, I wanted to help to get the social worker involve, family meeting whereby I could discuss his problem with them. So presently I am willing to meet with the social worker to see if that problem can be resolved.

Interviewer: At present, are you in charge of a ward in the hospital?

Participant: There is somebody who is in charge, but at times if he isn't there, I am the second in command, I find myself in there. Presently I am working in the male ward.

Interviewer: Have you had the opportunity to work in other units of the hospital?

Participant: yes, I worked in all of the hospital units; we rotate as time goes on.
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Interviewer: How often do you rotate in those areas?

Participant: We rotate every six months, the last time I worked three month in another ward and then one month in another ward, usually according to the policy of the hospital, it is six months but at times due to the shortage of whatever, they used to ask us to change our wards.

Interviewer: If I should ask you, the male and the female clients, who do you prefer working with?

Participant: Male, you know at times, to work with female they tend to be sexually inappropriate, you can be afraid for the patient to say you did this, that is litigation, you end up loosing your job for something that you did not do, you need to be cautious when you deal with females, because of the laws that are there of in this country., so that's why I preferred male than female.

Interviewer: are there times you have been accused by a female client?

Participant: Not specifically me, but some of my colleagues.

Interviewer: Were they guilty or acquitted?

Participant: They were not guilty, but the fact that they were accused, that stigma was always there.

Interviewer: what does the term spirituality mean to you?

Participant: eh, I do not know how to explain,… **TRY….**spirituality may be a way of ancestors. There are people that are linked to their ancestors in their spiritual world, whereby they happened to be the fortune tellers, even if the person is not a fortunate teller, if there is something that is going to happen it is linked to their ancestors, that is spirituality, another way is religious way, it is broad depending on the link you have with your ancestor or your God, to me spirituality is a way of linking with the supernatural world

Interviewer: Besides what you have just mentioned that spirituality is "having link with ancestors or god", are there other ways or things you could link spirituality to?

Participant(☹quiet)..... spirituality to me as a Christian, it means linkage or bond between me and God, whereby it may go to the extent of seeing thing that other people might not see, hearing god or speaking to me and can not explain what happen to you at a particular time.

Interviewer: Please describe your understanding of the relationship or connection if any between spirituality and psychiatric nursing.

Participant: Let me attacked it in this way, since it is a psychological problem that most of our client have, we always look at the fact that the new mental health act dealing with psychotic patients,, it does not take into consideration the spiritual part of the person. There is a connection which is spirituality but is not looked at the moment., no matter whether it is the religious part or the ancestors part, it is not looked at it, it has link with psychiatry because it happened to people who belong to their religion and have their belief with their ancestors or their god which help to improve their care.

Interviewer: What will you say if I should ask you if spiritual care is needed for our patients?

Participant: Yes, I think that might help a lot because we always looked at other areas, not spiritual area, it is neglected, if it is offer, we will see great changes in the people involved by helping in their recovery.

Interviewer: Why do you say that spirituality is neglected?

Participant: I say so because no one is able to recognize patient spiritual need, even the nurses working with the patients. Sometimes the patient is praying and nobody cares to reach that person and inquire what is happening to that patient. Another reason is that if I am not spiritual oriented, you see that there will be a problem in term of care. Also if we

do not have any body to help us in that area in tend of training, we will always avoid that area that is another reason.

Interviewer: Were you ever trained to offer spiritual care to the psychiatric clients?

Participant: No, although there are books concerning spiritual aspect which will be helpful, but here is no broad information in term of how really to deal with that area.

Interviewer: As you said spirituality is a neglected area in our care, what do you think could be done to integrate this area into our care?

Participant: The only thing is to develop as you are doing, to develop a program that will help psychiatric nurses to enlighten them on spiritual care to broaden our minds, I think that will help.

Interviewer: What could you recommend to the South African Nursing Council (SANC) concerning spirituality and psychiatric nursing?

Participant: I will recommend that spiritual care be integrated in every training program dealing with patient care, not only psychiatric nurses training.

Interviewer: What are the benefits of spirituality to the psychiatric clients?

Participant: Assuming that a patient was taken to church on Sunday, when he comes back from church, you will observed a change in the behavior, that is behavior modification, also it gives hope to the patients through depending on their gods or ancestors

Interviewer: How do you know when a client is expressing spiritual need?

Participant: It is difficult because some of them may not express it by saying it, it is really difficult to identify if the patient is expressing a spiritual need, but the way the person will be talking, the way the person will act, will make you feel that the intervention needed here is spirituality. 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. Also, the patient's behavior like praying a lot, singing a gospel song, talking to himself when you asked him he say I am talking to God, being alone, when you asked him, he say I want to be alone because I want to have a time to pray to my god.

Interviewer: What do you do to meet this need?

Participant: Mostly if the person say I want to see my pastor, we try by all means to contact that pastor if he had got the contact number, the part that is really difficult is when the person is dealing with the ancestors, like they want to see the sagoma, what I usually tell them is why not you take your medication and after here, you can see him, because we don't allow that in the hospital setting. Sometimes we gave them LOA (leave

of absent) to go home to perform such ritual and then come back. In some patients there can be changes in their condition, for some, they can be better than prior to their departure, but for some, they go and come back the same way.

Interviewer: What sort of things prevents you from giving spiritual care?

Participant: The fact that you are not spiritually orientated, my cultural belief as well. **Can you talk on that more? How**? Depending on your orientation, let say the patient has ancestor spiritual linkage, and I am spiritually Christian orientated, assuming that person come and tell me about ancestors belief, that is demonic to my belief and it will hinder me to allow this person or in helping this person in a proper way; also the lacked of knowledge in the area.

Interviewer: Is spiritual care a right or a privilege for the psychiatric client?

Participant: It is a right for them, according to me; they deserve spiritual care one way of the other.

Interviewer: What sort of things enables you to give spiritual care?

Participant: In long and short, knowledge, your own spiritual orientation.

Interviewer: Who do you think is responsible for offering spiritual care?

Participant: I think the nurses, because 24hrs they are with the patients.

Interviewer: What will be your concluding statement concerning the interview on spirituality?

Participant: One thing that I can say from the interview is it has enlighten me on certain thing that 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 do we fortified that area to come equal to others in term of caring so that we gave the patient a holistically approach, because if one aspect is neglected, then it is not holistic any more. So it should be integrated into training and workshops be held to help even doctors and nurses in that direction.

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THANK YOU FOR COMING

Interview # 6

Gender: female **Age**: 35years

Length of experience as a psychiatric nurse: 4 years

Interviewer: Please briefly tell me what your current job involves?

Participant: Firstly to offer holistic care to my patients, starting from the admission of the patient when they are referred from the clinic, if violent, administer medication to calm them, monitor the discharge of the patients, and make follow up on patients. Presently we have a large number of patients that relatives are not taking them home and we make outreach, go to the community to see if we can locate patient family because some family members will not want to pick their patients, some will even say to us that we should keep patient in the hospital and not discharge them.

Interviewer: **What do you think is responsible for family members not picking up their discharged patients?**

Participant: Sometimes it is due to financial constraint on family, also misconception that patient might have done something wrong and staying in the hospital is a means of punishing them, so they leave them there and some will tell us not to discharge them.

Interviewer: What do you do in that direction?

Participant: As of now, we have social workers that make follow ups in locating the family members.

Interviewer: What does the term spirituality means to you?

Participant: Spirituality means to me a system of belief that you have, whether you are a Christian or not, usually it is associated with your religion, what system of religion you believed in, some do not believe in Christianity, some do believed in ancestors. Spirituality also means a person feeling, how you feel in relation to situations.

Interviewer: Please describe your understanding of the relationship or connection if any between spirituality and psychiatric nursing care?

Participant: There is a connection, it depends if you are in line with a particular belief, that thing that you believed in that will set you well or better, for instance some have strong believed in ancestors that they believed can make them better, for the Christian patients, they will be singing gospel songs and they believed in their God and their God will make them better.

Interviewer: What do you think spirituality means to the psychiatric patient?

Participant: Most of the patients that I have come across believed that spirituality plays major role in their lives. HOW? In that you will hear them pray and say God please help us get better, and most of them rely on it as a healing power to get them better. It also brings comfort to patients who believed in God or super being. For those who asked to go home to perform religious rituals, they usually come back improved and calm.

Interviewer: How do you know when a patient is expressing a spiritual need?

Participant: Some will say I miss my pastor, some will asked don't you have Bible in this hospital? , Some will be singing gospel songs.

Interviewer: What sort of things do you do to meet those needs?

Participant: If the patient is singing gospel songs, we encouraged them most of the time, if asked to go to church, we allowed them to go, if want to go home to perform rituals, we contact the doctor for leave of absence(LOA)

Interviewer: What sort of thing prevents you from giving spiritual care?

Participant: 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.

Interviewer: What sort of things enables you to give spiritual care?

Participant: 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 belief; the availability of the Bible and having insight of the patient spiritual belief.

Interviewer: Who do you think is responsible for offering spiritual care to the psychiatric patients?

Participant: I think is the nurse, but if patient makes the request for his pastor to come , you help in making that arrangement for the pastor to come, the hospital has a pastor that also help to offer spiritual care, also I think it should be part of our training to help us do better.

Interviewer: What is your concluding statement on the interview on spirituality?

Participant: It should be included in training but it should be offered by people or nurses who feel like, because some people do not belief in God. I never thought of spirituality forming part of the psychiatric patient care.

Thank you very much for coming

Interview # 7

Gender: female **Age**: 27years

Length of experience as a psychiatric nurse: 3years and 4months

Interviewer: Please briefly tell me what your current job involves?

Participant: I work in the psychiatric out patient as registered nurse, we do repeat of the patient data, we do admission, we also calm patients who are aggressive, we do interviews of patients, basically that what I do.

Interviewer: What does the term spirituality means to you?

Participant: Spirituality to me means super being, God, somebody you can cry on, cry on in the sense that for me as a Christian, a Roman Catholic, I believed in God and I depend on him for all what I ask of him.

Interviewer: Please describe your understanding of the relationship or connection if any between spirituality and psychiatric nursing care?

Participant: There are people who are having callings, like for us in our culture, we have people who we call Sagoma, who believed that they can see things, they can predict your future, they can even cure you of bad spirit, but some of the people have perception about the mentally ill and sometimes we the health professional say these people are mentally ill also. I understand that nursing is a holistic dimension, you don't only treat a person as a person, you need to include their spiritual area, you see that they can be in the world but if it is Sunday, they go to church, so if these people should ignore all of these you see that that person will not get better because their spirituality is not being fulfilled.

Interviewer: How do view spirituality as being beneficial to the psychiatric client?

Participant: I think we all have super being because of the thing that you believed in, and if that is taken away from you, it is difficult to get better. Spirituality can improve their health and mental illness in the sense that we should not undermine their spirituality. Also their prognosis and their compliance with treatment will improve, also if you recognize what they believe in, don't just take it away, they also need that spiritual fulfillments as a person. Spirituality is very important for the psychiatric patients.

Interviewer: How do you know when a patient is expressing a spiritual need?

Participant: You will see those that are Christian will say today I will be going to church, today is a church day, you see the Indian community will be fasting on Tuesday

and Thursday and will tell you that they are not going to have anything today because they are fasting today. For where I work, we are not allowed to pray with patient because management says we are living in a diversified society, a multicultural community of many religions, so because of that we do not offer spiritual care to our patients; nothing is done to meet their spiritual needs. Even if the priests want to come, they are not allowed to come.

Interviewer: How do you view patient going home to meet their spiritual need?

Participant: Well, they are allowed to go home for pass out, if they request or even if their family members request, the doctor can grant them pass out to go home to perform that religious demand, sometimes family will not want to pick patient because they are mentally ill. For those that are allowed to go, most of them will come back much calmly, and very understanding. I have not seen a case where patient will come back worse than before.

Interviewer: **If our care for our patient should be holistic, how do you think we can address the spiritual dimension of our patients?**

Participant: We need to have more people involved, all those who are concern, because we have lot of people who are practicing different things or religions. This will help us to meet the spiritual needs of our patients very well.

Interviewer: Who do you think has the responsibility to offer spiritual care?

Participant: The health professionals, I mean the nurses because they spend more time with the patients than anybody else.

Interviewer: What sort of thing do you do to meet those needs of your patients?

Participant: Either we give them the pass out or if they asked for a room I can give them a room to pray, if relatives come and they want to pray with client, I can give them a separate room to pray.

Interviewer: What sort of things prevents you from giving spiritual care?

Participant: Management, only management because where I work, we are not allowed to offer spiritual care. Management prohibits that.

Interviewer: What sort of thing enables you to offer spiritual care?

Participant: Because I am a believer as well, I am a Christian, I have my own spiritual belief, if patient is not of my belief, and I can refer the patient to my colleagues who can

help, because spirituality is a unique and a sensitive thing. You need to have insight in the patient's belief before you can help him.

Interviewer: What is your view on this research dealing with spirituality?

Participant: Is something that I haven't thought about, it is the last thing I will think about, it is an eye opener, HOW? You have to think about it that it and try to involve it in our nursing care for the betterment of the patients.

Interviewer: What will be your concluding statement?

Participant: Well, the interview was very nice except that it was long; you make me think of things that I didn't think about in my profession, which is spirituality.

Thank you very much for coming

APPENDIX 6: Table 4.4 Significant statements from participants and locations in text

Table4.4: Significant statements and their locations in text

Significant statements	Location in transcript
Spirituality means more ideas, beliefs sometimes even emotional concern with connection with a higher being	Transcript 1 lines 56-57
Spirituality is connected to religious beliefs and practices	Transcript 1 line 57
Spirituality is related to personal belief, that is my personal belief	Transcript 1 lines 58,64
Spirituality is Higher being in term of human being	Transcript 1 lines 82
The system itself because there is no traditional healers as part of the management team, our negative attitudes, 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	Transcript 1, lines 184-187
Spirituality is part of life and it is an area that needs to be attended to and included in the psychiatric client care	Transcript 1 lines 201-203
Spirituality to me, it means Connecting with God on a daily basis, any way, anytime. For me, it is the Almighty God, because I am a Christian	Transcript 2 lines 316-317, 329
A part that needs to be always nurture as human beings because there where our strengths come from.	Transcript 2 lines 317-318
There are people who don't believe in God, but they have some sort of gods of their own they are connected to, their gods	Transcript 2 lines 323-324
It takes special people to nurse psychiatric patients; you got to have God giving skills to handle psychiatric patients	Transcript 2 lines 361-362
It is individual thing, I wouldn't say so, it is an individual thing	Transcript 2 line 383
I would say it is an area that is actually lacked, and not attended to	Transcript 2 line 500

Spirituality is a sense of being, is a sense of belonging, knowing the right from the wrong, and an eye opener	Transcript 2 lines 510-511
Spirituality actually had to do with religion and your relationship with God, to me it is the relationship between me and God, to others, it may be their higher power. It is also the way of living	Transcript 3 lines 648, 651-652
Spirituality is personal; it is a personal belief, very individual; often based on your own personal need	Transcript 3, lines 653, 716
I think that(spirituality) is what makes a person human	Transcript 3 line 655
There is a big gap in psychiatric care when it comes to spirituality	Transcript 3 line 671
We got a body, we got a spirit, we got a mind, all come together	Transcript 3 line 680
Without spirituality, I will be incomplete and my work will also be incomplete	Transcript 3 line 755-756
Spirituality is the lining of the globe that holds a person together, is a code of every person, without spirituality, you can't have mental health	Transcript 3 lines 782-783
Spirituality means those things that deal with religion, belief, or things that have to do with a person's understanding or his communication with his God; it is our connection to God	Transcript 4 lines 867-870
Instead of us saying psychosocial rehabilitation, we should say psychosocial spiritual rehabilitation	Transcript 4 lines 870-872
But they believed in ancestors, they are connected to their ancestors	Transcript 4 lines 877-878
It does give hope, a person can get hope through spirituality	Transcript 4 line 870, 909
There is a gap, a gap in that we don't really offer spiritual care for these patients	Transcript 4 lines 930-931
It will be useful if spirituality is incorporated in our care for the patients and in our training and curriculum	Transcript 4 lines 974-975
Before doctors and nurses used to believe in God mostly than now. As time goes on, they	Transcript 4 lines 1001-1002

believed in themselves	
Spirituality should be one area which should be visited, explored and tested in our daily care of our clients	Transcript 4 line 1052-1053
Spirituality may be a way of ancestors, is a way of linking with the supernatural world	Transcript 5 lines 1146-1147, 1151- 1152
The new Mental Health Act does not take into consideration the spiritual part of the person. There is a connection which is spirituality but is not look at the moment, it is neglected	Transcript 5 lines 1166-1167, 1168,1177
If I am not spiritual oriented, you see that there will be a problem in term of care	Transcript 5 lines 1184-1185
It takes a person to have spiritual understanding to be able to know when a person is expressing a spiritual need	Transcript 5 lines 1219-1220
The spiritual part which has equal importance like any other areas of the body, mentally, physically etc, so we need to look at that area	Transcript 5 lines 1262-1263
Because if one aspect is neglected, then it is not holistic any more	Transcript 5 line 1265-1266
It should be integrated into training to help even doctors and nurses in that direction	Transcript 5 lines 1266-1267
Spirituality means a system of belief that you have whether a Christian or not, it is associated with your religion	Transcript 6 lines 1307-1308
Spirituality also means a person feeling in relation to situations	Transcript 6 line 1310
Some have strong belief in ancestors that they believed can make them better, for the Christian patients, they believed in their God and their God will make them better.	Transcript 6 lines 1316-1319
You hear them(patients) pray and say God please help us get better and most of them rely on it as a healing power to get them better	Transcript 6 lines 1327-1328
I think being busy with my work, the condition of the patient, also if I am not a religious person, I won't offer spiritual help	Transcript 6 lines 1345-1347
If I am of the same faith of the patient, my own spirituality as a Christian	Transcript 6 line 1351
It should be included in training. I never thought	Transcript 6 lines 1365-1367

of spirituality forming part of the psychiatric patient care	
Spirituality means super being, God; anybody you can cry on , cry on and I depend on him for all what I ask of him	Transcript 7 lines 1386-1388
You see that a person will not get better because their spirituality is not being fulfilled. Spirituality is very important for the psychiatric patients	Transcript 7 lines 1399-1400, 1409
Those that are allowed to go home for pass out, most of them will come back much calmly and very understanding. I have not seen a case where patient will come back worse than before	Transcript 7 lines 1428-1430
Management, only management because where I work, we are not allowed to offer spiritual care. Management prohibits that.	Transcript 7, lines 1451-1452
Spirituality is a unique and sensitive thing. You need to have insight in the patient's belief before you can help him	Transcript 7 lines 1462-1463
Spirituality is something that I haven't thought about, it is the last thing I will think about, it is an eye opener	Transcript 7 lines 1467-1468

APPENDIX 7:

Table 4.5 Themes and Associated Significant Meanings and Locations in text

Theme	Associated Significant Meanings
The higher power of spirituality, religion and their relationship	1. Spirituality forms an integral part of a person total make-up, behavior responses to others and to his God or Higher Being(Transcript 1, lines56-58) 2. Spirituality is greatly related to all religions and is practice daily by a person related to that religion(Transcript 2, lines316-317) 3. There is a relationship between spirituality and religion. Spirituality enhances that relationship between the psychiatric nurse and his/her God or higher power(Transcript 3, lines 648, 651-652) 4. Spirituality is related to religion based on individual belief(Transcript 4, lines 867-870) 5. Spirituality is also linked to ancestor worship based on the belief involved(Transcript 5, lines 1146-1147,1151-1152) 6. Spirituality links a person to his/her religion based on the specific beliefs of that religion(Transcript 6, lines 1307-1308) 7. Spirituality is linked to religion and is considered as provider for patients' needs(Transcript 7, lines 1386-1388) 8. Spirituality is anything a person considered bigger or greater than him/her upon which he/she can depend or relate to for help, comfort and hope(Transcript 1, line 82) 9. Spirituality is what makes an individual to become conscious in knowing the right from the wrong (Transcript 5, lines 510-511) 10. Spirituality is a person response to prevailing situations(Transcript 5, lines 1310)

Theme	Associated Significant Meanings
Spirituality: Central to but forgotten in psychiatric nursing practice	1.A person own spiritual orientation enhances his/ her ability in offering spiritual care to psychiatric patients(Transcript 2, lines 361-362) 2. Spirituality forms part of a person total make- up and provides strength and hope in situations beyond human imagination(Transcript 2, lines 317-318) 3. There is a relationship between spiritual and religion. Spirituality enhances the relationship between the psychiatric nurse and his/her God or higher power(Transcript 3, lines 648, 651-652) 4.Psychiatric nurses acknowledged the importance of spiritual training to enable them detect patients spiritual needs (Transcript 5, lines 1219-1220) 5. Spirituality is important for all categories of psychiatric patients even for patients returning to the community(Transcript 4, lines 870-872) 6. Psychiatric nurses also acknowledge that spirituality is a source of hope in times of illness(Transcript 4, lines 870, 909) 7. Even the psychiatric patients themselves acknowledged the benefits of spirituality in their lives. They considered spirituality as a source of comfort and hope in time of illness(Transcript 6, lines 1327-1328) 8. Attending to patient's spiritual need is essential for the patient mental healing process(Transcript 7, lines 1399-1400, 1409) 9. Performing religious activities/rituals by psychiatric patients have been proven to be helpful in the overall condition of the patients(Transcript 7, lines 1428-1430) 10. Spirituality is considered a forgotten domain, For now it is seen as an important aspect in psychiatric patient mental health 11. Spirituality is essential for all but forgotten in terms of care provision(Transcript 1, lines 201-203) 12. Spirituality is not visible in psychiatric nursing practice(Transcript 3, line 671) 13. Spirituality is lacked in psychiatric-giving care(Transcript 4, lines 930-931) 14. Spirituality is even forgotten among policy makers dealing with mental health services(Transcript 5, lines 1166-1167) 15. Spiritual care for psychiatric patients continues to be invisible (Transcript 5, lines 1176-1177)

	16. Although spirituality has equal values as other domains, this domain remains unattended to(Transcript 5, lines 1262-1263) 17. Spirituality is still not being attended to by most nurses and other health care providers like the doctors. Many years ago, to some extent, Doctors and nurses were seriously engaged in offering spiritual care; this is not the case now(Transcript 5, lines 1266-1267) 18. Spirituality continues to be considered as a forgotten domain in the lives of the psychiatric patients 19. Spirituality has equal value and importance in the provision of care for the psychiatric patients(Transcript 3, lines 680) 20. In the absence of spiritual care, psychiatric patients' treatment is incomplete(Transcript 5, lines 1265-1266) 21. There is a strong connection between spirituality and psychiatric nursing care. This connection depends on the individual system of belief that make him/her better(Transcript 6, lines 1316-1319

Theme	Associated Significant Meanings
Psychiatric nursing for the spirit: Enabling and limiting factors	1. Psychiatric nurses lacked of spiritual training coupled with their personal perceptions about spirituality limit them from providing spiritual care(Transcript 1, lines 185-187) 2. Psychiatric nurses considered work load, patient's condition-"being aggressive" and lacked of personal spiritual orientation as limiting factors in providing spiritual care(Transcript 6, lines 1345-1347) 3. Institutional Policy sometimes limits psychiatric nurses from providing spiritual care(Transcript 7, lines 1452-1453) 4. Psychiatric nurses revealed that knowledge about spirituality coupled with their own spiritual orientation enhances their ability in offering spiritual care to psychiatric patients. (Transcript 2, lines 361-362; 5, line1252) 5. Psychiatric nurses own spiritual orientations enhance their abilities to offer spiritual care(Ttranscript3, lines 755-756) 6. Psychiatric nurses own spiritual orientations

	provide them supports in recognizing spiritual needs and offering spiritual care for their patients(Transcript 5, lines 1184-1185)

APPENDIX 8: Table 4.6 Themes and associated significant statements

Table 4.6 Themes and associated significant statements

Themes	Associated Significant Statements
Spirituality forms an integral part of a person total make- up- behavior and responses to others and to his God or Higher Being	Spirituality means more ideas, beliefs sometimes even emotional concern with connection with a higher being
There is a relationship between spirituality and religion	Spirituality is connected to religious beliefs and practices
Spirituality is unique to every individual, be it psychiatric nurses and patients	Spirituality is related to personal belief, that is my personal belief
Spirituality is anything a person considered bigger or greater than him/her upon whom he/she depends for help , comfort and hope	Spirituality is Higher being in term of human being
Spirituality is essential for all but forgotten in terms of care provision	Spirituality is part of life and it is an area that needs to be attended to and included in the psychiatric client care

Themes	Associated Significant Statements
Spirituality is greatly related to all religions and is practice daily by a person related to that religion	Spirituality to me, it means Connecting with God on a daily basis, any way, anytime. For me, it is the Almighty God, because I am a Christian
Spirituality forms part of a person total make-up and provides strength and hope in situations beyond human imagination.	A part that needs to be always nurture as human beings because there where our strengths come from.
Spiritual is unique to every person based on that person own belief and values.	There are people who don't believe in God, but they have some sort of gods of their own they are connected to, their gods
A person own spiritual orientation enhances his/her ability in offering spiritual care to psychiatric patients	It takes special people to nurse psychiatric patients; you got to have God giving skills to handle psychiatric patients
Spirituality is a personal matter and depends on the individual involved	It is individual thing, I wouldn't say so, it is an individual thing
Spirituality is not visible in psychiatric nursing practice	... I would say it is an area that is actually lacked, and not attended to
Spirituality is what makes an individual to become conscious in knowing the right from the wrong	Spirituality is a sense of being, is a sense of belonging, knowing the right from the wrong, and an eye opener

Themes	Associated Significant Statements
Spirituality is greatly related to all religions and is practice daily by a person related to that religion	Spirituality to me, it means Connecting with God on a daily basis, any way, anytime. For me, it is the Almighty God, because I am a Christian
Spirituality forms part of a person total make-up and provides strength and hope in situations beyond human imagination.	A part that needs to be always nurture as human beings because there where our strengths come from.
Spiritual is unique to every person based on that person own belief and values.	There are people who don't believe in God, but they have some sort of gods of their own they are connected to, their gods
A person own spiritual orientation enhances his/her ability in offering spiritual care to psychiatric patients	It takes special people to nurse psychiatric patients; you got to have God giving skills to handle psychiatric patients
Spirituality is a personal matter and depends on the individual involved	It is individual thing, I wouldn't say so, it is an individual thing
Spirituality is not visible in psychiatric nursing practice	... I would say it is an area that is actually lacked, and not attended to
Spirituality is what makes an individual to become conscious in knowing the right from the wrong	Spirituality is a sense of being, is a sense of belonging, knowing the right from the wrong, and an eye opener

Themes	Associated Significant Statements
There is a relationship between spirituality and religion. Spirituality enhances that relationship between the psychiatric nurse and his/her God or higher power	Spirituality actually had to do with religion and your relationship with God, to me it is the relationship between me and God, to others, it may be their higher power. It is also the way of living
Spirituality is unique to everybody and is based on that person own belief and values	Spirituality is personal; it is a personal belief, very individual; often based on your own personal need
Spirituality is part and parcel of a person total make-up; very important for survival	I think that(spirituality) is what makes a person human
Spirituality is lacked in psychiatric-giving care	There is a big gap in psychiatric care when it comes to spirituality
Spirituality has equal value and importance in the provision of care for the psychiatric patients	We got a body, we got a spirit, we got a mind, all come together
Spirituality is also an integral part of the psychiatric nurse inner self and provides strength in her provision of spiritual care to her patients	Without spirituality, I will be incomplete and my work will also be incomplete
Spirituality is universal to all and is a glue that holds people together with their Gods or higher powers	Spirituality is the lining of the globe that holds a person together, is a code of every person, without spirituality, you can't have mental health

Themes	Associated Significant Statements
Spirituality is related to religion based on individual belief	Spirituality means those things that deal with religion, belief, or things that have to do with a person's understanding or his communication with his God; it is our connection to God
Spirituality is important for all categories of psychiatric patients even for patients returning to the community	Instead of us saying psychosocial rehabilitation, we should say psychosocial spiritual rehabilitation
Spirituality is linked to all forms of religions	But they believed in ancestors, they are connected to their ancestors
Psychiatric patients also acknowledge that spirituality is a source of hope in times of illness	It does give hope, a person can get hope through spirituality
Spiritual care for psychiatric patients continues to be invisible	There is a gap, a gap in that we don't really offer spiritual care for these patients
Psychiatric nurses acknowledged that spirituality is important for the provision of psychiatric care but yet lacked knowledge and skills to offered	It will be useful if spirituality is incorporated in our care for the patients and in our training and curriculum
Many years ago, to some extent, Doctors and nurses were seriously engaged in offering spiritual care; this is not the case now.	Before doctors and nurses used to believe in God mostly than now. As time goes on, they believed in themselves
Spirituality should be included in training program to enable psychiatric nurses to offer it for psychiatric patients	Spirituality should be one area which should be visited, explored and tested in our daily care of our clients

Themes	Associated Significant Statements
Spirituality links a person to his/her religion based on the specific beliefs of that religion	Spirituality means a system of belief that you have whether a Christian or not, it is associated with your religion
Spirituality is a person responses to prevailing situations	Spirituality also means a person feeling in relation to situations
There is a strong connection between spirituality and psychiatric nursing care. This connection depends on the individual system of belief that make him/her better	Some have strong belief in ancestors that they believed can make them better, for the Christian patients, they believed in their God and their God will make them better.
Even the psychiatric patients themselves acknowledged the benefits of spirituality in their lives. They considered spirituality as a source of comfort and hope in time of illness	You hear them(patients) pray and say God please help us get better and most of them rely on it as a healing power to get them better
Psychiatric nurses considered work load, patient's condition and lacked of personal spiritual orientation as limiting factors in providing spiritual care	I think being busy with my work, the condition of the patient, also if I am not a religious person, I won't offer spiritual help
Psychiatric nurses own spiritual orientations	If I am of the same faith of the patient, my own

provide support in offering spiritual care for their patients	spirituality as a Christian
Spirituality continues to be considered as a forgotten domain in the lives of the psychiatric patients	It should be included in training. I never thought of spirituality forming part of the psychiatric patient care

Themes	Associated Significant Statements
Spirituality is linked to religion and is considered as provider for patients needs	Spirituality means super being, God; anybody you can cry on , cry on and I depend on him for all what I ask of him
Attending to patient's spiritual need is essential for the patient mental healing process	You see that a person will not get better because their spirituality is not being fulfilled. Spirituality is very important for the psychiatric patients
Performing religious activities/rituals by psychiatric patients have been proven to be helpful in the overall condition of the patients	Those that are allowed to go home for pass out, most of them will come back much calmly and very understanding. I have not seen a case where patient will come back worse than before
Spirituality is personal to every person and it depends on that individual belief	Spirituality is a unique and sensitive thing. You need to have insight in the patient's belief before you can help him
Spirituality is considered a forgotten domain, For now it is seen as an important aspect in psychiatric patient mental health	Spirituality is something that I haven't thought about, it is the last thing I will think about, it is an eye opener