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The role of spirituality in South African specialist psychiatric practice and training

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INTRODUCTION TO STUDY

This study on the role of spirituality in South African specialist psychiatric practice and training is presented in six chapters, including two chapters on the results. The background to the study is provided in Chapter 1 - "Introduction", which refers to the local and international literature, followed by the problem statement, purpose and objectives for the study. In Chapter 2 - "Research design and method", phenomenological enquiry using in-depth interviewing adopted as the qualitative research approach in this study is discussed. Sampling, data collection methods, the type of data analysis used, measures to ensure trustworthiness and ethical measures are explained. Chapters 3 and 4 are the two chapters on the results of the study. Chapter 3 - "Results I: Concept analysis (Step 1)", has two sections: Section 3.1 on the identification of concepts from the conducted interviews and reviewed literature (Step 1A); and Section 3.2 on the definition and classification of these identified concepts from the integrated data content (Step 1B). Chapter 4 - "Results II: Model construction, description and evaluation (Steps 2 to 4)", has three sections: Section 4.1 on relationship statements made with regard to the identified concepts; Section 4.2 on description and the evaluation of the model; and Section 4.3 on operational guidelines for the model. The discussion of the results is presented in Chapter 5 – "Discussion", and the study concludes with recommendations in Chapter 6 – "Conclusion and recommendations".

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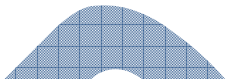
CHAPTER 1. INTRODUCTION





CHAPTER 1. INTRODUCTION

"As a result of the fact that human consciousness transcends materialistic explanations, psychiatry now finds itself at an important crossroad. The fostering of spirituality and well-being is crucial for psychiatry to achieve its meaning and purpose, but spirituality and well-being have been neglected because of the tendency toward materialistic reductionism." Robert Cloninger (2006)

INTRODUCTION TO BACKGROUND

In this chapter the background to the study on the role of spirituality in South African specialist psychiatric practice and training is provided, by referring to: recent developments in the South African health care environment; an overview of South African literature; the current bio-psycho-social paradigm in which psychiatry is practised and taught; the existing multidisciplinary team in mental health and interdisciplinary relationships between professions; an example of how spirituality has already been considered and integrated in the psychiatric domain. Although the review of the international literature was in fact a subsequent step in the methodology and hence "results" of the study, it is presented in this chapter for stylistic purposes. Following this background, a problem statement was formulated, and the chapter concludes with the purpose and objectives for this study.

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1.1 BACKGROUND

It has become apparent that spirituality is playing an increasing role in what were previously regarded as secular sectors, for example in business, government and health. In the business sector, for example, the concept of "spiritual intelligence" in addition to emotional and cognitive intelligence has found its place as an added strategic dimension

in organisational and human resource management (Regenesys Management, date unknown), (Zohar, Marshall, 2001), (Zohar, Marshall, 2000).

In government, the role and responsibility of the local secular state in national spirituality are, for example, contemplated in the context of the development of the Freedom Park heritage site in Pretoria. Through the Department of Arts and Culture, the Freedom Park as a "spiritual institution" was established in 2002 with government funding as a National Legacy Project according to the National Heritage Resources Act No. 25 of 1999, as an expression and a continuation of the processes of the Truth and Reconciliation Commission (Freedom Park: About us, date unknown), (Freedom Park Index, date unknown). The potentially politically charged aspects of local spirituality and religion and what these constructs may be taken to mean in different contexts, are demonstrated in a Freedom Park Trust publication (Freedom Park Trust, date unknown) on spirituality and the secular state in South Africa. This report investigated the concepts of religion, spirituality and the secular state in the context of the use of African cleansing and healing ceremonies as "*strategic interventions in the quest for symbolic reparation of the nation.*" The document offers insight into the arguments for the current - apparently preferred - use of the African traditional belief system, to achieve national spiritual objectives on behalf of the collective South African nation.

The perspectives of the author(s) of this Freedom Park Trust publication on the role of spirituality in the apparently "secular" public terrain of the state, and of government, demonstrate the importance and the far reaching ramifications of the definition of terminology and of what terms (such as spiritual, religion, profession, discipline) are regarded to mean in different settings. They considered the post-1994 political implications of the definition of spirituality and religion in South Africa. African healing ceremonies are described as *"cultural methods through which many societies and faith-*

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based communities have dealt with the issue of societal pain and the need for regeneration" (p3). As public events in the context of the Freedom Park national heritage site, these ceremonies would be aimed at *"eliminating the privatisation of pain by individuals and communities and transforming it into a public and a national pain that can be dealt with collectively in the public sphere" (p3).* The document states that the use of spirituality in the context of the relations between the state and spirituality is certainly a new situation, and also describes the restoration of indigenous African forms of spirituality, following its liberation from "*colonial spirituality*". Colonial spirituality is described as being of a religious type and largely Christian, which in colonial states constituted a close marriage between church and state pursuing the enterprise of "*conquering the indigenous epistemological space*" (p5). The quest for independence from colonialism is also a quest for freedom from the dominance of Western forms of spirituality. The document explores the different sections of the South African Constitution on this matter and concludes that South Africa has opted for a "cooperative model" between the state and religious communities.

An increasing role for spirituality has also been observed in health, mental health and psychiatry. In addition to the previously accepted bio-psycho-social dimensions, spirituality is now more commonly taken into account by different role players, from health authorities to individual practitioners. Within the discipline of psychiatry, this is evident from the focus that spirituality receives at international congresses such as meetings of the World Psychiatric Association, for example the 2005 XIII World Congress held in Cairo, Egypt (Janse van Rensburg, 2005) and the 2008 XIV World Congress in Prague, Hungary (World Psychiatric Association, 2008). Over recent years in South Africa, the increased role of spirituality in health has become evident in how the "Western scientific" model of health care has increasingly been regarded as only one approach that should be adopted next to another, in particular in parallel to traditional African healing practices with

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their much greater emphasis on the unseen, cosmological aspects of the emotional and relational lives of adherents. In this process, "indigenous knowledge systems" (IKS) have been introduced to local political and executive forums as an alternative approach to viewing traditional knowledge as subject matter, "science" or a "discipline" (Indigenous Knowledge Systems, 2006, 2004, 2000 & date unknown). Institutions such as the National Department of Health, the National Research Foundation and the Medical Research Council (MRC) have developed new policies and established new structures to accommodate this parallel approach. These organisations have, for example, jointly proposed the "National Reference Centre for African Traditional Medicine" as a model for South Africa in this regard (National Reference Centre for African Traditional Medicine 1, 2 & 3, dates unknown). The importance of having to reconsider the role of spirituality in health, mental health and psychiatry in South Africa has in particular been emphasised by recent legislation on African traditional health practice (South Africa, 2006). Great emphasis is placed on mental health by the Traditional Health Practitioner's Act no. 35 of 2004 (THPA), defining it as a significant part of what is regarded as the traditional health practitioner's spectrum of responsibilities. The scope of traditional health practice as defined by this Act includes a mental health element in: the maintenance and restoration of health or function (by traditional practice); the diagnosis, treatment and prevention of illness, and the rehabilitation to resume normal duties (by traditional practice), as well as the preparation of an individual for puberty, adulthood, pregnancy, childbirth and death.

A large body of South African and international literature describes the existence of these two parallel health systems (the "formal" and the "alternative" or traditional), while generally advocating a closer collaboration between medical/psychiatric interventions and more traditional or cultural/religious interventions. Formal figures for South Africa may be difficult to confirm, but from experience it can generally be observed that the majority of black South Africans will consult a traditional healer prior, to or concurrently with a

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biomedical practitioner. Studies on the pathways to mental health care have confirmed this trend (Obiodun, 1995), (Mkize & Uys, 2004). Following the official acknowledgement in the 1970's by the World Health Organisation (WHO) of the possible role of traditional healers in primary care, the use of alternative health practices has in many instances been encouraged and incorporated by authorities into formal health services as a strategy to address health needs. This has, however, often been the case in under-resourced rural populations with few formal health services at their disposal. In an overview of psychiatric services in Africa, Odejide et al., discussed and contextualised the extended practice of African traditional medicine and syncretic churches as part of local health systems (Odejide, Oyewunmi & Ohaeri, 1989). Okasha, in his review of psychiatric services in Egypt, not only acknowledged the practice of alternative therapies, but stated that traditional and religious healers have a major role to play in primary psychiatric care (Okasha, 2004).

1.1.1 LOCAL LITERATURE

A review of South African literature was undertaken as part of the background to this study (Janse van Rensburg, 2009), **(Appendix 1.1)**. This review explored the documented interface of traditional health practice with mental health care in South Africa since the 1950's. A total of 143 South African references were listed, representing reports in the literature from 1958 to 2004 and included articles, case reports, scientific letters, theses, conference papers and chapters in books. Five thematic categories were identified from the reviewed literature (Table 1.1).

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Table 1.1 Categories of main themes from South African literature on complementary therapies and mental health (Janse van Rensburg, 2009)

1. Population subgroups
1.1 Xhosa
1.2 Zulu
1.3 Zionist religious subgroup
1.4 Indian
1.5 Tswana/Sotho
2. African worldview
3. Trans-, cross- and multi-cultural
3.1 Communication: language barrier and interpreter bias
3.2 Conflict or synthesis: caught between the two paradigms
3.3 Boundaries of normality and abnormality
3.4 Application of Western diagnostic categories and interpretation of symptoms
3.5 Assignment of labels and resulting stigma
3.6 Terminology and definition of concepts
3.7 Importance of a cultural formulation
4. Collaboration and roles
5. Pathways to care

A prominent issue raised regarding African traditional health practice is whether the work done by traditional healers should be regarded as religion or psychotherapy. Some writers have compared the traditional healer to the Western psychotherapist and considered traditional health practice more as psychotherapy than a religion (Bührmann, 1977), (Berg, 2003). Others (Edwards et al., 1983), (Griffiths & Cheetham, 1982), referred to African cultural beliefs as being a religious and spiritual practice. They describe the role of traditional healers as rather being "priests before healers" with an intermediary function between the people and their ancestors: *"From the very outset, the traditional healer is directed by the spirit world of the ancestors. His powers arise out of this contact with the spirits – he is expected to have supernatural powers and to use them for healing purposes"* (Cheetham & Griffiths, 1982: p957). It is of note that during the draft phases of the legislation on traditional health practice in 2001, in reports submitted to parliament's Arts and Culture Portfolio Committee, representatives of South African traditional healers themselves defined their role and their knowledge base in terms of a religion (Parliamentary Portfolio Committee on Arts and Culture, 2001).

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Subsequent to 2004, a number of local authors have further contributed to the discourse, including the South African Medical Association (SAMA). From the responses of Sotho speaking participants in a qualitative review by Motlana of their experience of psychiatric illness and services, the majority of participants in their study confirmed that they consulted a traditional healer as a first option (Motlana et al., 2004). They still attributed schizophrenia to be due to poisoning or bewitchment. It appeared that the role of the church, traditional healers, rituals and medication were all inextricably linked. Ashforth notes that the distinction between witchcraft and healing in the African tradition is essentially a moral one, as both make use of "muthi" or traditional "medicine" (Ashforth, 2005). Witchcraft in the context of his article would refer to a malicious person using harmful (traditional) substances. Healers and witches both use supernatural forces but supposedly for different ends. Activities on both sides fall under the rubric of "African science". He also alludes to attempts of proponents of IKS to provide traditional African healing with scientific status, while contrasting it with a call made earlier by a prominent local black physician (pp218-219) "*to stop romanticizing the evil depredations of the sangoma in order to free patients from the tyranny of superstition*" (Motlana, 1988). He commented on how these positions emphasise the incommensurability of traditional healing practices with science. Robertson reported on three separate studies which were carried out among Xhosa-speaking Africans in Cape Town (Robertson, 2006). The first study documented common indigenous categories of distress and dysfunction in children seen by traditional healers and compared it with categories of the psychiatric diagnostic system. The second study investigated the beliefs and experiences of African indigenous healing and psychiatric services of users admitted for serious mental illness and their family members. The third study explored the same but in a community setting. Responses of interviewees in these studies strengthened the impression of local psychiatrists that diviners cannot cure serious mental illness. There was no evidence that indigenous healers provided a more holistic treatment than psychiatrists, or that they concerned themselves at all with their clients social circumstances. The studies also

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showed that traditional healers interpret their clients' behaviour and significant experiences merely in the context of relationships with the ancestors or of bewitchment. The SAMA document (South African Medical Association, 2006) represented a review of the work of a previous task team on collaboration between traditional healers and medical practitioners and aimed to inform decision-makers, professionals and non-governmental organisations on the relation between African traditional healing and the Western biomedical systems in South Africa. Based on the principle that the patient is pivotal in the health care equation and that traditional health practitioners play an important role in Africa, SAMA expressed the view that some degree of cooperation between the two systems is desirable. Prozesky provides a perspective for spirituality in general as an element in current health science education by pointing out that health care professionals deal with people who suffer or are in some kind of personal need (Prozesky, 2009). He concludes with the notion that embracing a spiritual dimension in the clinical management of patients may enrich the practice of health professionals and their teachers.

1.1.2 CURRENT APPROACH TO PRACTICE AND TRAINING

Considering the current approach to the practice and training of psychiatry as a specialist clinical discipline in South Africa, it has been practised and taught for some time now within a broader multi-disciplinary context in the field of mental health, with Engel's Bio-psycho-social Model as the paradigm for psychiatric practice and for undergraduate and postgraduate training (Engel, 1977), (Engel, 1980). As a medical discipline, different effective pharmacological classes of medication - such as antidepressants, anti-psychotics, anti-anxiety drugs and mood stabilisers - currently exist for a range of psychiatric disorders (Grebb, 1989), (Marder, 2000), (Rush, 2000). Evidence-based principles derived through rigorous clinical trials have, since the 1950's, established these medications as being superior in their effect to placebo or to no pharmacological treatment.

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At the same time, different psychotherapy modalities such as cognitive behaviour therapy are inherent to the standard approach to the management of psychiatric conditions (O'Brien & Woody, 1989). In addition, occupational therapy and social work interventions have also been regarded as indispensable aspects of the multi-dimensional assessment and management of patients. But despite these significant and dynamic ongoing advances in the field of psycho-pharmacological treatment, psychotherapy and psycho-social rehabilitation, no final solution or outcome can be offered in many chronic treatment scenarios which face psychiatry. Numerous randomised controlled trials (RCT) and meta-analytical studies over time have reported on the efficacy of, response to and remission of psychiatric symptoms on pharmacological treatment regimes, although no cure ("healing") for severe psychiatric conditions (SPC) such as schizophrenia or bipolar mood disorder can yet be claimed.

Many mental health care users diagnosed with long-term disorders invariably - possibly also often as a result of no psychiatric cure being available - also seek out cultural, religious and spiritual explanations and interventions in addition to, or as an alternative to, psychiatric and psychotherapeutic interventions. The reasons for this growing trend of looking beyond the historical dualistic mind-body view of "Western scientific" medicine in mental health and psychiatry, are also related to the inherent importance that people attach to cultural requirements and their religious beliefs per se. It may also be associated with the challenge of contending with the chronic and usually recurrent nature of many psychiatric disorders. In addition - or as a result - large numbers of users do not follow the full regimen of psychiatric medication due to side-effects, to poor response to treatment, or to limited insight into the need for treatment.

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In terms of the diagnostic approach and process, South African psychiatry has adopted the American Diagnostic and Statistical Manual (DSM) as a system of diagnosis and classification of disorders, although the European and WHO's International Classification of Disease (ICD) system is also referred to and used in general health information systems. Since the third edition of the American Psychiatric Association's DSM in the early 1980's which formally adopted the bio-psycho-social model, use of a multi-axial diagnostic formulation has become the standard approach in the local practice and teaching of psychiatry (American Psychiatric Association, 1980). These five axes are: I Clinical disorders or other conditions that may be the focus of clinical attention; II Developmental conditions (personality and intellectual capacity); III General medical conditions; IV Psychosocial and environmental problems; and V Global assessment of functioning. Current editions of both the DSM IV-Text Revision (TR), (American Psychiatric Association, 2003) and Chapter V of the International Classification of Disease (ICD-10), (World Health Organization, 1992) already advise the consideration of a service user's presentation in his/her cultural context. In addition to a glossary of culture-bound syndromes, the DSM IV-TR proposes that a cultural formulation should be added to the assessment of service users. The DSM IV-TR makes allowance for religious or spiritual problems identified during psychiatric assessment, by including these not as a psychiatric disorder but as an "additional condition that may be the focus of clinical attention", with an allocated "V-code" of V62.82 (Religious or Spiritual Problem) on Axis I (or Z71.8, as equivalent ICD-10 code) (American Psychiatric Association, 2003). The planning and development of an updated DSM V-version is currently under way and expected to be published in 2011 (Regier, 2005). According to Mezzich, the DSM V's structure of diagnosis will offer a more integrated format, drawing from different classification systems such as the ICD, Parts I and II of the International Classification of Functioning and the WHO's quality of life assessment scale (Mezzich, 2004). The DSM V may therefore eventually represent an even more comprehensive and holistic tool for assessing mental health status and related dimensions.

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Advances in psychiatry have significantly contributed to the fact that psychiatrists as medical specialists have obtained and generally maintained the position of "leader" of the multidisciplinary mental health care team (MDT) during the second half of the 20th century. This team consists typically of medical and nursing professionals, a psychologist, an occupational therapist and a social worker. While awareness and acknowledgment of interdisciplinary roles and functions grew, relationships between disciplines also acquired a political edge. Psychiatrists and the discipline of psychiatry have for example been scrutinised and criticised for "medicalising" people's emotional and behaviour problems. The discipline has been regarded to wield excessive professional and economic power with vested interests in keeping the "market share" and wanting to maintain the status quo for example because of the influence of the pharmaceutical industry (Szasz, 1971), (Ingleby, 1982). In post-apartheid South Africa, a conscious change in the public domain was made from "psychiatric" to "mental health", as is evident from policy documents at the time. These documents declared "mental health services" to be the preferred and politically more acceptable terminology to use (African National Congress, 1994), (South Africa, 1997). Thus in South Africa at least, the psychiatrist no longer has the position of undisputed leader of the MDT. This was affirmed in the subsequent mental health legislation - the Mental Health Care Act, No 17 of 2002 - which identified a psychiatrist as one of many categories of "mental health practitioners," including psychiatric nurses, psychologists and social workers (South Africa, 2004). As an important site for the negotiation of power relations between mental health practitioners and indigenous healers, Yen and Wilbraham, in a discourse analytic study, explored the constructions of culture and illness ("disorder") in the talk of psychiatrists, psychologists and indigenous healers, in which they discussed possibilities for collaboration in South African mental health care (Yen & Wilbraham, 2003a), (Yen & Wilbraham, 2003b). This changed approach towards relationships between existing members of the MDT, may also be

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indicative of other possible changes in interdisciplinary collaboration, for instance with regard to possible additional role players providing religious and spiritual care and support, as might for example be implied by the Traditional Health Practitioners Act no. 35 of 2004.

1.1.3 SPIRITUALITY AND SPECIALIST PSYCHIATRY

A specific instance where spirituality has already been incorporated as a dimension of specialist psychiatric and psychotherapeutic practice is in the work and writing of Robert Cloninger (Cloninger & Svrakic, 2000). His widely adopted theory of personality introduced a broadened and integrative approach to the psychiatric assessment, care and management of personality problems (Cloninger, Svrakic & Przybeck, 1993). His theory involves four temperament dimensions and three character dimensions. The three character dimensions include self-directedness, cooperativeness and self-transcendence. He developed and tested a 238-item self-rating instrument - the Temperament and Character Inventory (TCI), based on this model of personality problems or disorders. In an article based on an earlier book, he discussed the "science of well-being" as an integrative approach to mental health and its disorders (Cloninger, 2006 & 2004). He alluded to the practical failure of psychiatry to improve the overall well-being of societies in general and attributed the reasons for it to: (1) the focus of psychiatry on mental disorders and not on the development of positive mental health; (2) the focus on discrete categories of disease to label patients easily but with doubtful validity; (3) the prolonged training required by psychiatric methods of assessment and treatment as well as costly medication; and (4) that the treatments that focused on the body and/or mind have usually been anti-spiritual in orientation. According to him, the methods of improving well-being can be understood as working on the development of the three branches of mental self-government that can be measured as character traits using the TCI: self-directedness (being responsible, purposeful and resourceful), cooperativeness (being tolerant, helpful, compassionate) and self-transcendence (being intuitive, judicious and spiritual).

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Cloninger notes that most psychiatric service users in fact also want their psychiatrists or therapists to be aware of their spiritual beliefs and needs, because human spirituality has an essential role in coping with challenges and enjoying life.

1.2 INTERNATIONAL LITERATURE

Several international authors were identified that extensively reported on the role of spirituality in psychiatry (Koenig, 1999), (Koenig, McCullough & Larson, 2001), (Larson et al., 1986), (Larson et al., 1993), (Baetz et al., 2002a), (Baetz et al., 2002b), (Sims, 1999), (Culliford, 2002), (Gilbert, 2007b), (Verhagen, 2007), (Glas et al., 2007), (Zock & Glas, 2001), (Moreira-Almeida, 2007), (Moreira-Almeida & Koenig, 2006), (D'Souza, 2003), (D'Souza & Rodrigo, 2004). Koenig has been a most prolific writer on the subject, with more than 150 publications identified by the review for this study, including books and journal articles as the only, primary or joint author. Larson has also authored or co-authored numerous publications.

1.2.1 ORIENTATION IN TERMS OF SPIRITUALITY AND RELIGION IN PSYCHIATRY

The literature in this section is discussed in terms of three broad themes that were identified: providers' perspective; history and philosophy; and concepts and definition.

1.2.1.1 Providers' perspectives

(1) **Psychiatrists:** Morgan and Cohen commented on the observation that spirituality was slowly gaining recognition among North American psychiatrists (Morgan & Cohen, 1994). Sims referred to a study of psychiatrists working in London teaching hospitals. Although only 27% reported religious affiliation and 23% a belief in God, 92% felt that psychiatrists should be aware of the religious concerns of their patients (Sims, 1999). There was no evidence that psychiatrists' private religious beliefs had an important influence upon their clinical practice (Neeleman & King, 1993). Psychiatrists often ignore

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spirituality because: (1) it is considered unimportant; (2) it is considered important but irrelevant to psychiatry (like assuming the hospital has a safe water supply); (3) they may feel they know too little about it themselves to comment, or even to ask questions; (4) the very terminology is confusing and hence embarrassing; and (5) there may also be an element of denial in which it is easier to ignore this area than to explore it as it is too personally challenging (p99). Baetz et al., compared psychiatrists' and psychiatric patients' practice, attitudes and expectations regarding spirituality and religion (Baetz et al., 2002b), (Baetz et al., 2004b). Of both groups - registered psychiatrists responding to a survey (42% response) and psychiatric patients - about half felt there was "often or always" a place to include spirituality in psychiatric assessment. Although psychiatrists reported lower levels of personal spiritual and religious belief, they acknowledged that it was important to include this topic in patient care.

Curlin et al., compared the ways in which psychiatrists and physicians interpret the relationship between religion/spirituality and health and how they would address religion/spirituality issues in the clinical encounter (Curlin et al., 2007a). More than 1100 (out of 2000) physicians responded to a survey questionnaire. Psychiatrists are more likely (82% versus 44%) to note that religion/spirituality sometimes causes negative emotions and also more likely (92% versus 74%) to encounter religious/spiritual issues in a clinical setting. Compared to the other specialists, they also appear more comfortable and have more experience in addressing religion/spirituality concerns. Reporting on the same survey, Curlin et al., found that psychiatrists were less religious than other specialists and that religious physicians were less willing to refer patients to psychiatrists (Curlin et al., 2007b). This suggests that the historic tension between religion and psychiatry continues to shape the care that patients receive. Most physicians (56%) believed that religion/spirituality had "much" or "very much" influence on health, but few (6%) believed that it often changed "hard" medical outcomes. Rather, that it often helped patients to cope, that it gave patients a "positive" state of mind and that it provided

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emotional and practical support via the religious community. Religious physicians were more likely to report that their patients often mentioned religious/spiritual issues, were more likely to believe that it had a strong influence on health and were also more likely to interpret the influence in positive ways (Curlin et al., 2007c).

(2) **Family medicine practitioners**: Craigie et al., reviewed the references to religion in the Journal of Family Practice and discussed the dimensions and valence of spirituality (Craigie, Larson & Liu, 1990). Ellis et al., described the context in which physicians address patients' spiritual concerns (Ellis et al., 2002). In qualitative semi-structured interviews with 13 family physicians they found that physicians differ in their comfort and practice of addressing spiritual issues with patients, but affirm a role for family physicians in responding to patient's spiritual concerns. Factors that formed a context for discussion of spiritual issues with patients included perceived barriers, physicians' role definition, familiarity with factors likely to prompt spiritual questions and recognition of principles guiding spiritual discussions. Themes from these interviews included: physicians who reported regularly addressing spiritual issues did so because of the primacy of spirituality in their own lives and because of scientific evidence associating spirituality with health; patients' spiritual questions arise from their unique responses to chronic illness, terminal illness and life stressors; varying approaches to spiritual assessment; affirmation that spiritual discussions should be approached sensitively; and mutual physician-patient and situational barriers. Monroe et al., addressed primary care physicians' preferences regarding spiritual behaviour in medical practice in a survey inquiring about their willingness to address religion and spiritually in the medical encounter (Monroe et al., 2003). Most would not - except for the clinical setting of dying. On request however, most expressed willingness to comply even if it involved prayer. Peach - with Koenig responding (Koenig, 2003) - considered how Australian medical professionals should respond to the question of religion, spiritually and health (Peach, 2003). Particular reference was made to the situation in and literature from the United States. While

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acknowledging the limited understanding of the spirituality of Australians, it seemed reasonable for medical students to be aware of the importance of a spiritual aspect to people's lives, including those of Indigenous Australians. Research was required to improve the understanding of the Australian situation. McCauley et al., measured clinician beliefs and identified perceived barriers to integrating spirituality into patient care in a state wide, primary care, managed group in the USA (McCauley et al., 2005). Managed care practitioners within a time constrained setting might have had spiritual positions themselves, but time and lack of training were barriers in meeting patients' needs regarding spirituality and beliefs.

(3) **Other professionals (paediatricians, nursing professionals and psychologists**) - Armbruster et al., Grossoehme et al., and Catlin et al., reported on paediatrician beliefs about and characteristics associated with attention to spirituality and religion in clinical practice (Armbruster, Chibnall & Legett, 2003), (Grossoehme et al., 2007), (Catlin et al., 2008). The role of spirituality in nursing was also reported on by several authors (Weaver et al., 1998), (Greasley, Chiu & Gartland, 2001), (McClaughlin, 2004), (Kilpatrick et al., 2005), (Mohr, 2006), (Sesanna, Finnell & Jezewski, 2007). The role of spirituality in psychology (including marriage and family therapy) was reported on by Hathaway and others (Hathaway, Scott & Garver, 2004), (Hathaway, 2005) (Prest, Russel & D'Souza, 1999).

1.2.1.2 History and philosophy

One can refer to several authors such as Galanter, Koenig et al., Josephson et al., Koenig, Andreason, Breakey, Jakovljevic, Boehnlein and Moreira-Almeida, who discussed the role of spirituality and religion in psychiatry and medicine. Galanter described spiritual recovery movements and contemporary medical care (Galanter, 1997). Koenig et al., (1999b) provided "a rebuttal to skeptics" on religion, spirituality and medicine. Josephson et al., addressed developments in psychiatry regarding spirituality (Josephson, Larson &

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Juthani, 2000). Koenig in several editorials provided overviews on religion, spirituality and medicine (Koenig, 2000b), (Koenig, 2004b), (Koenig, 2007b). Andreason, as editor of the American Journal of Psychiatry at the time, stated "*We must practice and preach the fact that psychiatrists are physicians of the soul as well as of the body*" (Andreasen, 2001). Breakey in the International Review of Psychiatry (Breakey, 2001) and Jakovljevic in a Croatian journal, also discussed the status of religion, spirituality and psychiatry (Jakovljevic, 2005). Boehnlein provided a retrospective and prospective view (Boehnlein, 2006) and Moreira-Almeida (2007) provided an overview of the topic in a Brazilian context.

D'Souza and George identified the renewed focus on religion and spirituality as a "fourth revolution" in psychiatry, referring to the phenomenon as the "age of empowerment of the consumer" (D'Souza & George, 2006). D'Souza refers to international and Australian surveys that show that there is a need to incorporate the spiritual and religious dimensions of patients into their management (D'Souza, 2007). He describes doctors and clinicians as "healers" on the basis of the caring relationships that they are suppose to form with patients.

Bathgate reviewed psychiatry, religion and cognitive science and provided a brief overview of the development of ideas about the mind in Western thought (Bathgate, 2003). He referred to the oldest question in philosophy which is: "what is real and how can we know it?" He discussed how Descartes (1596-1650) drew the fundamental distinction between the mind and the world and how this dualism served to emphasise the conception of disembodiment, as the feature that distinguished humans from other species. He showed that neither much of contemporary Western religion nor of mainstream psychotherapeutic practice addresses the crucial issues of our embodiment - which is essential to an adequate understanding of mind - in and of the world. He refers to Lakoff and Johnson's statement: "*However, once the mind is taken to be disembodied,*

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the gap between mind and world becomes unbridgeable" (Lakoff & Johnson, 1999). Referring also to other ideas in Western philosophy from Plato to St Augustine in the Christian tradition, he comments that religious/spiritual considerations had largely disappeared from psychiatry in the twentieth century, with the one exception of Freud who emphasised the neurotic and regressive structure of all religious beliefs, drawing parallels for example between the defensive function of obsessive-compulsive disorders and the performance of religious rituals. Bathgate also discussed the positions of Winnicott, Kohut and Karl Jung. Kohut for example, held that religion is one of three great cultural enterprises, the others being science and art (Strozier, 2001). Bathgate also speaks of a belief that - through considering the role of spirituality - psychiatrists may contribute to the generation of more hopeful and empowering stories of intervention for patients. He argues that two elements offer an opportunity for a renewed relationship between medicine/psychiatry and the domain to which religion makes reference: first, our enhanced understanding of the evolutionary nature of our being and so of our essential embodiment as part of the natural world; and second, the possibilities for transformation suggested in certain religious traditions. *"Appropriately concerned as we are with the role of neurotransmitters and genetic predisposition, human behaviour cannot be explained without referring to the meaning and interventions we give to our acts and ideas"* (p 283).

Blanch reviewed the historical tension concerning the integration of religion and the science of mental health and concluded that the (American) mental health system is "*like the one-eyed giant described by (Thomas) Merton, (it) has a limited perspective on reality, and like a one-eyed giant, it has gained so much power from its grounding in a scientific model that it has become almost impossible to challenge"* (Blanch, 2007). She alludes to the views of William James (James, 2007) – the father of American psychology – a century ago, that religious experiences can and should be studied empirically (Hart, 2008). She suggests that what the system lacks most, is *"to open the other eye to the*

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wisdom that comes from other sources – from cultural and religious systems of thought and from inner spiritual knowing" (p259).

Koenig, in an article on the historical background and reasons for the separation between religion and medicine, reviews prehistoric times through ancient Egypt, Greece, early Christianity though the Middle-Ages, Renaissance and the Age of Enlightenment (Koenig, 2000a). He refers to reasons for the continued separation being that religion may either have become irrelevant to health, or that it may have a number of negative effects. He refers to Freud and more recently Ellis and Watters, who share the view of religion's negative effects on mental health and that it lies at the root of emotional disturbance, low self esteem, depression and possibly even schizophrenia (Ellis, 1962), (Ellis, 1980), (Watters, 1992). Koenig also notes studies that reported on religion's negative health effects (Rokeach, 1960), (Dunn, 1965), (Bateman & Jensen 1958), (Wright, 1959), (Cowan, 1954), (Neeleman & Lewis, 1994). These studies - according to him - are older studies however, which did not take relevant covariates into account.

Turbott notes that an epistemological gap exists between religion, spirituality and psychiatry over what constitutes rational explanation and what impediment this may be to the rapprochement of the two (Turbott, 2004). He refers to Halasz, who suggested an ambitious project with his proposal to "reclaim psychiatry's soul and reinstate the psyche in psychiatry" by including "the study of the soul" to the study of anatomy, biochemistry and physiology (Halasz, 2003). *"Rapprochement may best be achieved by increasing psychiatric awareness and knowledge of the issues, and by a willingness to embrace intellectual, cultural and religious pluralism."* The spiritual challenge to psychiatry, according to Halasz, is a three-way tension between "brain-less", "mind-less" and "soul-less" psychiatry. He quotes Andreasen's statement in 2001 about psychiatrists "*being physicians of the soul... as well as the body*" and contemplates whether this is merely lip-

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service. If it is to be a real challenge, then "*psychiatry first has to reinstate its soul*" - as the soul of the profession has been lost (Halasz, 2003).

Bartocci and Dein review the "divorce of religion and psychiatry" (Bartocci & Dein, 2007). Medicine - profoundly influenced by the process of modernisation, professionalisation and secularisation - has become progressively divorced from the subjective experience of illness and consequently religion has been relegated to the sphere of subjectivity rather than science. *"Hence psychiatry with its objective, morally neutral application of scientific knowledge became separated from religion."* (p48) However, a recent rapprochement is evident and although the roots of this reunion are unclear, it is likely that several factors may be playing a mediating role: the increasing influx to the industrialised world of people from developing countries who hold strong religious convictions; disillusionment with materialism; a search for more spiritual ways of being; the inability of psychiatry to address existential questions of ultimate concerns; and an internal underlying tension among psychiatrists relating to a perception that their current practice is too limited.

A systematic analysis of quantitative research on religious variables found in four psychiatric journals between 1978 and 1982 revealed a considerable lag in the diffusion of academic knowledge and skills to evaluate religion in psychiatric theory, concept and methodology (Larson et al., 1986). Only 59 articles of more than 2000 reviewed included a religious variable and the most often chosen variable was a single static measure (e.g. denominational denotation), rather than multiple dynamic measures (e.g. religiosity scales with multiple dimensional domains). Larson et al., reviewed the DSM-III-R (Revision) Glossary for Technical Terms for its references to religion at the time (Larson et al., 1993). Although the glossary used religion in constructive or cautionary reminders, the high rate of illustrative case examples of psychopathology that involve religion indicated cultural insensitivity in interpreting religion and stereotyped religion as clinically harmful. Turner et al., reviewed the DSM-IV's new diagnostic category entitled religious or spiritual

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problem under "Other conditions that may be a focus of clinical attention" (Turner et al., 1995). They noted that this category contributed significantly to a greater cultural sensitivity. They stated that historically spirituality was not widely distinguished from religion until the rise of secularisation during the previous century. Many people became disillusioned with religious institutions, often seeing them as preventing rather than facilitating a personal experience of the transcendent. They concluded that the new DSM-IV category marked a significant breakthrough in the face of psychiatry's longstanding tendency either to ignore or pathologise the religious and spiritual dimensions of human existence. Lukoff et al., also considered the new DSM-IV V-code category for "Spiritual or Religious Problem" at the time, describing the rationale for the new category, the history of the proposal, transpersonal perspectives on spiritual emergency, types of spiritual problems, differential diagnoses and counselling approaches (Lukoff, Lu & Turner, 1998). The rationale for the category included the prevalence of religious and spiritual problems, the lack of training in religious and spiritual issues and the ethical mandate to provide training according to the Ethical Principles of Psychologists (since 1992) and the Accreditation Council for Graduate Medical Education (since 1995). They concluded with a reference to the decline in mainstream American religious institutions, while at the same time the number of people who reported that they personally believe in God or some spiritual force has been increasing. During the 25 years prior to the article, they noted a significant increase in people adopting spiritual practices including meditation, martial arts, tai chi, chanting and yoga techniques.*"There has also been an explosion of interest in mystical, esoteric, shamanic, and pagan traditions that involve participation in sweat lodges, goddess circles and the rituals of many small new spiritual schools and New Age groups"* (p20). Scott et al., also consider the V-Code (V62.89) category of the DSM-IV that allows for the explicit identification of a non-pathological religious or spiritual focus in treatment, but indicate that it may be under-appreciated by many clinicians (Scott et al., 2003). Although its development as a non-pathological category reflects a much more culturally sensitive approach, they point out that this separation in the diagnostic

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framework may compartmentalise clinical focus on religious or spiritual domain in a manner that may still be largely avoided or ignored in routine clinical practice. Secondly, its conceptualisation still focuses on those aspects of religion and spirituality that are contributors to clinical difficulty, yet religious and spiritual functioning appears to be a significant domain of adaptive functioning that deserves attention in its own right.

Carr writes about the context of spirituality, religion, mental health and psychiatry and refers to: secularisation that apparently has failed to have its anticipated outcome; the prominence of books on spirituality in regular bookshops; the debates about what spirituality means in education (including values, morality and even religion); and also to what he terms "fluidity" on the psychiatric (especially psycho-analytic) front. He discusses three issues: the social function of spirituality and religion; the relationship between the dyad and the third; and the external and internal validation of individual spirituality (Carr, 2000). He states that spiritual counselling without reference and use of the religious tradition in which it is embedded, is inadequate and even deviant. At the same time de-contextualised psychiatry is similarly vulnerable. The validation of individual spirituality involves a critical understanding that does not a priori discount the role of spirituality in people's lives, but acknowledges it.

Fabrega and an influential panel of commentators including León, Tasman, Lòpes-Ibor Jr, Wig, Sims, Mezzich, Moussaoui, Okasha, Bartocci and Rhi, (Fabrega, 2000), (Leon et al., 2000), provide important directives on how the practice of psychiatry may remain incomplete unless an understanding of the spiritual dimension is added to the existing bio-psycho-social theoretic approach. In this article Fabrega reviews the "secular credo" of all contemporary and modern medical disciplines and regards it as the product of a non-spiritual worldview. Medical disciplines' claims to expertise are based on a philosophy about the reality of the outside world termed scientific objectivism and realism. "*The sufferings and agonies of both physical and mental illness undermine a person's whole*

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social and cultural standing and bring into play spiritual and religious considerations. Yet, the secular credo formulates these as falling outside the periphery of medical theory and practice" (p525). Fabrega regards the general clash of values between science and secularism with spirituality and culture as a function of modern medicine's shedding of its broader mandate to heal. *"Restoring cultural psychology to its rightful central position in the architecture and substance of psychopathology would require members of the discipline to take some account of the cultural and spiritual character not only of the life of circumstances of the victim of pathology but of the composition of psychopathology itself"* (p528). Because the causes and manifestations of psychopathology are more deeply connected to culture and spirituality and are not purely mechanical distortions easily demarcated from personhood, attacking psychopathology with an impersonal agent is insufficient. *"To neglect the cultural character of psychopathology and handle it like general disease is to make of a psychiatrist a technician intent on relieving signs of disease by prescribing illusory magic bullets.... Furthermore, this has the effect of rendering the discipline vulnerable to purely political economic influences tied to world capitalism, such as the simplistic marketing strategies of international pharmaceutical cartels"* (pp528-29).

Rhi refers to the shaman as the first spiritual healer who can be regarded as *"a prototype of the modern physician and psychotherapist*" (Rhi, 2001). As an archaic healer the shaman had the role of physician and priest, being himself the guide of the soul. Investigators have dealt with the issues of spirituality within the framework of culture and mental health. In contrast with an original "healing" mandate that psychiatry might have had, he concurs with Fabrega and points out that conservative psychiatry came to adopt a one-sided materialistic, mechanistic view of man and devoted itself solely to the chemical treatment of symptoms of disease. He argues that to regain elements of healing in mental health and psychiatry according to the original "shamanic prototype", a synthesis of both orientations (to health and religion) can only be achieved individually. "*We do not need to*

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matriculate religious healers into the medical field or add the term spiritual well-being to the previous concept of mental health without seriously considering the applied concept" (p576). Rhi advises that *"fundamental change must begin with the individual psychiatrist and clergyperso*n". Medical education and psychiatric residency training should take into serious consideration the influences of religious cultures on the worldview of the patient, the teleological meaning of suffering and the creative influence of spirituality on the maturation of personality.

Gallagher et al., comment on mental health professionals' consideration of the influence of religion and spirituality in American life: *"Spirituality is a theme that animates a great deal of dialogue and discourse in the realms of religion, mental health and medicine. It is a complex phenomenon that eludes easy and compact definition. Spirituality is hard to circumscribe because it emerges not from an affirmative sighting but rather in response to perceived faults in earlier paradigms and modes of thought about religion"* (Gallagher, Wadsworth & Stratton, 2002: p694). Four "platforms of discourse" can be selected to discuss the role of spirituality: the meaning of life; neurotheology; spiritual healing; and the seriously ill patient in a clinical setting. They suggest that mental health professions have been reluctant to deal with spiritual concerns that clients may express, possibly due to the posture of civil inattention that envelops such concerns in the culturally diverse society of the United States and to the added discomfort felt by mental health professions regarding their lack of spiritual training and experience.

Larimore et al., reviewed the evidence for the incorporation of basic and positive spiritual care into clinical practice, which demonstrated that: *"there is frequently positive association between positive spirituality and mental and physical health and well-being; most patients desire to be offered basic spiritual care by their clinicians; most patients censure clinical professions for ignoring their spiritual needs; most clinicians belief that spiritual interventions would help their patients but have little training in providing basic*

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spiritual assessment and care; and professional associations and educational institutions are beginning to provide learners and clinicians information on how to incorporate spirituality and practice…" (Larimore, Parker & Crowther, 2002: p69).

Sims reviews the development of British psychiatry in the 20th century (Sims, 2003). By 1950, psychiatry viewed the spiritual concerns of patients and religious faith of psychiatrists and patients with suspicion and often hostility. In the 1960's religious feeling was often equated with neuroticism. In the 1970's, newly qualified psychiatrists started to discuss the relationship between their Christian faith and their practice as psychiatrists. During the 1980's there was an increasing confidence by this small minority in marking out legitimate territory for the overlap between religious faith and psychiatric symptoms. Progress during the 1990's became more public, with the address of the patron of the College (the Prince of Wales) in 1991 and the Archbishop of Canterbury in 1995, culminating in the founding of the Spirituality and Psychiatry Special Interest Group of the British College of Psychiatrists in 2000.

Gilbert provides an overview of the situation in the United Kingdom (UK) considering the demand that came strongly from users, carers and professionals for the spiritual dimension to be taken into account of in the diagnosis, treatment and care of people with mental ill-health (Gilbert, 2007b). In Gilbert's view, in the UK however, evidence from research is less clear than in the United States. He provides a concise summary of the spectrum of British writing (including the work and views of Swinton, Coyte, Powell, Anderson, the Staffordshire University Monograph, Fullford and Woodbridge) and organisations involved in current investigation of the field (e.g. the Healthcare Commission, Commission for Social Care Inspection, the National Health Service Confederation and the Royal College of Psychiatrists through its special interest group).

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McLaughlin reviews the literature from a nursing perspective on the incorporation of individual spiritual beliefs in treatment of in-patient mental health consumers (McClaughlin, 2004). She refers to D'Souza and Larson, as well as to requirements of the American Joint Commission on Accreditation of Health Care Organisations (AJCAHCO) for a spiritual care element and to definitions by the North American Nursing Diagnosis Association (NANDA) of certain nursing diagnoses (such as "*spiritual distress*", "*risk of spiritual distress*" and "*readiness for enhanced spiritual well-being*"). While formal standards for spirituality in clinical care were being awaited at the time, she concludes that the care of individual patients may already be benefiting from the already achieved policy positions. Another nursing review of the literature by Mohr, concludes that spirituality and religion are too often neglected in psychiatric mental health assessment and intervention (Mohr, 2006). She refers to authors such as Post, Puchalski, Koenig, Larson and others. With more than 850 studies reviewed, she discusses relevant findings in terms of the negative effects of religious involvement and spirituality, how religion and spirituality manifest in psychopathology, the clarifying of issues and the role of the nurse in mental health care.

1.2.1.3 Concepts and definition

Culliford also quotes Andreason's statement (Andreasen 2001) - referred to above - that "*… psychiatrists are physicians of the soul as well as of the body*" (Culliford, 2002). He sets a definition of spirituality within: the context of the World Health Organisation's quality of life (WHO-QOL) domains; the facets proposed for a WHO-QOL Spirituality, Religious and Personal Beliefs (SRPB) module; and the dimensions of human experience. He refers to an often quoted definition of spirituality by Murray and Zentner: "*In every human being there seems to be a spiritual dimension, a quality that goes beyond religious affiliation that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes essentially into focus in times*

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of emotional stress, physical (and mental illness), loss, bereavement and death" (Murray & Zentner, 1989). Culliford identifies a new paradigm of research moving beyond positivism that includes qualitative research approaches such as participant observation, phenomenology and unstructured in-depth interviews. He defines the elements of spiritual care, as well as spiritual values and skills that are needed.

In clarifying the term spirituality, D'Souza and George use an explanation of two realms of existence – the outer and the inner (D'Souza & George, 2006). This is where the outer realm consists of a person's interaction with the world and the inner realm is defined as the individual's interaction with the transcendental.

Koenig reviews the research on religion, spirituality and mental health (Koenig, 2009). He defines religion in this context to involve beliefs, practices and rituals related to the sacred, or that which relates to the numinous (mystical, supernatural or God, ultimate truth or reality). Spirituality according to him is more difficult to define and is considered to be more personal, largely free of rules, regulations and responsibility, whereas religion is viewed as divisive and associated with conflict and war. As there is no unique, distinct, generally accepted definition, researchers have struggled to identify valid measures for spirituality which makes it difficult to conduct research on spirituality. Standard measures of spirituality today contain questions about the meaning and purpose of life, connections with others, peacefulness, existential well-being, comfort and joy. "*Clinicians need to be aware of the religious and spiritual activities of their patients, appreciate their value as a resource for healthy mental and social functioning and recognize when those beliefs are distorted, limiting and contribute to pathology rather than alleviate it"* (Koenig, 2009: p.289).

Sesanna et al., through a strategy of concept analysis according to Walker and Avant's methodology, have done an extensive examination of the body of nursing and health-

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related literature to clarify the definition of spirituality (Sesanna, Finnell & Jezewski, 2007). The thematic analysis of the content of 90 articles between 2000 and 2005 yielded four themes on the definition of spirituality: (1) spirituality as a religious system of beliefs and values; (2) spirituality as life meaning; (3) spirituality as non-religious systems of beliefs and values; and (4) spirituality as metaphysical or transcendental phenomena. They identify the limitations of an empirically based definition for spirituality and express the need to develop such a definition which includes the perspective of individuals who are recipients of health care.

(1) **Health care users**: Greasley et al., and Russinova and Cash report on studies that included the views of users on the definition of spirituality, using focus groups and semi-structured interviews (Greasley, Chiu & Gartland, 2001), (Russinova & Cash, 2007). Greasley et al., aim to clarify the issue of spiritual care in the context of mental health nursing through a series of focus group discussions with service users, carers and mental health nursing professionals about the concept of spirituality and the provision of care. According to participants, spiritual care relates to the acknowledgement of a person's sense of meaning and purpose and is associated with the quality of interpersonal care in terms of an expression of love and compassion towards patients.

Russinova and Cash (2007) also focus on users of services – persons with serious mental illnesses – in conducting in-depth semi-structured interviews with 40 individuals on the meanings that these people would attribute to the concepts of religion and spirituality. Two broader dimensions representing participants' understanding of both religion and spirituality were identified: core characteristics describing the nature of each phenomenon; and a functional characteristic dimension. This study provide evidence that individuals with serious mental illnesses who recognise the presence of a spiritual dimension in their lives have a deep yet finely nuanced understanding of the concepts of religion and spirituality.

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(2) **Spiritual professionals**: Lapierre as a professional spiritual/religious worker, presented a model from a Judaeo-Christian perspective to describe spirituality qualitatively (Lapierre, 1994). This model consists of six factors: "the journey"; transcendence; community; religion; "the mystery of creation"; and transformation. "*Once an individual decides to respond to a discovery of meaning and purpose, then the journey begins – a journey of the spirit.*" (p156) In the process of becoming, evil will then be anything that may undo parts of what people have become.

Waldfogel defines spirituality as distinct from - yet connected to - the biological, psychological and social dimensions of an individual that contribute to the person's sense of wholeness and wellness (Waldfogel, 1997). He elaborates on four elements of spirituality, including: the meaning and purpose of life, transcendence, connection with others, and spiritual energy.

Meador and Koenig clarify conceptual issues and set some principles of practice (Meador & Koenig, 2000). They propose three broadly framed aspects of care within psychiatric practice to which the religious and spiritual lives of patients and clinicians will frequently have relevance: (1) a response to suffering; (2) social support; and (3) a sense of meaning and coherence when telling the story of one's life.

Pembroke considers the appropriate spiritual care by physicians from a theological perspective (Pembroke, 2008). He argues that when spiritual care by physicians is linked to the empirical research indicating a salutary effect on health of religious beliefs and practices, an unintended degradation of religion is involved. He contends that it is much more desirable to see support for the patient's spirituality as part of holistic care. He criticises the simplified deduction that when the previously mentioned positive link between religion and health is cited, clinicians are encouraged to support patients'

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spirituality for the sake of "an added medical benefit". He argues that it is not legitimate to use religion as a means to an end, as it is an end in itself. He quotes Cohen et al., who observes: *"Physicians must walk a fine line between the practice of medicine and between sympathetic response to patients' spiritual needs and professional coercion"* (Cohen et al., 2001: p46).

(3) **Spirituality and religion:** According to Yuen, the common ground that religion and spirituality share is a search for the sacred through the experience of subjective feelings, thoughts and behaviours (Yuen, 2007). Healing in this context then becomes more than a technical cure or fix and includes a journey to integrate these questions into one's life.

As part of a framework to incorporate a spiritual dimension to the training in psychotherapy, Bienenfeld and Yager propose definitions for spirituality, religion, religiosity and faith, and for religious behaviour: *"Spirituality at its broadest is a person's attempt to make sense of his/her world beyond the tangible and the temporal. It strives to connect the individual with the transcendent and transpersonal elements of human existence. It may, but need not, include religion. Religion is an organized system of beliefs, practices and rituals. Usually, it is shared with others, but each individual creates his/her own version"* (Bienenfeld & Yager, 2007: p180).

In his article, Verghese emphasises the importance of spirituality in mental health in an Indian context (Verghese, 2008). Spirituality is a globally recognised concept. It involves belief and obedience to an all powerful force, usually called God, which controls the universe and the destiny of humanity. It involves the ways in which people fulfil what they hold to be the purpose of their lives, a search for the meaning of life and a sense of connectedness to the universe. "*Religion is institutionized (sic) spirituality. Thus there are several religions having different sets of beliefs, traditions and doctrines. They have*

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different community-based worship programs. Spirituality is the common factor in all these religions. It is possible that religions can lose their spirituality when they become institutions of oppression instead of agents of good will, peace and harmony. They can become divisive instead of unifying." (p233)

(4) **Religion and culture**: Dein discusses the usefulness of the terms religion and spirituality from a cultural perspective (Dein, 2005). He points to the increasing distinction between religion and spirituality and the need for conceptual clarification in this area. He covers the current use of the term spirituality in Western cultures which is derived from both Christian spirituality and "New Age" thinking which often appropriates ideas from Eastern religious traditions. This situation is contrasted with other monotheistic religions where there is no distinction between religion and spirituality. "*Although some understand the spiritual as more diffuse and less institutionalized than religion, others take it to be the very heart of religion and encountered through religious and mystical experiences*" (p529). Dein considers spirituality and health and the relevance of spirituality for psychiatry. Observations on how religion and spirituality are used in lay context, affirm the assertion that no single perspective on religion has dominated postmodern culture, but multiple perspectives exist simultaneously.

As a research fellow at a Dutch university, Chattopadhyay reflects that the renewed interest in the interaction of religion and spirituality and health and medicine in Western countries has significant implications for the ethos of medicine in India (Chattopadhyay, 2007). Religion and spirituality play important roles in the lives of Indian people, and Indian physicians need to acknowledge religious issues respectfully and address the spiritual needs of their patients. Incorporating religion and spirituality into health and medicine may go a long way towards making the practice of medicine more holistic, ethical and compassionate.

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1.2.2 THE REALITY OF SPIRITUALITY AND RELIGION FOR PRACTITIONERS AND USERS

To outline the discourse on spirituality and religion in mental health, Gilbert refers to global events in the USA, Britain and France over the past years and quotes the Mercia Group's statement from their review of the evidence base on faith communities in the UK: *"Over the last 50 years, the discourse in Britain about 'racialised minorities' has mutated from 'colour' in the 1950s and 1960s… to 'race' in the 1960's 70's and 80's to 'ethnicity' in the 90s… and to 'religion' in the present time"* (Gilbert, 2007a). Faith seems to be one of the most prominent national and international issues of the day. The large scale migration and immigration of people to different foreign settings, together with the associated struggle for continued identity and a sense of self, has spirituality as a vital element of this process. For example after the September 11 attacks on the "Twin Towers" in New York, many people of an Asian ethnicity wish to identify themselves by their religious rather than ethnic affiliation. The article describes a conference set up by the National Institute of Mental Health in England (NIMHE), Staffordshire University, and the National Forum on Spirituality and Mental Health to explore how belief systems can affect people's well-being and their recovery from mental illness. Nine faiths were invited to the conference in November 2006: Baha'i, Buddhism, Christianity, Hinduism, Islam, Judaism, Sikhism, Zoroastrianism and the Humanists.

Sims uses the term "cure of souls" as point of departure and considers how three groups would differ in their understanding of its meaning: psychiatrists, religious people and patients (Sims, 1999). He discusses psychiatrists and their problem with the "spiritual realm" as well as the position of "religious people" and how patients become caught in the crossfire. He quotes Bhugra, who explained the problem as two next door neighbours: "*(the) two neighbours (psychiatry and religion)... should be on very good terms, but, due to a long-forgotten episode over the niggle about the size of the fence, have fallen out. It is high time that commonalities are ascertained and shared and differences are put to one*

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side" (Bhugra, 1996). Patients caught in this conflict are reluctant to talk to their psychiatrists about their religious beliefs and practice, and to ministers of religion about their psychiatric symptoms and treatment.

Sperry considered patients, psychiatrists, professional and scientific developments and treatment settings (Sperry, 2000). Patients less "at home" in the religious traditions may be searching for a sense of healing and spiritual direction from other sources, including psychotherapy and alternative medicine, as well as traditional medicine and psychiatry. *"This 'three-pronged' search for healing, spiritual direction and 'cure' provides the background for a rapprochement between psychotherapy and spirituality and propels these individuals into psychiatric treatment* (p518)." Sperry refers to London, who describes the role that psychiatrists and psychotherapists - whether they want or not - may have acquired by default of religious institutions, as being that of "secular priests" (London, 1985: pp24-36). He discusses three different levels of incorporating spirituality into psychiatric practice, based on four characteristics: spiritual assessment; processing patients' religious and spiritual issues using spiritual practices; developing an integrative philosophy of clinical practice involving the spiritual dimension; and integrating the spiritual dimension and spiritual practices into the personal lives of psychiatrists. In the USA the field of psychiatry has mandated training in religion and spirituality for residents and many psychiatrists are experimenting with different ways of incorporating the spiritual dimension into their professional and personal lives. It is, however, not clear how managed care and third-party payers will respond to these developments.

Fallot addresses perspectives on the roles of spirituality and religion in recovering from serious mental illness (Fallot, 2007). Consumers noted both potentially supportive and burdensome roles of religions and spirituality recovery. Professionals reported both hope for, and discomfort with, these domains in the context of mental health services. Recommendations based on consumer perspectives included: mental health programs

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should adopt a holistic approach to both assessment and intervention, that includes spirituality in an explicit way; and that it is important for service providers and programs to have an open and inclusive understanding of spirituality and religion, sensitive to the many differences of experience and conviction among consumers. This requires clinicians to take a respectful and individualised approach to spiritual and religious realities, attuned to varying needs of individual consumers over time across a situation. The most obvious recommendation based on professional perspectives has been the need for more extensive training and education for human service providers in spirituality that is pertinent to the particular service setting in which staff and consumers work together (including pre-professional, in-service and continuing education opportunities). Such training should address the skills and knowledge required to understand and evaluate the ways in which spirituality relates to consumers' overall well-being. Is should also facilitate skills to be able to talk with consumers about spirituality in a manner that is neither intrusive nor reductionistic, but communicates respectful openness to the consumer's unique spiritual experiences, both negative and positive. Adequate assessment flows naturally into service planning and delivery, and referrals to religious professional, faith-based organisations or centres of spiritual activity may all be appropriate based on an adequate understanding of, and collaborative response to, the consumer's needs and preferences. Some programmes may wish to add their own services that address explicitly the role of spirituality in relationship to mental health problems and recovery.

Brooks and Koenig have reported on government and faith-based organizations (FBO) as partners in health, especially with regard to health education and services in the community (Brooks & Koenig, 2002) Limited infrastructure and liability are among the barriers to the expansion of FBO's. They advocate the future redefined and carefully framed partnership between these two role players to synthesise the best of both worlds. In terms of the capacity of physical facilities to accommodate spirituality, Puchalski notes that health care institutions should provide a respectful and supportive clinical

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environment in which patients can express their spirituality and religiosity (Puchalski, 2001).

1.2.2.1 Approaching incorporation

(1) **Salience and benefit**: Levin et al., summarise previous reviews of the field of religion and spirituality in medicine (Levin, Larson & Puchalski, 1997), referring to: a 1987 study that reviewed more than 200 published studies over a century; and subsequent reviews examining cause-specific morbidity and mortality rates (e.g. cancer and hypertension) in different religious groupings, with evidence of religious involvement as an epidemiological protective factor (Levis, 1997). Yet there still remains some resistance within academic medicine, because of views that religion may be unimportant to physicians personally, the belief that religion is not "real" and that it is mostly a nuisance to overcome in the clinical setting.

Matthews et al., reviewed the literature on epidemiological and clinical studies regarding the relationship between religious factors and physical and mental health status in the areas of prevention, coping and recovery (Matthews et al., 1998). They concluded that the findings in the literature suggest that religious commitment might play a role in enhancing illness prevention, coping with illness and recovery.

In a regular continued education update for family physicians, Koenig refers to research that is increasingly demonstrating a relation between religion/spirituality and health (Koenig, 2004a). Religious beliefs and practices are associated with: lower suicide rates; less anxiety; less substance abuse; less depression and faster recovery from depression; greater well-being, hope and optimism; more purpose and meaning in life; higher social support; and greater marital stability. Physicians should be aware of this and understand its clinical implications.

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Moreira-Almeida et al., presented the main studies and conclusions of a large systematic review of 850 studies on the religion-mental health relationship published during the 20th century identified through several databases (Moreira-Almeida, Neto & Koenig, 2006). The majority of well-conducted studies found that higher levels of religious involvement are positively associated with indicators of psychological well-being (life-satisfaction, happiness, positive affect, higher morale) and with less depression, suicidal thoughts and behaviour, or drug/alcohol abuse. Usually the positive impact of religious involvement on mental health is more robust among people under stressful circumstances (such as the elderly, those with disability and medical illness).

(2) **Theoretical approaches:** As director of a palliative care unit, Rumbold has reviewed spiritual assessment in health care practice in terms of the three major models of health: biomedical, bio-psycho-social or social (Rumbold, 2007). From a biomedical perspective in which health is implicitly defined as the absence of disease, spirituality lies beyond the scope of medical expertise. He then refers to the 1948 WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease" and to Engel's articulation of the "bio-psycho-social" approach to care, which gives more attention to quality of life. This model is usually extended to include spirituality (Sulmasy, 2002). Where generally in society, health care may be seen as even encompassed by spirituality (rather than the other way round), personal determination of spirituality may be an essential element of autonomy in this regard. In his view, to have professionals also indiscriminately taking charge of spiritual care may undermine a patient's sense of control and may even be invasive and presumptuous (p S61). It also needs to be considered what the role is that illness and treatment may play in an individual's personal spiritual journey. He lists criteria and describes a process for appropriate spiritual assessment.

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Editorials on spirituality and clinical conditions have included those by Koenig and Cohen (Koenig, 2003), (Koenig, 2005), (Koenig & Cohen, 2006). Koenig, in a major multi-part series of publications reviewed religion, mental health and related behaviours and developed a theoretical model to illustrate the complex pathways by which religion may influence physical health. He summarised the results of a comprehensive and systematic review of research examining religion's relationship to physical health and mortality (Koenig, 2001a), (Koenig, 2001b), (Koenig, 2001c). In the section on religion and medicine (Part II in the series) he included more than 630 data-based reports that focused on religion and well-being, hope and optimism, meaning and purpose, depression, suicide, anxiety, psychosis, social support and marital stability, alcohol and drug abuse, cigarette smoking, extra-marital sexual behaviour and delinquency. Reasons for the positive association between religion and these clinical and social settings were explained as: religious belief provides a positive worldview that gives experiences (whether positive or negative) meaning; religious beliefs and practices may evoke positive emotions (joy, wonder or awe, thankfulness); religion provides rituals that ease and sanctify major life transitions (adolescence, marriage, death); and as an agent of social control, religious beliefs provide guidance on and structure for the kinds of behaviours that are acceptable and conform to social norms. In the next section (Part III) he describes the model that he developed of the complex influence of religion on physical health, taking into account factors such as genetics, childhood training, psychological and social influences (fight-flight response, immune function), health behaviours and lifestyle influences on physical health and health care practices. Psychosocial influences and immune function are also further discussed alluding to depression, stress-induced immune changes (infections, cancer, wound healing, cardiovascular disease). He discusses the important role that social support plays in moderating the physiological effects of stress and improving health outcomes. *"If religious beliefs and practices improve coping, reduce stress, prevent or facilitate the resolution of depression, improve social support, promote healthy behaviours and prevent alcohol and drug abuse, then a plausible mechanism exists by which physical*

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health may be affected." In the last section (Part IV) of the series he reviews research that has tested the validity of this model. The systematic literature review covers the following topics: pain and functional disability; heart disease, blood pressure and stroke; immune and neuro-endocrine function; infectious disease; and cancer. Implications for medical practice that he identified in conclusion, included: addressing the spiritual needs of patients; considering the wishes of patients in this regard; and clarifying the role of the physician as assessor, orchestrator of resources, supporter of patient beliefs, participator in religious practices, prescriber and referrer.

D'Souza reviews the importance of incorporating spiritual history into a psychiatric assessment (D'Souza, 2003). Physicians should be trained to explore the patient's spirituality with sensitivity and skill. D'Souza and Rodrigo describe an approach to "spiritually augmented cognitive behavioural therapy" (SACBT), which was developed and tested by a multidisciplinary team involving various clinical professionals, members of the hospital's pastoral team and an indigenous elder (D'Souza & Rodrigo, 2004). This approach incorporates techniques to find meaning and validate the individual's belief system into treatment. Meditation, prayers and rituals, while simultaneously monitoring the effects of beliefs and rituals on symptoms and patients' acceptance of treatment, form the behavioural components of SACBT.

Puchalski provides a detailed approach to the role of spirituality in critical care (Puchalski, 2004). Her article covers "suffering", "health versus care" and spirituality in clinical care (ethical issues, patients' understanding of illness, effect on health care decisions, patients' need, a resource in coping). She describes aspects of spiritual care, care options and interventions, as well as spiritual history taking using the "FICA" model. "FICA" refers to: F, faith and belief; I, importance/influence; C, community; A, address/action in care. She refers to a consensus conference on the role of spirituality and health where a diverse group of academic physicians, chaplains and medical ethicists acknowledged that, from

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an ethical perspective, a willingness and ability to address patients' spiritual issues - as they arise in the context of health care - is essential. To attend to patients' spirituality is a need, not an amenity. It was also felt that the recommendation for physicians to be attentive to patients' spiritual issues comes from an ethical obligation physicians have to treat the whole person and, in doing so, to respond compassionately to patients' spiritual and existential concerns. Participants have noted that spiritual care was not in one person's domain, but it is the responsibility of everyone on the health care team – nurse, physician, social worker and chaplain – to address the spiritual issues of patients. Spiritual care, as with good medical care, should be interdisciplinary.

As an approach to psycho-social rehabilitation, Fallot's article as summarised in the abstract addresses issues of religious experience in diagnosis, including the importance of the religio-cultural context and overall functioning in diagnostic assessments (Fallot, 2001). It then examines the roles of spirituality in recovery, exploring both positive and negative relationships between religion and consumers' well-being. Finally, it describes several ways in which spiritual and religious concerns may be integrated into psychosocial rehabilitation services, including: conducting spiritual assessments; offering spiritually-informed discussion groups; incorporating spiritual dimensions into personal psychotherapy; and facilitating linkages to faith communities and spiritual resources. Also discussing the role of spirituality in psychosocial rehabilitation, Longo and Peterson discusses the attention that the role of spirituality in mental health and general wellness has received in psychological literature, referring to three barriers to the acceptance of spirituality as a clinical tool in mental health treatment (Longo & Peterson, 2002). These barriers are: the history of mental health treatment; professional stereotypes and confusion; and fears about the meaning of spirituality. They support the reintroduction of spirituality and its incorporation as a "tool", as an adjunct to treatment. As a resource in coping, it provides social support and plays a role in (positive) self-esteem and hope.

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Cloninger's theory of personality is widely known and taught. His 238-item self-rating instrument - based on this model - the Temperament and Character Inventory (TCI) has been widely used, tested and reported on (Cloninger, 2006), (Cloninger & Svrakic, 2000). Based on studies in character development and emotional consistency, he developed a psychotherapy programme that involves a sequence of 15 intervention modules of "voyages to well-being". Each model is about 50 minutes long, suitable for use in self-help format or as an adjunct to individual or group therapy. These stages of therapy correspond to stages of spiritual development, but are based on explicit psychobiological principles.

Vaillant's recent article and book (Vaillant, 2008b), (Vaillant, 2008a), are built on the disciplines of ethology (animal behaviour) and neuroscience, - which have enabled, according to him - the scientific study of positive emotions such as love, joy, awe and compassion. He discusses the three evolutions, genetic, cultural and the maturation of human spirituality (or "adult development") by sketching the development (phylogeny) of positive emotions for the species over millennia, and the individual embryology (ontogeny) of positive emotions over time. Discussing the "third evolution" he states: *"Adolescents, like religions, strive for identity and unity. Teenagers need dogma. If you do not believe your identity is your only identity, you have no identity. Religious communities, like adolescent cliques, are deliberately homogenous. Such communities tend to exclude or even attack other communities... the identity formation of adolescence also reflects a developmental necessity"* (p61-62). He concludes this section, by suggesting that a faith emphasising trust and positive emotion is more mature than a faith made up of words, prohibitions and rigid beliefs. After discussing seven positive emotions (faith, love, hope, joy, forgiveness, compassion, awe/mystical illumination) in separate chapters, he concludes with the last chapter on the difference between religion and spirituality.

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Anandarajah's models provide common ground for the further exploration of the spirituality in medicine: *"The explosion of evidence in the last decade supporting the role of spirituality in whole-person patient care has prompted proposals for a move to a bio-psycho-social-spiritual model for health. The '3H' model (head, heart, hands) and the 'BMSEST' models (body, mind, spirit, environment, social, transcendent) evolved from the author's 12-year experience with curricula development regarding spirituality and medicine, 16-year experience as an attending family physician and educator, lived experience with both Hinduism and Christianity since childhood, and a lifetime study of the world's great spiritual traditions. The '3H' model offers a multidimensional definition of spirituality, applicable across cultures and belief systems, providing opportunities for a common vocabulary for spirituality. Therapeutic options, from general spiritual care (compassion, presence, and the healing relationship), to specialized spiritual care (e.g. by clinical chaplains), to spiritual self-care are discussed. The 'BMSEST' model provides a conceptual framework for the role of spirituality in the larger health care context, useful for patient care, education, and research"* (Anandarajah, 2008).

After reviewing literature on neuroscience, psychiatry and cognitive and evolutionary psychology, Flannelly et al., describe a new approach referring to "evolutionary threat assessment systems" (ETAS) in the brain (Flannelly et al., 2007). This involves the idea of how "primitive brain mechanisms" that evolved to assess environmental threats underlie psychiatric disorders and how beliefs can affect psychiatric symptoms through these brain systems. According to them, three brain structures that are consistently implicated in psychiatric symptomology are also involved in threat assessment and self-defense: the prefrontal cortex, basal ganglia and parts of the limbic system. Based on this, they proposed how beliefs about the world can moderate psychiatric symptoms through their influence on ETAS. Following up on their previous article on the ETAS theory, Flannelly et al., subsequently discuss beliefs about God, psychiatric symptoms and evolutionary psychiatry in a study on the association between specific beliefs about

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God and psychiatric symptoms among a representative sample of more than 1000 adults (Flannelly et al., 2009). They considered three pairs of beliefs about God that served as independent variables: "close and loving", "approving and forgiving" and "creating and judging". Dependent variables were: general anxiety, depression, obsessive-compulsion, paranoid ideation, social anxiety and somatisation. In this study, the strength of participants' belief in a "close and loving God" had a significant salutary association with overall psychiatric symptomology. *"Based on ETAS Theory, one would predict a significant inverse association between a protective God for those symptoms that have cognitive input (such as social anxiety), but no association for those that do not."* They conclude by stating that the ETAS theory enumerates specific structures in the brain that may be affected by religious and other beliefs, and it offers testable hypotheses about the effects of different beliefs on the brain and psychiatric symptoms.

1.2.2.2 Users' perspectives

Authors also addressed service users' perspectives on spirituality/religion and psychiatry or mental health (King & Bushwick, 1994), (Baetz et al., 2002a), (Baetz et al., 2002b), (Baetz et al., 2004a), (Baetz et al., 2004b), (Baetz et al., 2006), (Baetz et al., 2007), (Mann et al., 2005), (Russinova & Cash, 2007). D'Souza reported on a study in which 79% of Australian patients responded to a questionnaire (D'Souza, 2002). Of this group almost 80% rated spirituality as very important and 82% thought their therapists should be aware of their spiritual beliefs and needs.

(1) **General population**: Authors on the views of the general population on spiritual/religious aspects include Mansfield, on the doctor "as God's instrument" (Mansfield, Mitchell & King, 2002), Johnson on African-Americans' views (Johnson, Elbert-Avila & Tulsky, 2005) and Flannelly on belief in life after death (Flannelly et al., 2006).

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(2) **Children and adolescents**: Authors on the role of spirituality in the care of children and adolescent users included Josephson and Dell (Josephson, Dell, 2004b), (Josephson, Dell, 2004a), (Dell, Josephson, 2006). Kroll and Erikson refer to a literature review by Weaver et al of five major adolescent journals from 1992-1996 (Weaver et al., 2000), which showed that more than 10% of articles published over this period included a measure of religiosity (Kroll & Erickson, 2002). They then discuss studies that have investigated personality and spirituality, whether religiousness protects against depression, the negative effects of religious strain of struggle, religiosity and family attitudes, as well as religion and mental health.

Dew et al., studied religion, spirituality and depression in adolescent psychiatric out-patients (Dew et al., 2008a), (Dew et al., 2008b), (Dew et al., 2009). Results of the first study suggested that clinicians should assess religious beliefs and perceptions of support from the religious community as factors intertwined with the experience of depression and consider the most important ways of addressing these factors that are sensitive to adolescents' and their families' religious values and beliefs. In the second study several aspects of religiousness/spirituality appeared to be correlated to depressive symptoms in adolescent psychiatric patients. These findings suggest that perceived social support and substance abuse account for some of these correlations.

In an issue of the journal Child and Adolescent Psychiatric Clinics of North America dedicated to the topic of religion and spirituality in child and adolescent psychiatry, Josephson and Dell start with the clarification of terminology and give a historic overview of developments (Josephson & Dell, 2004a). Child psychiatrists should be aware of the role of spirituality and religion because: of the shared interest in developmental themes; it informs parental decision-making; and it offers a treatment resource for children and families.

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(3) **Elderly and end of life/terminal illness**: Authors also reported on the spiritual/religions aspects in the elderly (Koenig & Larson, 1998), (Chen & Koenig, 2006), (Blazer, 2007), (Pargament et al., 2004), (Breitbart et al., 2004). They discussed the focus on meaning and spirituality in psychotherapeutic interventions at the end of life. Holt provides a case report (Holt, 2004).

(4) **Clinical scenarios**: The role of spirituality and religion has been reported on in clinical settings such as: pulmonology (Ehman et al., 1999); ophthalmology (Magyar-Russell et al., 2008); family medicine (King & Bushwick, 1994), (Oyama & Koenig, 1998), (MacLean et al., 2003), (McCord et al., 2004); HIV risk and prevention (Loue & Sajatovic, 2006); nursing (Wilding, Muir-Cochrane & May, 2006); occupational therapy (Wilding, 2007); and alcohol rehabilitation (Goldfarb et al., 1996), (Koenig et al., 1994), (Galanter, 2006), (Galanter, 2008).

Fallot and Heckman have examined the types of religious/spiritual coping of women trauma survivors with co-occurring mental health and substance use disorders (Fallot & Heckman, 2005). The findings suggested according to them, that more childhood abuse and childhood sexual violence are especially associated with negative religious coping in adulthood, where struggling with spiritual issues is actually undermining recovery from trauma. Bellamy et al., (2007) describe the relevance of spirituality for people with mental illness attending consumer-centred services (club houses and “drop-in” centres). Analysis of responses to a questionnaire showed that about two thirds rated spirituality as important in their lives. Being older and female were two demographic variables with a significant association with spiritual activities.

Sexton and Sorlie reported on the use of traditional healing among Sámi psychiatric patients in the north of Norway (Sexton & Sorlie, 2008). The Sámi people lived throughout northern Norway, Sweden, Finland and Russia and their culture was originally based on

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shamanism and a nature-orientated religion. In a survey with 186 participants, about 60% had some ("a little") to a strong cultural affiliation with the Sámi group. Affiliation was associated with a significantly higher use of traditional and complementary treatment modalities. This suggests that the different aspects of traditional healing within the health services of this particular group should be given consideration.

1.2.3 ROUTINE ASSESSMENT OF SPIRITUALITY AND RELIGION IN PSYCHIATRY

The literature in this section is discussed in terms of two broad themes: presentation and symptoms; and assessment, measurement and research.

1.2.3.1 Presentation and symptoms

Authors addressed how spirituality may affect the presentation and symptoms of illness (Hathaway, 2003), (Hopkins & Battin, 2004) (McConnell et al., 2006). Carter considers that the majority of African Americans are evangelical Christians and that more than 60 of the 125 American medical schools offered classes in spirituality and health at the time (Carter, 2002). He states that although there is a lack of empirical evidence that religion improves health outcomes, physicians should understand patients as a bio-psycho-social-spiritual whole. He presents two case histories to demonstrate how religion/spirituality significantly influences treatment decisions and results.

(1) **Psychosis**: Keks and D'Souza examined the links between spirituality and psychosis through illustrative cases (Keks & D'Souza, 2003). They conclude that spirituality may be critical for dealing with the assault that psychosis effects on the identity and personality of patients and that it may play a role in replacing some of the loss, as well as in psychotherapeutic support and recovery.

Koenig discusses religion, spirituality and psychotic disorders. His article examines: the religious beliefs and activities among non-psychotic persons in the Unites States, Brazil

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and other areas of the world; the historical factors contributing to the wall of separation between religion and psychiatry; the reviewed studies on the prevalence of religious delusions in patients with schizophrenia, bipolar and other severe mental disorders; how clinicians can distinguish pathological from non-pathological religious involvement; and how persons with severe mental illness use non-pathological religious beliefs to cope (Koenig, 2007c).

In terms of psychosis and schizophrenia, Leão and Neto evaluated the impact of spiritual practices in the "clinical and behaviour evolution" of patients with mental disabilities in a Brazilian institution (Leão & Neto, 2007). Two groups were compared (with and without spiritual practices) using the interactive observation scale for psychiatric inpatients. They reported a positive association of spiritual practices with clinical and behavioural aspects of these inpatients. Huguelet et al., reported on a qualitative study of taped interviews with 100 psychiatric out-patients in Geneva, Switzerland with a diagnosis of schizophrenia (Huguelet et al., 2006). They found that religion was an important aspect of the lives of patients with schizophrenia and it was often not related to the content of their delusions. Fewer of their attending clinicians were religiously involved and in half of the cases, their perceptions of patients' religious involvement were inaccurate, even if they reported feeling comfortable with such issues.

Mohr et al., conducted semi-structured interviews about religious coping with a sample of 115 Swiss outpatients with psychotic illness (Mohr et al., 2006). Positive aspects of religion reported by participants included: instilled hope, purpose and meaning, lessened psychotic symptoms, increased social integration, possible reduced risk of suicide attempt and reduced alcohol abuse. Negative aspects included that for some it did induce despair. They argued that religion is important for patients and should be included into the psychosocial dimension of care, as religion is neither a strictly personal matter nor a strictly cultural one. In 2007 they reported a follow-up on the assessment of spirituality

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and religiousness in schizophrenia in terms of a “clinical grid” that they developed and tested (Mohr et al., 2007). They reported that religion is a multifaceted construct and their principal component analysis elicited four factors: a subjective dimension; a collective dimension; synergy with psychiatric treatment; and ease of talking about religion with the psychiatrist.

(2) **Mood and anxiety**: Authors covered the role of spirituality/religion in mood and anxiety (McCullough & Larson, 1999), (Baetz et al., 2004a), as well as personality assessment and depression (Grucza et al., 2003), (Cloninger, Svrakic & Przybeck, 2006), (Vaccaro, 2007), (Koenig, 2009) and meditation therapy for anxiety disorders (Krisanaprakornkit, Krisanaprakornkit & Piyavhatkul, 2007).

Garroutte et al., reported on a study of spirituality and attempted suicide among American Indians (Garroutte et al., 2003). Commitment to Christianity and/or commitment to tribal cultural spirituality were measured. Those individuals with a commitment to either were not significantly associated with suicide attempts. But those with a high level of cultural spiritual orientation (after having adjusted the data for main confounders) had a relatively reduced prevalence of suicide. This suggests support for the perception about the effectiveness of American Indian suicide-prevention programmes emphasising orientations related to cultural spirituality.

Baetz et al., (2004a) report on the association between spiritual and religious involvement and depressive symptoms in a Canadian population. To examine the relationship between religious practice and its salience to depressive symptoms, data from the 2002 Canadian National Population Health Survey were analysed. Results suggested that more frequent worship attendees had significantly fewer depressive symptoms. Baetz et al., (2006) followed this up with odds ratios for lifetime, 1-year incidence and past psychiatric

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disorders. They reported that higher worship frequency was associated with lower odds of psychiatric disorders.

1.2.3.2 Assessment, measurement and research

The development of standardised measuring instruments for spirituality/religiousness based on uniform and universal definitions of the concepts of spirituality and religion has been a challenge due to the overlap and differences, as well as the spectrum of domains that these constructs may include. Instruments, scales and indexes used include Cloninger's Temperament and Character Inventory (TCI) (Cloninger, 2006) and the World Health Organisation's Quality of Life Measure for assessment of spirituality, religion and personal beliefs (WHO-QOL SRPB) (Culliford 2002), (Moreira-Almeida & Koenig, 2006) and (Fleck & Skevington, 2007).

Moreira-Almeida and Koenig discuss the WHO-QOL SRPB that was used in a cross-cultural study in 18 countries, while considering the attributes of an ideal inclusive, trans-culturally validated measurement of religiousness/spirituality (Moreira-Almeida & Koenig, 2006). They mention the risk of being too broad and losing the core meaning of the words (spirituality and religiousness), as a particular problem in trying to create an inclusive and world-wide acceptable measure. If domains included in such measures are too similar to (positive) psychological domains (e.g. well-being, mental health, meaning and purpose of life and altruistic values), the problem of a circular, tautological correlation of psychological health with itself is evident. They note that five of the eight facets of the WHO-QOL SRPB (hope, meaning of life, optimism, forgiveness and a sense of awe and wonder) may actually not essentially be measuring spirituality/religiousness. They point to the crucial importance of clear and standardised definition of terms.

Several other measuring instruments have also been developed and referred to in the literature. These include: the Quality of Life Index (QLI), (Mezzich et al., 2000); the

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"Multidimensional measurement of religiousness/spirituality for use in health research" (Fetzer Institute); the "Religious Coping Index and questionnaire on spiritual and religious adjustment to life events"; the "Brief Multidimensional Measure of Religiousness/Spirituality" (BMMRS) (Pargament et al., 2004), (Mohr et al., 2007), (Dew et al., 2008a), (Dew et al., 2008b), (Hall, Koenig & Meador, 2009); the Springfield Religiosity Scale and the Hoge Intrinsic Religiosity Scale (Oyama & Koenig, 1998); the "Spirituality well-being scale" (SWBS) (Tsuang et al., 2002 & 2007); the "Interactive Observation scale for Psychiatric Inpatients" (IOSPI) (Leao & Neto, 2007); the "Feagin's Orientation to Life and God Scale" (Goldfarb et al., 1996); religious coping scales (Fallot & Heckman, 2005); the "Duke Religious Index" (DUREL); the "Episcopal Measure of Faith Tradition" (Hall, Koenig & Meador, 2008), (Hall, Meador & Koenig, 2008), (Hall, Koenig & Meador, 2009); and various semi-structured questionnaires (Galanter et al., 2007), (Ehman et al., 1999), (Johnson, Elbert-Avila & Tulsky, 2005), (Huguelet et al., 2006), (Mansfield, Mitchell & King, 2002); (Magyar-Russell et al., 2008), (Mohr et al., 2006).

In an earlier review of measures of religious commitment in two psychiatric journals, Larson et al., found that for nearly two-thirds of the measures, studies either made no hypotheses or reported no results concerning the relationship of religious commitment to mental health status (Larson et al., 1992). Dimensions of these measures included: ceremony, meaning, social support, prayer and relationship with God.

Scott et al., investigated the clinical utility of the "Spiritual Well-being Scale" (SWBS) with psychiatric inpatients - in particular of possible "ceiling effects" of this scale in this population, but statistical analysis suggested a lack of significant ceiling effects (Scott, Agresti & Fitchett, 1998).

King et al., - a group of English psychologists - characterised the core components of spirituality using narrative data from a purposive sample of people, some of whom were

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near the end of their lives (King et al., 2006). They aimed to develop a standardised measure of spirituality that went beyond conventional religious beliefs for use in psychological and health research. Principal themes identified from the interviews included: a search for meaning in the world; ideas on God, religion, meditation, prayer and life after death; and their reactions to the world around (in particular the beauty or grandeur of nature). They constructed a 47-item instrument that was evaluated in 372 people recruited in medical and non-medical settings. Analysis of these statements led to a 24-item version that was evaluated in a further sample of 248 people recruited in similar settings. The final 20-item questionnaire was performed with high test-retest and internal reliability and measured spirituality across a broad religious and non-religious perspective. They discussed the achievement of four goals with this project: the development of a reliable internally consistent scale to assess the strength of spiritual beliefs; subjecting the scale to rigorous tests of reliability; the inclusion of aspects outside of traditional religious beliefs; and evidence that the instrument would be sensitive in different socio-demographic and religious settings.

Katerndahl and Oyiriaru also developed and validated an instrument to measure each dimension of a bio-psycho-social-spiritual model in terms of its dimension-specific symptoms, appraisals and functional status in an unselected group of primary care patients (Katerndahl & Oyiriaru, 2007). This instrument was administered to 289 patients and their responses were analyzed to develop five inventory scales ("BioPSSI") for: impaired functional status; physical symptoms; psychological symptoms; and spiritual symptoms. Internal consistency and construct validity were assessed based on dimension-specific health care utilisation.

Koenig expresses concerns about measuring "spirituality" in research in view of the changing and expanding definition of the concept (Koenig, 2008a). Instruments to measure spirituality reflect this trend and are "heavily contaminated" with questions

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assessing positive character traits or mental health such as optimism, forgiveness, gratitude, meaning and purpose in life. He points out that such research may be meaningless and tautological. He argues that spirituality should be defined and measured in traditional terms as a unique, uncontaminated construct.

These authors, and others, also reported further on research in spirituality and psychiatry (Larson et al., 1986), (Weaver et al., 1998), (Matthews et al., 1998), (Koenig et al., 1999a), (Kilpatrick et al., 2005), (Koenig, 2006), (Koenig, 2008b), (Koenig, 2009)), (Baetz et al., 2002a) (Baetz et al., 2004a), (Blazer, 2007), (Bradshaw, Ellison & Flannelly, 2008). An annotated bibliography on religion, spirituality and medicine by Koenig (2006) was published in the Southern Medical Journal.

Tsuang et al., (2002 & 2007) reported on studies on spirituality and the mental health of twins that investigated the associations between empirically defined dimensions of spirituality, personality variables and psychiatric disorders in Vietnam era veterans. The aim of their later study was to determine whether associations with health variables are primarily attributable to explicitly religious aspects of spiritual well-being, or to "existential" aspects that reflect a sense of satisfaction or purpose in life.

1.2.4 TRAINING OF SPIRITUALITY IN PSYCHIATRY

Since 1995, the American Accreditation Council for Graduate Medical Education (AACGME) has required that all residency training in psychiatry must include religion and spirituality in the curriculum. The Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice was produced in 1996 by a non-profit organisation, the National Institute for Health Care Research. In 1996, the American Medical Association's Psychiatric Residency Review Committee (AMAPRRC) also introduced explicit requirements for the education of residents on spiritual sensitivity in a culturally sensitive context. In 1992 only one medical school had a formal course in

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spirituality and medicine. By 2001 more than 70 medical schools offered such courses (Puchalski, Larson & Lu, 2001).

1.2.4.1 Undergraduate

Firstly, the role of spirituality in patient care and its incorporation into undergraduate medical curricula was addressed (Graves, Shue & Arnold, 2002), (Musick et al., 2003), (Fazzio et al., 2003), (King et al., 2004) (Barnett & Fortin, 2006). Puchalski and Larson listed the initial 17 medical schools that received grants to support the development of curricula in spirituality and medicine (Puchalski & Larson, 1998). Although the different courses are taught in ways that reflect the particular philosophies and curricula of the individual schools, they share some key components: students are taught to include a spiritual assessment as part of routine history; the role of spirituality in health care as demonstrated by published research; illustrative cases are discussed; chaplains and other spiritual counsellors are seen as integral members of the mental health care team; spiritual beliefs are integrated into problem-based cases; emphasis is placed on communicating effectively and compassionately with chronically ill and dying patients about suffering, beliefs and choices; students are taught how to break bad news with care and compassion; students are encouraged to explore their own belief systems and how these may hinder or help the ability to cope with stress; major religious traditions are reviewed and specific aspects of religious or cultural traditions that may affect health choices and coping skills are addressed.

Puchalski et al., refer to the Association of American Medical Colleges (AAMC) that, with the National Institute for Healthcare Research, co-sponsored several conferences on curricular development in spirituality and medicine. In the USA medical school courses students learn to work with the many facets of spirituality and focus on the clinical integration of these themes into pregnancy and childbirth, chronic pain, psychiatric illness, addiction and dependency disorders, disability and care of the dying (Puchalski, Larson &

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Lu, 2001). Often sessions on spirituality of the care giver are included, to help students recognise the spiritual dimension of their own lives and how it affects their professional practices. Teaching methods include didactic sessions, small group discussion, reflective writing, storytelling, case presentation and discussion, panel discussions with patients, physicians, chaplains, role playing and the use of poetry and literature to convey spiritual and existential themes.

1.2.4.2 Postgraduate

Secondly, spirituality in postgraduate psychiatric education and training has been addressed (Puchalski, Larson & Lu, 2000 & 2001), (Lawrence & Duggal, 2001), (McCarthy & Peteet, 2003), (Lim et al., 2008). Spirituality in the training of residents in internal medicine training (Pettus, 2002), (Todres, Catlin & Thiel, 2005) and in family medicine was discussed (Anandarajah & Hight, 2001), (Luckhaupt et al., 2005), (Kligler et al., 2007).

Targ reviews a curriculum on spirituality, faith and religion for psychiatry residents in the United States (Targ, 1999). She refers to the required focus for physician education about religion and stated that to the three major points usually quoted (religion as a source of meaning, religion as a framework for values and religions as a context to the appreciation of human diversity), a fourth - spirituality as a potential source of higher functioning for the patient - must be added. She also mentions grants that were awarded to develop experimental programmes to train psychiatric residents in issues surrounding spirituality, faith and religion. One of these, a programme of the California Pacific Medical Centre and University of California, San Francisco, included didactic as well as clinical inputs available to both psychiatry residents and psychology interns. During the course of three years, 12 lectures were included or alternatively on a monthly basis in a one-year elective (a more informal seminar in the evenings). Two elective clinical experiences included a

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(year-long) rotation through the breast cancer (personal support/life style intervention) programme, or through the “health and healing“-clinic. She discusses the training objectives or the didactic training and the clinical rotations.

Puschalski et al., on spirituality courses in psychiatric residency programs, considered patient need, religions and spirituality in clinical practice and training for psychiatric residents (Puchalski, Larson & Lu, 2000). Areas in which residents should demonstrate competence (knowledge, skill and attitudes) are tabled and the incentives of the John Templeton Foundation are described. Puchalski Larson & Lu (2001) reviewed the updated requirements of the ACGME in 2001, including six competencies that programs must assess. Three competencies involve cultural issues and issues of sensitivity to patients’ background and values. They set out model curriculum objectives and assess courses that were submitted to the Templeton awards programme.

Coyle identifies twelve myths of religion and psychiatry as a lesson for training psychiatrists in spirituality sensitive treatments (Coyle, 2001). Considering each of the 12 perceived untrue statements on the topic, he presented several conclusions: psychiatrists are not representative of the general population in their religious/spiritual beliefs; selection bias and influences in the field itself could contribute to different spiritual/religious beliefs among psychiatrists; the psychiatric profession would be expected to define and assert its own mental health and yet there are objective evidences of less-than-optimal emotional and psychological stability (amongst psychiatrists); the current (poor) level of sophistication (on the interface of religion and psychiatry) should humble the profession; although confirmation is necessary, there is evidence of highly significant beneficial effects of at least certain types of religiosity/spirituality; religious and spiritual beliefs are powerful forces and as such, are capable of powerful destructive effects; the effects of religion/spirituality are understandably complex and highly individualised in nature; despite data in support of health and of pathology associated with religious or spiritual

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dimensions, there are ongoing impediments to the implementation of such knowledge; large percentages of the general population expect and desire a spiritual component to their care; one's spirituality/religiosity is inexorably linked with one's mental state; patients are and should be concerned about the psychiatrist's personal beliefs; it is natural to run from that which we do not understand or lack in competence; suggestions for avoiding "spirituality boundary violations" include working towards universal themes and being inclusive, toward mental health and toward positive aspects of mental health and attempting to stay in tune with patient's/trainee's development. The seemingly natural occurrence and prevalence of various forms of spirituality in the global society further confirms the importance and relevance of including spiritual factors in psychiatric care. He states: *"Furthermore, the very credibility of our profession lies in how we ultimately come to integrate spirituality into our understanding and treatment of the human psyche."* (p167)

Grabovac and Ganesan review spirituality and religions in Canadian psychiatric residency training (Grabovac & Ganesan, 2003). They surveyed all 16 residency programmes in Canada at the time, to determine the extent of currently available training in religion and spirituality as they pertain to psychiatry. They conclude that most Canadian programmes offer minimal programmes on issues pertaining to the interface of religion, spirituality and psychiatry. They propose a lecture series focusing on religious and spiritual issues to address the apparent gap. They tabulate selected elements of a proposed academic lecture series, including: introduction; religion and spirituality in human development; overview of selected major religions (Buddhism, Taoism, Hinduism, Christianity, Islam, Judaism); transpersonal psychology; first nations' spirituality and shamanism; and religious and spiritual issues in psycho-therapy.

Lev-Ran and Fennig reviewed contemporary psychiatric training in Israel, raising issues that the authors felt were not adequately addressed in contemporary psychiatric residency programmes (Lev-Ran & Fennig, 2007). Young psychiatrists avoided showing interest in

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the area of spirituality and religion for fear of a negative impact on their careers. Other issues included basic issues of doctor-patient relationship, different cultural trends such as the increase in popularity of complementary and alternative medicine, the increase in substance abuse, the increasing popularity of different spiritual movements and trans-cultural aspects affecting the prevalence and understanding of different psychopathologies in various sectors of the population.

Grabovac et al., assessed a six-hour (separate sessions) mandatory postgraduate course on "*The interface between spirituality, religion and psychiatry*" which was implemented as a pilot study at the University of British Columbia (Grabovac, Clark & McKenna, 2008). The course objectives were to increase residents' understanding of clinically relevant spiritual/religious issues and their comfort in addressing these issues in their clinical work. This curriculum was drawn from the American 1997 model curriculum developed by Larson and colleagues. Session 1 covered definitions of religion and spirituality and the historical relationship between the two fields. Session 2 reviewed scientific evidence for associations between spirituality, religion and mental health. Session 3 reviewed the clinical assessment process with a focus on history taking and formulation. Session 4 was a case-based discussion of spirituality related phenomenology. Session 5 focused on transference and counter-transference, and Session 6 was a case-based discussion with a panel of faculty. To assess this course, a 20-item Likert scale was used that covered six domains: personal spiritual attitudes, professional practice attitudes, trans-cultural psychiatry, competency, attitude change, and change in practice patterns.

1.2.5 SCOPE AND BOUNDARIES OF PROFESSIONAL SPECIALIST PSYCHIATRIC PRACTICE

The literature in this section is discussed in terms of two broad themes: ethics; and psychotherapy.

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1.2.5.1 Ethics

Post et al., wrote a perspective on physicians and patient spirituality, covering professional boundaries, competence and ethics (Post, Puchalski & Larson, 2000). The first section of their article summarised the evidence for the claim that for many patients, spirituality that includes faith in a higher being is important and beneficial. The subsequent sections covered spiritual needs assessment and professional boundaries. Basic spiritual needs assessment and referral to a spiritual worker should be uncontroversial. Other questions arise when a physician may wish to act as spiritual advisor. Post et al., alluded to the general mandate that keeps professional roles apart (doctor and pastoral caregivers) and noted that the pressure to blur the boundaries between professions often comes from patients (e.g. the desire to have physicians pray for them). The focus of biomedical ethics over the past decades has been on demystifying the authority of the paternalistic "priestly" physician of old, thereby allowing greater patient empowerment through autonomy and self-determination. A distinction must be drawn between prayer as an alternative or substitute therapy and prayer as an adjunct to conventional medical therapy. A physician who initiates prayer without first being asked presents an ethical concern, in that patients may feel coerced. Some guidelines would preclude physicians from praying openly with a patient without his or her explicit request and permission. Engagement in public prayer around the bedside when a patient desires it, may be appropriate if led by an "identified religious leader" distinct from the treating medical team where possible to avoid an appearance of religious coercion. Physician-led prayer may be acceptable when pastoral care is not readily available, when the patient is intent on prayer with the physician, and when the physician can pray without having to feign faith and without manipulating the patient.

Puchalski concurs with Post et al., that physicians should strive to discuss patients' spiritual concerns in a respectful manner and that they should be vigilant in avoiding imposing their beliefs onto the patients (Puchalski, 2001). She refers to the objectives of

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the Association of American Colleges of Medicine's (AACM) relating to empathy, communication and compassion which note: *"Physicians must be compassionate and empathetic in caring for patients… In all of their interactions with patients they must seek to understand the meaning of the patients' stories in the context of the patients' beliefs and of family and cultural values."* Physicians can encourage religious and spiritual practices with their patients if these practices are already part of the patient's belief system. "*However, an agnostic patient should not be told to engage in worship any more than a highly religious patient should be criticized for frequent church attendance."* Proselytising is never appropriate in the clinical setting. Physician-led prayer is generally not recommended as this blurs the boundaries between physician and clergy and also might be construed as a physician imposing his/her beliefs on a patient.

Daaleman provides a case history, and as context referred to the conflicted position of religion and spirituality in end-of-life care and to the significant use of complementary and alternative medicine (Daaleman, 2004). He discusses a patient's view on belief, illness and meaning, as well as the physician's social role and then an approach to an ethical paradigm of spirituality. Firstly, this paradigm must be congruent with ethical principles that guide other aspects of clinical practice. The concept of power (the empowering beliefs of the patient, and the power that physicians wield through illness scripts and trajectories) is basic to understanding and ethically considering spirituality in clinical practice. He quotes Brody's guidelines: (1) physician and patient should use all their power to effect a good patient outcome that is determined by the patient's definition of the presenting problem, and by a contextual understanding of the patient's life course; (2) physicians should share their power by informing the patient about the nature and treatment of the disease (including – as templates and trajectories – a contextual interpretation of illness); (3) physicians should be supportive of the sources of patients empowerment (e.g. belief in healing or prayer); and (4) physicians should regard the physician-patient relationship as a primary therapeutic tool (Brody, 1992).

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In considering the roles of the chaplain and the physician, Handzo and Koenig propose that the role of the physician is to assess spiritual needs as they relate to health care (i.e. screening) and to refer to a professional pastoral caregiver as indicated (Handzo & Koenig, 2004): "*The chaplain is the spiritual care specialist on the healthcare team and has the training necessary to treat spiritual distress in all its forms. Seeing the physician as the generalist in spiritual care and the chaplain as the specialist is a helpful model*" (p1242).

Winslow and Wehtje-Winslow describe the role of trust and of the preservation of personal and professional integrity in respectful clinical care and then discusse five guidelines in terms of the ethical boundaries of spiritual care: (1) health care professionals should seek a basic understanding of patients' spiritual needs, resources and preferences; (2) respect requires that health care professionals follow the patient's expressed wishes regarding spiritual care; (3) health care professionals should neither prescribe spiritual practices nor urge patients to relinquish religious beliefs or practices; (4) health care professionals who care for the spiritual needs of patients should seek to understand their own spirituality; and (5) participation in spiritual care should be consistent with professional integrity (Winslow & Wehtje-Winslow, 2007).

1.2.5.2 Psychotherapy

Spirituality, religion and psychotherapy was discussed by several authors (Cloninger, 1987), (Cloninger, 1994), (Cloninger, 2000), (Karasu, 1999), (Cloninger & Svrakic, 2000), (La Torre, 2002), (Epstein, 2004), (D'Souza & Rodrigo, 2004), (Perez, Simao & Nasello, 2007), (Morley, 2006), (Bienenfeld & Yager, 2007), (Wagenfeld-Heintz, 2008), (Johnson & Friedman, 2008), (Holliman, 2009), (Peteet, 2009).

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In an essay on "opening psycho-analytical space to the spiritual", Stone discusses the paradigm shift from modernism to postmodernism, the meaning of spirituality, the understanding of the psycho-analytical space and "the congruence between psycho-analysis and age-old spiritual traditions" (Stone, 2005). In response, Cohen agrees with Stone that analytical clinicians should be more aware of their patients' spirituality and should incorporate that aspect of their patient's subjectivity into their work (Cohen, 2006). She feels though that Stone's vague notion of spirituality and her view of spiritual development reflect a cultural bias toward individual autonomy that promotes a limited conceptualisation of religion.

Hathaway presented the paper *"Preliminary Practice Guidelines for Religious-Spiritual Issues"* at the annual convention of the American Psychological Association (APsyA) (Hathaway, 2005). The paper presented 26 preliminary guidelines for clinical work with religious/spiritual issues, developed as part of an exploratory project for the "Psychology of Religion" division of the APsyA. These guidelines cover assessment and evaluation of religious/spiritual issues, intervention and multicultural practice and diversity.

The objective of Bienenfeld and Yager was to provide a framework to bridge the observed gaps between psychotherapy and the spiritual dimensions of religious life, between the beliefs and practices of patients and therapists and between evidence for the influence of spirituality on health and the lack of its integration into psychotherapeutic training (Bienenfeld & Yager, 2007). They cited the reasons for making the effort and set some educational objectives, including: a clear definition of terms; an usable outline for the investigation of these issues; a framework for spiritual development; distinctions between religious belief/behaviour and psychopathological ones; and self-awareness (including personal history and counter transference). Elias et al., presented a training program for a therapeutic program for a therapeutic intervention involving relaxation, mental images and spirituality (Elias et al., 2007).

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With regard to the role of spirituality in the training of psychotherapy, Aponte presents a view on the political bias, values and spirituality in the training of psychotherapists. He states that psychologists today face a different scenario. Not one of science versus religion, but one in which the way that the spiritual affects emotions and connections to people must be considered – disregarding of how we would define spirit, soul, faith or moral state (Aponte, 1996). He identifies the point of departure as: "*to discuss spirituality, we must first define it".* After defining spirituality, Aponte identifies the cultural fragmentation and subsequent greater insecurity, depression and anxiety in an unstable human environment in the American society as the reason why spirituality has become an essential component to consider in practice and training. Therapists enter training, whatever their disciplines, with their own social, cultural and religious biases. They join schools and institutes that have official positions or where trainers have their own pet convictions about social politics, values and spirituality. He offers some considerations:

- there is a need to look beyond the narrow view that treats spirituality strictly as formal religion;
- therapists need the sensitivity and expertise to help their patients navigate within these most complex and mysterious connections between people's spirituality and their everyday problems;
- even less are trainers (of psychotherapists) conversant with how therapists may use their own spirituality to understand and relate to the spirituality of those they are treating;
- training institutions need to assume responsibility for what they tell their trainees about spirituality and not to leave the values, morals and worldviews (which frame the therapy that clinicians deliver) unknown, unattended and unspoken;
- no training in psychotherapy is complete without looking at the therapist as a person with his/her private life experiences, psychology and spirituality;

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- there is training directed towards the therapist as a person that belongs to the classroom, but there is also a more practical experience appropriate to supervision; and
- spirituality need not only be part of some training specially focused on spirituality, it can also be incorporated into any personal training that a clinician receives, such as didactic analysis of the coaching of the family of origin.

1.2.6 REFERRAL AND COLLABORATION BETWEEN PSYCHIATRISTS AND SPIRITUAL PROFESSIONALS

The literature in this section is briefly referred to here in terms of two broad themes: religious traditions; and spiritual professionals' perspective.

1.2.6.1 Religious traditions

Morris wrote a seminal text book on religion and anthropology, as an update and sequel to a previous text by him in 1987 *"Anthropological Studies of Religion"* (Morris, 2006). He outlined the different approaches to the anthropological study of religion (e.g. intellectualist, emotionalist, structuralist, interpretive, cognitive, phenomenological and sociological). This text has a regional and ethnographic focus, while he mostly adopted a sociological approach in the discussion of religion in terms of shamanism, Buddhism, Islam, Christianity and Christianity in Africa, Hinduism, African-American religions, Melanesian religions and Neo-paganism and the New Age Movement. Other authors in this literature review also wrote on aspects of the different faith traditions (Loewenthal, 1995), (Wig, 1999), (Garroutte et al., 2003), (Yip, 2004), (Dein, 2005), (Rhi, 2001), (Lapierre, 1994), (Carter, 2002), (Chattopadhyay, 2007), (Sexton & Sorlie, 2008).

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1.2.6.2 Spiritual professionals' perspectives

A few authors addressed spiritual professional/religious worker perspectives in the medical literature that was reviewed for this study (Weaver et al., 2001), (Weaver et al., 2002), (Koss-Chioino, 2005), (Catanzaro et al., 2007), (Krippner, 2007), (Pembroke, 2008), (Agara, Makanjuola & Morakinyo, 2008). As a proper exploration of this theme represents an additional review of the non-medical literature as well, it was regarded to be beyond the scope of this inquiry (Van den Berg & Van den Berg, 2007), (Kourie, 2006).

1.3 PROBLEM STATEMENT

Considering the local South African background and the context of the subsequent international literature review, it is clear that the role of spirituality in health and mental health care is not a new thought. Since the late 1980's it has increasingly been explored by local and international authors and has generally been acknowledged to play an important role in the mental health and well-being of people and patients. The constructs of spirituality and religion have already - for some time and to some extent - been considered in the current accepted professional approach to the practice and training of specialist psychiatry. While dealing with the reality of multi-cultured, multi-religious South African communities on a daily basis, local psychiatry as a specialised branch of clinical medicine should, at the same time, continue to be practised and taught within the required evidence-based prerequisites, within the existing ethical requirements, and within the discipline of a scientific, medical profession. The formal incorporation of a spiritual dimension may therefore still have a significant theoretical impact on the local definition and content of the practice and teaching of psychiatry, as well as a practical and logistical impact on local mental health care infrastructure, the available resources and on systems of service delivery. It may, as such, contribute to an increase in cost and in demands on human resources available for formal mental health care services in South Africa. Numerous practical and ethical questions from a health systems, health education and

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peer review perspective remain, on if, and how to appropriately consider a spiritual dimension in South African specialist psychiatric practice and training.

In what can therefore currently be regarded as a changing environment for health and mental health care delivery in South Africa, it seemed important for local psychiatrists themselves to consider from within the discipline, as to what they would judge the role of spirituality to be in specialist psychiatric practice and teaching and to reaffirm, or redefine - if necessary - psychiatry's relationships and boundaries with the members of the existing, or with a potentially extending multidisciplinary mental health team.

1.4 STUDY PURPOSE AND OBJECTIVES

The purpose of this study was, therefore, to capture the views and experience of local psychiatrists on the role of spirituality in South African specialist psychiatric practice and training, and, based on these views and experiences, to develop a provisional model for the role of spirituality in local psychiatry as a scientific, medical profession within clinical medicine.

The objectives of the study were:

- to explore, analyse and describe the views and experience of current specialist psychiatrists on the academic circuit of a local department of psychiatry - as a case scenario at one particular teaching institution - on the role of spirituality and specialist psychiatric practice and training;
- to interpret these views and the experience of the local group of academic psychiatrists in the context of the views of authors in the international medical literature on the role of spirituality and psychiatry; and
- to construct a descriptive, practice-orientated model with operational guidelines on the role of spirituality in local specialist psychiatric practice and training.

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SUMMARY CHAPTER 1

Spirituality has gained importance in recent years in traditionally secular areas such business, government, health and psychiatry. Reference was made to South African literature, covering the past 50 years, on complementary therapies and mental health, and the relationship between traditional health practice and the Western scientific health system in South Africa. Many psychiatric disorders are chronic and recurrent in nature and despite the efficacy of psycho-pharmacological agents in the alleviation of psychiatric symptoms, no cure ("healing") for serious psychiatric conditions can yet be claimed. How current diagnostic systems in psychiatric practice account for spiritual or religious problems was summarised. Changes in what are being regarded as more politically correct South African terminology and structuring of services were alluded to. The work of Cloninger was referred to as an example of how the constructs of spirituality/religion have already been considered in aspects of specialist psychiatric practice. Themes from the review of the international literature, which although a subsequent methodological step of the study were discussed in this chapter for stylistic reasons, included: orientation in terms of spirituality and religion in psychiatry; the reality of spirituality and religion for practitioners and users; routine assessment of spirituality and religion in psychiatry; training of spirituality in psychiatry; scope and boundaries of spirituality in psychiatry; and referral and collaboration on spirituality in psychiatry.

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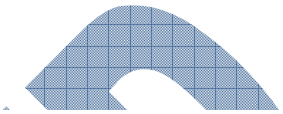
CHAPTER 2. RESEARCH DESIGN AND METHOD







CHAPTER 2. RESEARCH DESIGN AND METHODS

"All choreographers make a statement and begin, explicitly or implicitly, with a question: What do I want to say in this dance? In much the same way, the qualitative researcher begins with a similar question: What do I want to know in this study?" Valerie Janesick (2003)

INTRODUCTION TO METHODS

A description of the study's methodology is presented in this chapter, including a context for the study as a qualitative inquiry and an overview of a phenomenological approach and of theory development as a strategy of inquiry. The theoretical perspective that was adopted for the study is discussed, as well as the approach to theory development, with particular reference to the methodology of Chinn and Kramer for nursing theory development (Chinn & Kramer, 1995). This approach includes four processes: creating conceptual meaning; structuring and contextualizing; generating and testing theoretical relationships; and application of theory. Sampling for the study, data collection and content analysis, measures to ensure trustworthiness and ethical measures are discussed. The four steps in the theory or model constructing process that were adopted for this study are explained: (1) concept analysis; (2) relationship statements; (3) model description and evaluation; and (4) operational guidelines. These steps represent the first three processes of the Chinn and Kramer methodology.

2.1 DESCRIPTION OF THE STUDY

In order to achieve the objectives for this study, the study was designed as an explorative, descriptive, contextual, phenomenological and theory-generating qualitative investigation. In-depth, semi-structured interviews with individual academic specialist psychiatrists affiliated to a local South African university were conducted as primary data source.

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Considering selected journal articles from a review of the international literature as secondary data items, the content of the conducted interviews was subsequently compared and integrated with the content of the literature on the subject. The field study of this investigation therefore comprised of conducting the interviews and reviewing the literature. To the extent that these interviews collectively represent the views and experience of participants from one local teaching institution, this part of the study may also be regarded as a case study. A layered grounded analysis was made of the interview and literature content. The content was interpreted by writing narratives through which final categories of concepts were identified. The identified concepts were then defined by determining their denotative (dictionary) and connotative (subject) meaning.

In addition, this study also included a theory-generating component. A practice-orientated model was constructed based on one single core concept that was identified from the final integrated concept categories. This model was developed considering local psychiatry as a specialist discipline, within the framework of clinical medicine. The model was generated according to principles for nursing theory development, as summarised in Figure 2.1, (Dickoff, James & Wiedenbach, 1968a), (Dickoff, James & Wiedenbach, 1968b), (Chinn & Kramer, 1995), (Hardy, 1986), as well as by considering the principles for social theory development (Mouton, 1996), (Babbie & Mouton, 2001). The methodology for this study also referred to the tradition of qualitative inquiry in clinical medicine as described by Crabtree and Miller (Crabtree & Miller, 1999), (Miller & Crabtree, 2003).

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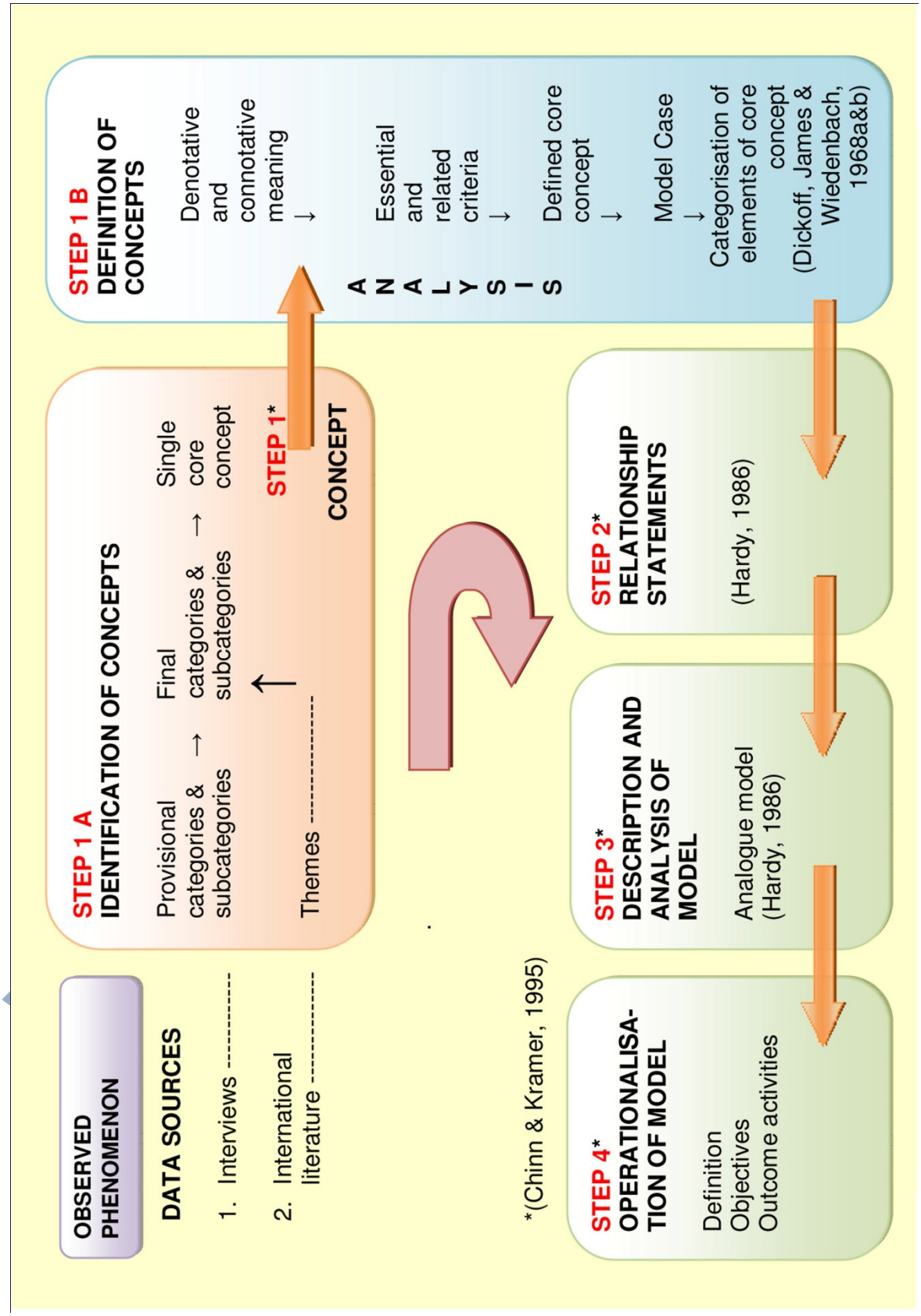

Figure 2.1 Research design and methods for the qualitative inquiry into the role of defined spirituality in local specialist psychiatric practice and training

2.1.1 CONTEXT WITHIN QUALITATIVE RESEARCH

Qualitative research is defined by Denzin and Lincoln as *"a situated activity that locates the observer in the world"*, consisting of a set of interpretative, material practices that make the world visible and which transform the world and turn it into a series of representations by including field notes, interviews, conversations, documents, photographs, recordings and memos to self (Denzin & Lincoln, 2003). *"At this level qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them."* (p5) Qualitative researchers are committed to the naturalistic perspective and to the interpretive understanding of human experience.

Denzin and Lincoln identified seven "historical moments" in American qualitative research: a traditional phase (1900-1950); a modernist/golden age (1950-1970); a "blurred genres" phase (1970-1986); a "crisis of representation" phase (1986-1990's); a postmodern phase; an experimental and new ethnographies phase (1990-1995); a post-experimental inquiry phase (1995-2000); and a future phase (from 2000 onwards) (Denzin & Lincoln, 2003: pp3,19-29). Flick also referred to these historic phases, but added a German perspective to it (Flick, 2006: pp16-24).

Janesick compares qualitative research with choreography and dance and includes certain decisions to be made at the beginning of the study or "warm-up" phase (Janesick, 2003). These decisions are about the question(s) that will guide the study, the selection of a site and participants, access and entry to the site and agreements with participants, the timeline, the selection of an appropriate research strategy, the place of theory in the study, the identification of the researcher's own beliefs and ideology, and identification of appropriate informed consent procedures and dealing with ethical problems that may

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present. This first phase, according to Janesick, is followed by "exploration and exercises" (looking for meaning, relationships regarding structure/occurrence/ distribution of events and point of tension) and then by the last phase of "illumination and formulation". Cutcliffe explains that the questions that qualitative research can answer relate to how processes occur, what an experience is like, how a culture contributes to influence behaviour, and how people live, cope, process and experience their daily lives (Cutcliffe, 2005).

Denzin and Lincoln (2003) summarise the five phases that constitute the qualitative research process as follows:

(1) positioning the researcher as multicultural subject;

(2) interpretive theoretical paradigms and perspectives;

(3) selecting strategies of inquiry (including case study, ethnography, action research, phenomenology, or grounded theory);

(4) applying methods of data collection and analysis of material collected (interviewing, observing, focus groups); and

(5) the art, practices and politics of the interpretation and presentation of the findings (judging adequacy, writing, evaluation).

2.1.2 RESEARCHER AS INSTRUMENT

Denzin and Lincoln (2003: pp5-7) described the researcher as a "quilt maker": *"The researcher may be seen as 'bricoleur', as a maker of quilts, or, as in filmmaking, a person who assembles images into montages. The qualitative researcher who uses montage is like a quilt maker or a jazz improviser. The quilter stitches, edits and puts slices of reality together. The process creates and brings psychological and emotional unity to an interpretive experience"*.

Like the dancer and choreographer who must be in tune with the body, the researcher must be in tune with the process of rendering a true account of the observed, experienced

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or studied content. *"Qualitative design requires the researcher to become the research instrument. This means the researcher must have the ability to observe behaviour and must sharpen the skills necessary for observation and face-to-face interview"* (Janesick, 2003: p57).

2.1.3 THEORETICAL PARADIGM

At the most general level Denzin and Lincoln (2003: p33) identify four interpretive paradigms: positivist and postpositivist; constructivist-interpretive; critical; and feminist-poststructural. Flick (2006: pp20-22) summarized different research perspectives according to three theoretical points of reference: symbolic interactionism and phenomenology; ethnomethodology and constructionism; and structuralist or psychoanalytical positions. Guba and Lincoln compared the basic beliefs of alternative inquiry paradigms in terms of three questions: ontology ("What is the form and nature of reality and what can be known about it?"); epistemology ("What is the nature of the relationship between the inquirer and what can be known?"); and methodology ("How can the inquirer go about finding out what can be known?") (Guba & Lincoln, 1994: p144-153).

Positivism originated from the philosophical debates in psychology in the late nineteenth century, the so-called *Methodenstreit*. (Fulford, Thornton & Graham, 2006). This was concerned with whether the human sciences should try and emulate the natural sciences or should go their own methodological way. The positivists argued that the human sciences were no different from the natural sciences. "Logical empiricism" is the name given to a family of views derived from logical positivism. The logical empiricist's picture of science emphasises the role of observations and makes a distinction between an independent language of observational concepts and a dependent language of theoretical concepts (Fulford, Thornton & Graham, 2006: p167, pp293-294). The ontology of positivism is commonly called "naive realism", the epistemology is dualist and objectivist, while the methodology is experimental and manipulative (Guba & Lincoln, 1994: p146).

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In contrast, the constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create methodologies) and a naturalistic (in the natural world) set of methodological procedures (Denzin & Lincoln, 2003: p35). Crabtree and Miller explain that constructivist inquiry is based on that knowledge that helps humans maintain cultural life, symbolic communication and meaning: "*Constructivists claim that truth is the result of perspective; it is relative. There is no objective knowledge. 'Interpretivists' trace their roots back to phenomenology and hermeneutics."; "Pluralism, not relativism is stressed, with focus on the circular dynamic tension of subject and object.";* and *"A constructivist inquirer enters the interpretive cycle and must be faithful to the performance or subject, must be both apart from and part of the dance, and must always be rooted in the context. There is no ultimate truth; there are context-bound constructions that are all part of the larger universe of stories"* (Crabtree & Miller, 1999: p9-10). Guba and Lincoln (1994: p146) state: "*Constructions are not more or less 'true', in any absolute sense, but simply more or less informed or sophisticated. Constructions are alterable, as are their associated realities*".

In terms of the descriptions of Denzin and Lincoln (2003: p35) and Guba and Lincoln (1994: pp146-147), a constructivist position was adopted in the approach to this study, as it was undertaken from a relativistic ontological viewpoint ("*realities are apprehendable in the form of multiple, intangible mental constructions*"), with a *subjectivist epistemology ("findings are created as the investigation proceeds*") and with a naturalistic set of methodological procedures ("*constructions can be elicited and refined through interaction between and among investigator and respondents*").

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2.1.4 STRATEGIES OF INQUIRY

Phenomenology, the research method adopted for this study, is one of many qualitative strategies of inquiry. This approach was regarded as appropriate because it was necessary to use indirect ways of data gathering (interviewing) on the observed phenomenon that spirituality is playing an increasing role in what were previously regarded as secular sectors. Phenomenology as a method is designed to describe the subjective, lived experience of people and to comprehend the meanings that people place on these experiences. "*Phenomenology results in interpretive narratives that describe meaning as fully as possible.*" (Chinn & Kramer, 1995: p145) As a philosophy of science, phenomenology greatly emphasizes the difference between the practice of science in the natural and social sciences. Edmund Husserl (1859-1938), the pioneering figure of the phenomenological approach, rejected the unanimity of science and urged to "return to the things themselves" (Botes, 2007: p66).

According to Crabtree and Miller, *"phenomenology seeks to understand the lived experience of individuals and their intentions within their 'life world'... "; "...it is the search for essences. It answers the questions, what is it like to have a certain experience?"* (Crabtree & Miller 1999: p28) Creswell also described phenomenology as *"a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by the participants"* (Creswell, 2004). He states: "*Understanding the lived experiences marks phenomenology as a philosophy as well as a method, and the procedure involves studying a small number of subjects through extensive and prolonged engagement to develop patterns and relationships of meaning. In this process, the researcher brackets or sets aside his or her own experiences in order to understand those of the participants of the study."* (p13)

Although this study also included a theory-generating component, it did not investigate a social process and also did not make use of theoretical sampling or returned to the field to

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conduct subsequent interviews. Grounded theory was therefore not the primary method of inquiry adopted in this study. Instead, nursing theory development as described by Dickoff, James and Wiedenbach (1968a&b) and by Chinn and Kramer (1995) provided the format for the theory-generating process of this inquiry. But because the methodological steps for this study included the coding of data and the identification of a single core concept for model construction, and because it continuously provides a trail of evidence on how concepts were grounded in the source data, it can however be noted that the strategy of inquiry for the study also included elements of grounded theory methods.

Dickoff, James and Wiedenbach played a major role during the 1960's in the early formal movement to develop theory originating in nursing. They debated the relationship of nursing theory to basic sciences theory at the time, contributing to the establishment of meta-theory for nursing as a discipline. Wiedenbach is also known for her conceptual model which represents a grand nursing theory, on the art of nursing that meets patients' needs through individualised care (Wiedenbach, 1964). Chinn and Kramer identify four processes for creating empirical grounded theory: creating conceptual meaning; structuring and contextualising theory; generating and testing theoretic relationships; and applying the theory (Chinn & Kramer, 1995: p77). Part of this process is the empirical grounding of emerging relationships. In this context, where the theorist derives relationship statements that are grounded in empiric evidence, they allude to the original work of Glaser and Strauss (1967) on grounded theory (Chinn & Kramer, 1995: p98). Chinn and Kramer conclude: "*Regardless of the approach, inductive investigators whose purpose it is to contribute empiric knowledge for the discipline, systematically organize and describe their research results in the form of proposed theory."* (p145)

Grounded theory does however also have philosophical roots in phenomenology and searches to identify the core social psychological and/or social structural process within a

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given social scene (Crabtree & Miller, 1999: p29). Grounded theory is a research tradition originally worked out by Glaser and Strauss which has made major contributions to medical sociology and nursing literature (Glazer & Strauss, 1967). Chinn and Kramer (1995) define grounded theory as "*theory generated from inductive research processes, where the source of data is empiric reality*" (p215). They describe grounded theory as an approach that has been used in nursing: "*This is a form of field methodology that requires the simultaneous processes of collecting, coding, and categorizing empiric observations and forming concepts and relationships based on the data obtained.";* and *"Grounded-theory methods result in relationship statements or propositions that the researcher has observed in empiric experiences*." (Chinn & Kramer, 1995: p145)

Referring to Annells and Ashworth (Annells, 1997a), (Annells, 1997b), (Ashworth, 1997), Addison also noted that in addition to being widely used in the medical sociology and nursing disciplines, grounded theory is now also used in other qualitative health care inquiry such as in family medicine (Addison, 1999: p149). "Grounded" means based in and connected to the context-dependent observations and perceptions in the social scene. The researcher constantly and recursively compares research interpretations, in the form of "memos" against the data - a process termed "constant comparative method". It can essentially be regarded as consisting of systematic inductive guidelines for collecting and analysing data to build middle-range theoretical frameworks that explain the collected data. Throughout the research process, grounded theorists develop analytic interpretations of their data to focus data collection further, which in turn is used to inform and refine their developing theoretical analysis. The goal of grounded theory is to develop classifications and theory grounded in the particular social scene investigated (Crabtree & Miller, 1999: p29). According to Creswell (2004: p13): *"Grounded theory is a strategy of inquiry in which the researcher derives a general, abstract theory in the process, action, or interaction grounded in the views of participants. This process involved using multiple stages of data collection and the refinement and interrelationship of categories of*

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information. Two characteristics of this design are the constant comparison of data with emerging categories and theoretical sampling of different groups to maximize the similarities and the differences of information". In Flick's approach, the model of the process for grounded theory research includes: theoretical sampling; theoretical coding; and writing the theory (Flick, 2006: pp98-100).

While postmodernists and poststructuralists have criticized the positivistic tendency of Glaser and Straus's original position on grounded theory, Charmaz argues that if a constructivist position is assumed, it reaffirms the studying of people in their natural setting (Charmaz, 2003). Therefore, according to her: grounded theory strategies need not to be rigid or prescriptive; a focus on meaning furthers interpretive understanding; and grounded theory can be adopted without embracing earlier positivist leanings (2003: p251). She states that constructivist grounded theory assumes that people create and maintain meaningful worlds through dialectical processes of conferring meaning on their realities and acting within them; and that it recognises the interactive nature of both data collection and analysis, resolves criticisms of method, reconciles positivist assumptions and postmodern critiques, and fosters the development of qualitative traditions through the study of experience from the standpoint of those who live it (pp269-70).

2.1.4.1 Clinical medicine

Regarding qualitative methods in clinical research settings, Miller and Crabtree, list nine basic premises that typify the biomedical model of clinical medicine: scientific rationality; individual autonomy, rather than family or community; the body as machine, with emphasis on physiochemical data and objective, numerical measurement; mind/body separation; diseases as entities; the patient as object; emphasis on the visual; diagnosis and treatment from the outside; and reductionism and the seeking of universals (Miller & Crabtree, 2003: pp397-434). They contextualise the use of qualitative research in terms of these premises of the world of biomedicine and its inherent scepticism towards qualitative

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methods. They argue that a "*clinical model of mediation"* should be adopted to mediate multiple perspectives. This would mean to: centre the researcher in the clinical world; focus on the questions that dawn there; acknowledge what is of value in biomedicine and highlight what is missing, silent or ignored; assume quantitative objectivism on the one hand and qualitative revelation on the other; follow a natural history path (characteristic of indigenous medical traditions and the early history of Western medicine) that is still an important aspect of primary health care; be participatory (including patients and clinicians in the research work); preserve and celebrate anomalies; allow "truth" to be emergent and not preconceived and not to be defensive or forceful; respect the plea for clinical action and the perceived need for coherence voiced by nearly all participants in the clinical world; and practice humility and patience (Crabtree & Miller, 2003: p404). According to them, examples of useful perspectives that may be added to clinical biomedicine through qualitative research include: an understanding of disease as a cultural construction; knowledge of additional medical models (e.g. bio-psycho-social); the holistic model; homeopathy and non-Western models (such as Chinese, Ayurvedic), shamanism; and the recognition of faith and the importance of spirituality in human life (pp404-405).

Strauss and Schatzman, two prominent figures in the development of qualitative research methods, were involved in an early sociological study of psychiatry, psychiatric professions, treatment philosophies and institutions (Strauss et al., 1964). Generally speaking, however, very few qualitative inquiries are routinely undertaken in psychiatry as a clinical discipline, in particular by psychiatrists. The apparent reasons for this, relate to be the extent to which the biomedical environment in which psychiatry operates, only regards empirical investigations (such as randomised controlled trials) as valid methods of inquiry to add to the (evidence-based) knowledge of psychiatry as a scientific discipline in clinical medicine. Culliford however, identifies a new paradigm for research in psychiatry and mental health moving beyond positivism, which includes qualitative research approaches such as participant observation and phenomenology, using data such as

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unstructured in-depth interviews (Culliford, 2002). Chibeni and Moreira-Almeida remark on the scientific exploration of "anomalous" psychiatric phenomena and recommend that exploring the "unknown" in psychiatry - such as the relationship between spirituality and mental health - may warrant a broadened perspective of inquiry that includes qualitative investigation (Chibeni & Moreira-Almeida, 2007).

2.1.4.2 A practice-orientated model

Where the essential part of the method for this inquiry consists of model construction, it seems important to clarify the meaning of some of the terms used in the process. Janesick (2003: p57) explains that when qualitative design requires the development of a model it is *"…like the designer or architect who builds a model, the choreographer or dancer who captures the dance on film, or the artist who creates a drawing or series of drawings, the researcher can use the model as a tool for further work or it can serve as a simple historical record"*.

(1) **Concepts**: Mouton describes the "components" of (social) knowledge in a hierarchy of different levels: first concepts (words); then statements (definitions, hypotheses); conceptual frameworks (typologies, models, theories); and research paradigms (e.g. structural functionalism, behaviourism, etc.), (Mouton, 1996). Concepts as "carriers of meaning" need to be combined into sentences that make up statements or propositions. Individual semantic and/or epistemic statements are combined in more complex kinds of frameworks (typologies, models and theories) and eventually into very broad theoretical paradigms or research traditions (p180). He defines concepts as the most elementary symbolic constructions by means of which people classify or categorise reality: *"Concepts... are the primary analytical instruments by means of which we come to grips with reality. One could say that concepts are the symbolic constructions by means of which people make sense of their worlds." (p181)* Where a concept is a symbol of

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meaning, a "definition" is a statement that delimits or demarcates the meaning of a word in terms of its sense and reference.

(2) **Model**: Modelling is a technique used to describe and explain, as well as to generate ideas or predictions. A model provides a systematic representation of phenomena by identifying patterns and regularities amongst variables (Mouton, 1996: pp187&195). While theories are distinguished from models in that they provide an explanation of phenomena by postulating an underlying causal mechanism, a rigid distinction between a model and a theory may not always be necessary. As "scientific metaphors" or analogies, the heuristic function of models is its most common characteristic, as models suggest ways of answering questions. The relationship between variables may be best expressed in terms of a model (Mouton, 1996: p196).

Hardy (1986) explains that in a theory the relationships between variables contained may best be explained in terms of a model. A model is a simplified representation of a theory or of certain complex events, structures or systems. Constructing a model forces the theorist to specify the precise relationship between components: "*Models like theories are isomorphic systems which are selective representations of the empirical world with which the scientist is concerned"* (1986: p347). According to Hardy (1986), models may be analogous, iconic or symbolic. Analogue models direct attention to resemblances between theoretical entities and familiar subject matter (e.g. using the analogy of a mechanical pump to explain the workings of the heart). Iconic models are direct representations, while symbolic models represent phenomena figuratively. Models have no truth value themselves. While the model may be "true" in one aspect of science, it does not mean that it will be true or hold up in another area: *"A major question to consider is the extent to which the model faithfully represents the phenomena of interest"* (p348).

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(3) **Theory**: In their original discussion of practice-orientated nursing theory Dickoff, James and Wiedenbach identify various kinds of theories, including: factor-isolating (first level or "naming") theories; factor-relating ("situation depicting" or second level) theories; situation-relating (third level or "predictive") theories; and situation-producing (fourth level or "prescriptive") theories. Ingredients of fourth level prescriptive theories include: specified goal content as an aim for activity; prescriptions for activity to realise the goal content; and a survey list to serve as a supplement to present and future prescription for action toward the attainment of the goal (Dickoff, James & Wiedenbach, 1968a).

Theories as deductive systems aim to explain and predict future phenomena or events and therefore an explanatory function is usually attributed to a theory. To establish their comprehensive definition of theory for nursing, Chinn and Kramer have considered the dimensions of meaning of the definitions of theory by different authors (1995: pp71-73). McKay defined theory as *"a logically interconnected set of confirmed hypotheses*" (McKay, 1969). Dickoff and James (1968) defined it as "*a conceptual system of framework invented to some purpose".* According to Watson (1985): "a*n imaginative grouping of knowledge, ideas, and experience that are represented symbolically and seek to illuminate a given phenomenon*"; and Ellis (1968): "c*onceptual and pragmatic principles forming a general frame of reference for a field of inquiry.*" From these Chinn and Kramer (1995) synthesised their own definition of theory: *"a creative and rigorous structuring of ideas that project a tentative, purposeful and systematic view of phenomena",* which incorporates a range of methods for the development of theory and represents theory as both process and product.

2.1.4.3 Developing theory

The four methodological steps that were followed in this study were based on the processes in the description of the development of empiric theory by Chinn and Kramer (1995: p77). The scope of this study was however limited to elements of the first three of

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these processes (creating conceptual meaning, structuring and contextualising theory and testing theoretical relationships). The fourth process - applying the developed theory in a clinical setting - was beyond the scope of the study and will have to be pursued by subsequent investigations.

(1) **Creating conceptual meaning**: According to Chinn and Kramer (1995, pp78-91) creating conceptual meaning provides a foundation for developing theory. But, while theorists provide definitions of terms used within theory, forming word definitions is not the same as creating meaning. Conceptual meaning conveys thoughts, feelings and ideas that reflect the human experience of the concept. Interacting experiences that form the meaning of an idea include: the word(s) or other symbolic label; the thing itself (object, property, event); and the feelings, values and attitudes associated with the word and with the perception of the thing. Creating conceptual meaning formulates as exactly as possible what is intended so that members of the discipline can follow the reasoning and logic on which a theory is based. Creating conceptual meaning produces a tentative definition of the concept and a set of tentative criteria for determining whether the concept exists in a particular situation.

An early step in the process of creating conceptual meaning is to select (identify) the concept - a word or phrase that communicates the idea the researcher wishes to convey. Words that are created to convey a special meaning within a discipline are called technical or professional terms. Selecting a concept is a process that often involves a great deal of ambiguity. To provide a sense of direction, the purpose in selecting a concept must be clear (for example to measure or define, or generate research hypotheses, develop a database).

Once a concept has been selected, the process of creating conceptual meaning proceeds by using sources from which one can generate and refine criteria that include indicators

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for the concept. Dictionary definitions provide synonyms and antonyms and convey commonly accepted ways in which words are used. Existing theories provide another source of definitions that sometimes extend beyond the limits of common linguistic usage. A useful approach to creating conceptual meaning is to construct cases that represent the experience that is explored. In addition, visual images (photographs, drawings) are useful sources in creating conceptual meaning, as are popular and classical literature, music and poetry. Professional literature as a source would provide meanings that are pertinent to the practice of the discipline.

Criteria for the concept emerge gradually and continuously as definitions, various cases, other sources and varying contexts and values are considered. The process involves providing guidelines for how to conceptualise meaning. Assessing the adequacy of the created conceptual meaning is related to the processes used for creating meaning and to the conceptual meaning itself. Adequately created meaning is valid and reliable, but also reasonable and communicable.

(2) **Structuring and contextualising theory**: This involves the forming of systematic linkages between and among concepts, resulting in a formal theoretic structure (Chinn & Kramer, 1995: pp91-97). If theory is structured as an outcome of grounded research, the interrelationships between data clusters guide the structure that is being created (p92).

The approaches to structuring and contextualising theory include: identifying and defining concepts; identifying assumptions; clarifying the context within which the theory is placed; and designing relationship statements. As the concepts are specified or begin to form, early ideas about the structure of their relationships begin to emerge. There are usually one or two primary or central concepts around which the theoretic relationships build. Antecedent, coincident or intervening, and consequent concepts imply prediction within a linear time frame. As initial ideas are formed concerning relationships between concepts,

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the concepts themselves become clearer. As the concepts of the theory are identified and conceptualised, theoretical definitions emerge, which form the basis for and reflect empiric indicators and operational definitions for concepts that are needed for research and convey a general meaning of the concept. Operational definitions are different in that they indicate as exactly as possible how the concept is to be assessed in a specific study.

Assumptions are underlying givens that are presumed to be true. Philosophical assumptions form the philosophical grounding for a theory. Non-philosophical assumptions also affect the value of the theory and are those assumptions that could be empirically investigated. An assumption would not require empirical evidence, but it is fundamental to the relationships that are proposed. It is these relationships, not the assumptions that will be empirically tested. Theory that arises from inductive methods is contextualised as a result of the process itself. Contexts that are too broad or too narrow limit the application of the theory.

Relationship statements describe, explain or predict the nature of the interactions between the concepts of the theory and may range from a simple relationship between two concepts to complex relationships accounting for the interaction between several concepts. The process of designing relationship statements requires specific attention to the substance, direction, strength and quality of interactions between concepts. Hardy (1986: pp342-353) explains the categorisation of concepts by comparing theory with language, as both consist of elements, formulations and a set of definitions (i.e. comprising syntax and semantics). Syntax is concerned with the occurrence of concepts in the axioms, postulates or hypotheses of a theory, with the relationships between the concepts and between the hypotheses of a theory, while semantics is concerned with the specific meaning attributed to the concepts. Syntax of theory is described through statements about the types of relationships between concepts. Types of relationships include: causal (“If A, always B”); probabilistic (“If A, probably B”); time order (“If A, later

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B"); concurrent ("If A, also B"); sufficient ("If A, then B, regardless"); conditional ("If A, then B, but only if C"); and necessary ("If A and only A, then B"), (Hardy, 1986).

(3) **Generating and testing theoretic relationships**: The activity of generating and testing theoretic relationships draws on one or more subcomponents: empirically grounding emerging relationships; naming empiric indicators; and validating relationships through empiric methods (Chinn & Kramer, 1995: pp97-100).

The process of empirically grounding emerging relationships involves connecting experiences with representations of those experiences. A social context is selected in which the phenomenon is likely to be observed. "*From the observations of the interactions and circumstances of that context, the theorist derives relationship statements that are grounded in empirical evidence, a process called grounded theory.*" (p 98)

A particular challenge with respect to generating and testing theoretical relationships is the selection of empirical indicators for a concept. Through the processes for creating conceptual meaning, it will be possible to suggest a full range of possible empirical indicators for a concept. Empirical indicators and operational definitions are used to represent concepts as variables in empiric research and are empirically formed for concepts arising from inductive approaches. Part of the process for identifying empiric indicators, especially when primary deductive processes are used, is to state operational definitions. Operational definitions specify the standards or criteria to be used in making the observations. Measurement tools may for example be developed to assess variables as defined by operational definitions.

Generating and testing theoretical relationships also requires creating a design that tests designated relationships. The purpose of deductively testing any relationship statement is to provide empirical evidence that the relationships proposed in the theory are adequate

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when represented in a specific situation. If theoretic statements are not supported by empirical evidence, one of four disparities may exist: the meaning of concepts has not been adequately created; the relationship statement is not adequately structured; the empirical indicators of the concept are not adequately named; and the operational definitions are inadequate or inconsistent.

2.1.5 DATA COLLECTION AND TYPES OF ANALYSIS

The means of qualitative data collection include participant observation, writing of field notes, document or visual data reviews, focus groups and interviews (structured, semi-structured, unstructured). In this study, in-depth semi-structured interviews, as well as the international literature were regarded as data.

Structured or focused interviews usually proceed after a uniform stimulus (such as a pre-analysed film or radio broadcast) was presented to participants with the aim of providing a basis for interpreting statistically significant findings of a parallel or later quantitative study (Flick, 2006: pp150-152). During semi-structured interviews, interviewees are supported by methodological aids (such as "structure laying technique") to reconstruct a participant's statements about the issue under study into a structure (pp157-159). In unstructured interviews no structuring techniques are employed and only non-directive techniques such as reflecting, paraphrasing, clarifying and summarizing are used.

2.1.5.1 Sampling

Flick (2006: pp122-134) points out that sampling can be encountered at different stages of the research process: during data collection (case sampling); during data interpretation (material sampling); and during the presentation of findings (presentational sampling).

In the data collecting phase of this study, a purposive sample for the interviews was drawn from the current group of consultants of the Division of Psychiatry on the circuit of

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the University of the Witwatersrand (WITS) in Johannesburg, as primary target group for this study, including academic psychiatrists attached to the Charlotte Maxeke Johannesburg Academic Hospital, Tara the H. Moross Centre, Sterkfontein Hospital, Helen Joseph Hospital and the Chris Hani Baragwanath Hospital, as well as to community psychiatric services and the WITS Donald Gordon Medical Centre.

Sampling was also necessary in the selection of data items during the literature review. A reference list was compiled of journal articles from the database search which were regarded as the most important reference articles on spirituality and practice related issues, training and users' perspectives. The decisions about which articles to include in the review also represent a situation of purposive sampling.

2.1.5.2 Interviews

As primary data source, in-depth semi-structured interviews were conducted with a group of local academic psychiatrists to gain in-depth knowledge from participants about their experience of and view on the role of spirituality in specialist psychiatry practice and training (Kvale, 1983). Participants were presented with one open-ended question: ***"What is your experience of and view on the role of spirituality in specialist psychiatric practice and training?"*** Basic data on the demographic and professional profile of each participant was collected by means of a short biographical questionnaire completed by all participants **(Appendix 2.1** - **Interview schedule)**. During the actual interviews, concepts were explored and elaborated on only through non-directive techniques such as reflecting, paraphrasing, clarifying and summarising. Participants' responses were documented, analysed and compared. Each interview was audio-taped and transcribed, while field notes were compiled after each interview describing underlying themes, dynamics and circumstances during the session, as well as the researcher's impressions. This also enabled the bracketing of the researcher's own conceptual framework during

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the data collection phase of the study. Interviews were conducted until data saturation was reached.

2.1.5.3 Literature

Flick (2006: pp57-64) identified several forms of literature inclusion in a qualitative study: theoretical literature about the topic; empirical literature about earlier research; methodological literature; and theoretical and empirical literature to contextualise, compare and generalise findings. In terms of the use of empirical literature, Strauss and Corbin also list several ways of using literature, including: concepts from the literature can be a source for making comparisons with (other) collected data; literature can be a secondary source of data, for example, quotations from interviews in articles may compliment studied material; areas for theoretical sampling can be suggested by the literature; and literature can be used for confirming findings or can be overcome by the (new) study's findings (Strauss & Corbin, 1990/1998).

In this study, local (theoretical) literature on the South African context for this study was used in the first part of Chapter 1 (paragraph 1.1.1), to provide the background for this inquiry on the role of spirituality in South African specialist psychiatric practice and training. Methodological literature was used in this chapter, to contextualise this study within qualitative research inquiry. In addition, the review of the international medical literature on spirituality and psychiatry in this study was used as a secondary data source, following only after the completion of the interviews. Although it was a style requirement to present the international literature review in Chapter 1 (paragraph 1.2), as a step in the methodology, the literature was only reviewed in the second phase of Step 1 - on completion of the interviews, after which the content of the interviews with local psychiatrists was compared and integrated with the content of the international literature. References to the selected articles and their summarised, coded content were used to

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compliment the studied interview material. The international literature was also used as part of the method to determine the connotative (subject) meaning of identified concepts.

To sketch out the terrain of the subject of spirituality and psychiatry for this study, different types of literature were initially considered. An overview of the topic was obtained by also referring to less formal types of writing such as selected news media articles and publications aimed at a more general readership. The provisional literature overview therefore included books ("popular", subject and textbooks) and chapters in books, scientific journals (articles, editorials, opinions and reviews, letters and replies), as well as some references to the news media (Time Magazine, Newsweek, local newspapers). Journal articles that were formally included as data items were identified from the comprehensive review of the international literature. The literature search was conducted with the support of staff from the WITS Faculty of Health Sciences Library using the phrase "spirituality and psychiatry". Databases covered by the search included: African Digital Library, Biblioline, BioMed Central, BMJ Clinical Evidence, Cochrane Library, Sabinet, Cudos, DOAJ, Ebsco Host, First Search OCLC, Thomson Gale, Ovid SP, JStor, MDConsult, Nexus, Oxford Scholarship Online, ProQuest, Psychiatry Online, PubMed, SAePublications, SAGE Premier Online, Science Direct, Scopus, Springer and Wiley Interscience. A record of each selected reference was entered into an Excell spreadsheet according to a structured data sheet **(Appendix 2.2 - Datasheet for the entry of literature records)**.

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2.1.5.4 Content analysis

Tesch's original framework organises qualitative data analysis types (Tesch, 1990), (Babbie & Mouton, 2001: pp489-516). In this framework she provided a flow diagram for making relevant choices about what analytical approach to follow. The points of departure in this framework include: interest in the characteristics of language; interest in the discovery of regularities; and interest in the comprehension of meaning of text or action. A

phenomenological approach as a strategy of inquiry would, as such, be interested in the discovery of regularities and will therefore be involved in the identification and categorisation of content elements (concepts) and the exploration of their connections.

Janesick (2003: p64) considers how finding categories and the relationship and patterns between and among categories leads to completeness in the narrative. She refers to Denzin's use of Husserl's phenomenological approach (Denzin, 1989), suggesting five steps: locate key phrases and statements; interpret the meanings of these phrases; obtain (the participants') interpretation of these findings; inspect what these interpretations reveal about essential, recurring features of the phenomenon; and offer tentative statements of definition of the phenomenon in terms of the essential, recurring features.

Discussing interpretive practice, Gubrium and Holstein (2003) refer to Schutz's development of social phenomenology using Husserl's philosophical phenomenology as point of departure to investigate the structures of consciousness that make it possible to apprehend an empirical world (Schutz, 1970). *"The myriad phenomena of everyday life are subsumed under a delimited number of shared constructs (or types). These 'typifications' make it possible for individuals to account for experience, rendering various things and sundry occurrences recognizable as particular types of objects or events"* (Gubrium & Holstein, 2003: p217).

Concurring with Flick, Charmaz (2003) identifies the elements of grounded content analysis such as grounded theory development to include: the coding of data (line-by-line, dimensionalising, axial coding, conditional matrix); memo writing (an intermediate step detailing the properties of codes and clarifying how categories of codes may connect and fit into the larger process); theoretical sampling ; and re-analysis (including computer-assisted analysis). The coding of data starts the chain of theory development and generating action codes facilitates the making of comparisons (between different people,

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between the same individuals with themselves at different times, between different incidents, of data within categories and between different categories), (Charmaz, 2003). Theoretical coding was introduced by Glaser and Strauss and further elaborated by Glaser, Strauss and Corbin (Glazer & Strauss, 1967), (Glaser, 1978), (Strauss, 1987), (Strauss & Corbin, 1990). Coding here is understood as representing the operations by which data are broken down, conceptualised, and put back together in new ways. It is the central process by which theories are built from data. Strauss and Corbin have identified three types of coding: open, axial and selective coding (Strauss & Corbin, 1998).

(1) **Open-coding**: Refers to the creation of certain categories pertaining to certain segments of text and is aimed at expressing data and phenomena in the form of concepts. Open coding may be done line-by-line, by sentence or paragraph or by coding the entire text. Units of meaning classify expressions (single words, short sequences of words) in order to attach annotations and "concepts" (codes) to them (Flick, 2006).

(2) **Axial coding**: Is the next step to refine and differentiate the categories resulting from open coding. It is the process whereby data is put back together in new ways after open coding, by specifying categories and making connections between categories and subcategories. Axial categories are enriched by their fit with as many passages as possible. Relationships between categories and their subcategories are thus established or clarified (Flick, 2006: p301). Three kinds of categories are identified: conditional (leading to development in the object of study), strategic or interventional (all actions and interactions relevant to the object of study), and categories which denote consequence (including all outcomes of action or interaction).

(3) **Selective coding**: Is the process of selecting a core category (concept) and continues axial coding at a higher level of abstraction, elaborating the development and integration of axial coding in comparison to other groups (Flick, 2006: p302). A core category

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(concept) is the central phenomenon around which all other categories are integrated. In this way, the formulation of "the story of the case" (or study) is found and the result should be one central category and one central (core) phenomenon or concept. For Chamaz (2003) categories for synthesising and explaining data arise from focused codes and turn description into conceptual analysis by specifying properties analytically. As categories are being developed and refined, gaps in the data and the theory may become apparent. If grounded theory was the strategy of inquiry, these gaps would be filled by theoretical sampling (taking the researcher back to the data and the field to gain more insight), which helps to identify conceptual boundaries and to pinpoint the fit and relevance of the categories.

The type of data analysis used in this study was layered grounded thematic content analysis through the coding of data. Open coding was used for the analysis of the thematic content of the interviews as well as the content of the literature. The central story line and provisional categories and subcategories of concepts from the interviews were finalised after consensus was reached between the researcher and an independent coder. Key quotations from the interviews were included in the interpreting narrative on the data, to provide the necessary evidence that the provisional identified concepts were derived from, or grounded in the interview content.

Concepts and categories were also identified from the literature review. These categories were compared and integrated with the provisional categories from the interviews, to compile a list of final categories from the integrated data. Key references from the reviewed literature were included in the narrative interpreting the integrated data, to also provide the necessary chain of evidence that the final identified concepts were grounded in the integrated data. From the narrative on the integrated data, a single core concept for model construction was indentified. The elements of the identified core concept were defined by exploring their denotative and connotative meaning. Essential and related

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criteria were established for the definition of each element of the core concept. A model case was constructed to provide a context in which the defined core concept may have to be considered. The elements of the defined single core concept were then categorised according to the activity of a "prescriptive (or fourth level) theory" as described by Dickoff, James and Wiedenbach (1968a). This categorisation of the core concept elements - in terms of an agent of activity, receivers of activity, procedures, context, dynamic and outcome of activity - formed the basis for the rest of the model construction process.

2.1.6 INTERPRETATION AND PRESENTATION

Charmaz explains how the rendering of the developed theoretical framework in writing ("writing the story") is the final part of the process of theory development and how the style of writing can also reveal the theorist's paradigm as either objectivist/positivist or constructivist: *"Simple language and straightforward ideas make theory readable. Theory remains embedded in the narrative, in its many stories"* (Charmaz, 2003: p278). Flick states that text (writing) is not only an instrument for documenting data and a basis of interpretation, but is in itself an instrument of mediating and communicating findings and knowledge. In this context, writing becomes relevant in qualitative research for presenting the findings of the project, as a starting point for evaluating the proceedings which led to them and as a point of departure for reflexive considerations about the overall status of the research (Flick, 2006: p398). *"Where trustworthiness and credibility replace reliability and validity of data and findings as the criteria for evaluating qualitative research* (according to Lincoln and Guba) *the problem of grounding is transferred to the level of (the quality of the) writing and reporting"* (Flick, 2006: p404), (Lincoln & Guba, 1985).

In this study, an initial description of the content of the interviews and a subsequent description of the combined, integrated content of interviews and literature were provided as interpretive narratives (central storylines). In addition, the relationships between the categorised elements of the defined core concept, the subsequent construction and the

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eventual attributes of the constructed model based on the categorised core concept, were also described. In this way the findings and knowledge from the data were further mediated in order to derive a practical operationalisation of the described model for possible implementation in different settings of local specialist psychiatric practice and training.

2.1.7 MEASURES TO ENSURE TRUSTWORTHINESS

Flick (2006: pp367-383) addresses the problems involved in assessing qualitative research in terms of reliability, validity and objectivity with its usual application in quantitative measurement. He refers to the discussion by Kirk and Miller of "quixotic" reliability (how far a particular method can continuously lead to the same measurements or results); "diachronic" reliability (the stability of measurements or observations in their temporal course); and "synchronic" reliability (the constancy or consistency of results obtained but by using different instruments). (Kirk & Miller, 1986) The question of validity can be summarised as whether the researchers see what they think they see: "Is the explanation credible?" Reformulating the concept of validity to be more useful for qualitative methods, focused for example on how far researchers' specific constructions are empirically grounded in the material that they have studied and how far this grounding is transparent to others. Considering objectivity, interpreted as consistency of meaning when two or more independent researchers analyse the same data, the basic strategy here is to triangulate results from different researchers (Flick, 2006).

In view of the doubtful application of the "classical" criteria of assessment to qualitative methods, Guba, and Lincoln and Guba suggested alternative criteria (Guba 1981), (Lincoln & Guba 1985). Trustworthiness, credibility, transferability, dependability and confirmability are suggested as referents for qualitative research. This allows for researchers to cross-check their work through member checks and audit trials. As this study was mainly approached from a constructivist position, credibility, transferability,

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dependability and confirmability, according to Guba (1981), were considered to be the more applicable trustworthiness strategies to take into account. Credibility, dependability and confirmability strategies include: prolonged and varied field experience; reflexivity (field journal); triangulation; member checking; peer examination; and code-decode procedures. Transferability strategies include a dense description of the data and stepwise replication.

Triangulation is the simultaneous display of multiple, refracted realities and is the term used for the combination of different methods, study groups, local and temporal settings and different theoretical perspectives in dealing with a phenomenon. Denzin (1989) suggests four types of triangulation: data (different time, space, and persons); investigator (different from researcher); systematology (multiple perspectives and hypotheses); and methodological (different, combined). Triangulation may be used as an approach to further ground the knowledge obtained with qualitative methods (Flick, 2006: p390). Janesick (2003: pp66-68) also refers to triangulation, but when considering interdisciplinary triangulation (between art, sociology, history, dance, architecture, anthropology), she continues by identifying "crystallisation" as a better concept or lens through which to view qualitative research designs and their components. *"The image of the crystal with many facets – that grow, change and alter, but is not amorphous - replaces the land surveyor and the triangle."* She referred to Richardson who explained crystallisation as part of the postmodern project (Richardson, 1994). In crystallisation, the writer tells the same tale from different points of view (Denzin, 1989: p8): *"Viewed as a crystalline form, as a montage, or as a creative performance around a central them, triangulation as a form of, or alternative to, validity can thus be extended".*

Krefting discussed truth value, applicability, consistency and neutrality as measures to ensure trustworthiness were discussed (Krefting, 1991). Truth value refers to the fact that the data is rich and reflects participants' knowledge. Applicability as a measure refers to

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being able to utilise results of the research in similar contexts with similar participants. Consistency refers to being able to follow the research methodology and come to similar conclusions. Neutrality refers to the research being free from researcher bias (Myburgh & Poggenpoel, 2007).

This investigation was conducted considering credibility, transferability, dependability and confirmability, as described by Guba and Lincoln and Guba, as appropriate measures of trustworthiness (Guba 1981), (Lincoln & Guba 1985). To this purpose, triangulation, reflexivity (field notes) and peer examination were included as measures in this study. Triangulation was incorporated in the study, by including independent (open) coding of the interview content, in addition to the researcher's own coding, as well as using two sources of data to consider multiple viewpoints (interviews and literature). By investigating a phenomenon in clinical psychiatry, while referring to the methods for the development of nursing theory in the way and extent that it did, the methodology for this study may also have incorporated interdisciplinary triangulation, or "crystallisation" as explained by Janesick (2003). In addition, truth value, applicability, consistency and neutrality, as discussed by Krefting, were also considered in the interpreting and presenting of the findings of this inquiry (Krefting, 1991). Field notes were compiled during the process of conducting the interviews, to reflect on the particular circumstances of, and impressions about each interview. As this study is primarily a phenomenology inquiry, to further enhance its trustworthiness, a bracketing statement on the investigator's personal position has also been included as **Appendix 2.3 - Personal position of researcher** (Botes, 2007). Peer examination formed part of the measures incorporated in this study, by including a step in the description and evaluation of the model, to present the draft model to an evaluating panel of experts. The panel consisted of model building experts, but also included a number of academic psychiatrists, who provided the peer review of the model. The meeting with the panel was audio-taped and transcribed in the same way that the

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individual interviews with participants were initially done. A review of the draft model presented to the panel was then undertaken, considering the critique of each member.

2.1.8 ETHICAL MEASURES

Permission to conduct the study was obtained from the academic and clinical heads of the Division of Psychiatry of the University of the Witwatersrand (WITS). Ethical clearance for this study (Protocol number M070220) was applied for and granted by the WITS Human Research Ethics Committee (WHREC) in 2007 **(Appendix 2.4 - Ethics clearance certificate)**. Informed consent for participation from individual participants was obtained separately. The invitation to participate and the informed consent forms that were used included brief background material about the context and method of the study **(Appendix 2.5 - Invitation to participate in the study and informed consent)**. As suggested by the WHREC, the organised profession, as represented by the South African Society of Psychiatrists (SASOP) through its regional structures in Southern Gauteng, was informed about the intent, scope and progress of the study, with the request to make the researcher or the WHREC aware of any ethical concerns or problems arising from the study or participation in the study by its members. Participants were also informed that queries about, or problems with, the study could be directed to the WHREC or through the SASOP structures. No remuneration was offered for participation in the study. In addition, written consent to audio-tape the meeting with an evaluating panel consisting of model-building experts and invited academic psychiatrists, was also obtained individually from participating members. This meeting occurred during Step 3 of the methods for this study, as part of the description and evaluation of the model.

2.2 STEP 1. CONCEPT ANALYSIS

The first step of the method for this study corresponds with the first Chinn and Kramer process of creating conceptual meaning. This step of theory development consists of

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"Step 1A" - the identification of concepts (the field study); and "Step 1B" - the definition and classification of concepts.

2.2.1 IDENTIFICATION OF CONCEPTS - THE FIELD STUDY (STEP 1A)

To identify the concepts for inclusion from the interviews, the transcripts of the interviews were analysed by the researcher, as well as by an independent coder using open coding. Following consensus between the researcher and the independent coder, the main storyline (providing a narrative for the content from the interviews) and provisional categories and subcategories of concepts were derived. Open coding of the summarised text of each literature record was used to identify concepts from the (international) literature. The two sets of categories and subcategories from the interviews and from the literature were compared and then integrated to finalise the concepts. A single core concept was identified from these final categories for inclusion in the model.

The outcome of **Step 1A** in this process of theory building was the "components" derived from the analytical activity of this phase, namely a final set of identified **categories and subcategories** of concepts, and the **identification of a single core concept.**

2.2.2 DEFINITION AND CLASSIFICATION OF CONCEPTS (STEP 1B)

The meaning of the identified single core concept derived from the final categories and subcategories of concepts from the combined, integrated interview and literature content, was established by: (1) clarifying dictionary definitions of concepts to derive denotative meaning; and (2) confirming conceptual or connotative (subject) definitions as found in the international subject literature. Essential and related criteria were established for the definition of each element of the core concept. In addition, a hypothetical model case was drafted in this section, to demonstrate the meaning and context in which the model might

have to be applied. In constructing this case, a scenario was presented that best demonstrated the scope and extent of the pertaining issues.

Following the definition of the elements of the core concept, these elements of the core concept were categorised according to the six aspects of the survey list of the activity for a "prescriptive (or fourth level) theory" as described by Dickoff, James and Wiedenbach (1968a). These aspects corresponded to the following questions:

(1) Who or what performs the activity?

(2) Who or what is the recipient of the activity?

(3) In what context is the activity performed?

(4) What is the end point of the activity?

(5) What is guiding procedure, technique, or protocol of the activity? and

(6) What is the energy source for the activity?

These aspects of activity formed the six vantage points according to which the elements of the core concept for this study were classified. These were: (1) agency ("Agent"); (2) patiency or recipiency ("Receivers"); (3) framework ("Context"); (4) terminus ("Outcome"); (5) procedure ("Procedure"): and (6) dynamics ("Dynamic").

The first outcome of **Step 1B** in this process of theory building was the "compilation" derived from the synthetical activity in this phase, namely the **defined core concept** that was grounded in and assembled from the components of the previous step in a new way.

The second outcome of **Step 1B** was the classification or categorisation of the elements of the core concept according to the survey list for **4th level theory attributes** (Dickoff et al., 1968) as agent, receivers, procedure, context, dynamic, and outcome.

The further modelling of the defined and categorised single core concept from the combined data content was then approached by:

- translating these categorised concept elements into an analogy adopted for the proposed model (Hardy, 1986);
- compiling a graphic representation of the model; and
- drafting a framework of guidelines for the operationalisation of the model.

2.3 STEP 2. RELATIONSHIP STATEMENTS

While focus, during Step 1, was on the semantics of the identified concepts, this second step of the method for the study addressed syntax. It corresponded with the second Chinn and Kramer process of structuring and contextualising theory. In this second step of theory development, systematic linkages between and among concepts were formed, resulting in a formal theoretical structure (Hardy, 1986: pp342-353). Structuring and contextualising was done according by: (1) identifying and defining concepts; (2) identifying assumptions; (3) clarifying the context within which the theory has been placed; and (4) designing relationship statements (Chinn & Kramer, 1995: p92).

The outcome of **Step 2** in this process of theory building was the "structure" and "context" derived from the integrative activity in this phase, namely **statements** explaining the relationship of concept elements in relation to each other and to the whole.

2.4 STEP 3. DESCRIPTION AND EVALUATION OF THE MODEL

The third and fourth steps of the method for this study corresponded with the third Chinn and Kramer process of generating and testing theoretic relationships. The fourth Chinn and Kramer process of applying the theory was beyond the scope of this study.

Firstly, an overview of the proposed model was described, making use of an explanatory analogy. The draft model was then presented to a panel consisting of model construction experts and invited senior academic psychiatrists as peer review members. Criteria for evaluating theories included those identified by Hardy (1986) and by Chinn and Kramer

(1995: pp135-136) **(Appendix 2.6 - Guidelines for the evaluation of theory).** Hardy (1986) included criteria such as: meaning and logical adequacy; operational and empirical adequacy; generality; contribution to understanding; predictability; and pragmatic adequacy.

The critique of the panel members was audio-taped and transcribed. A review of the model was made taking the critique into account. This step was included in the theory developing process, to enhance trustworthiness and to identify how to better align the proposed model with the purpose to develop practice-orientated theory for a model on the role of spirituality in local specialist psychiatric practice and training. The final model was described in terms of the guidelines of Chinn and Kramer (1995: pp118-119). These guidelines for the description of theory include purpose, assumptions, concepts, definitions, relationships and structure **(Appendix 2.6 - Guidelines for the description of theory).** The description and evaluation were done bearing in mind that psychiatry in South Africa operates as a scientific specialist discipline within clinical medicine, but also in close association with various other more socially-orientated mental health care disciplines such as nursing, psychology, social work and occupational therapy.

2.5 STEP 4 . OPERATIONAL GUIDELINES

Following the description of the model, practical guidelines were compiled to operationalise the model as a frame of reference in different practice scenarios for which it was intended.

The outcome of **Steps 3 and 4** in this process of theory building was the "rendering" derived from the critical activity in this phase, namely a clear, simple, general and accessible **operationalised model**, based on the grounded core concept from the previous steps, which is of importance to the practical scenario for which it is intended.

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In conclusion, the four steps - concept analysis (Step 1), relationship statements (Step 2), model description and evaluation (Step 3) and operational guidelines (Step 4) - that were followed to develop a practice-orientated model in this study represent the first three processes of the Chinn and Kramer method for nursing theory development. Considering the meaning and the categorisation of the defined core concept elements, the relationship statements that were formulated and the description of the model in the previous steps, as well as considering the operational guidelines in this last step, it will be possible to select empirical indicators to represent these defined concepts as variables in future empirical research to test the theoretical relationships of these variables. The model that resulted from these processes, and the hypotheses that it may contain, can subsequently be applied and tested in relevant practical scenarios. After review and testing, the model can be re-adjusted and re-applied in an ongoing manner.

SUMMARY CHAPTER 2

In this chapter, the study was identified as being an explorative, descriptive, contextual, phenomenological and theory-generating qualitative investigation. A context for this study within qualitative inquiry was provided. The theoretical paradigm for the study has been identified as a constructivist position. The use of a phenomenological approach with layered grounded analysis as a strategy of inquiry and method of data analysis was discussed. The use of in-depth interviews as a primary data source compared with international literature as a secondary data control was discussed. Finally, the four consecutive steps of the study based on the first three processes of Chinn and Kramer for creating empiric theory, were clarified. In the next two chapters, results of this investigation will be reported on in terms of the flow-diagram of the methodology summarised in Table 2.1.

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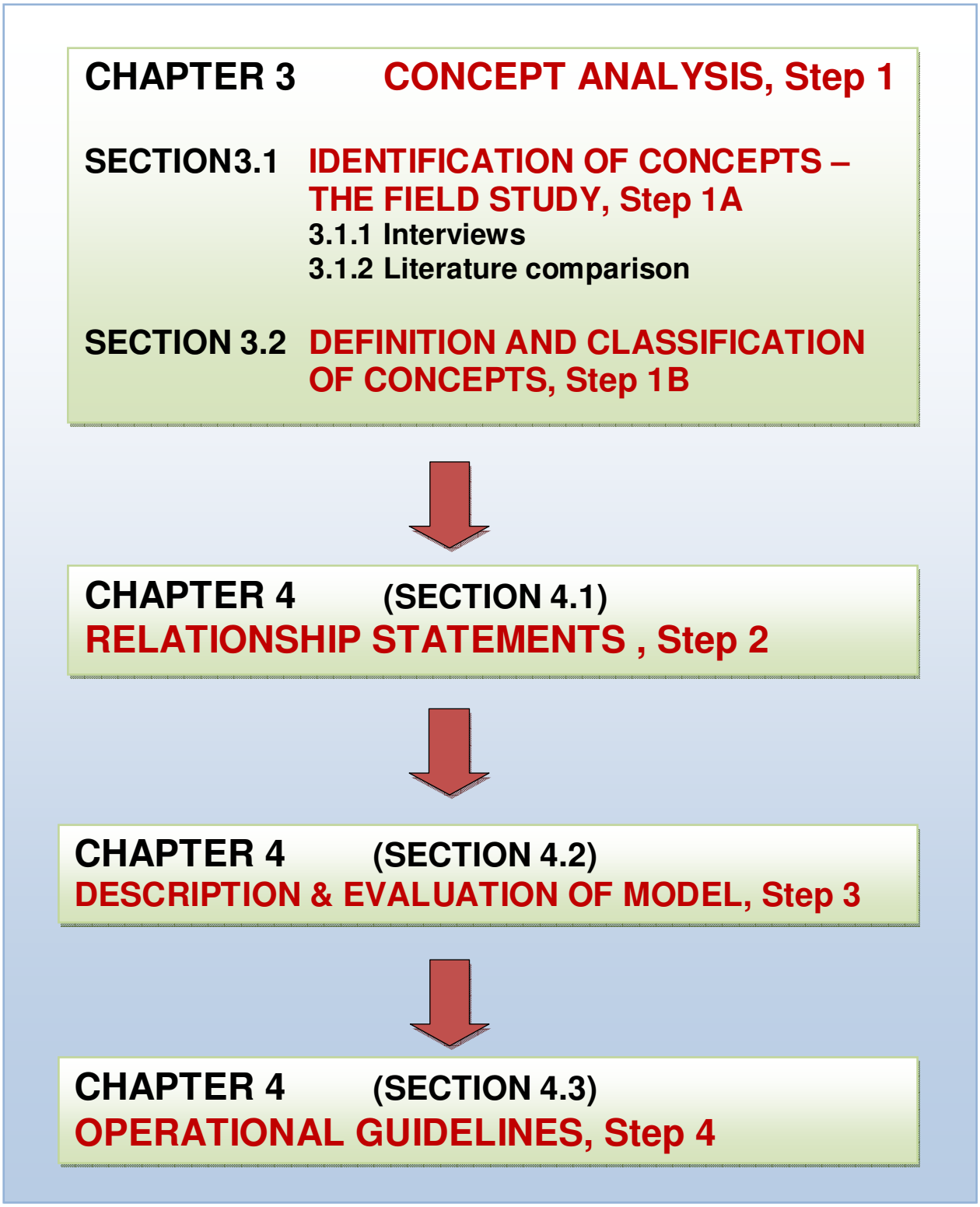
Table 2.1 Flow-diagram for the reporting on the results of this study



CHAPTER 3. RESULTS I: CONCEPT ANALYSIS (STEP1)



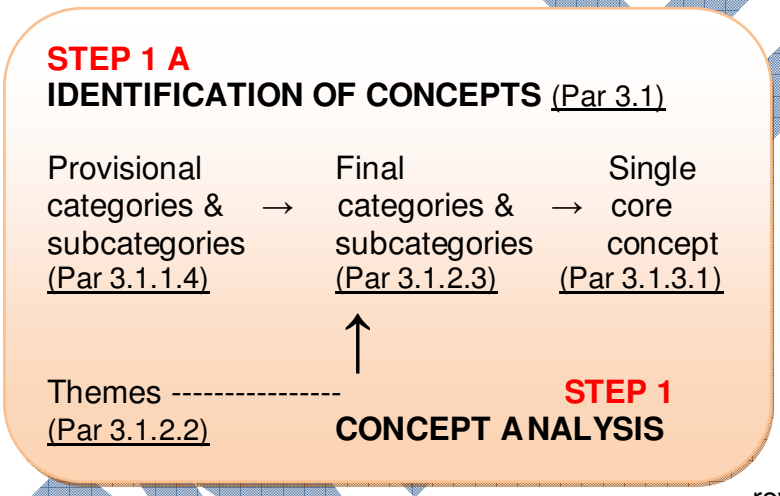
CHAPTER 3. RESULTS I: CONCEPT ANALYSIS (STEP1)

"The product of the interpretive bricoleur's (maker of quilts) labour is a complex, quilt-like bricolage, a reflexive collage or montage – a set of fluid, interconnected images and representations. This interpretative structure is like a quilt, a performance text, a sequence of representations connecting the parts to a whole."

Norman Denzin and Yvonna Lincoln (2003)

INTRODUCTION TO CONCEPT ANALYSIS

In order to accommodate the bulk of the reporting on the results, two "results chapters" were structured. This chapter reports on the first part of the results of the theory development approach that was adopted for this study. The chapter is divided in two sections: **Section 3.1 Identification of concepts** (representing the field study of interviews and literature review), or **"Step 1A"**; and **Section 3.2 Definition and classification of concepts**, or **"Step 1B"**. Sections 3.1 and 3.2 of this chapter together represent "**Step 1**" **(Concept analysis)** of the methodology. This first step corresponds with the first Chinn and Kramer process of "creating conceptual meaning".



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3.1 IDENTIFICATION OF CONCEPTS - THE FIELD STUDY (STEP 1A)

Firstly, concepts are identified from the in-depth semi-structured interviews as the primary data source through open coding. A main storyline is compiled based on the interview content and the identified concepts are structured in provisional categories and subcategories (paragraph 3.1.1). These categories are then compared and matched with the main concepts identified from the literature as a secondary data source (paragraph 3.1.2). Final categories and subcategories from the integrated interview and literature content are identified. An interpretive narrative on the integrated data is compiled from which a single core concept for the proposed model is identified.

3.1.1 INTERVIEWS

Interviews were conducted with academic psychiatrists affiliated to the Division of Psychiatry of the University of the Witwatersrand with current involvement in the training of undergraduate and postgraduate students in psychiatry. Participants were presented with the open-ended question: ***"What is your experience of and view on the role of spirituality in specialist psychiatric practice and training?"*** Data saturation was achieved after thirteen interviews.

Participants completed a short biographical questionnaire providing basic data on the demographic and professional profile of each participant. Participants' age ranged from 33 to 71 years, six were male and seven female. Participants' professional experience after qualifying as psychiatrists ranged from two to 29 years and they were mostly currently employed as senior and principal psychiatrists. Their stated personal religious/spiritual identification included: discontinued religious ties, with currently only spiritual interests; being raised in an organised religious context, but with no current religious/spiritual affiliation or interest; continued serious and even strict organised religious affiliation with active participation; continued organised membership with

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extended spiritual orientation/awareness; continued identification with original religious/cultural background, but currently with a more general spiritual awareness; and an inclusive more internalised spiritual orientation, with no previous particular traditional religious adherence.

3.1.1.1 Field notes

Interviews were conducted in different settings, including mostly participants' own offices but in a few cases in a public meeting place such as a coffee shop. Some interviews were therefore interrupted by some routine activities such as a phone call or a visitor at the door, but with no major interference. In one instance, technical problems with the recording device were experienced, but a back-up instrument was available. Interviews were conducted in English and no problems were experienced with the articulation of concepts or with language. A number of participants submitted literature or reading material as part of their response to the research question **(Appendix 3.1 - Literature and reading material submitted by participants)**. Where appropriate (journal articles), the material was included in the literature comparison.

Interviewing as a means of collecting data was found to be a natural and comfortable choice for this study, as it is a familiar tool for the investigator and for the participating psychiatrists' in their routine task of conducting clinical assessments of people. Participants were therefore generally comfortable, open and enthusiastic about discussing the research question from a personal and a professional point of view. Regardless of their own religious position and the importance of spirituality in their personal lives, participants reflected freely on their views and experience of the role of spirituality in specialist psychiatric practice and training. Subjective responses to the research question ranged from a measure of apprehension and discomfort in younger participants, to an opportunity to define and contextualise a whole career in psychiatry. The benefit of the responses by participants on the training of psychiatrists was that it ranged from younger

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participants who referred to their own training recently, to older experienced participants who reflected on many years of teaching registrars in psychiatry. The fact that the investigator was also a psychiatrist with more than ten years of experience in the field, and sharing a biomedical background and training in a tradition of biological psychiatry, provided common ground for the interviews and for the sharing of experience and information by participants. This allowed for and "insider's" or emic view of, and report on the views and experience of one group of academic psychiatrists affiliated with a training institution in South Africa.

3.1.1.2 Triangulation through independent coding

A provisional analysis of the content and meaning of the transcribed interviews was made by the researcher and then compared with the analysis of an independent coder using open coding. Process comments by the independent coder included these recorded below.

- "Some participants found the topic difficult and somewhat overwhelming."
- "Consensus was not reached (amongst participants) as to 'who' should be addressing the spiritual aspect."
- "Consensus was not reached (amongst participants) as to whether the role of spirituality on specialist psychiatric practice and training should be formalised or structured."
- "A tentative definition of spirituality emerged as a phenomenon of 'being comfortable with yourself'."

The independent coder identified the following main theme from the interviews:

> *"Participants' views and experience on the role of spirituality in specialist psychiatric practice and training (SPPT) are diverse and mostly embedded in their personal and academic worldview of science and people, as well as their own spiritual awareness. The current model used in SPPT is lacking and spirituality is*

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neglected. Internal and external challenges are identified in incorporating spirituality in SPPT. There is a gist that 'there are ways of doing it'."

The central storyline and subsequent provisional categories and subcategories for the interviews were established after a consensus discussion between the researcher and independent coder.

3.1.1.3 Central storyline of interviews

Awareness of spirituality, "mindfulness", or an open-minded approach towards spirituality should be facilitated in specialist psychiatric practice and training. Participants had diverse views and experiences on the role of spirituality in psychiatry, but all stated that spirituality should be considered in current specialist practice and training. Their views were influenced by their personal attitudes towards spirituality and religion and by their trained academic world view of medical science and of patients. Participants believed that the understanding that spirituality refers to an individual process towards meaning and being, while religion refers to the social and organised aspects of faith traditions. The importance of clear ethical and professional boundaries in specialist psychiatric practice was highlighted as was the fact that the personal views of psychiatrists on spirituality and religion should not be enforced in any way by them on each other, or on their patients. Psychiatrists were not regarded as having a primary role as spiritual workers themselves. Yet the importance of the incorporation of an in-depth exploration of spirituality and religion and the meaning thereof for individual users in the history taking and clinical interviewing of routine psychiatric assessments was identified. In the training of psychiatrists, it was advised that awareness of spirituality and its relevance to specialist psychiatry, as well as the knowledge and skill of individual trainees in assessing and identifying the place of spirituality in the management of users' mental health care should be facilitated. This may also warrant the re-orientation of the teachers (mentors) in psychiatry concerning the place of spirituality in specialist practice. The referral of users to

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relevant spiritual workers on an individual basis was preferred when indicated, according to users' individual needs. Concerns were however raised, about time and resource constraints. Closer, more regular and perhaps also more formal collaboration by local individual psychiatrists and also by the profession of psychiatry, with the spectrum of relevant spiritual workers was proposed. But participants were generally very tentative about how this collaboration should be approached or implemented.

3.1.1.4 Provisional categories and subcategories from interviews

Six provisional categories and related subcategories of concepts were identified from these interviews as set out in Table 3.1.

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Table 3.1 Provisional categories of concepts from interviews with psychiatrists

CATEGORIES	SUBCATEGORIES
1. Personal and professional orientation towards spirituality	1.1 Own view and attitude towards spirituality 1.2 Academic view of medical science and of patients
2. Spirituality and religion as a reality for practitioners and users	2.1 Definition of spirituality and religion 2.2 Extended model of care: "bio-psycho-social-spiritual"
3. Scope and boundaries of professional specialist psychiatric practice	3.1 Ethics of spirituality in psychiatric practice 3.2 Continued education and peer review
4. Spirituality and religion in routine mental state assessment and health care	4.1 Need assessment 4.2 Communication and appropriate intervention 4.3 Liaison and referral
5. Awareness, knowledge and skill of trainees in psychiatry regarding spirituality	5.1 Understanding of spirituality and its role in mental health care 5.2 Didactic learning on spirituality and religious faith traditions* 5.3 Approach towards spirituality and religion in psychiatry 5.4 Personal growth, professional development and competency ** (e.g. through lectures, seminars, reading, group discussions, individual projects/cases)*
6. Referral and collaboration between psychiatrists and spiritual workers	6.1 Facilitating appropriate referral and intervention for individual users 6.2 Information sharing and mutual awareness between disciplines 6.3 Addressing stigmatisation of users with psychiatric conditions

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(1) **Personal and professional orientation towards spirituality**

Within the first category of concepts, two subcategories were identified: "Own view and attitude towards spirituality"; and "Academic view of medical science and of patients".

(1.1) **Own view and attitude towards spirituality**

To orientate themselves as individuals towards the concepts of spirituality and religion from a personal perspective, was often the initial step and a practical way for participants to respond to the research question of what their views and experiences were concerning the role of spirituality in specialist psychiatric practice and training. "***I think the first thing for me is that there is a difference for me between spirituality and being religious, and I think that's where my starting point would be when considering these questions. Spirituality is sort of an understanding of where the specialist – or I would say 'my' – mindset is with regard to my own belief systems and also where I am in my own space"***. Several participants orientated and associated themselves personally with having a spiritual rather than a religious position, while others have orientated from a religious position, or from not having a spiritual or religious position at all. The personal motivation for choosing psychiatry as a career and psychiatry as a discipline that has an unique inter-relatedness with spirituality was reflected on **(Appendix 3.2 - Interview Quotations Q1, Table 3.1.1.i)**.

(1.2) **Academic view of medical science and of patients**

Once their own positions had been clarified, it seemed easier for participants also to define spirituality and its role more clearly in broader therapeutic and didactic contexts. ***"I personally feel that it is extremely important both in my career as a psychiatrist and in training others; to take into account the individual belief systems of patients whether they be from the same religious affiliation or not"***. The failure to address spiritual/religious issues in their own training was referred to several times. ***"But in terms of actual sort of postgraduate training - and in fact even undergraduate training - it's not incorporated in any way. So I think that that in itself is lacking and on top of that I think it's probably maybe the most neglected part***

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because, I mean one sees the more you encounter patients over the years, the importance of spirituality". Other options and developments than to contrast the spiritual/religious and the 'scientific' domains in terms of each other, in an 'either/or-choice' position, were alluded to: **"*… It can be incorporated into a model which the patient accepts and which you as the treating doctor accept and you know the outcome can be actually good"***. To review the philosophical reasons why the dimensions of "science" and "religion" have been separated in the first place may also be informative. The strict (Western) definition of what is scientific and people's subjective fears and uncertainties about matters of faith may be part of these reasons. **"*I think what psychiatry in particular has…because it's been regarded for so long, because we didn't have tests and this sort of thing it was regarded so long as a sort of – not fictitious – but a slightly suspicious branch of medicine, you know with the psycho-analysts making interpretations and this sort of thing, and so psychiatrists fought so hard to say: 'Look, we're part of medicine, we're part of hard science, we also use double-blind trials and this sort of thing...' so I think it's been a particular fight within psychiatry itself"* (Appendix 3.2 - Interview Quotations Q2, Table 3.1.1.ii)**.

(2) **Spirituality and religion as a reality for practitioners and users**

Within the second category of concepts, two subcategories were identified: "Definition of spirituality and religion"; and "Extended model of care: 'bio-psycho-social-spiritual'".

(2.1) **Definition of spirituality and religion**

According to participants, the reality of a spiritual dimension in the current practice of psychiatry should be acknowledged. The differentiation between spirituality and religion may however not always be clear, but exploring - as a psychiatrist - the role of both in a person's life, is important. **"*Ja, I think one needs to make a real clear definition on what spirituality means, because many people equate spirituality with religion. Spirituality I suppose also has a lot to do with one's tradition... putting one's thoughts together and spending a lot of time with yourself and a lot of introspection. I think there's a definite role for that and I think***

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that's what spirituality is..."; ***"Now I think it's good that we try to keep up our religious beliefs, but we can't get away from the fact that we are spiritual beings; we can't get away from the fact that a number of patients come in with (religious/spiritual problems)…"***.

Religious-cultural factors can be regarded as part of the social context in which people function. To consider a person's religious and cultural background is essential when formulating advice and intervention, for example to understand the impact that divorce may have for a Muslim woman, or the difficulty experienced by female patients from certain cultures in seeing and expressing their views to a male psychiatrist. ***"...People who don't have an understanding of the cultures and the system - their advice would be 'Leave your husband' - not realising that in that culture for that woman to leave her husband... it's not easily done"***. On occasion, it may therefore be more conducive to refer a user from a certain faith tradition to a psychiatrist of the same persuasion or gender.

At the same time, specific stereotypes about people (White, Muslim, African, etc.) continue to exist, in Africa and elsewhere. In South Africa it may be more difficult and important not to judge a situation from a stereotypical perspective. In the complex South African society it is essential to have adequate awareness and skill to accommodate, understand and respect different backgrounds in order to interpret symptoms and to make diagnoses. ***"You have to…you've got to judge mental illness in the context of what their beliefs or practices in the community are. So I suppose one has to have an understanding of what those beliefs and practices are, in order in the context of that, to judge whether their behaviour or their functioning is in fact functional or not"***. This will require special attributes e.g. awareness, understanding, open-mindedness, empathy, flexibility and an interest in people, to operate in a domain with so many unanswered questions and uncertainties. Existing sensitivities, the need to be "politically correct", not to be prejudiced or biased and not to discriminate, are still prominent and important to manage correctly in the current South African context **(Appendix 3.2 - Interview Quotations Q3, Table 3.1.2.i)**.

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(2.2) **Extended model of care: "bio-psycho-social-spiritual"**

Participants felt that, although it may still be easier to maintain a division between the bio-psycho-social and spiritual dimensions, it is more important to achieve a holistic view of users and mental health care. If only to the extent that spirituality and religion inherently imply the adherence to a sound moral code, it should be regarded as a beneficial factor in the lives of people. Spirituality is central in the transcendence of difficult life situations, such as chronic illness and death, confirming the applicability of a balanced four-dimensional bio-psycho-socio-spiritual model. ***"I have a paradigm which I give to my patients and tell them that perhaps we need to look at balance in our lives and the balance is like having the wheels of a car balanced; there are four wheels and there are four areas"***.

It may therefore be appropriate, especially if a systems approach is adopted, to extend the current "bio-psycho-social" model to include spirituality as an additional, fourth dimension of care. ***"… It is inconceivable if you take a systems approach not to bring in the spiritual aspect of things... inconceivable..."; "…Perhaps I've just always believed and maybe this is a very idiosyncratic thing of my own, but if you don't understand the person's relationship and sexual life and their value system and any religious aspects of their life, then you don't know the patient"***. Spirituality may be the more pervasive element, but it affects all three other dimensions. Spirituality as opposed to religion, however, may even be the generic integrative "fibre" that weaves all four dimensions into a whole **(Appendix 3.2 - Interview Quotations Q4, Table 3.1.2.ii)**.

(3) **Scope and boundaries of professional specialist psychiatric practice**

Within the third category of concepts, two subcategories were identified: "Ethics of spirituality in psychiatric practice"; and "Continued education and peer review".

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(3.1) **Ethics of spirituality in psychiatric practice**

It was evident from the interviews that the ethical aspects of what is appropriate and acceptable as a health worker in declaring one's personal position about religion and spirituality are important. A psychiatrist's (or other health worker's) own position and views towards spirituality and religion should not impact on other colleagues' or on users' position on the matter, nor on the professional assessment of users, or on appropriate clinical management decisions. It is appropriate to set and maintain proper boundaries in this regard. ***"But in terms of imposing one's spirituality and background onto your patient population, I think that's a very emotive issue and an issue that needs a huge amount of boundaries… "; "Now I think that it's most important that psychiatrists don't impose their own belief system upon the patient."; "I think herbalists and traditional healers are the same as Jewish people or Catholics or Muslim and that's a worldview. And those worldviews can be quite…if you get a medical intern wearing the burka with only the eyes showing, I mean that's a very physical manifestation of a worldview."; "But I suppose the way I rationalised it (specific phenomena of a particular faith tradition) and the way I think it impacts on my specialist training (as a member of that faith tradition) is that I subscribe to a scientific medical point of view in my practice and although I can appreciate someone else's religious beliefs, I can't allow that to impact on the way that I practise psychiatry"*** **(Appendix 3.2 - Interview Quotations Q5, Table 3.1.3)**.

(3.2) **Continued education and peer review**

There is no primary role for the psychiatrist to attempt to be a spiritual or religious adviser within the context of a professional psychiatric consultation, although some specialist psychiatric practitioners may see it as appropriate to incorporate spiritual or religious interventions done by themselves. The (in-) appropriateness of such interventions should be clearly established and should be monitored and reviewed by, for example, professional bodies. ***"As you probably know, in the APA (American Psychiatric Association) and the Royal College (of Psychiatrists) and so on, there are spirituality groups. You see, this is***

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the wide stuff, which I find I'm a bit uncomfortable with (that's) because it's a sort of broad, fuzzy-wuzzy meditation…" **(Appendix 3.2 - Interview Quotations Q6, Table 3.1.3)**.

(4) **Spirituality and religion in routine mental state assessment and health care**

Within the fourth category of concepts, three subcategories were identified: "Need assessment"; "Communication and appropriate intervention"; and "Liaison and referral".

(4.1) **Need assessment**

Considering the place and role of religion and spirituality in the lives of users, it should be part of the routine clinical assessment and management, whether a psychiatrist in his/her personal capacity would consider religion or spirituality important or not. ***"I know that the patients don't always give you honest answers, but in the same way as I ask them about their marital life, their sexual life, general hobbies and interests, I ask every patient."; "…But the other thing that I think we really need to ask people is their religious history – where they've come from, what they've done, what part they've had in it, where have they been"***. Questioning should not only be a superficial screening, but an adequate understanding must be achieved of words and phrases used in their context. Language barriers should therefore also be taken into account. **"*So that even perhaps if as a psychiatrist you don't have particular faith, I believe it's important that you give that space to your patient to explore that area and whether their faith or their road to spirituality is of assistance to them in nurturing that and if it's hindering them to get them to question that...*"**.

Religious-cultural background also influences the way in which symptoms and problems are presented and the content thereof. Individuals with proven psychiatric disorders will often lose their insight when they default on medication, resulting in the recurring of symptoms such as mania (including religiosity) and delusional thought content (for example involving God or their specific religious calling). **"*So my experience with spirituality…I mean, I think often with patients who are manic or psychotic it becomes more***

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difficult if the delusions have a spiritual context. So I suppose people are more tolerant of delusions or unusual beliefs if they have spiritual content. It's plausible. But I still think the bottom line is whether the person is functioning or not". The reality that physical disorders such as temporal lobe epilepsy that often presents with symptoms similar to religious-spiritual experiences, must also be considered. ***"I think even in terms of this hospital we have a very Christian side and then we also have a huge number of sangomas and traditional healers on the other hand, and the overlap between let's say for example temporal lobe epilepsy and psychosis ... is huge"*** **(Appendix 3.2 - Interview Quotations Q7, Table 3.1.4.i)**.

(4.2) **Communication and appropriate intervention**

Spiritual and religious positions also go beyond psychiatry to the rendering of health care in a broader sense. ***"I do think it (spirituality) actually broadens us as people and I think it goes beyond just psychiatry. I think it should be in terms of the health care and how health care is given in different other contexts, you know what I mean? I don't think it just applies to psychiatry"***. In an extended health care setting for example, sufferers from long-term medical diseases such as auto-immune conditions or life-changing malignant disorders often resort to additional or alternative approaches such as spiritual modalities (for example meditation) to cope with the ongoing effects of these illnesses, as well as with the difficulties experienced in the treatment thereof. ***"But even if we're not going to have some kind of generic treatment called 'spiritual treatment' …bio-psycho-social-spiritual, at least we are talking about perhaps allowing the patients and being comfortable for the patient to be able to talk about their own spiritual walk in a particular area"; "…It's not really a major issue for me as a specialist and with more experience, because I can appreciate that a patient has religious points of view and that impacts on the way I treat them, but I can engage in a dialogue with them now because I am comfortable enough to do that without feeling defensive"***. Many mental health care users, for example from a Muslim background, may consult a religious worker/leader in the first instance and may only later be referred for a psychiatric assessment. Psychiatry may generally still be regarded as unfamiliar territory by more

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traditional or conservative religious groups. Users may present with unclear symptoms and may interpret these from their cultural perspective, but may actually be in need of psychiatric care, especially when they have experienced a loss in functionality. A helpful approach may be to collaborate with family and particularly spiritual workers to address the stigma of, and misunderstanding about psychiatric conditions. ***"I think with any kind of spirituality where it becomes an issue is when maybe the patient or the family get into conflict between their particular beliefs and the psychiatric treatment that's offered and given. …And I think that to ignore it (the stigma of and misunderstanding about mental illness) is often not helpful because you may end up with people leaving treatment that they really need"*** **(Appendix 3.2 - Interview Quotations Q8, Table 3.1.4.ii).**

(4.3) **Liaison and referral**

It may therefore be necessary to address different worldviews appropriately with understanding, to reduce prejudice and stigma and to ensure freer access to psychiatric care for the user. ***"I suppose the easy answer is to say that in an ideal situation if the patient comes from this sort of background it should be possible, it should a rule for the Western medicine specialist and the traditional healer to work together. In the same way as a psychologist, occupational therapist, social worker and the nurse can join in with the psychiatrist, why shouldn't a traditional healer join in as well?"*** Some users may have to be allowed to continue with certain religious elements, for example ceremonial cleansing for prayer in the Muslim tradition, which might even serve an actual therapeutic purpose. Some users may distinctly prefer to consult a psychiatrist from a specific persuasion, for example a Christian psychiatrist from whom they may expect specific directives or at least some interpretation and understanding of their symptoms from that particular tradition.

The experience of the conflict between a traditional African understanding and the Western scientific view about the cause of HIV/AIDS and the associated stigma may also be used as a model to understand and describe the differences in approach that may

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exist towards psychiatry and mental health. ***"I was reading a book…"*** Steinberg (2008), **(Appendix 3.1 - Literature and reading material submitted by participants), "*...about HIV in the Eastern Cape and why people don't actually go for testing… and he looks at some of the psychological training and areas behind how people cope or adapt to the old worldview. How they kind of incorporate the traditional healing... So it's a way of incorporating your worldview and your traditions within the face of modern medicine without losing face"***. It would thus also be important to allow enough space for these other worldviews about mental health and that people do not "lose face" while they have to come to terms with the reality of psychiatric conditions.

The arrangement to collaborate with spiritual workers should therefore not exist in a primary health care setting alone, but also in specialist care within the context of evidence-based "Western medicine". ***"I think if one practices with the openness of mind to say: 'This is now beyond what I'm capable of intervening effectively' and then look at either doing a multi-disciplinary thing or liaising with other health workers as well as spiritual leaders to help with the management of the patient"; "So in a sense that I don't have the necessary cultural background to understand the patient's particular pathology when it relates very strongly to traditional religion or culture, I would make room for a traditional healer to deal with those aspects. But where there are clear symptoms for which the patient needs treatment, I would expect that the traditional healer would not interfere with any medical treatment..."*** However, specialist care does not require an additional "type" of spiritual approach, although the patient must be regarded holistically. Actual referral of users to spiritual workers does not currently happen that often, though, **(Appendix 3.2 - Interview Quotations Q9, Table 3.1.4.iii)**.

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(5) **Awareness, knowledge and skill of trainees in psychiatry regarding spirituality**

Although initially tentative, most participants actually contributed structured suggestions concerning how the future training of psychiatrists might possibly be approached differently. Suggestions were made for example, with regard to the acknowledgment of the role of spirituality, to create awareness and open mindedness and to facilitate knowledge without being prescriptive or compromising accepted professional boundaries. Elements to be considered in specialist training included: a general openness and awareness and a space to consider a spiritual element in psychiatry in addition to the existing bio-psycho-social approach; general skills towards accompaniment and counselling, e.g. with regard to death and chronic illness (which should have been accomplished as part of undergraduate skills training); knowledge of different traditions and worldviews as a basis through didactic training; demonstrating an integrated approach by candidates with emphasis on the skill, depth and quality of interviewing and diagnostic formulation; and opportunities to discuss and address possible (personal and professional) problems that individual trainees may have. Opportunities may include integrative workshops, discussions, debate and ongoing dialogue, but more importantly would mean that mentors and senior consultants as role models, would have to be demonstrating such an integrated approach themselves.

Within the fifth category of concepts, the following four subcategories were identified: “Understanding of spirituality and its role in mental health care”; “Didactic learning on spirituality and religious faith traditions”; “Approach towards spirituality and religion in psychiatry”; “Personal growth, professional development and competency”.

(5.1) **Understanding of spirituality and its role in mental health care**

Through openness and awareness, a competent psychiatrist should appropriately identify a presenting spiritual problem and refer accordingly, while still operating within his/her

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own professional frame of reference. *"I suppose something deficient in our own training was a very, very… and I mean, as you said earlier, the overlap between the clinical and very sterile medical part of psychiatry, versus the more open-hearted involving Gestalt looking part of therapy, and now we want to go a spiritual route"; "I think you could say people in training in psychiatry – more than any other group in medicine – need to understand the person's background and their spiritual beliefs in that context"; "I think…I certainly think particularly psychiatrists – doctors as well – but as psychiatrist you need more than simply to be just good at your job and know diagnoses and I think a lot of psychiatrists have it without acknowledging it – compassion for example, feeling for the other person – those are all spiritual qualities"*. It may remain contentious and problematic to involve trainees in formal training on spirituality. A system of mentorship may however be useful **(Appendix 3.2 - Interview Quotations Q10, Table 3.1.5.i)**.

(5.2) **Didactic learning on spirituality and religious faith traditions**

Basic knowledge and information about main spiritual/religious themes should be included in the training of psychiatrists, but in particular an awareness and understanding of the reality and importance of a spiritual dimension in psychiatric practice should be established. *"Maybe in some form of…I don't know, religious studies, maybe not so much even…not concentrating on any particular religion but maybe a more sort of broader understanding on religion and mankind and the different religious faiths and their different understandings of things in the world"; "You know I certainly think just from a straight knowledge point of view of course it's essential that we have an understanding of what our patient's beliefs are, and we do have to have – I think – an understanding of what Islam is about and you know, what Christianity is about and various religions like that. I do think you need (to) on a didactic level"*. Interested candidates and practitioners can from there build on this basis through more individual reading and development. Incorporating applied anthropology and systems theory into the basic training of psychiatrists may be appropriate. *"I think that anthropology would have a lot to offer in a broad cultural, spiritual*

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sense. I think they should have a course in anthropology, making people aware of what…could be useful. I think that might be more useful and maybe even a course in comparative religions might be useful but that's just all kind of theoretical. It should just be a sensitising thing" **(Appendix 3.2 - Interview Quotations Q11, Table 3.1.5.ii)**.

(5.3) **Approach towards spirituality and religion in psychiatry**

It was regarded to be essential, that candidates should be taught how important the interpretation of a specific clinical history and presentation in terms of a person's values and beliefs are. *"I think in the first place the first thing would be to try and impress upon new entrants to psychiatry how important these sides of the patients' lives are likely to be to them... and to make them aware of that if they weren't aware before"*. It is also important to avoid a superficial "ticking-of-boxes" type of questioning. How to explore qualitatively the content and actual meaning of patients' responses when taking their histories is of great importance. The latter should be learnt first-hand from observing more senior experienced teachers demonstrating this approach in their interviewing of patients. *"In fact one way of doing it could be through like mentorship programmes and things like that as opposed to formal teaching and training, but that in itself also poses difficulties and problems in terms of finding... a suitable mentor..."* To underline the importance of a spiritual dimension in the training of psychiatrists in the present milieu, written and oral examination of candidates should include questions on an approach to, or how to include spirituality in the therapeutic formulation of a patient. General skills such as knowing the cultural nuances of how to address people from different backgrounds (for example an elderly black person) would be a basic requirement. *"I think probably those are possibly labelled 'soft skills'. I think you need a lot of information and what I find myself struggling with a lot of the time is whether something is culturally appropriate or not"*. Although trainees may tend to focus on facts that they expect to be tested on eventually, they should anticipate that the testing of "softer" skills may also be included, for example, the ability to see people in their socio-cultural-religious context **(Appendix 3.2 - Interview Quotations Q12, Table 3.1.5.iii)**.

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(5.4) **Personal growth, professional development and competency**

New trainees generally seem to be limited by the perspectives stemming from their own backgrounds and therefore need to acquire an approach and the skill to understand and interpret how people from different backgrounds may present. The pressures of service delivery and the need to fill posts in psychiatry with (any) willing applicants, however, seems to override a more selective approach where more rounded, perhaps older and more experienced candidates are considered for training in psychiatry. ***"For me the registrars who are better are those who are a bit older and have a bit more life experience. We get a whole lot of these little girls ... and then I think to expect them to have some kind of insight or understanding into spiritual issues is too much of a leap for them"***; ***"For example; we had a patient of Islamic faith in the ward who was clearly psychotic yet the family felt that this was a possession – a demonic possession or a bad wind I think they termed it – and it became a huge problem for the registrar to have to understand where that patient was coming from. And I think the best way to deal with that is to identify that there's stress within the registrar and to deal with it head-on"***.

The capacity to self-reflect is an important attribute of a competent psychiatrist and achieving that should be part of the training of a specialist. It should be an objective for the training of psychiatrists to facilitate freedom, openness and the space to discuss personal positions on spirituality and religion with registrars during their training. ***"I mean the parallels I see are very clearly when they now talk about mindfulness in developing mindfulness in psychotherapy. There's very much the same approach in meditation practices in spirituality. And I think that what is important is to allow trainees the opportunity to explore and to realise the importance of reflection in a way that is not threatening to them"***.

The notion to aspire to a type of common ("generic") spirituality, or to facilitate general "spiritual skills" in psychiatrists themselves was generally not deemed practical or

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desirable by participants. Awareness, open-mindedness, sensitivity, a capacity to self-reflect and understanding were attributes of a psychiatrist that all participants emphasised. An opportunity may also have to be provided to trainers/supervisors (mentors) of candidates to explore and consolidate their own space with regards to spirituality, the capacity to self-reflect and to demonstrate an integrative approach **(Appendix 3.2 - Interview Quotations Q13, Table 3.1.5.iv)**.

(6) **Referral and collaboration between psychiatrists and spiritual workers**

Within the sixth category of concepts, three subcategories were identified: "Facilitating appropriate referral and intervention for individual users"; "Information sharing and mutual awareness between disciplines"; and "Addressing stigmatisation of users with psychiatric conditions".

(6.1) **Facilitating appropriate referral and intervention for individual users**

It may be difficult and logistically challenging to organise the liaison between specialist psychiatrists and spiritual workers into formalised referral systems, or to integrate them generally into the existing multi-disciplinary mental health care team. ***"It's such a problem. And how are you going to find a spiritual worker who is able to embrace absolutely every part of spirituality? With a vast difference of people in our community?"; "To me spirituality is something separate from health-workers as a parallel thing. I don't think you are going to create a job in a hospital, because then you need to create…then I must hire an Anglican minister and a Muslim and a Jew and a traditional healer all to work in the hospital. But why, because they aren't health-workers?"; "I think that that (a formal referral system) is problematic. Um, I think spirituality and spiritual issues and a particular somebody (religiously or whatever) who the patient is particularly involved with, is required to give input; I would approach that person directly. But in terms of sending all patients off to someone for a spiritual kind of assessment, I have a problem with that"; "I think not (a spiritual person on the multi-disciplinary team). I would think it would be more a referral thing. You know, for example we***

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have a lot of patients who go for marital counselling with their pastor or the Imam is involved in some way with the family, so we tend to use those".

A holistic approach is, however, preferable also in a specialist setting, where practitioners from different disciplines communicate with each other about their mutual patients. But, it may pose some logistic difficulty such as travelling or sharing facilities. ***"Well I basically think the onus is upon the practising psychiatrist to familiarise yourself with...especially the sector or the area that you are servicing the people in and identify the relevant bodies and relevant authorities that you would want to liaise with concerning things like this. And with a patient's permission and obviously respecting confidentiality and so on. To refer directly to these people."*** For example, pharmaceutical intervention is known to be effective in the treatment of psychosis, but the referral of "neurotic" problems to spiritual workers may be more appropriate. At the same time, the identifying of serious mental illness by spiritual/religious workers and their referral to psychiatrists still often take an unnecessary long time, to users' detriment **(Appendix 3.2 - Interview Quotations Q14, Table 3.1.6.i)**.

(6.2) **Information sharing and mutual awareness between disciplines**

Defining the relationship as a parallel process alongside each other (psychiatry/health and spirituality) may still be the practical approach, while acknowledging that health workers themselves may be from different worldviews and backgrounds, but responsible for their particular area of work in the first place. ***"I think tradition goes both ways. We could teach them about psycho education, they could teach us and I think... dialogue…for example just even psychiatry and medicine, in this hospital we are so divided. And just opening up those channels of communication could really, really improve the situation. So by opening up dialogue with different people of different ideas."*** The interface with spiritual workers presents the opportunity and challenge, to: establish a mutually informative collaboration where psychiatry has achieved a presence and acceptance/acknowledgement on the one hand; and confront and correct misperception and stigma in more fundamentalist religious

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perspectives where necessary, on the other. ***"You know I think we were able to say: 'Look, we don't like it when you do this and this and this' and they said: 'We don't like it when you tell our patients not to come visit us' and that sort of thing. And I do think you can get a…I think you have a much better chance of getting a decent working relationship and try also to weed out some of the not so good practices on both sides. I don't think we are perfect either…."*** **(Appendix 3.2 Interview Quotations Q15, Table 3.1.6.ii)**.

(6.3) **Addressing stigmatisation of users with psychiatric conditions**

Previous experiences/perceptions, however, are still the basis for continued ambivalence and conflicting views and feelings that psychiatrists have about how to interact practically with spiritual workers on the care of users. ***"Ja, I think stigma and discrimination (represents) a huge problem and just in terms of the patients that we're seeing are so marginalised. But on the other hand I suppose if we could try to de-marginalise our patients..."; "I mean what I'm trying to say is accommodating spiritual beliefs to the extent of disadvantaging them from the benefits of other interventions. And yet one needs to balance that with not being imposing and you know, basically describing to people what they should be believing and practising. It's a delicate balance."; "I'd like to think that if the traditional healers could come along and persuade me that they have got a cure for some of the things that I have difficulty with. I would jump at it. I'd like to believe that. Maybe I'm fooling myself. But all the evidence over the years (shows) that the traditional healers often tend to make people worse rather than better"***. Knowledge of psychiatry and the benefits of e.g. pharmacological and psychological interventions should also be promoted amongst different groups of spiritual/religious workers.

Dialogue between the organised profession of psychiatry (for example SASOP) and organised spiritual/religious workers may be a starting point. Engagement on the level of societies, councils, and practitioner groups may be indicated, in terms of trying to look at standards of care and referral systems. **"*So I think it's a matter of engaging with them***

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(traditional healers) and I think that one can engage at a systemic level with societies, councils, and practitioner groups in terms of trying to look at standards of care and referral systems. And I think what would be necessary would be a lot of education on both sides, you know"; "I think it would be best if (communication) were to be done at an organisational level. I mean that doesn't deter us from doing it at an individual level which we've had to do already. Within the context of the unit we've engaged with many spiritual workers and it's been quite...it hasn't been a problem."; "I think only with the idea of the traditional healers association being formed, more recognition of traditional healers, perhaps we as psychiatrists and organisations need to start looking and engaging with them and to say: 'are we in agreement and how can we work in collaboration'." Particular initiatives by district, provincial of national health services must be noted. Continued dialogue amongst psychiatrists themselves about spirituality may also be a good idea **(Appendix 3.2 - Interview Quotations Q16, Table 3.1.6.iii)**.

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3.1.2 LITERATURE COMPARISON

The reviewed journal articles from the international medical literature review for this study were regarded as the secondary data items from which themes and concepts were also identified. These were compared and integrated with concepts identified from the in-depth interviews with local psychiatrists.

3.1.2.1 Overview of journal articles

A provisional exploration of the topic was obtained by also referring to less formal types of writing such as selected media articles in magazines such as Time Magazine and to general books on the subject **[Appendix 3.3 - Summary of literature].** A total of 255 literature records were included in the formal review. Of these were: books (7); chapters in books (3); editorial comments (37); journal articles (202); and letters and reviews (6). A significant increase of literature records on the topic of spirituality and psychiatry over the past 20 years was noted. From 1986 to 1999: n=39; 2000 (n=15); 2001 (n=20); 2002 (n=19); 2003 (n=20); 2004 (n=24); 2005 (n=14); 2006 (n=29); 2007 (n=44); 2008 (n=22) and 2009 (n=9). Countries of origin of the literature records or authors were: United States (n=190); United Kingdom (n=15); Australia (n=13); Brazil (n=8); Canada (n=12); from Europe (n=6) - including the Netherlands, Germany, Norway and Switzerland; and other (n=11) - including China, Croatia, India, Israel, Nigeria, South Africa and South Korea. Most literature records (n=204) were qualitative investigations or essay-type of overviews and commentaries. Of these records, most were essays or commentaries (n=158), while others were literature reviews (n=22), conducted action research (n=10), or used focus group discussions (n=2), semi-structured (n=7), or unstructured interviews (n=5). A total of 51 inquiries were quantitative in nature, using questionnaires in surveys (n=45), or structured scales of measurement (n=6).

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Qualitative studies that used a phenomenological and a grounded theory approach were by: Loue and Sajatovic on spirituality and HIV-risk and prevention in a sample of severely mentally ill Puerto Rican Women, (Loue & Sajatovic, 2006); and Hilty et al., on a day in the life of a psychiatry resident (Hilty et al., 2005). Sesanna et al., through concept analysis according to the methodology of Walker and Avant, examined the body of nursing and health-related literature to explore the reported definitions of spirituality (Sesanna, Finnell & Jezewski, 2007). Focus group discussions were used by Agara et al., in a study on the management of perceived mental health problems by spiritual healers in Nigeria (Agara, Makanjuola & Morakinyo, 2008) and by Galanter in a study on spirituality, evidence-based medicine and Alcoholics Anonymous (Galanter, 2008). Several studies conducted and analysed interviews (Ellis et al., 2002), (Hathaway, 2005), (Wagenfeld-Heintz, 2008), (Garroutte et al., 2003), (Huguelet et al., 2006), (Mohr et al., 2006), (Mohr et al., 2007), (Wilding, Muir-Cochrane & May, 2006), (Wilding, 2007), (Russinova & Cash, 2007). Reviewing medical and psychiatric educational activities and interventions, action research and phenomenological inquiry were used in studies on medical and psychiatric training (Barnett & Fortin, 2006), (Grabovac, Clark & McKenna, 2008), (Elias et al., 2007).

3.1.2.2 Concepts and categories from literature

The awareness that spiritually is generally playing an increasingly important role in the lives and identities of individuals and groups in recent times (“a surge”, “revitalised interest”, “a fourth revolution”) was reiterated by most of the literature reports. Societies in Europe, Britain and the United States – through the migration of people – have become increasingly heterogenous (pluralistic, “creolised”) in recent years. This was regarded as an important associated factor in the observed growth of interest in religious/spiritual matters. In addition, earlier trends of secularisation in Western countries have apparently failed to have its anticipated outcome. This reported increase in the importance of spirituality and religion in the lives of people - who also make use of the health care

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system - has per se become reason enough for health care professionals to have to be cognisant of it and to consider its role in the process of assessing and managing clinical conditions.

Authors considered the historical development of the relationship between spirituality/religion and science/clinical medicine (including psychiatry) over time. Different philosophical positions and traditions were reviewed. Although traditionally a "divorce" existed between religion and psychiatry, more recently a process of "rapprochement" has been reported in the literature. In addition, a review of the "secular credo" of contemporary medicine was called for. Psychiatry has to "reclaim its soul". It also has to (re-)gain elements of healing and not only treat symptoms of disease pharmacologically. The extent to which spirituality and religion have already been (re-) considered and (re-) incorporated in the practice of psychiatry, can be tracked in the history of its inclusion in current diagnostic systems as non-pathological construct.

Concepts and phrases that were used in the literature in connection with the understanding of spirituality included: "journey"; "connectedness"; and "meaning". The close relationship between the constructs "spirituality" and "religion" was discussed by several authors. The usefulness of the differentiation of religion from culture in non-Western societies was questioned, because of its pervasiveness in all aspects of life and death in these communities. The definition of terms and the clarification of concepts and boundaries between and within disciplines appear to be prerequisites for the constructive engagement with the question on the role of spirituality in health and psychiatry. Definition of terms should also include users' perspectives.

Psychiatry and religion were described as "*two neighbours who share the same fence*" and who probably have to re-establish commonalities for the sake of the people making use of both domains' services. The unease of some people with religion may, however,

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compel psychiatrists and psychotherapists in some instances to act as “secular priests” providing at least some spiritual input in their contact with patients. Health service programmes, facilities and budgets have to provide for the adequate assessment of needs and for an environment in which patients can express their spirituality and religiosity. The perceived beneficial influences that spirituality appears to have on health outcomes (“salience”, “salutary effects”) have often been reported on. Nevertheless, to consider the incorporation of a spiritual dimension into the current bio-psycho-social approach to mental health and psychiatry, would necessarily also include cognisance and understanding of its negative influence and role in psychopathology. Different theoretical approaches towards incorporating spirituality into the existing approach to psychiatry have been described, including: a “bio-psycho-social-spiritual” model; a model explaining the complex influence of religion and physical health; a model for “spiritually augmented cognitive behavioural therapy”; a detailed approach to the role of spirituality in critical care; an approach to psycho-social rehabilitation; an element of the theory of personality; an evolutionary model (with spirituality following genetic and cultural evolution as a “third evolution”) ; and a multidimensional model of spirituality applicable across cultures and belief systems.

Defining roles and responsibilities also anticipates the development of professional, service and academic guidelines to guide and monitor the discipline’s practice in this regard. With regard to the shared disciplinary boundary and the relationship between religion/spirituality and science/medicine, phrases such as “interface”, “frontier”, “fence”, “barriers”, “common roots”, “walking a thin line” and “mapping” were used. It was not regarded as being appropriate for the psychiatrist to assume responsibility for primary spiritual interventions in the management of patients’ clinical problems, or for psychiatrists to impose their own religion/spiritual position on patients, students or each other.

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The role of spirituality in the clinical presentation of the symptoms of disease was explored for the general population, for children and adolescents, the elderly and end of life/terminal illness scenarios and in different clinical scenarios, such as depression, anxiety and psychosis. Religion was found to be an important aspect for patients with schizophrenia, often not related to the content of delusional symptoms.

In order to compare and research aspects of spiritually/religion and its role in clinical medicine and psychiatry, reliable standardised measurement instruments which include appropriate domains or elements of the two constructs (spirituality and religion) are necessary. Currently used instruments such as the WHO-Quality of Life Measure for Spirituality, Religion and Personal Beliefs may still be too broad, thus losing some of the core meaning of the constructs.

The role of spirituality in psychotherapy also has to be determined and clarified. Gaps between psychotherapy and the spiritual dimensions of religious life and between patients and therapists must be bridged. Spirituality must be addressed in the training of psychotherapists as a responsibility of the training institutions, in order not to leave the values, morals and worldviews – which frame the therapy that therapists provide – unknown or unattended.

Psychiatrists have generally been reported to be less religious than their patients or than their fellow clinicians. They do, however, encounter religious/spiritual issues more often in their type of practice and are in fact relatively more comfortable about engaging with these problems than general practitioners or physicians. Lack of time and training was cited as barriers and reasons why clinicians may not engage in the management or referral for patients' spiritual needs.

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Most users of services who participated in studies reported that they would rate spirituality as very important in their lives and would expect clinicians (including psychiatrists) to acknowledge this in their clinical assessment and management. The assessment of spirituality and religious beliefs in children and adolescents was regarded as important, because of the shared interest in developmental themes and because spirituality and religious beliefs offer a treatment and support resource for children and families.

The appropriate incorporation of the role of spirituality and religion into the current approach to assessment and management of patients may require additional knowledge and skill, both on undergraduate and postgraduate level. Undergraduate medical students may need to assess spirituality as part of the routine process of history taking and examination. They have to know how to communicate and convey difficult diagnostic and prognostic information regarding chronically ill and dying patients. Postgraduate residents in psychiatry should demonstrate competence regarding the assessment of psychopathology within a patients' religious-cultural context. Stigmatisation of the interest in religious of spiritual matters should be eliminated.

The anthropological study of spirituality and religion in the different faith and belief traditions may be an appropriate approach towards including spirituality and religion in the didactic training of undergraduate and postgraduate teaching of psychiatry and in the continued professional development of qualified psychiatrists. Although the collaboration between psychiatrists and spiritual professionals was generally encouraged, the physician or psychiatrist as "generalist" in spiritual care should rather refer appropriately to a relevant spiritual professional who may act as the "spiritual care specialist", but reference to this was usually made with regard to pastoral services rendered from a Christian perspective.

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The following main concept categories (MCL) were identified from the literature, with the number of references referred to in each category (Table 3.2):

- MCL1 - Principles in practice: concepts and definition, history and philosophy, approach, ethics;
- MCL2 - Presentation and symptoms of illness (clinical conditions);
- MCL3 - Measurement and research;
- MCL4 - Psychotherapy;
- MCL5 - Providers' perspectives (psychiatrists, family medicine practitioners);
- MCL6 - Users' perspectives (general, children and adolescents, elderly, end of life/terminal illness);
- MCL7 - Training (undergraduate and postgraduate);
- MCL8 - Religious-spiritual traditions (African traditional, Buddhist, Christian, Hindu, Humanist, Islam, Jewish, New Age, Shamanism); and
- MCL9 - Spiritual professionals' perspectives.

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Table 3.2 Summary of main categories identified from the literature (MCL)

1. **MCL1 - Principles in practice (n=75)**	
- general; concepts; definition	Lapierre (1994); Levin et al. (1997); Waldfogel (1997); Matthews et al. (1998, 1999); Breakey (2001); Greasley et al. (2001); Meador & Koenig (2000); Andreasen (2001); Culliford (2002a & 2002b); Kroll & Erikson (2002); Josephson & Dell (2004a & 2004b); Bhugra & Osbourne (2004); Koenig (2004b); Dein (2005); Kilpatrick et al. (2005); Jakovljevic (2005); D'Souza & George (2006); Weaver & Koenig (2006); Chattopadhyay (2007); Blanch (2007); D'Souza (2007); Sesanna et al. (2007); Yuen (2007); Russinova & Cash (2007); Bartocci & Dein (2007); Gilbert (2007a); Bienenfeld & Yager (2007); Eichelman (2007); Koenig (2004b); Pembroke (2008); Verghese (2008); Hall et al. (2008a); Koenig (2009); Vaillant (2008)
- historic/philosophic	Larson et al. (1986); Larson et al. (1993); Turner et al. (1995); Lukoff et al. (1998); Fabrega (2000); Leon et al. (2000); Carr (2000); Koenig (2000a); Powell (2001); Rhi (2001); Gallagher et al. (2002); Larimore et al. (2002); Bathgate (2003); Sims (2003); Scott et al. (2003); McLaughlin (2004); Turbott (2004); Mohr (2006); Hart (2008)
- approach	Sims (1999); Sperry (2000); Fallot (2001); Longo & Peterson (2002); Brooks & Koenig (2002); Halasz (2003); D'Souza (2003); Puchalski (2004); D'Souza & Rodrigo (2004); Moreira-Almeida & Koenig (2006); Cloninger (2006); Rumbold (2007); Gilbert (2007b); Flannelly et al. (2007); Wilding (2007); Vaillant (2008b); Anandaranjah (2008); Flannelly et al (2009);
- ethics	Post et al. (2000); Puchalski (2001); Daaleman (2004); Handzo & Koenig (2004); Winslow & Winslow (2007)
2. **MCL2 - Presentation and symptoms of illness (n=37)**	Carter (2002); Keks & D'Souza (2003); Hathaway (2003); Hopkins & Battin (2004); McConnell et al. (2006); Koenig (2007c)
- clinical conditions	Baetz et al (2004b & 2006); Moreira-Almeida et al. (2006); Koenig (2001a; 2001b); Koenig & Cohen (2006); Fallot (2007); Koenig (2009);
- mood and anxiety	McCullough & Larson (1999); Baetz et al. (2002c, 2004b); Garoutte et al. (2003); Grucza et al. (2003); Cloninger et al. (2006); Krisanaprakornkit et al. (2007); Vaccaro (2007); Dew et al. (2008a & 2009); Koenig (2009)
- psychosis and schizophrenia	Huguelet et al. (2006); Mohr et al. (2006 & 2007); Leao & Neto (2007); Koenig (2007c & 2009)
- alcohol and drug abuse	Koenig et al. (1994); Galanter et al. (2007); Galanter (2006 & 2008); Koenig (2009)
- physical conditions	Koenig (2001c)

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3. **MCL3 - Measurement and research (n=33)**	Larson et al. (1986); Cloninger (1991); Cloninger et al. (1998); Larson et al. (1992); Scott et al. (1998); Mezzich et al. (2000); Weaver et al. (2003), Kilpatrick et al. (2005); Moreira-Almeida & Koenig (2006); King et al. (2006); Galanter et al. (2007); Fleck & Skevington (2007); Katerndahl & Oyiriaru (2007); Anandarajah & Hight (2008); Koenig (2007a, 2008); Tsuang & Simpson (2008); Hall et al. (2008a, 2008b & 2009); Larson et al. (1986); Weaver et al. (1998); Koenig et al. (1999); Kilpatrick et al. (2005); Koenig (2006, 2008 & 2009); Baetz (2002a, 2004b); Tsuang et al. (2002; 2007); Blazer (2007); Bradshaw et al. (2008)
4. **MCL4- Psychotherapy (n=18)**	Cloninger (1987 & 1994); Aponte (1996); Karasu (1999); Cloninger (2000); Cloninger & Svrakic (2000); La Torre (2002); D'Souza & Rodrigo (2004); Epstein (2004); Stone (2005); Cohen (2006); Perez et al. (2007); Bienenfeld & Yager (2007); Elias et al. (2007); Morely (2007); Wagenfeld-Heinz (2008); Johnson & Friedman (2008); Holliman (2009); Peteet (2009)
5. **MCL - Providers' perspectives (n=27)**	
- psychiatrists	Morgan & Cohen (1994); Sims (1999); Neeleman (1993); Baetz (2002b, 2004a); Curlin et al. (2007a, b & c); Wagenfeld-Heinz (2008)
- family medicine practitioners	Craigie et al. (1990); Ellis et al. (2002); Monroe et al. (2003); Peach (2003); McCauley et al. (2005); Koenig (2003)
- other specialists	Armbruster et al. (2003); Grossoehme et al. (2007); Catlin et al. (2008)
- nursing	Weaver et al. (1998); Greasley et al. (2001); McLaughlin (2004); Kilpatrick et al. (2005); Mohr (2006); Sesanna et al. (2007)
- psychology	Hathaway et al. (2004 & 2005); Prest et al. (1999)
6. **MCL6 - Users' perspectives (n=32)**	King & Bushwick (1994); Baetz (2004a, b & 2006); Bellamy et al. (2005); Mann et al. (2005); Russinova & Cash (2007)
- general population	Mansfield et al. (2002); Flannely et al. (2006)
- clinical scenarios	Oyama & Koenig (1998); Ehman et al. (1999); Goldfarb et al. (1996); Greasley et al. (2001); D'Souza (2002); MacLean et al. (2003); McCord et al. (2004); Fallot & Heckman (2005); Johnson et al. (2005); Loue & Sajatovic (2006); Wilding et al. (2006); Wilding (2007); Magyar-Russell et al. (2008); Sexton & Sorlie (2008)
- children and adolescents	Josephson & Dell (2004b); Dell & Josephson (2006); Ancharsäter et al. (2006); Dew et al. (2008a & 2009)
- elderly	Koenig & Larson (1999); Chen & Koenig (2006); Blazer (2007); Pargament et al. (2009)
- end of life/terminal illness	Holt (2004); Breitbart et al. (2004)

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7. **MCL7 - Training (n=26)** - under graduate - post graduate	Levin et al. (1997); Barnett & Fortin (2001); Lawrence & Duggal (2001) Goldfarb et al. (1996); Puchalski & Larson (1998); Graves et al. (2000); Hull et al (2001); Pettus (2002); Musick et al. (2003); Fazzio et al. (2003); King et al. (2004) Aponte (1996); Targ (1999); Puchalski et al. (2000b & 2001); Coyle (2001); Anandarajah et al. (2001); Grabovac & Ganesan (2003); McCarthy & Peteet (2003); Luckhaupt et al. (2005); Hilty et al. (2005); Todres et al. (2005); Kligler et al. (2007); Lev-Ran & Fennig (2007); Grabovac et al. (2008); Lim et al. (2008)
8. **MCL8 - Religious-spiritual traditions (n=11)** African traditional, Buddhist, Christian, Hindu, Islam, Jewish, New Age, Shamanism	Wig (1999); Garoutte et al. (2003); Yip (2004); Dein (2005); Morris (2006); Rhi (2001) ; Lapierre (1994); Carter (2002); Chattopadhyay (2007) ; Loewenthal (1995); Sexton & Sorlie (2008)
9. **MCL9 - Spiritual professionals' perspectives (n=11)**	Galanter (1997); Weaver et al. (2001, 2002); Carter (2002); Koss-Chioino (2005); Catanzaro et al. (2006); Krippner (2007); Van den Berg & Van den Berg (2007); Pembroke (2008); Agara et al. (2008); Kourie (2006)

3.1.2.3 Final categories and subcategories from integrated content

Referring to paragraph 3.1.1.4 and Table 3.1, where provisional categories and subcategories of concepts were identified from the interviews, and to the main concepts identified from the literature (paragraph 3.1.2.2 and Table 3.2) these categories were compared and integrated. The overlap between and necessary adjustments to the categories were identified, in order to derive the final concepts for definition, classification and structuring of the proposed model. The framework and order for the final integrated categories and subcategories of the concepts are summarised in Table 3.3. These final categories were largely consistent with the six provisional categories, but in a slightly different order. For example, provisional Category 3 ("Scope and boundaries of professional specialist psychiatric practice") was moved to Category 5 in the final framework ("Scope and boundaries of spirituality in psychiatry"). Provisional Category 5 ("Awareness, knowledge and skill of trainees in psychiatry regarding spirituality") was consolidated as Category 4 ("Training of spirituality in psychiatry").

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Table 3.3 Final categories from integrated interview and literature content

CATEGORIES *, **	SUBCATEGORIES *, **
1. **Orientation in terms of spirituality and religion in psychiatry**	1.1 Own view of and attitude towards spirituality 1.2 Academic view of medical science and of patients 1.3 Providers' perspectives (MCL5) 1.4 Principles in practice: history and philosophy (MCL1) 1.5 Definition of spirituality and religion; concepts and definition(MCL1)
2. **Reality of spirituality and religion for practitioners and users**	2.1 Extended model of care: "bio-psycho-social-spiritual" 2.2 Principles in practice: approach(MCL1) 2.3 Users' perspectives (MCL6)
3. **Routine assessment of spirituality and religion in psychiatry**	3.1 Need assessment 3.2 Communication and appropriate intervention 3.3 Liaison and referral 3.4 Presentation and symptoms (MCL2) 3.5 Assessment, measurement and research (MCL3)
4. **Training of spirituality in psychiatry (MCL7)**	4.1 Understanding of spirituality and its role in mental health care 4.2 Didactic learning on spirituality and religious faith traditions* 4.3 Approach towards spirituality and religion in psychiatry 4.4 Personal growth, professional development and competency
5. **Scope and boundaries of spirituality in psychiatry**	5.1 Ethics of spirituality in psychiatric practice; Principles in practice: ethics (MCL1) 5.2 Continued education and peer review 5.3 Psychotherapy (MCL4)
6. **Referral and collaboration on spirituality in psychiatry**	6.1 Facilitating appropriate referral and intervention for individual users 6.2 Information sharing and mutual awareness between disciplines 6.3 Addressing stigmatisation of users with psychiatric conditions 6.4 Religious-spiritual traditions (MCL8) 6.5 Spiritual professionals' perspectives (MCL9)

* **Black text – categories from interviews (discussed in par 3.1.1.4);** ** **Red text – categories from literature (listed as themes in par 3.1.2.2);** MCL – Main category identified from literature

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(1) **Orientation in terms of spirituality and religion in psychiatry**

From the interviews, three subcategories emerged: psychiatrists' own view and attitude towards spirituality (1.1); their academic view of medical science and patients (1.2); and the definition of terms (2.1). From the literature, the definition of the categories was also discussed extensively (MCL1), as well as: providers' perspectives on spirituality in health and psychiatric care (MCL5); and historical and philosophical issues (MCL1), (See Tables 3.1 & 3.3). In view of the fact that the provisional concept categories identified from the interviews were discussed in paragraph 3.1.1.4, the following discussion of final categories will focus on the literature component of the integrated content.

(1.1) **Providers' perspectives (MCL5)**

The literature reported on the perspectives of psychiatrists, family practitioners and other professionals such as paediatricians, psychologists and nursing professionals. While psychiatrists are traditionally less inclined to be religiously or spiritually orientated than their clients or colleagues in other specialties (Sims, 1999), (Baetz et al., 2002a), (Baetz et al., 2004b) and (Curlin et al., 2007a), (Curlin et al., 2007b), (Curlin et al., 2007c), they are reported to be more comfortable and to have more experience in addressing religious/spiritual concerns. They concur that to explore spirituality and religious issues is important in the clinical assessment and management of patients, despite of their own views or position about it. This was also observed with regard to family practitioners (Ellis et al., 2002), (Monroe et al., 2003) (Peach, 2003), where participants in semi-structured interviews affirmed a role for family practitioners, although they differed in being comfortable addressing spiritual issues in their practice. A psychiatrist does not necessarily have to have personal spiritual beliefs or convictions him/herself, but as a clinician has to understand the importance thereof and has to have skill and knowledge to make accurate assessments and appropriate referrals. The gap that may exist in the awareness and acknowledgement of the role of spirituality and the ability to address it appropriately in a clinical setting, should be addressed through training initiatives.

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(1.2) **Principles in practice: history and philosophy (MCL1)**

Many authors have referred to the significant increase over the past two decades in focus, research attention and publications in the field of spirituality/religion in general but also in particular regarding health, mental health and psychiatry (D'Souza & George, 2006), (D'Souza, 2007), (Bathgate, 2003), (Lakoff & Johnson 1999), (Blanch, 2007). Tracking the history of the split between religion and psychiatry over the past 200-300 years, authors referred to Freud's negative views of religion and the influence of his teaching on psychiatry in the 20th century (Koenig, 2000a).

In addition to the historic split ("divorce") between spirituality/religion and psychiatry, according to Koenig (2000), (Powell, 2001), (Daaleman, 2004), (Bartocci & Dein, 2007) and others, a recent process of reconciliation ("rapprochement") has been observed over the past two decades in the long-divided healing traditions of science/medicine and spirituality/religion (Sperry, 2000), (Sims, 2003), (Turbott, 1996), (Halasz, 2003).

The extent to which spirituality and religion has currently been (re-)considered and (re-) incorporated into the practice and training of specialist psychiatry is reflected by the history of its incorporation into the diagnostic classification systems, in particular the Diagnostic and Statistical Manual (DSM). Authors mentioned how the concepts were considered first in the DSM-III (Larson et al., 1986), (Larson et al., 1993) - where religion was still used in culturally insensitive examples of psychopathology only, and then in the DSM-IV, as a separate category that may be a focus of clinical attention, but which is not regarded as psychopathology (Turner et al., 1995), (Lukoff, Lu & Turner, 1998), (Scott et al., 2003). Although its inclusion as a non-pathological entity in the DSM-IV was commended, the authors commented on how the diagnostic category was still conceptualised in terms of spirituality and religion's contribution to clinical difficulty. The current role of spirituality in the world was also discussed against the background of the

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"failure" of the anticipated outcome of the earlier process of secularisation. The social function of spirituality has to be recognised as well as the internal validation of individual spirituality (Carr, 2000).

A particular tone and direction about how the role of spirituality should be regarded in the psychiatric profession was set by prominent international academics and role players in the World Association of Psychiatry (Fabrega, 2000) and (Leon et al., 2000). Strong affirmative comments were made by this panel on Fabrega's review that advised adjustment to the secular viewpoint which dictates all contemporary, modern medical disciplines (including psychiatry). This must happen, according to him, through restoring cultural psychology to the equation in order to account for the cultural and spiritual character in the circumstances of people, as well as in the composition of psychopathology itself. As the causes and manifestation of psychopathology are more deeply connected to culture and spirituality, he calls for the restoring of cultural psychology to its rightful place in the taxonomy, nosology and rationale of systems of diagnoses. Medical education and psychiatric residency must therefore take the influences of spirituality and religious cultures on the worldview of the patient into account.

A conceptualisation of the traditional shaman as "prototype" of healer was used to contrast it with the one-sided materialistic, mechanistic view of patients - currently pervading modern medicine - that only chemically treats symptoms of disease (Rhi, 2001). It was argued that for medical professions and psychiatry to reckon with the influence of spirituality and religion, it would firstly imply that they would have to embark on a process of reviewing their responses to perceived faults in earlier paradigms and modes of thought that they might have had about religion (Gallagher, Wadsworth & Stratton, 2002). Authors reported on the different official policy positions of the medical profession and the discipline of psychiatry in different countries. This provided some perspective on the process, time and resources that were invested - following awareness

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- to achieve acknowledgement of the role that spirituality plays in the lives of people and to respond to it appropriately as a profession (Gilbert, 2007a), (Gilbert, 2007b).

(1.3) **Concepts and definition (MCL1)**

No single perspective on the definition of spirituality seems to dominate in the postmodern culture. Multiple perspectives seem to exist (Culliford, 2002), (Andreasen, 2001), (Murray & Zentner, 1989), (Koenig, 2009), (Sesanna, Finnell & Jezewski, 2007), (Greasley, Chiu & Gartland, 2001), (Russinova & Cash, 2007), (Waldfogel, 1997), (Meador & Koenig, 2000), and (Pembroke, 2008).

Attributes of spirituality that were described included:

- "a journey, transcendence, community, mystery of creation, transformation" (Lapierre 1994);
- "the meaning and purpose of life, transcendence, connection with others and energy" (Waldfogel 1997);
- "relationships with others in faith community" (Josephson & Dell, 2004a);
- "inner realm reacting with the transcendental" (D'Souza & George, 2006); and
- "a person's attempt to make sense of the world" (Bienenfeld & Yager, 2007).

Considering the definition of the constructs of spirituality and religion, authors regarded religion to have attributes such as:

- "organized systems of principles, beliefs, rituals, practices, related symbols" (Josephson & Dell, 2004a);
- "the outer realm reacting with the world" (D'Souza & George, 2006);
- "institutionalised spirituality, with different sets of beliefs, traditions and doctrines" (Verghese, 2008); and
- "beliefs, practice and rituals related to the sacred or the 'numinous'" (Koenig, 2009);

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- Dein commented that the use of a Western definition of religion may not be useful in a cultural comparison with non-Western traditions (Dein, 2005).

The overlap between the two constructs “spirituality” and “religion” as well as the differences was explored. The overlap between the two constructs included the search for the sacred and the process of establishing meaning (Yuen, 2007) and the difference, that spirituality includes religion and relations with others, but is not limited by organised religion (Josephson & Dell, 2004a). Other differences included the fact that religion pertains to organised, structured, socialized, “external” behavioural aspects, while spirituality refers to the individual's (internal) capacity and inclination to explore and experience the transcendent on a cognitive and an emotional level.

Boundaries and shared territories in terms of the relation of spirituality and religion to the cultural domain have been considered. The limitations of distinguishing between religion and culture and non-Western communities were pointed out by Dein (2005). Comments were made about the potential of religious institutions to become oppressive and divisive once contact with spiritual content has been lost. Cognisance should be taken of other healing traditions, including Indian, Chinese and different indigenous perspectives (Verghese, 2008). Dimensions and domains of each construct (spirituality, religion and culture) were listed, discussed and reviewed.

While authors were mostly from the USA - but also UK, Australia and India – and had mainly a Judeo-Christian point of departure, principles and arguments can still be applied or translated to different other religious and cultural traditions (Dein, 2005). The (re-) introduction of spirituality into health, mental health and psychiatry would make the field more ethical, caring and compassionate. Emphasis was placed on a holistic perspective and on an approach that clearly includes spirituality (Chattopadhyay, 2007). The role of spirituality in the lives of people in itself – and not whether individual (mental health)

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practitioners would pursue spirituality in their personal lives – could be regarded as reason enough to have to take cognisance of the role of spirituality in the process of medical and psychiatric assessment of and intervention for patients. In the United States for example, curricula were developed and care programmes adjusted in response to specific regulatory requirements of official training and care accreditation bodies.

(2) **Reality of spirituality and religion for practitioners and users**

Final subcategories of this second category include: an extended model of care: "bio-psycho-social-spiritual" (2.1), from the interviews; and an approach (MCL1); and users' perspectives on the role of spirituality (MCL6), from the literature, see Tables 3.1 & 3.3. One participant in the interviews, incidentally not pursuing a personal position of spirituality or religion, described it as "inconceivable" not to bring the spiritual aspect of peoples' lives into consideration in a psychiatric assessment and diagnostic formulation, see Participant 7 - in Paragraph 3.1.1.4 (2.2).

The reality of spirituality for psychiatry as a secular field and how this phenomenon may be approached has been discussed in detail in the literature as well. Gilbert (2007b) outlined the discourse on spirituality and mental health over past decades and showed how it changed from focus on issues around "race" and "colour" in the 1950's and 60's to religion in the present time.

As was pointed out in previous paragraphs, an approach towards considering the reality of spirituality in specialist psychiatry would first of all have to achieve clarity about the nature and definition of the boundary that exists between two adjacent, "neighbouring" territories (Sims, 1999), (Bhugra, 1996). How does one define, respect and maintain an appropriate common boundary? On the one hand, it must be clear what is outside of the one discipline's territory and scope, but inside of the other's. On the other hand, it must be clear what the inherent commonalities and mutual responsibilities may be and how the

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practical “passing through” in terms of communication and referral between the disciplines will operate. Achieving clarity will require personal and communal decisions about the nature of such collaboration, whether it should be approached as an “impenetrable secure wall” or as a permeable, negotiated (but controlled) “mechanism”, area or procedure of passage.

Most authors recommended a cooperative, “dealing with the differences and difficulties” attitude. A clear role for the “spiritual professional” as part of the extended multi-disciplinary team has been outlined in several reports. In the contexts of these reports, this term most often referred to a (Christian) hospital chaplain or minister of religion with professional (theological) training and expertise and experience in the counselling of patients in clinical settings. How this would translate to all spiritual advisers from all the other different faith traditions and belief systems, is one of the practical issues to resolve in a South African context. “Turf battles” between these spiritual professionals and health workers would be another matter which would benefit from clear guidelines and training in this regard (Sims, 1999). Removal of such perceived tensions between the patient’s spiritual adviser and her/his psychiatrist may in itself allow patients to be more open about matters concerning their mental health and therefore may probably be more compliant with their psychiatric treatment.

Instances where patients themselves are less comfortable with religious advice and therefore search out the advice of psychiatrists and psychotherapists instead, may - according to Sperry (2000) - place a bigger onus on the latter two disciplines to provide some form of spiritual directive as “substitute secular priests” (London, 1985). According to Fallot (2007), consumers noted both the potentially supportive and burdensome roles of religions and spiritual recovery, while professionals reported both hope for, and discomfort with, these domains. Incorporation of the awareness and acknowledgement of the role of psychiatry in the lives of people and in their mental health or illness may be

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done on different levels. It may range from basic and personal awareness about the role of spirituality to corporate, official acknowledgement and integration requiring spirituality to be part of training and care programmes. Brooks & Koenig (2002) and Puchalski et al. (2001) reported on the need for programmes, facilities and service providers to make allowance for spirituality in terms of infrastructure, budget and environment for patients to express their spirituality and religiosity.

(2.1) **Principles in practice: approach (MCL1)**

Positive associations between spirituality (salience) and better health outcomes were identified from research reports and were used by some authors to motivate the importance of spirituality's role in clinical settings (Levin, Larson & Puchalski, 1997), (Matthews et al., 1998), (Koenig, 2004a), (Moreira-Almeida, Neto & Koenig, 2006). A positive effect was also reported on medical conditions such as cardiovascular disease, hypertension, stroke and other stress and life style related conditions (Koenig, 2001d), (Koenig & Cohen, 2006). The psychopathological symptoms that apparently benefitted from spirituality/religious involvement, included: depression (Baetz et al., 2004a); suicidality (Garroutte et al., 2003); anxiety; and substance abuse (Koenig et al., 1994), (Galanter, 2006), (Galanter, 2008). Explanations for the positive influence of spirituality/religion included that religious belief provides a positive worldview which gives experiences meaning and which also acts as an agent of social control.

Rumbold (2007) referring to Sulmasy (2002) discussed the principles of spirituality and psychiatry in practice. On a clinical level, approaches to including spirituality and religion in routine clinical history taking, in "spiritually augmented cognitive behavioural therapy" and the use of more established models for family medicine practice were discussed (D'Souza 2003), (D'Souza & Rodrigo, 2004). Puchalski (2004) described a model ("FICA") that refers to faith and belief (F), importance and influence (I), community (C) and address/action (A). The place of spirituality in psycho-social rehabilitation was reviewed

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(Fallot, 2001), (Longo & Peterson, 2002). Applications in this regard may include: conducting spiritual assessments; discussion groups; facilitating linkages to faith communities and spiritual resources.

A theoretical model was described by Koenig to illustrate the complex pathways in which religion may influence physical health (Koenig, 2001a), (Koenig, 2001b), (Koenig, 2001c). His model demonstrates the complex influence of religion on physical health, considering genetics, childhood training and other social influences. Again, it should be noted, that being studies on North American population groups, these reports primarily referred to a Christian spirituality/religion perspective. How and whether a salient effect also translates to other traditions and systems was not addressed. Other theorists such as Cloninger, Vaillant, Anandarajah and Flannelly also presented more elaborate theories on the reality of spirituality for psychiatry. Cloninger's Temperament and Character Inventory (TCI) based on his theory of personality with different temperament and character dimensions, has been part of the teaching curriculum in psychiatry for many years (Cloninger, 2006), (Cloninger & Svrakic, 2000). Vaillant, (2008b, 2008a) used arguments pertaining to genetic evolution and language development, to propose the maturation of human spirituality as the "third" human evolutionary process. He suggested that three evolutions could be identified, the genetic (Darwinian) evolution, a cultural evolution (mediated by the development of language) and then the maturation of human spirituality. Anandarajah (2008) described two multidimensional models for spirituality applicable across culture and belief systems that could be used for patient care, education and research. The models provide common ground for the further exploration of the spirituality in medicine. Flannelly et al, (2007 & 2009) discussed the ideas contained in their "ETAS" (Evolutionary threat assessment systems) theory, referring to how brain mechanisms that evolved to assess environmental threats underlie psychiatric disorders.

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(2.2) **Users' perspectives (MCL6)**

The majority of actual and potential service users have indicated in studies that they regard the role of spirituality and religion in general and in health matters as very important. It is important as a coping resource and to establish meaning from negative and trying experiences such as illness, loss and end of life situations. This is the case for the population in general as well as for current outpatient and inpatient users of psychiatric services and facilities. The role of spirituality and religion was also regarded as important in a child and adolescent setting (Josephson & Dell, 2004a) (Dell & Josephson, 2006), (Dell & Josephson, 2006), (Ancharsäter et al., 2006), (Kroll & Erickson, 2002), (Dew et al., 2008b), (Dew et al., 2009), as well as for the elderly and end of life/terminal illness scenarios (Koenig et al., 1999a), (Chen & Koenig, 2006), (Blazer, 2007), (Pargament et al., 2004), (Breitbart et al., 2004), (Holt, 2004).

(3) **Routine assessment of spirituality and religion in psychiatry**

The third final category identified from the interviews included the subcategories: need assessment (4.1); communication and appropriate intervention (4.2); liaison and referral (4.3); and from the literature: presentation and symptoms (MCL2); and assessment, measurement and research (MCL3), (Tables 3.1 & 3.3). An understanding of a person's religious background and involvement is central to an adequate grasp of the context and content of clinical presentation and symptoms of psychopathology. It is also integral to the implementation of appropriate interventions, diagnostic formulation and possible referral to a spiritual professional.

(3.1) **Presentation and symptoms (MCL2)**

Spirituality and religion may affect aspects of the presentation and symptoms of illness in different clinical scenarios (Hathaway, 2003), (Hopkins & Battin, 2004), (McConnell et al., 2006). To attend to the clinical needs of certain population groups, an understanding of how a religious or faith tradition may influence the presentation of patients is important

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(Carter, 2002). It is well established how spirituality, for example, can influence the particular content of psychotic symptoms (Keks & D'Souza, 2003), (Koenig, 2007c). It is a necessary skill to be able to differentiate between pathological and non-pathological religious involvement. Reviews of the literature over the years have covered the influence of religion and spirituality in a variety of psychiatric conditions such as mood and anxiety, psychosis and schizophrenia, alcohol and drug abuse (McCullough & Larson, 1999), (Baetz et al., 2002a), (Grucza et al., 2003), (Cloninger, Svrakic & Przybeck, 2006), (Krisanaprakornkit, Krisanaprakornkit & Piyavhatkul, 2007), (Vaccaro, 2007), (Koenig, 2009), (Leao & Neto, 2007), (Koenig et al., 1994), (Galanter, 2006), (Galanter, 2008), (Moreira-Almeida, Neto & Koenig, 2006). The role of spirituality in patients with schizophrenia was reported on (Huguelet et al., 2006), (Mohr et al., 2006), (Mohr et al., 2007). Commitment to tribal cultural spirituality among American Indians was found to be a protective factor in suicide attempts (Garroutte et al., 2003). Fewer depressive symptoms were found using national health survey data in Canada (Baetz et al., 2004a), (Baetz et al., 2006).

(3.2) **Assessment, measurement and research (MCL3)**

Flowing from routine clinical assessment and from the investigation of possible direct associations between spirituality/religion and medical conditions is the need for accurate measuring instruments in order to compare findings. In research, clear definitions are fundamental to the assessment of different measures and measurements of spirituality and religiousness and to evaluate reported associations between spirituality and health outcomes. The development of clinical measures for research is intimately linked with the process of defining the constructs of spirituality and religion. Examples of measuring instruments include: Temperament and Character Inventory (TCI); WHO-QOL SRPB; Quality of Life Index (QLI); “Multidimensional measurement of religiousness/spirituality for use in health research“ (Fetzer Institute); Religious Coping Index and Questionnaire on Spiritual and Religious Adjustment to Life Events; Brief Multidimensional Measure of

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Religiousness/Spirituality (BMMRS); Springfield Religiosity Scale; Hoge Intrinsic Religiosity Scale; Spirituality well-being scale (SWBS); Feagin's "Orientation to Life and God Scale"; Duke Religious Index (DUREL), Episcopal Measure of Faith Tradition; and various semi-structured questionnaires that were used in reported studies.

Clinical assessment and objective measuring of spirituality and religiousness also translate to be a research concern. Moreira-Almeida and Koenig addressed the issue of measuring and comparing variables with reference to the official WHO tool for assessment of spirituality, religion and personal beliefs (the WHO-QOL SRPB), (Moreira-Almeida & Koenig, 2006). Valid instruments for measuring spirituality and religiousness in different communities (as products of an approach to incorporate the role of spirituality in psychiatry) and the level of differentiation that must be appropriated in this regard, demonstrate the high degree of integration that may exist between the different domains on each side of interdisciplinary boundaries. King et al., developed and tested a 20-item questionnaire that goes beyond conventional religious beliefs for use in psychological and health research (King et al., 2006). Katerndahl and Oyiriaru developed and validated an instrument for each of the dimensions of a bio-psycho- social-spiritual model (Katerndahl & Oyiriaru, 2007), while Koenig (2009) warned against domains correlating with positive psychological aspects, which may result in a tautological comparison.

(4) **Training of spirituality in psychiatry (MCL7)**

The fourth final category identified from the interviews and the literature retained the provisional subcategories: understanding of spirituality and its role in mental health care (5.1); didactic learning on spirituality and religious faith traditions (5.2); approach toward spirituality and religion in psychiatry (5.3); and personal growth, professional development and competency (5.4). Concepts from the literature further related to overall provisional Category 5 and were thus consolidated as Category 4 in the final framework (MCL7), (Tables 3.1 & 3.3).

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What content should be included and what outcome should be achieved in formal (undergraduate and postgraduate) studies or in in-service training, or with continued education? Undergraduate curricula in the United States have been developed following requirements from the national accreditation body (Graves, Shue & Arnold, 2002), (Musick et al., 2003), (Fazzio et al., 2003), (King et al., 2004), (Barnett & Fortin, 2006). Skills that these undergraduate students have to demonstrate include competency in: assessing spirituality as part of routine history taking and clinical examination; communicating bad news; and managing the scenario of the death or dying of a patient. Spirituality has also been introduced on a postgraduate level as a requirement of the American national residency review committee. Postgraduate students in psychiatry in that country are expected to: be able to recognise spirituality as a potential resource; determine the role of spirituality/religion in psychopathology; and manage its role adequately in psychiatric intervention, referral and therapy. The development of training programs in American medical schools for undergraduate and postgraduate students over the past decade, happened against the background of specific regulations adopted by various regulating and accreditation bodies such as the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges and the American Medical Association's Psychiatric Residency Review Committee (Puchalski, Larson & Lu, 2001). Trainers and training institutions for psychotherapists (whatever disciplines) must provide trainees with an opportunity to achieve the competency in assessing and managing the role of spiritually and religion in therapy appropriately. For psychiatric residents, spirituality as a potential source of higher functioning for the patient must be included in the training programme (Targ, 1999), (Puchalski, Larson & Lu, 2000), (Puchalski, Larson & Lu, 2001). Myths about religion and psychiatry should be dispelled (Coyle, 2001) and perceptions of young psychiatrists - that an interest in spirituality and religion should be avoided for fear of a negative impact on their careers - should be corrected (Lev-Ran & Fennig, 2007). Ways of introducing courses in spirituality in medical

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curricula and psychiatric residency programs in the United States and Canada have been well documented. Topics may include: definitions of religion and spirituality and the historical relationship between the two fields; scientific evidence for associations between spirituality, religion and mental health; the clinical assessment process with a focus on history taking and formulation; spirituality related phenomenology; and transference and counter-transference (Grabovac & Ganesan, 2003), (Grabovac, Clark & McKenna, 2008).

(5) Scope and boundaries of professional specialist psychiatric practice

The fifth final category identified from the interviews and the literature was moved from provisional Category 3 and includes subcategories: ethics of spirituality in psychiatric practice (3.1 and MCL1); continued education and peer review (3.2); and psychotherapy (MCL4), see Tables 3.1 & 3.3. Based on the assessed need of the individual patient, appropriate referral to a spiritual professional should be facilitated. Guidelines for ethical and professional practice in this regard should be developed.

(5.1) Ethics (MCL1)

Defining boundaries, domains and roles will also have to result in the drafting of practical, ethical and professional guidelines for psychiatry and related disciplines (Post, Puchalski & Larson, 2000). What must be regarded as part of the scope of professional psychiatry should be clear and must be congruent with the general ethical principles that guide clinical practice (Puchalski, 2001). Although the role of spirituality should be considered in clinical settings such as psychiatric practice, the psychiatrist is not regarded as primary provider of spiritual interventions and guidance for patients (Daaleman, 2004), (Brody, 1992). Appropriate knowledge and skills to assess the (positive and negative) role of spirituality and religion – or the lack thereof – should be facilitated. What would constitute inappropriate spiritual interventions by psychiatrists, while involving third party funders for instance, will have to be identified and monitored (Handzo & Koenig, 2004). Verification between training curricula, proven competency and ongoing professional conduct and

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practice is essential. Greater patient empowerment through autonomy and self-determination should be achieved (Winslow & Wehtje-Winslow, 2007).

(5.2) **Psychotherapy (MCL4)**

Spirituality, religion and psychotherapy also present issues of definition, of training and of establishing scope and boundaries, as psychotherapists face a different scenario in this regard than in the past. Psychotherapists now have to consider in what ways the spiritual affects emotions and connections to people. That educators of psychotherapists should provide training and supervision that will facilitate therapeutic skills, can be well motivated (Elias et al., 2007), (Stone, 2005), (Cohen, 2006). The process in the early 1990's to negotiate and submit motivations to the DSM Working Group on religion and spiritually also included consultation with the American Psychological Association. Guidelines for psychologists on religious-spiritual issues also needed to be confirmed (Hathaway, 2005). In fact, each training institution has to establish its official position and assume responsibility for ensuring that values, morals, worldviews and norms are not left unknown or unspoken (Aponte, 1996).

(6) **Referral and collaboration between psychiatrists and spiritual professionals**

The sixth final category identified from the interviews and the literature includes the provisional subcategories from the interviews: facilitating appropriate referral and intervention for individual users (6.1); information sharing and mutual awareness between disciplines (6.2); addressing stigmatisation of users with psychiatric conditions (6.3); and from the literature religious/spiritual traditions (MCL8); and spiritual professionals' perspective (MCL9), see Tables 3.1 & 3.3.

(6.1) **Religious-spiritual traditions (MCL8)**

Interview participants were not convinced that the route of a formal referral system to spiritual professionals, or the spiritual professional as additional member of the current

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multi-disciplinary team, should be followed. According to them, decisions based on the assessed need of individual users should rather be the approach. “Homogenous” scenarios where members of a population in a particular area all belonged to the same faith tradition or belief system, would have simplified the logistics of identifying relevant spiritual professionals to whom to refer. If the role of spirituality is to be considered in the approach to health and clinical care, it should be done with a perspective that can accommodate all religious traditions equally. This will include the main traditions such as Buddhist, Christian, Hindu, Muslim, Jewish, but also regional traditions such as African traditional and other indigenous beliefs, as well as worldviews such as Humanism and atheism/agnosticism. No preference for one particular tradition should be given over the other, because a practitioner or a dominant group may be from the one tradition or the other. A sociological and anthropological understanding of spirituality and religions should be achieved (Morris, 2006). The unique approach of each tradition relevant to health, mental health and clinical medicine should be understood and explored (Loewenthal, 1995), (Wig, 1999), (Garroutte et al., 2003), (Yip, 2004), (Dein, 2005), (Rhi, 2001), (Lapierre, 1994), (Carter, 2002), (Chattopadhyay, 2007), (Sexton & Sorlie, 2008). Literature referring to a “spiritual professional” routinely described a resident Christian minister of religion in a hospital with experience and training in the pastoral care of patients with medical conditions. How this would translate in the heterogenous South African multi-cultural/religious communities, may present a logistical and potentially politically charged challenge. The practicality of identifying the spectrum of traditions in a local context that needs to be considered, of exploring the options of the particular tradition’s representative in an area, of establishing a mutual understanding about the shared (and different) areas of responsibility, as well as of the monitoring of the outcome of a collaborative relationship, may require a great deal of effort from the discipline of psychiatry and from local service delivery structures.

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(6.2) **Spiritual professionals' perspectives (MCL9)**

Views and experiences of professional spiritual workers on the role of spirituality in health and psychiatry should be established and taken into consideration (Weaver et al., 2001), (Weaver et al., 2002)), (Koss-Chioino, 2005), (Catanzaro et al., 2007), (Krippner, 2007), (Van den Berg & Van den Berg, 2007), (Agara, Makanjuola & Morakinyo, 2008), (Kourie, date unknown) To build up relationships of mutual trust and understanding, will require (mental) health education initiatives aimed at patients and the spiritual professionals to whom they choose to be referred. As an effort to also address the continuing stigmatisation of mental health conditions, positive mental health promotion, illness prevention and treatment outcome intervention may however prove to be a rewarding and worthwhile exercise.

3.1.3 NARRATIVE ON INTEGRATED DATA

To consolidate the interpretation of the findings from the combined interviews and literature source data, a descriptive narrative on the integrated content that was reviewed thus far, is presented here. To provide evidence of how the single core concept (identified in paragraph 3.1.3.1) has been grounded in the preceding integrated data, concepts that were eventually incorporated into the single core concept from the narrative that follows here were highlighted with underlined text.

The discussion about the validation of the roles of spirituality and religion and how this should be addressed, also as part of health and medical assessment and intervention, has become a discourse of increasing importance in the medical literature over the past two decades. From the literature and from the interviews with the thirteen local academic psychiatrists on their views and experience in this regard, it became apparent that "mindfulness" - or "an open-minded approach" - towards spirituality should be facilitated and that spirituality should be incorporated in the approach to specialist psychiatric

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practice and training, This discourse on the role and importance of spirituality is in many instances still marginalised in clinical and academic settings.

Although interview participants had diverse views and experiences on the role of spirituality in psychiatry, all agreed that it should be considered in current local specialist practice and training. The awareness that spiritually is generally playing an increasingly important role in the lives and identities of individuals and groups in recent times ("a surge", "revitalised interest" in spirituality), was discussed in many literature reports. This applied to people in general and to patients and their families. Spirituality is generally regarded as a resource in coping, it forms part of the individual's identity and is drawn upon to derive meaning from different experiences, including challenging circumstances such as illness and loss. Religious expression as opposed to spirituality, is generally still associated with more negative meaning, while some religious thought content may also form part of psychopathology.

Several participants in the interviews orientated and associated themselves personally with having a spiritual rather than a religious position, while others orientated from a religious position, or from not having a spiritual or religious position at all. The exclusion of spiritual/religious issues from their own training was referred to by a number of the local interview participants. According to the literature, the gap that may exist in the awareness and acknowledgement of the role of spirituality and the competency to address it appropriately in a clinical setting should be addressed through training initiatives. The literature reported extensively on the perspectives of psychiatrists, family practitioners and other professionals such as paediatricians, psychologists and nursing professionals. For instance, while psychiatrists were usually found to be personally less religiously or spiritually inclined than their clients or than colleagues in other specialties, they were reported to be more comfortable and to have more experience in addressing religious/spiritual concerns in their practice.

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According to some authors, subsequent to the historic split between religion and science, a process of reconciliation ("rapprochement") has been observed in recent years in the long-divided healing traditions of medicine/psychiatry and spirituality/religion. The extent to which spirituality and religion are currently considered in the practice and training of specialist psychiatry, is reflected by the history of its incorporation into the diagnostic classification systems since the 1980's. A particular direction about how the role of spirituality should be regarded in the psychiatric profession was - for example - also set by a panel of prominent international academics and role players in psychiatry. They strongly affirmed the view that an adjustment is needed to the traditionally secular viewpoint which thus far has dictated all contemporary, modern medical disciplines, including psychiatry.

To deal with the role of spirituality in a practical way, local specialist psychiatry may start to consider the importance of spirituality by clarifying concepts, roles and definitions. Once the meaning of constructs has been clarified, it may then be considered how to incorporate it further into existing approaches to the practice and teaching of psychiatry in a more formal way. Defining spirituality adequately may also establish recognition for it as a domain in which additional options for appropriate intervention for patients may be explored. From the interviews, the differentiation between spirituality and religion may not always be clear, but - as psychiatrists - exploring the role of both in a person's life, was regarded as important.

In the complex South African society it is essential to have adequate awareness and skill to accommodate, understand and respect different religious-cultural backgrounds in order to interpret symptoms and to make diagnoses. To review the philosophic reasons why the dimensions of science and religion have become separated in the first place, may also be informative. In the literature, no single perspective on the definition of spirituality seems to dominate in the postmodern culture: multiple perspectives seem to exist. Attributes of

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spirituality that were considered in its definition included: “a journey, transcendence, community, mystery of creation, transformation”; “meaning and purpose of life, transcendence, connection with others, energy”; “relationships with others in a faith community”; “inner realm reacting with the transcendental”; and “a person’s attempt to make sense of the world”.

In the topography of the medical and health environment, psychiatry as a discipline itself typically occupies a boundary or transitional (bridge) position, relative to the other clinical disciplines and to the human science disciplines with which it interacts routinely from a bio-psycho-social perspective. Psychiatry’s role in particular in this position is, and has been, to identify and offer biomedical interventions for psychopathology presenting with behavioural, cognitive, thought, mood and perceptual symptoms. From this position, psychiatrists as mental health practitioners, encounter multi-cultural, multi-religious and spiritually diverse South African health care users on a daily basis.

Although spirituality may mostly be regarded as part of the sphere of the adjacent territory of religion, adequately defined spirituality - as opposed to religion - has the potential to be an integrative ingredient in a more holistic bio-psycho-social-spiritual perspective. It may even be the integrative “fibre” that weaves all four dimensions into a whole. According to interviewees, spirituality is central in the transcendence of difficult life situations such as chronic illness and death, confirming the applicability of a balanced four-dimensional bio-psycho-socio-spiritual model. Most authors have recommended a cooperative “dealing with the differences and difficulties” attitude. A clear role for the “spiritual professional” as part of the extended multi-disciplinary team has been outlined in several reports. In the case where patients themselves are less comfortable with religious advice and therefore search out the advice of psychiatrists and psychotherapists instead, this may place a greater onus on the latter two disciplines to provide some form of spiritual directive as “substitute secular priests”.

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Positive associations (salience) between spirituality and better health outcomes were identified from several research reports and were used by some authors to further motivate the importance of spirituality's role in clinical settings. Several authors recently presented more elaborated theories on the reality of spirituality for psychiatry.

An understanding of the dynamic and influence - the reality - of spirituality and religion in the clinical presentation of illness should be a basic part of the paradigm in which clinical assessment and decision-making occurs. The spiritual and religious content of different faith traditions and belief systems should be familiar constructs to psychiatrists, also in order to identify and manage psychopathology and unconstructive behaviour more effectively. From the interviews, considering the prominent place and role of religion and spirituality in the lives of users, it was felt that it should be part of the routine clinical assessment and management, whether psychiatrists in their personal capacity would consider religion or spirituality important or not.

Psychiatry per se, may still be unfamiliar territory to more traditional or conservative religious/cultural groups. Service users from these traditions may present with less clear symptoms which may have be interpreted from their cultural perspective, while the individuals may actually be in need of psychiatric *care*. A helpful approach may be to collaborate with the family of such users and with the particular spiritual worker(s) that they may prefer, to address stigma and misunderstanding about psychiatric conditions. It may be necessary to appropriately address different worldviews with understanding, in order to reduce prejudice and stigma and to ensure freer access to psychiatric care. It would be important to allow enough space for patients with other worldviews about mental health so that people do not "lose face" while they have to come to terms with the reality of psychiatric conditions. In the literature it was also discussed how spirituality and religion may affect the presentation and symptoms of illness in different clinical scenarios. To

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attend to the clinical needs of particular population groups and an understanding of how a religious or faith tradition may influence the presentation of patients, are important.

Reviews of the literature over the years covered the influence of religion and spirituality in a variety of psychiatric conditions such as mood and anxiety disorders, psychosis and schizophrenia, alcohol and drug abuse. A theoretical model was described to illustrate the complex pathways in which religion may influence physical health. Explanations for the positive influence of spirituality and religion included that religious belief provides a positive worldview which gives experiences meaning and which also acts as an agent of social control. In research, clear definitions are fundamental for the assessment of different measures and measurements of spirituality and religiousness and to evaluate reported associations between spirituality and health outcomes. The development of clinical measures for research is intimately linked with the process of defining the constructs of spirituality and religion.

It can be envisaged that the incorporation of the role of spirituality in the approach to psychiatric practice and training may be a progressive process. It may be achieved by firstly facilitating awareness (mindfulness) of spirituality and of its defined role in health and medicine. This should be done among practitioners and teachers of psychiatry, among undergraduate and postgraduate students and among users. In the United States spirituality has been introduced on postgraduate level as a requirement of the national residency review committee. Postgraduate students in psychiatry in that country are expected to: be able to recognize spirituality as a potential resource; determine the role of spirituality/religion in psychopathology; and manage its role adequately in psychiatric intervention, referral and therapy. Ways of introducing courses in spirituality in medical curricula and psychiatric residency programmes in the United States and Canada have already been well documented.

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Most participants in the interviews actually contributed structured suggestions towards how the future training of local psychiatrists may possibly be approached differently. Suggestions were made with regard to the acknowledgment of spirituality's role, creating awareness and open-mindedness and facilitating knowledge without being descriptive, or compromising accepted professional boundaries. Through openness and awareness, a competent psychiatrist should appropriately identify a presenting spiritual problem and refer accordingly, while still operating in his/her own professional frame of reference**.** Basic knowledge and information about main spiritual/religious traditions should be included in the training of psychiatrists. How to explore the content and actual meaning of patients' responses thoroughly when taking their histories is of great importance. The latter should be learnt first-hand from observing more senior experienced teachers demonstrating this approach in their interviewing of patients. New trainees generally seem to be limited by the perspectives arising from their own backgrounds and therefore need to acquire an approach and the skill to understand and interpret how people from different backgrounds may present. The capacity to self-reflect is an important attribute of a competent psychiatrist, and achieving that should be part of the training of a specialist.

The psychiatrist's personal pursuit of religion or spirituality was not found to be a determining factor in the central role that spirituality has in the lives of patients. Psychiatrists should not encourage or participate in actual religious or spiritual practices with their patients or students, while clear ethical principles and review should guide the practice of psychiatry in this regard. In fact, the incorporation of defined spirituality into the existing bio-psycho-social approach should only be undertaken within specific ethical, professional boundaries and guidelines. From the interviews, a psychiatrist's (or other health worker's) own position and views concerning spirituality and religion should not impact on other colleagues' or on service users' position on the matter, nor on the professional assessment of patients, or on appropriate clinical management decisions.

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From the literature too, defining boundaries, domains and roles will also have to result in the drafting of practical, ethical and professional guidelines for psychiatry and related disciplines. Verification between training curricula, proven competency and ongoing professional conduct and practice is essential. Subsequent incorporation may be achieved by realising the appropriate integration of the role of spirituality in the ongoing reality of day-to-day practice, training and research activities. According to interview participants, there is no primary role for the psychiatrist to attempt to be a spiritual or religious adviser within the context of a professional psychiatric consultation. Such involvement should be monitored and reviewed by professional bodies. From the literature, spirituality, religion and psychotherapy also present issues of definition, of training and of establishing scope and boundaries. Psychotherapists face a different scenario in this regard than in the past and they now have to consider in what ways the spiritual affects emotions and connections to people.

From the interviews, it was noted that pharmaceutical intervention is known to be effective in, for example, the treatment of psychosis, but the referral of "neurotic" problems to spiritual workers may be more appropriate. The interface with spiritual workers presents opportunities and a challenge, to: establish a mutually informative collaboration where psychiatry has achieved a presence and acceptance/acknowledgement on the one hand; and confront and correct misperception and stigma in more fundamentalist religious perspectives where necessary, on the other. Dialogue between the organised profession of psychiatry and organised spiritual/religious workers may be a starting point in addressing stigma and wrong perceptions.

Incorporation of spirituality should accommodate all cultural-religious traditions and belief systems in the heterogenous South African society equally. From the literature, if the role of spirituality is to be considered in the approach to health and clinical care, it should be done with a perspective that can accommodate all religious traditions equally. No

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preference for one particular tradition should be given over the other, as a result of a practitioner or a dominant group being from the one tradition or the other. The views and experiences of different professional spiritual workers on the role of spirituality in health and psychiatry should be established and taken into consideration. To build up relationships of mutual trust and understanding will require health education initiatives aimed at patients and the spiritual professionals to whom they may choose to be referred.

The consequential outcome of such an incorporation of the role of defined spirituality into the practice and training of South African specialist psychiatry may promote a more integrated engagement with patients as people and their clinical care. It may enable practitioners and students to assess problems more clearly and to be more integrative in the management of patients whom they consult. It may also enhance the meaningfulness and the actual experience of healing in some aspects of patients' individual or collective bio-psycho-social-spiritual functioning.

3.1.3.1 Core concept for proposed model

The intended outcome of this phase of the process of theory building was to derive a core concept for the proposed model. Considering the preceding narrative on the integrated data on the final categories and subcategories of concepts, the core concept for the proposed model is identified as:

"**Incorporating** the role of defined **spirituality** into the existing bio-psycho-social approach to local **practice and teaching of specialist psychiatry** - within specific professional and ethical **boundaries** - while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society **equally**."

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SUMMARY SECTION 3.1

In this section, the identification of categories of concepts and subcategories from the conducted interviews and from the literature (the field study) and the identification of the single core concept from the combined integrated content were completed. This represents the first part (Step 1A) - of the first Chinn and Kramer process of creating conceptual meaning for developing theory.

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3.2 DEFINITION AND CLASSIFICATION OF CONCEPTS (STEP 1B)

"... *to discuss spirituality, we must first define it...*" Harry J Aponte (1996)

INTRODUCTION SECTION 3.2

STEP 1 B
DEFINITION OF CONCEPTS

CONCEPT ANALYSIS

Denotative and connotative meaning (Par 3.2.1)
↓
Essential and related criteria
↓
Defined core concept (Par 3.2.2)
↓
Model Case (Par 3.2.3)
↓
Categorisation of elements of core concept (Dickoff, James & Wiedenbach, 1968a&b) (Par 3.2.4)

In this section, definitions for elements of the core concept that was identified from the integrated interview and literature data, are formulated by establishing their denotative (dictionary) and connotative (subject) meaning. Referring to the established denotative and connotative meaning, a definition of the core concept is provided for the further development of the model. A model case is used to illustrate the possible context in which the theoretical model may be applicable in a local practical setting. Finally, the elements of the core concept are classified according to the six aspects of activity for a "prescriptive" - or fourth level - theory, as described by Dickoff, James and Wiedenbach (1968a).

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3.2.1 DENOTATIVE AND CONNOTATIVE MEANING

In this paragraph, **bold** and underlined text is used to provide evidence of how the essential and related criteria for the definition of the single core concept were identified from the dictionary and subject meaning. **Bold text** highlights the concept, while underlined text highlights the identified criteria. Bold and underlined text in direct quotations form authors in this section therefore represents the researcher's emphasis. Dictionaries referred to here, include the: American Heritage Dictionary of the English Language (AHD), Free Online Dictionary (FOD), Cambridge Online Dictionary (COD), Collins English Dictionary (CED), Encarta Dictionary (ED), Oxford English Dictionary 1989 (OED89), 1986 (OED86), 1966 (OED66), 1933 (OED33), and Merriam Webster Dictionary (MWD),

The single core concept that was identified from the combined data for model construction is (paragraph 3.1.3.1):

> "**Incorporating** the role of defined **spirituality** into the existing bio-psycho-social approach to local **practice and teaching of specialist psychiatry** - within specific professional and ethical **boundaries** - while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society **equally**."

Denotative (dictionary) and connotative (subject) meaning for the following elements of the core concept will now be established:

- **incorporate;**
- **spirituality;**
- practice and teaching of **specialist psychiatry**;
- professional and ethical **boundaries**; and
- all traditions and belief systems **equally** accommodated.

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3.2.1.1 Incorporate

Essential and related criteria for the concept "incorporate" are summarised in Table 3.4 (p180).

(1) **Dictionary meaning**

According to AHD (The American Heritage Dictionary of the English Language, 2003) **incorporate** is defined as:

> "to unite with or blend indistinguishably into something already in existence; to admit as a member to a corporation or similar organization; to cause to merge or combine together into a united whole; to cause to form into a legal corporation; to give substance or material form to; embody; substantiate; –*intr* to become united or combined into an organized body; –*adj* combined into one united body, merged; from Latin *incorporāre*, to form into a body".

According to the FOD (Free Online Dictionary, 2003) **incorporate** means:

> "united into one body; combined; formed into, or; organized and maintained as a legal corporation; united or combined into a whole; in Business: organized as a legal corporation, especially in commerce (abbreviation Inc)".

According to the MWD (Merriam Webster Dictionary, Date unknown):

> "to unite or work into something already existent so as to form an indistinguishable whole; to blend or combine thoroughly; to form into a legal corporation; to admit to membership in a corporate body; to give material form to; to unite in or as one body"

(2) **Subject meaning**

According to *All Business Glossaries* (Barron's Educational Series, 2007), the business definition of **incorporate** is:

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"to organize and be granted status as a corporation by following prescribed legal procedures; to include, as to *incorporate* additional materials in a report; to provide a geographic area a legal status (cities generally are *incorporated* entities)"; in real estate terms: "to form a corporation under state regulations provided by the Secretary of State; "to provide a geographic area the legal status of a political subdivision of the state".

An **incorporated company** is, for example, defined as:

"a private company limited by shares is a type of company incorporated under the laws of England and Wales, Scotland, that of certain Commonwealth countries and the Republic of Ireland; a (US) company that has been granted a charter legally recognizing it as a separate entity having its own privileges, rights, and liabilities distinct" (Incorporated company, Date unknown); and **incorporation** as "the forming of a new corporation (a corporation being a legal entity that is effectively recognized as a person under the law). The corporation may be a business, a non-profit organization, sports club or a government of a new city or town" (Incorporation, Date unknown).

According to the Dictionary of Financial Terms (Free dictionary, 2008), **incorporation** is:

"a legal process through which a company receives a charter and the state in which it is based allows it to operate as a corporation; a corporation has a separate and distinct legal and tax identity from its owners, in fact in legal terms, a corporation is considered an individual - it can own property, earn income, pay taxes, incur liabilities, and can be sued."

In a medical practice or psychotherapeutic context **incorporate** means (Saunders Comprehensive Dictionary, 2007):

- the union of a substance with another, or with others, in a composite mass;

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- a primitive unconscious defence mechanism in which aspects of another person are assimilated into the self.
- a legal procedure by which a (veterinary) practice is turned into a company; unless the company is run entirely (by practitioners) there is the risk that the professional ethic that the good of the patient is paramount may be overcome by a more profit-conscious set of rules; there are many advantages to incorporation in terms of financial security and adequacy of financial return to the (practitioner).

Table 3.4 Essential and related criteria for the concept "incorporate"

ESSENTIAL CRITERIA	RELATED CRITERIA
Unite	blend (indistinguishably into something already existing) admit (as member to a corporation or organisation) merge combine (together into a whole, into one body) form (into a legal corporation) give substance or form to embody become (united or combined into a organised body) organise maintain
form	legal process, procedure grant status (a charter to a company or corporation; distinct legal and tax identity) organise include provide (legal) status unify (in a composite mass) assimilate

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3.2.1.2 Spirituality

Although spirituality has been the construct identified in the core concept to be defined in this section, definitions of both spirituality and religion are discussed in this paragraph, because of their closely related nature and due to the often overlapping meaning attached to the two constructs. Essential and related criteria for the concept "spirituality" are summarised in Tables 3.5a and 3.5b (pp182-183 and pp199-202).

(1) **Dictionary meaning**

Spirituality is defined as:

- **Oxford English Dictionary, 1989 (OED89)**:
  - body of spiritual or ecclesiastical persons [historic], a spiritual society
  - that which has spiritual character; ecclesiastical property or revenue held or received for spiritual services [historic];

  [**ecclesiastic(al)** refers to a "politically assembly of citizens of an ancient Greek state", to a church congregation, a "duly summoned assembly"; pertaining to church especially as an organised institution" (AHD)]
  - the quality or condition of being spiritual; attachment to or regard for things of the spirit as opposed to material or worldly interests
  - an immaterial or incorporeal thing or substance, a spirit
  - the fact or state of being spirituous or of consisting of pure spirit, volatile state or quality
  - the fact or condition of being spirit or of consisting of an incorporeal essence

- **Oxford English Dictionary, Supplement 1986 (OED86)**
  - "spiritual home": a place or milieu, other than one's home, which seems especially congenial or in harmony with one's nature, or to which one feels a sense of belonging or indebtedness
  - "spiritual healing": cure or healing attributed to the agency of (a) spirit; faith-healing

- **Oxford Dictionary of English Etymology, 1966 (OED66)**
  - pertains to the spirit, ecclesiastical; *spīrituālis (Latin)*;

  [**spirit**: a breath of life; vital principle; intelligent incorporeal being, immaterial element of human being; vital power; any of four substances so named by the alchemists, liquid nature of an essence]

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- **Oxford English Dictionary, 1933 (OED33)**
  - of, or pertaining to the spirit or higher moral qualities, especially regarded to in a religious aspect;
  - of, belonging to, concerned with, sacred or ecclesiastical things or matters, as distinguished from secular affairs; pertaining to the church or the clergy; ecclesiastical
  - of persons: standing together in a spiritual relationship; ecclesiastical, religious; devout, holy, pious, morally good, having spiritual tendencies or instincts
  - of, pertaining to, consisting of, spirit, regarded in either a religious or intellectual aspect; of the nature of a spirit or incorporeal supernatural essence, immaterial
  - consisting of pure essence or spirit; volatile; spirituous, alcoholic
  - of, or pertaining to, emanating from, the intellect of higher faculties of the mind; intellectual.

- **American Heritage Dictionary of the English Language (AHD), Free Online Dictionary (FOD) and Cambridge Online Dictionary (COD):**
  - the state, quality or fact of being spiritual (AHD and FOD); and
  - the quality of being concerned with deep, often religious feelings and beliefs, rather than with the physical parts of life – COD.

Spiritual means:

- of, relating to, consisting of, or having the nature of spirit; not tangible or material (AHD); and
- concerned with or affecting the spirit or soul; a spiritual approach to life; spiritual fulfilment; spiritual values; unearthly love (Merriam Webster Dictionary - MWD).

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Spirit is defined as:

- that which is traditionally believed to be the vital principle or animating force within living beings (AHD, MWD, FOD);
- that which constitutes one's unseen, intangible being; the vital force that characterizes a human being as being alive (Encarta Dictionary - ED), and (MWD)
- the characteristics of a person that are considered as being separate from the body, and which many religions believe continue to exist after the body dies (COD);
- the soul, considered as departing from the body of a person at death (FOD).
- the essential and activating principle of a person; the will (AHD);
- a fundamental emotional and activating principle determining one's character (MWD);
- the part of a human associated with the mind, will, and feelings (FOD);
- will or sense of self (ED);
- temper or disposition of mind or outlook especially when vigorous or animated; or the immaterial intelligent or sentient part of a person (MWD).

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Table 3.5a Dictionary meaning of the concepts "spirituality", "spiritual" and "spirit"

ESSENTIAL CRITERIA	RELATED CRITERIA
spirituality body, society	persons, ecclesiastic/ecclesia (congregation, duly summoned assembly); organised institution church, clergy spiritual relationship
spirituality quality	character; condition; tendency, instinct higher moral qualities, especially regarding a religious aspect regarding in a religious or intellectual aspect (inner) state fact (of being spiritual; of being concerned with deep, often religious feelings and beliefs)
spiritual consisting of	pertaining to, relating to having (the nature of spirit; not tangible; concerned with spirit or soul) concerned with affecting
spirit vital principle	incorporeal, immaterial; (supernatural) essence breath of life, intelligence, power animating force (within living beings) (a human being's) unseen, intangible being vital force (that characterizes a human being as being alive) characteristics (of a person) separate from body (soul); mind, will and feelings; sense of self; disposition of mind or outlook; immaterial, intelligent or sentient part essential and activating principle fundamental emotional and activating principle

Considering the different OED meanings dating back from 1989 to 1933 and the comparison thereof with a range of six other dictionaries' meanings for the construct "spirituality", it demonstrated the extent to which "spirituality" and "religion" has been used in relation to each other, especially, for example, with regard to the associated meaning of it referring to "ecclesiastic" (*ekklẽsia - Greek*), or assembly. In the older meanings (OED33), "religious" was actually used synonymously in some respects. What is also of note in the older meanings of the OED33 is the association that was made with "intellect", "intellectual aspects" and "higher faculties of the mind".

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In order to contrast the dictionary meaning of "spirituality" with that of "religion", religion as defined by the AHD and FOD is also noted here:

Religion is:

- the expression of man's belief in and reverence for a superhuman power recognized as the creator or governor of the universe;
- any particular integrated system of this expression for example *'Hindu religion'*;
- the **spiritual** or emotional attitude of one who recognizes the existence of a superhuman power or powers;
- any objective attended to or pursued with zeal or conscientious devotion;
- sacred rites or practices;
- from Latin – *religiō*, bond between man and the gods, *religāre,* to bind back: *re* - back and *ligāre*, to bind, fasten.

Religious according to the AHD refers to:

- of, pertaining to, or teaching **religion**;
- adhering to or manifesting religion;
- pious; godly; extremely faithful; scrupulous; conscientious: *religious devotion to duty;*
- pertaining to be or belonging to a monastic order; *synonyms: religious, devout, saintly, pious, sanctimonious, puritanical.*

ESSENTIAL CRITERIA	**RELATED CRITERIA**
religion expression	integrated system (of man's belief in and reverence for super human powers;) attitude (spiritual or emotional) objective attended to or pursued (with zeal) collection of (what is regarded as) sacred rites, practices and behaviour bond what is done (action) in response to personal beliefs

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(2) **Subject meaning**

The dictionary definitions of **spirituality** were extended and brought into perspective by considering the connotative meaning attached to the concept "**spirituality**" that was reported on in the reviewed literature (paragraphs 3.1.2.2 and 3.1.2.3). Providing and reviewing definitions for **spirituality** and religion formed an essential part of many reviewed literature articles.

Lapierre presented a model for **spirituality** from a Judeo-Christian perspective consisting of six factors: - "the journey"; - transcendence; - community; - religion; - "the mystery of creation"; and – transformation (Lapierre 1994). **Spirituality** according to him involves a lifelong journey (a process, progression) culminating when the traveller encounters God. Perhaps it continues even further into the next life. He further argued that God is experienced as transcendent, as opposed to imminent and stated that while the search for God is a very private affair, members of religions such as Christianity, Judaism and Islam often find that being in community with like-minded believers is important to their faith. Community refers to the element of connectedness and relationship in the definition of spirituality without which it would be difficult to continue to function as individuals. He described religion as often being experienced as a collection of rituals, rules, patterns of life and other behaviour to which one must adhere to in order to be accepted in particular religious groups. Religion is often understood as being that which a person does (action) in response to specific personal beliefs about divine being or things.

Turner et al., discussed the definitions of **spirituality** and religion that was adopted into the DSM-IV diagnostic V-code category "**Spiritual** or religious problem" (Turner et al., 1995). Attempts within the clinical literature of the time to address religious of **spiritual** concerns raised a number of issues regarding definition. Both religion and **spirituality** involve a sense of meaning and purpose in life, provide a source of love and relatedness and intend to keep believers in right relationship to the unknown and unknowable. While

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these terms have been used in some sources interchangeably, in other definitions **spirituality** subsumes religion. For example, Miller stated that **spirituality** involves "transcendental processes that supersede ordinary material existence (Miller 1990p261). This includes, but is not limited to systems of religion". Still others consider them mutually exclusive. While there was no consensus, the authors and the DSM-IV Task Team adhere to the term religion to refer to: *"adherence to the beliefs and practices of an organised church or religious institution"* (Shafranske & Maloney, 1990: p72). **Spirituality** is used to describe *"the transcendent relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation*" (Peterson & Nelson, 1987). Turner et al., (1995) point out that the definitions cited here also closely paralleled the definition of religion and **spirituality** offered in the Thesaurus of Psychological Index Terms (Walker, 1991), which states that "religiosity" is associated with religious organizations and personnel (p184), whereas "**spirituality**" refers to (personal) capacity, to the degree of involvement or state of awareness or devotion to a higher being or philosophy, not always related to conventional religious beliefs (p208). They also refer to Vaughan who wrote on transpersonal psychology and noted: *"Whereas **spirituality** is essentially a subjective experience of the sacred, religion involves subscribing to a set of beliefs or doctrines that are institutionalized..."* (Vaughan 1991). Types of religious problems according to the DSM-IV V-Code include: change in denominational membership or conversion to a new religion; intensification of adherence to beliefs and practices; loss or questioning of faith; guilt; and cults. Types of **spiritual** problems include: mystical experiences; near-death experiences; **spiritual** emergence/emergency; meditation; separation from a **spiritual** teacher; terminal illness; addiction.

De Quincey a philosopher and **spiritual** mentor recently defined consciousness about **spiritual** matters as: the ability or capacity to know (experience); to be aware of (subjectivity); and to feel (sentience), along with the ability to create and express intentions and make choices. He sees this as non-physical aspects of reality. *"Besides the*

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capacity for (1) sentience (feeling) and (2) subjectivity (awareness), consciousness is what enables anybody (3) to know anything (source of knowledge), (4) to be for anything or be about anything else (the source of intentionality), (5) to choose anything (the source of value), (6) to have self-direction (the source of purpose) and (7) to be for itself (to have intrinsic meaning)" (De Quincey, 2009: p27).

Aponte, a psychotherapist, looks at **spirituality** as a way of life that provides a worldview, moral standards and form for living (Aponte 1996). This way of life springs from a belief system that speaks to the nature of people, the purpose of life and our relationship to the world and its ultimate source. The **spirituality** operating in most people is highly personal, not fully conscious and not cohesively integrated into their lives. It is constantly in conflict and evolving within and among the individual, family and society. Although partially hidden from one's awareness as individuals and as a society, it is at the heart of all the choices that one makes in life. "*At a personal level spirituality is the seat of identity, morality and self-worth. At the level of social systems, **spirituality** is the value framework that drives society, community and family. At all these complex levels of human life and interdependence, **spirituality** is manifested in our politics, culture, ethnicity, race and religion. **Spirituality** with its values, morality and world view, defines priorities, obligations and roles of people in society. Ultimately, **spirituality** is the foundation upon which is built the structures of our personal psychology and relationships, as well as our society"* (p489).

Waldfogel identifies four elements of **spiritually**: meaning of life, transcendence, connection with others and **spiritual** energy (Waldfogel, 1997). Experiences of joy, love, forgiveness and acceptance depend on, and are manifestations of, optimal **spiritual** well-being. Although the role of spirituality may change during an individual's life time, the sense of **spirit** is often central to personal identity. The experience of personal meaning, purpose, or truth brings integrity to the individual's sense of self and world, particularly in

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the face of uncertainty and change. Transcendence is a profound and potentially transformative experience that can have a vast array of manifestations. Relations with others are fundamental to human experience and contribute to personal resilience, but can also be a source of distress. Most conceptualisations of **spirituality** posit an energy (referred to as "life force", "prana", "chi" or "ruach") or spectrum of energies – that exists in the individual and in the cosmos – which can be accessed to affect physical events.

Sims adds "soul" to the process of definition (Sims 1999). He referred to soul – as having an old English or Gothic origin – meaning "quick-moving", the principle of life. **Spirit** is of Latin origin – meaning "breath", and similarly implies the animating or vital principle of man. He points to the similarities in their origins, referring to different characteristic of human life. Both are regularly contrasted with the body to describe that part of man that is immaterial, not physical, independent of mundane constraints. He offers a working definition for the practising psychiatrist of the word **spiritual** as "that what a person lives for, his/her motivating force". This could be seen as having five aspects of meaning: (1) aims and goals (looking for meaning in life, what one regards as essential); (2) human solidarity (the interrelatedness of all, both doctor and patient, consciously and unconsciously-shared aims and beliefs); (3) wholeness of the person (in which **spirit** is not separate from body or mind but includes them); (4) moral aspects (what is seen as good, beautiful, enjoyable, as opposed to what is bad, ugly, hateful); (5) awareness of God (the connection between God and man).

Post et al., explained **spirituality** as pertaining to ultimate meaning and purpose in life (Post, Puchalski & Larson, 2000). They state that patients are especially concerned with **spirituality** in the contexts of suffering, debilitation and dying. For some patients, these concerns may be taken up entirely within the context of human relations, values and purpose. For others, their resolution involves faith in a higher being in the universe, one that is a source of assurance and hope. Defining **spirituality** and religiosity is closely

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associated with the assessment and measurement of it and the developing of structured instruments for the purpose. One example of such a scale includes the following domains: belief in a power greater than oneself, purpose in life, faith, trust in providence, prayer, meditation, group faith, the ability to forgive, the ability to find meaning in suffering and gratitude for life (Hatch et al. 1998).

Considering issues of definition, Rhi notes that the term **spirituality** was preferred to the term religion by those investigators who were seeking a wider range of religious experiences outside the organised religious group, for the term religion excluded the more general **spiritual** beliefs of people (Rhi, 2001). He defines **spirituality** as the nature of the human mind to relate to transcendental power and regards **spirituality** and religiosity as inseparable, for **spirituality** is the crucial component of religious life. He restated the older psychological definition of religion by Jung: *"Religion, as the Latin word denotes, is a careful and scrupulous observation of what Rudolf Otto aptly termed the numinosum, that is, a dynamic agency or effect not caused by an arbitrary act of will."* (Numinosum is either the quality belonging to a visible object or the influence of an invisible presence that causes a peculiar alteration of consciousness.) Jung, contrary to Freud, was convinced that human beings as "homo religiosus" possess the primordial potential to produce **spiritual** religious experiences. Rhi explained that what is usually called religion means a structured institution equipped with dogma, rules and so forth, and does not refer to Jung's definition thereof: *"the religious denomination that actually originated from our basic religious drives; the experience of the numinosum."* Applying this Jungian definition would therefore result in equating "religion" with "**spirituality**".

The concept of **spirituality** was one of the themes from the content analysis of the qualitative study by Greasley's et al., on the views of service users (Greasley, Chiu & Gartland, 2001), carers and mental health nursing professionals. While also referring to the definition of Murray and Zentner - they found that participants' perspectives included

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four components: - God, religion and metaphysical beliefs; - meaning and purpose; - interpersonal values (love, caring/concern, kindness, companionship, compassion); and - personal well-being (emotional well-being, healthiness, inner peace, hope), (Murray & Zentner, 1989).

According to Anandarajah and Hight, **spirituality** is a complex and multidimensional part of the human experience (Anandarajah & Hight, 2001). It has cognitive, experiential and behaviour aspects. The cognitive or philosophical aspects include the search for meaning, purpose and truth in life and the beliefs and values by which an individual lives. The experiential and emotional aspects involve feelings of hope, love, connection, inner peace, comfort and support. These are reflected in the quality of an individual's inner resources, the ability to give and receive **spiritual** love, and the types of relationships and connections that exist with self, the community, the environment and nature, and the transcendent (e.g., a power greater than self, a value system, God, cosmic consciousness). The behaviour aspects of **spirituality** involve the way a person externally manifests individual spiritual beliefs and an inner **spiritual** state. Many people find **spirituality** through religion or through a personal relationship with the divine. However, others may find it through a connection to nature, through music and the arts, through a set of values and principles or through a quest for scientific truth.

Culliford sets a clear definition of **spirituality** within: the context of the quality of life (WHO-QOL) domains of the World Health Organisation (WHO); the facets proposed for the WHO-QOL **Spirituality**, Religious and Personal Beliefs (SRPB) module; and the dimensions of human experience. The WHO-QOL domains include: physical health; psychological health; level of independence; social relationships; environment; and **spiritual**, religious and personal beliefs (Culliford, 2002). The facets of the WHO-QOL SPRB include: transcendence; personal relationships; a code to live by; and specific religious beliefs. He referred to an often quoted definition of **spirituality** by Murray and

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Zentner (1989): "*In every human being there seems to be a* ***spiritual*** *dimension, a quality that goes beyond religious affiliation that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in God. The* ***spiritual*** *dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes essentially into focus in times of emotional stress, physical (and mental) illness, loss, bereavement and death."* Elements of **spiritual** care according to him would include: an environment for purposeful activity (creative art, structured work, enjoying nature); feeling safe and secure, being treated with respect and dignity, allowed to develop a feeling of belonging, of being valued and trusted; having time to express feelings to staff members with a listening ear; opportunities and encouragement to make sense of and derive meaning from experiences, including illness; and receiving permission and encouragement to develop a relationship with God or the Absolute, thus a time, place and privacy in which to pray and worship, education in **spiritual** matters, encouragement in deepening the faith, feeling universally connected and perhaps also forgiven. **Spiritual** skills include: being able to create a still, peaceful state of mind; being able to stay mentally focused in the present; developing "above-average" levels of empathy, discernment and courage; having the capacity to witness and endure distress while sustaining an attitude of hope; being self-reflective and honest with oneself, especially about areas of ignorance, also when angry, afraid or in doubt; having an "above average" level of being able to give without feeling drained; being able to grieve appropriately and let go.

Josephson and Dell clarify the terms as follows: (1) religion refers to an organised system of principles and belief, rituals, practices and related symbols that bring individuals closer to sacred or ultimate truth/reality; it also encompasses an individual's relationship with other people, whether inside or external to a community of individuals with similar beliefs, rituals and practices; (2) **spirituality** includes religions and relationships with others in a faith community, yet is not limited to the concepts encompassed by organised religion

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(Josephson & Dell, 2004a). **Spirituality** includes an individual's search for understanding of life's deepest mysteries and most perplexing questions about what is sacred, transcendent, or of ultimate importance. They differentiate it from worldview (a term taken from Freud's 1933 article – "*weltanschauung*": intellectual constructions, or belief system, a philosophy of life that addresses life's most basic questions – that refers to origins, purpose, the meaning of suffering and death and what constitutes the good life. A world view can be part of the belief system of an organised religion or stand on its own. Religious preference refers to an individual's claim of belonging to a particular religious group. Church affiliation refers to belonging to a church, synagogue or mosque, or other house of worship by having one's name on a roll or membership list. Church involvement describes attendance, participation in groups and committees, or contributing financial support, but should not be mistaken for being synonymous with personal religious piety or sincerity of personal faith. Religious belief refers to a belief in God and teachings found in sacred religious texts. Personal religious behaviour is distinct from church or group religious behaviour and includes individual prayer, meditation, study of religious texts and other behaviours required or seen as **spiritually** beneficial by an individual's faith tradition.

Dein discusses the varied meanings of religions and **spirituality**: notions of tradition and religion are often imposed on other cultures by Western scholars (Dein, 2005). He regards religions as "bounded systems", independent of the wider society, culture or politics, as a definitive model for all cultures is a limitation, where religion often forms an integral part of non-Western culture and society. For this reason he argues that religion is not a useful term for cross-cultural comparison. He alludes to an earlier more apt conceptualisation that distinguishes between the "sacred" and the "profane" to identify the essential feature of all systems referred to as "religious" (Durkheim, 1912). The dictionary definition of religion may not work well for settings other than Western Christianity. It must be pointed out that it is only in the modern period (since the Enlightenment) that emphasis

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is placed on the cognitive, intellectual, doctrinal and dogmatic aspects of the conception of religion. In early Christianity the word religion referred to a total phenomenon including both the subjective orientations of the worshippers and the hierarchical organisation of the church. In the middle ages it was faith, not religion that was the keyword, with the word religion reserved for monastic life. Western definitions of religion generally emphasise its authoritarian, institutionalised, official, formal, hierarchical nature, including prescribed rituals and established ways of believing. Religiousness has increasingly become characterised as "narrow and "institutional", whereas **spirituality** has increasingly become characterised as "personal" and "subjective". The historic and cultural use of the term **spirituality** is tracked to distinguish Christian **spirituality** from the so called "New Age" **spirituality**, or "life-spirituality". Christian roots of the term date back to the Latin term "*spiritus*" meaning breath or "*pneuma*" as referred to in Christian writings. This term is used in the context of: a relationship with a higher power; a search for meaning through relatedness; and the animating and vital principle in persons. **Spirituality** is personal, often contrasted with the material, physical and external and frequently associated with myth, symbol and emotion (Bartocci & Dein, 2007).

Mohr et al., (2006) noted that although **spirituality** and religion are often used interchangeably, there are important differences. **Spirituality** has been described as a person's experience of, or a belief in, a power apart from his or her own existence, as an individual's search for meaning, a sense of relationship or connection with a power or force, but that force or power need not to be a deity – as agnostics and atheists can have a rich **spiritual** life despite the lack of deity in their belief systems. Religion is the outward practice of a spiritual system of beliefs, values, codes of conduct and rituals. It is an organised system of practices and beliefs in which people engage. "*Religion is a platform for the expression of **spirituality**…"* (Mohr et al., 2006).

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Moreira-Almeida and Koenig discuss an inclusive, trans-culturally validated measurement of religiousness/**spirituality** (Moreira-Almeida & Koenig, 2006). The Quality of Life Measure of the World Health Organization for assessment of **spirituality,** religion and personal beliefs (WHO-QOL SRPB) was used in a cross-cultural study in 18 countries. Although the definition of the terms **spirituality** and religion undoubtedly have a long history of controversy, there is general agreement that these constructs are related to the search for the sacred or transcendent, which includes concepts of God, a higher power, the divine and/or ultimate reality. The sacred represents the most vital destination sought by the religious/**spiritual** person. They refer to the definition of the Merriam-Webster dictionary definition that defines **spirituality** as "sensitivity or attachment to religious values" or "the quality or state of being **spiritual**". Spiritual is defined as "of, or relating to sacred matters" or "of, relating to, consisting of, or affecting the spirit: incorporeal". The definitions used in their work are:

- religion is an organised system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred or the transcendent (God, higher power, or ultimate truth); and
- **spirituality** is the personal quest for understanding answers to ultimate questions about life, about meaning and about relationship with the sacred or transcendent, which may (or may not) lead to, or arise from, the development of religious rituals and the formation of community.

According to Koenig, religion involves beliefs and practices and rituals related to the sacred, where the sacred is defined as God, the numinous (mystical or supernatural) or ultimate truth (Koenig, 2007a), also see Rhi (2001). Religion is a unique construct, different from other psychological and social phenomena. **Spirituality** on the other hand, is more difficult to define, as its definition has changed – from one based in religion to a more diffuse concept, self-defined by each individual. The result is that there is no widespread agreement on what **spirituality** means. Koenig again reviews the definition of

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terminology with the aim of research measurement, assessment and comparison (Koenig, 2009). He alludes to **spirituality** that is more difficult to define and considered to be more personal, largely free of rules, regulations and responsibility, where religion is viewed as divisive and associated with conflict and war. As there is no unique, distinct, accepted definition, researchers have struggled to identify valid measures for **spirituality** which (according to Koenig) makes it impossible to conduct research on **spirituality**. He refers to standard measures of **spirituality** (including aspects such as meaning and purpose of life, connections with others, peacefulness, existential well-being, comfort and joy) which are closely related to almost all variables for well-being and positive psychological states. These measures may therefore be prone to futile tautological comparisons. Koenig's use of these terms therefore mainly refers to religion as it is aimed at research and how to measure and compare religious variables. His definition of religion is thus quite broad and means a great deal more than just institutional religion or religious affiliation.

Chattopadhyay also reviews the definition of the two concepts (Chattopadhyay, 2007), referring to religion (from Latin – "*religare*", i.e. "to bind together"; Merriam Webster) as "a set of beliefs, practices and language that characterizes a community that is searching for transcendent meaning in a particular way, generally based upon belief in a deity" (Sulmasy, 2002), (Astrow, Puchalski & Sulmasy, 2001). Religion thus organises the collective experiences of the group of people into a system of beliefs and practices. Religious involvement or religiosity therefore refers to the degree of participation in, or adherence to, the beliefs and practices of an organised religion (Mueller, Plevak & Rummans, 2001). Researchers have also differentiated between intrinsic and extrinsic religiosity. Intrinsic refers to "living" religion – practising and believing for its own sake. Extrinsic refers to "using" a religion, that is, practising and espousing beliefs for the sake of something else than the religious pursuit (Sulmasy, 2002), (Mythko & Knight, 1999). Spirituality (from Latin – "*spiritualitas*", i.e. "breath" - MWD) refers to a person's or group's relationship with the transcendent (Sulmasy, 2002), (Astrow et al., 2001). It has also

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been characterised as an experiential process whose features include quest for meaning and purpose, transcendence (being human is more than material existence), connectedness (with others, nature or the divine) and values (love, compassion, justice); (Mueller et al., 2001), (Emblen, 1992). It appears that compared to religion, **spirituality** is a broader concept (Sulmasy, 2002), (Astrow et al., 2001). Most institutionalised religions aim to foster **spirituality**. It is also important to remember that religiosity and **spirituality** are not mutually exclusive concepts and therefore they can overlap and also exist separately (Mytko & Knight, 1999).

Spirituality relates to that dimension of people as human beings which erects frameworks of meaning that provide a motivating force to our lives (Gilbert, 2007b). **Spirituality** is associated with the pilgrimage of life; connection with other people and the natural world; a sense of the sacred and a reaching out to something beyond ourselves. Religion encompasses many aspects within the concept of **spirituality**, usually in the context of belief in a transcendent being or beings, with a meta-narrative which seeks to explain the origins of the world and those living in it and the questions which face human beings around life, suffering, death, re-awakening in this world or another. Religion can provide a worldview which is acted out in narrative, doctrine, symbols, rites, rituals, sacraments and gatherings, and the promotion of ties of mutual obligation. It creates a structure which can either be a framework for meaning or a restricting and restrictive straightjacket.

Sesanna et al., examine the body of nursing and health-related literature to clarify the definition of **spirituality** (Sesanna, Finnell & Jezewski, 2007). The thematic analysis of the content of 90 articles between 2000 and 2005 yielded four themes on the definition of **spirituality**: **spirituality** as religious system of beliefs and values; **spirituality** as life meaning; **spirituality** as non-religious systems of beliefs and values; and **spirituality** as metaphysical or transcendental phenomena. A compiled list of attributes from the above

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four categories fell in two domains: intrinsic and extrinsic. These attributes were summarized as Table 3 on page 257 of their article:

Intrinsic Attributes of **Spirituality**	Extrinsic Attributes of **Spirituality**
transcendence; holy or sense of holy; belief; incorporeal; divine; godly; heavenly; meaning; purpose; faith; sacred; religious attitudes; secular; transpersonal reality; acknowledgment of unconscious self; nonmaterial forces; inner essence; harmonious interconnectedness between God/man/ultimate reality; mystical; love; honesty; caring; imagination; wisdom; compassion; reverence; awe; values; personal philosophy/principals; interpretative lens; reflection; reason; restoration; feelings; thoughts; expanded consciousness; eternity; soul; existential; within, between, and beyond people; beyond superficial appearance; hope; spiritual yearning; force/energy larger or greater than self; man's inner resources; and supernatural/nonmaterial dimensions	religious community, religious affiliation, church/religious services, church attendance, prayer, Bible study, tradition, property or revenue of the church, ecclesiastic, clergy/cleric, verbal and contemplative prayer/praying, use of positive affirmations, relationship or communication with God/higher power, search for sacred, religious practices, dogma, hierarchical structures, priests/ministers/rabbis/gurus, meditation, need for others, religious or spiritual expression or experience, co-participation in shared human experience, relationships, religious ritual/behaviour, religious code, professing, art, poetry, music, nature, creative expression, meaningful work, and productivity

According to Bienenfeld and Yager, **spirituality**, at its broadest, is a person's attempt to make sense of his/her world beyond the tangible and temporal (Bienenfeld & Yager, 2007). It strives to connect the individual with the transcendent and transpersonal elements of human existence. It may, but need not, include religion. Religion is an organised system of beliefs, practices and rituals. Usually, it is shared with others, but each individual creates his/her own version. Religiosity and faith are descriptions of the extent and depth to which a person holds the beliefs of his/her religion. Religious behaviour is the action one takes in the conduct of religion, including such elements as prayer and other observance.

Pembroke writes that religion is a social and cultural structure or construct. Religions embrace a myth that seeks to explain where humanity come from, what the purpose of human life is; the moral duties that people must embrace and what our destiny is (Pembroke, 2008). The myth is embodied in symbolic practices or rituals that sustain it over time and provide **spiritual** nourishment and guidance for believers. **Spirituality** is a

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more general category and involves the quest for meaning and a commitment to transcendence of the ego. The **spiritual** person identifies making meaning out of one's existence as a central human task. The journey into meaning usually involves self-transcendence. That is, persons who call themselves spiritual commit themselves to a reality beyond the self. It may be one's family, nature, or justice and peace in the society. **Spirituality** has an immanent and transcendent from. Immanent refers to an orientation in which persons believe that all resources they need to find, meaning and self-transcendence can be found within the self. The centre of self-transcendent **spirituality** however, is located in God. God takes the initiative in the divine-human relationship. **Spirituality** is the quest for a deeper relationship with God. In and through this relationship, believers open themselves to the divine grace that enhances and enriches their **spiritual** resources.

According to Verghese, religion is institutionalised spirituality. Thus, there are several religions having different sets of beliefs, traditions, and doctrines (Verghese, 2008). They have different types of community-based worship programs. **Spirituality** is the common factor in all these religions. It is possible that religions can lose their **spirituality** when they become institutions of oppression instead of agents of goodwill, peace and harmony. They can become divisive instead of unifying, for example, the mediaeval holy wars of Europe, the religion-based terrorism and conflicts of modern times are examples. Institutions of religions are supposed to help to practise **spirituality**. They need periodical revivals to put **spirituality** in place.

In the chapter on the difference between religion and **spirituality** in his book, Vaillant identifies five differences (Vaillant, 2008b). The first difference is that religion refers to the interpersonal and institutional aspects of religiosity/**spirituality** that are derived from engaging with a formal religious group's doctrines, values, traditions, and co-members. By contrast, **spirituality** refers to the psychological experiences of religiosity/**spirituality** that

relate to an individual's sense of connection with something transcendent and are manifested by the emotions of awe, gratitude, love, compassion and forgiveness. Secondly, religion arises from culture, **spirituality** from biology. *"Religion and cults are as different from **spirituality** as environment is from genes. Like culture and language, religious faith traditions bind us to our own community and isolate us form communities form others. Like breathing, our **spirituality** is common to us all."* (pp187-188) The third difference is that religion is more cognitive and **spirituality** is more emotional *"Thus, cognitive religious schisms over belief divide the world and at the same time limbic commonalities toward 'melody' bind the world together."* (p188). Fourthly, cults and religions tend to be authoritarian and imposed from without, while **spirituality** is more likely to be democratic and arise from within. The fifth difference often cited by Western critics of religion is that **spirituality** is tolerant and religion is intolerant. Humans are all **spiritual** beings but *"if you don't believe your religion is the only religion, you have no religion"*.

Anandarajah has developed two models for **spirituality** in multicultural whole-person medicine (Anandarajah, 2008). She lists the attributes if the "3H" model in "*Table 1 - The '3H' Dimensions of spirituality with examples*" of her article (Anandarajah, 2008):

Cognitive (Head)	*Experiential (Heart)*	*Behavioural (Hands)*
Beliefs Values Ideals Meaning Purpose Truth Wisdom Faith (belief)	Love Compassion, altruism, forgiveness Connection, relationship with: self, others, community, environment, nature, the transcendent Inner energy Strength, resilience Inner peace, comfort, support Hope Faith (trust) Transcendence	Duties Daily behaviour Moral obligations Choices Life choices Medical choices Specific practices: prayer, meditation, yoga, chanting, rituals, diet, nature walks, etc. Participation in religious community

The "3H" model (head, heart, hands) offers a multidimensional definition of **spirituality**, applicable across cultures and belief systems, that provides opportunities for a common

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vocabulary for **spirituality** The "BMSEST" model (body, mind, spirit, environment, social, transcendent) is based on Maslow's triangle for the hierarchy of needs, and provides a conceptual framework for the role of **spirituality** in the larger health care context, useful for patient care, education, and research.

Table 3.5b Essential and related criteria for the concepts "spirituality", "spiritual" and "spirit"

ESSENTIAL CRITERIA	RELATED CRITERIA (Black text – dictionary meaning, Red text – meaning from subject literature)
spirituality	
quality	condition; higher moral qualities (regarding a religious aspects) (inner) state (of progressive awareness or devotion); transcendental fact (of being spiritual; of being concerned with deep, often religious feelings and beliefs; concerned with transcendent, higher being, God, metaphysical beliefs) dimension (beyond religious affiliation; striving for inspiration, reverence, awe, meaning, purpose; with frameworks of meaning providing a motivating force) nature of the human mind to relate to transcendental power
journey	process (experiential); the sacred is most vital destination sought way of life (providing worldview on nature of people, relationship to world and its ultimate source) progression, experience transformation - (journey) into meaning involves self-transcendence - transcendental (a profound and potentially transformative experience) pilgrimage of life (individual's) search (for meaning of life, understanding of perplexing questions about what is sacred, important) (personal) quest (to understand answers to ultimate questions; quest for a deeper relationship with transcendent, God; about life, death, re-awakening) (personal, subjective) experience (of the sacred) transforming experience of transcendence

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ESSENTIAL CRITERIA	RELATED CRITERIA (Black text – dictionary meaning, Red text – meaning from subject literature)
(spirituality) relationship	body, society; spiritual relationship, church, clergy persons, ecclesiastic/ecclesia (congregation, duly summoned assembly); organised institution degree of involvement with a higher being or philosophy connectedness (to world and its ultimate source) connection (with self, other people and natural world, with a power or force – not necessarily a deity) evolve constantly (within and among individual, family, society); human solidarity, interrelatedness keep, maintain (a right relationship; transcendent relationship with Higher Being) striving to be in harmony with universe person's or group's relationship with transcendent
capacity	character; tendency, instinct being able to; being (self-reflective); belief (faith) personal characteristic, developing intrinsic attributes progressive consciousness, not cohesively integrated awareness (of transcendent, God, etc) sense of sacred, reaching out beyond the self committed to a reality beyond the self (person's experience of power apart from own existence) heart of all life choices; seat of identity, morality, self-worth; interpersonal/ societal values; determining aims and goals; priorities, obligations, roles, purpose foundation (of structures of personal psychology, relationships and of society) faith, extent and depth to which beliefs are held; has changing role over life time; sensitivity to religious values
spiritual concerning	pertaining to, relating to (spirit) having (the nature of spirit; not tangible) consisting of spirit or soul; soul – 'quick moving', 'breath', 'pneuma', 'spiritus'; contrasted with the body (incorporeal, immaterial); intrinsic living psychological experiences; from biology; more emotional (heart); more democratic arising from within; more tolerant affecting/providing - sense of (personal) meaning, purpose and truth in life - making meaning of one's existence - ultimate meaning and purpose in life - personal quest for understanding ultimate questions

WITHDRAWN

(spiritual)	- wholeness of the person (including body and mind) - source of love and relatedness - personal meaning and truth - integrity to individual sense of self and world; particularly with change, uncertainty, suffering, emotional distress and death (associated with myth, symbol and emotion; more personal, largely free of rules and regulations; including religion and relationships with others, but not limited by organised religion; broader concept than religion, can overlap and co-exist separately; common factor in all religions; crucial component of religious life; wider range of religious experience outside organised group)
spirit vital principle	animating force (within living beings); power; supernatural essence, breath of life, intelligence (a human being's) unseen, intangible being; incorporeal, immaterial vital force (that characterises a human being as being alive) characteristics separate from body - soul; mind, will and feelings; sense of self; disposition of mind or outlook; immaterial, intelligent or sentient part animating principle essential and activating principle fundamental emotional principle energy ("life force", "chi", "ruach"), spectrum of energies inner resources; manifestations of optimal spiritual well-being (include experiences of joy, love, forgiveness and acceptance); central to personal identity motivating force (what a person lives for) 'numinosum' – dynamic agency or effect not caused by arbitrary act or will

Essential and related criteria for "religion" are noted here to contrast it with that of "spirituality":

ESSENTIAL CRITERIA	**RELATED CRITERIA** **(Black text – dictionary meaning, Red text – meaning from subject literature)**
religion expression	attitude (spiritual or emotional) objective attended to, pursued (with zeal) what is done, action (in response to personal beliefs about divine things) (personal) behaviour (including prayer, meditation, study of texts) outward practice (of a spiritual system of beliefs, values, codes, rituals) extrinsic (used for the sake of something else); cognitive ("head") meta-narrative, providing a worldview that is acted out in narrative, doctrine, symbols, rites, gatherings, ties of mutual obligation practising, espousing

WITHDRAWN

(religion)	
organised	integrated system (of man's belief in and reverence for superhuman powers; faith) collection (of what is regarded as sacred rites, practices and behaviour; of rituals, rules, patterns of life) bond; "bounded systems" in Western society; 'religare' – to bind together institutional, structure structured institution equipped with dogma, rules, etc. a set of (beliefs, practice, language) organised system (of principles, beliefs, rituals, practices, symbols; practices and beliefs related to sacred in which people engage) authoritarian, institutionalised, official, formal, hierarchical nature, prescribed rituals, established ways of believing narrow and institutional religious organisations and personnel framework for meaning, or restrictive straightjacket institutionalised spirituality; belief in God and teaching found in sacred religious texts
(religion) organised	subscribing to a set of institutionalised beliefs or doctrines excluding the more general spiritual beliefs of people integral part of non-Western culture and society social and cultural structure or construct, embracing myth explaining human origin, purpose and destiny systems of religion interpersonal and institutional; from culture; more cognitive; authoritarian and imposed from without; intolerant
community	adherence to beliefs and practices of an organised group organised collective experiences of group into a system of belief and practice like-minded believers adherence (to beliefs and prescribed behaviour) in order to be accepted (in religious group); preference (claim of belonging to group) religious affiliation attendance (meetings, participation, financial support) denomination degrees of participation
	(inseparable from spirituality, 'numinosum'; according to Jungian definition – 'religion is spirituality'; platform for the expression of spirituality; when religion loses spirituality, it can become divisive; associated with conflict and war)

WITHDRAWN

3.2.1.3 Practice and teaching of specialist psychiatry

In this element of the identified core concept that has to be defined, **specialist psychiatry** refers to "***a specialized, medical, professional, scientific discipline***". Essential and related criteria for the concept "practice and teaching of specialist psychiatry" are summarised in Table 3.6 (pp210-212).

(1) **Dictionary meaning**

A **specialist** according to AHD is:

- one who has devoted him/herself to a particular branch of study or research; - a physician certified to limit his/her practice to a specialised field;
- a specialist area or **speciality** refers to a distinguishing mark or feature, a special characteristic, a peculiarity;
- **specialisation** refers to the act of specialising, or the process of becoming specialised;
- a **specialist psychiatrist** is a licensed physician specially trained to practice psychiatry.

As far as the root **"psyche"** of the concept **psychiatry** is concerned, according to AMH, it refers to:

- the soul or spirit, as distinguished from the body;
- the mind functioning as the centre of thought;
- feeling and behaviour;
- consciously or unconsciously adjusting and relating the body to its social and physical environment;
- from Greek ***psukhē***, breath, life, soul; - *classical mythology (a maiden loved by Eros and united with him after Aphrodite's jealousy was overcome);* became the personification of the soul; **psychiatry**
- **"psycho"** refers to the mind or mental process.

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Psychiatry, according to AHD, is defined as:

- **the medical study, diagnosis, treatment and prevention of mental illness**; probably from French *psychiatrie,* from *psychiatre* psychiatrist, from *psych-* and Greek *iatros,* physician (MWD)
- **medicine**: the science of diagnosing, treating, or preventing disease and other damage to the body or mind; the branch of this science encompassing treatment by drugs, diet, exercise, and other non-surgical means; the practice of medicine; any drug or other agent used to treat disease or injury; [Latin *medicīna*, the art of the physician, from *medicus*, doctor, from *medērī*, to heal];
- **study**: the act or process of studying; the pursuit of knowledge, by reading, observation or research; attentive scrutiny; a branch of knowledge; a branch or department of learning; a work resulting from studious endeavour, as a monograph or thesis
- **diagnosis**: the act or process of identifying or determining the nature of a disease through examination; the opinion derived from such an examination; an analysis of the nature of something; the conclusion reached by such analysis;
- **treat**: to act or behave in a specified manner toward; to regard or to consider in a certain way; **treatment**: the act or manner of treating something, such as a person or a subject; the application of remedies with the object of effecting cure; therapy;
- **prevent**: to keep from happening, as by some prior action; avert, thwart; to keep (someone) from doing something, hinder, impede;
- **mental** refers to: of, pertaining to the mind; intellectual; done or performed by the mind; existing in the mind; relating to the mind;
- to be **ill** means: not healthy, sick; not normal, unsound; resulting in suffering; distressing; **illness** is a sickness of body or mind; **disease** is defined as an abnormal part of an organism, especially as a consequence of infection, inherent

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weakness, or environmental stress, that impairs normal physiological functioning; a condition or tendency, as of society, regarded as abnormal and pernicious.

A **profession** according to the AHD is:

- an occupation or vocation requiring training in the liberal arts or the sciences and advanced study in a specialised field; the body of qualified persons of one specific occupation or field; the act or an instance of professing; declaration, claim; an avowal of faith in a religion; from Latin *professiō*, declaration, confession, from *profitērī*;
- **professional** therefore is: of, or related to, engaged in, or suitable for a profession; engaged in a specific activity as a source of livelihood; performed by persons receiving pay; and having great skill or experience in a particular field or activity.

Science according to the AHD is:

- the observation, identification, description, experimental investigation, and theoretical explanation of natural phenomena; such activity restricted to a class of natural phenomena; such activity applied to any study; any activity that appears to require study and method; knowledge; especially knowledge gained through experience;
- **scientific** is therefore: of, pertaining to, or used in science; broadly having or appearing to have an exact, objective, factual systematic, or methodological basis; from Latin *scientificus*, "producing knowledge".
- **knowledge** is defined as: the state or fact of knowing; familiarity, awareness, or understanding gained through experience or study; that which is known; the sum or range of what has been perceived, discovered, or inferred; learning; erudition: *men of knowledge*; specific information about something; **evidence based knowledge** refers to the data on which a judgement or conclusion may be based,

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or by which proof of probability may be established; that which serves to indicate or suggest; in contrast to **occult knowledge** which refers to: of, pertaining to dealing with, or knowledgeable in supernatural influences, agencies or phenomena; beyond the realm of human comprehension (unseen, intangible); mysterious, inscrutable; available to only the initiate, not divulged, secret; hidden from view, concealed.

Discipline refers to (AHD):

training that is expected to produce a specified character or pattern of behaviour, especially that which is expected to produce moral or mental improvement; controlled behaviour resulting from such training; a state of order based upon submission to rules and authority; a set of rules or methods, such as those regulating the practice of a church or monastic order; a branch of knowledge or of teaching; **train** means: to coach in or accustom to some mode of behaviour or performance, to make proficient with specialised instruction and practice, to prepare physically - as with a regimen, to make fit; a **trainee** is a person who is being trained; and **training** is the act, process, or routine of one who trains.

Practice refers to (AHD):

- do, or perform habitually or customarily; making a habit of it; to exercise or perform repeatedly in order to acquire or polish a skill: *practise a dance step*; to give lessons or repeated instructions to; drill: *to practise students in handwriting*; to work at, especially as a profession (*practise law)*; to carry out in action; observe *(practise one's religion);*
- a **practitioner** is somebody who practises an occupation, profession, or technique.

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Teach means (AHD):

- to impart knowledge or skill to; to give instruction to; to provide knowledge of; instruct in; to cause to learn by example or experience; to advocate; preach;
- a **teacher** is one who teaches, especially a person hired by a school to teach; while **teaching** is the work or occupation of teachers, or a precept or doctrine;
- a **mentor** is a wise and trusted counsellor or teacher; "*Moore and Kierkegaard have become mentors of two different philosophical movements*"; **mentoring**.

A clinical medical **discipline** – such as psychiatry - therefore constitutes a profession that is based on certain scientific knowledge and skill, which is being practised, applied and taught by practitioners trained in medicine and its particular branches of specialisation.

(2) **Subject meaning**

On the classification of human **knowledge**, Donaldson and Crowley stated that it has traditionally been considered in the context of disciplines (Donaldson & Crowley, 1986). Referring to the Oxford Dictionary, they defined a **discipline** as "a branch of instruction or education, a department of learning or **knowledge**." Institutions of higher education are organised around these branches of knowledge into colleges, schools, departments. "*As a result of the complex way in which disciplines evolve, **disciplines** can be and have been identified and organized around a variety of characteristics and combination of characteristics… In identifying disciplines and classifying them, we are dealing with the nature and structure of the whole of human **knowledge**"* (p243). According to them, the broadest classifications of **disciplines** depend upon a view of the inherent nature of all phenomena. A distinction on the part of philosophers between the generality of natural phenomena and the particularity of human events leads to a distinction between the "**sciences**" (such as physics and sociology) which seek general laws for repeating behaviour and the "humanities" (**disciplines** such as history - which focus on unique events, or ethics - which deals with human choices and value orientations). Amongst the

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sciences themselves, the biological **sciences** become distinct from physics and chemistry because they deal with the recognition of the phenomena of life and with living as opposed to nonliving things. In this context they considered the distinction between academic **disciplines** (such as physics, physiology, mathematics, history and philosophy) and emerging **professional disciplines** (such as law, medicine and nursing). The aim of academic **disciplines** is to know and their theories are descriptive in nature. **Professional disciplines** are directed toward practical aims and thus generate prescriptive as well as descriptive theories. The **professional disciplines** therefore – in addition to basic and applied research (appropriate for the generating and testing of descriptive theories) – also utilise clinical research (appropriate for the generating and testing of prescriptive theories. Although the **discipline** and the **profession** are inextricably linked and greatly influence each other's substance, they must be distinguished from each other (Donaldson & Crowley, 1986). The **discipline** (which is the body of knowledge) must not be confused with its associated practice realm (which embodies the processes of conducting research, giving service and educating). "***Professions*** *evolved because the service they provided was valued. Given the emphasis placed upon* ***science*** *and rationality in the post-industrial age, it is not surprising that there was a strong impetus for establishing a* ***scientific*** *and theoretical basis for* ***professional practice****. The process of upgrading* ***professional practice*** *also entailed the establishment of closer relations between* ***knowledge*** *serving as a basis of* ***professional practice*** *and* ***knowledge*** *in the academic disciplines. Since the university traditionally has been the locus of development of theoretical* ***knowledge****, the* ***professional disciplines*** *were eventually housed there along with the academic* ***disciplines***" (p247).

Johnson referred to the definition of a **profession** as being a "learned vocation." While there may be differences on what distinguishes a **profession**, there is universal agreement that a theoretical body of knowledge is an essential attribute (Johnson 1986).

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*"A **profession's** service to society is an intellectual one, and a sound, **scientific** basis for that service is indispensible. Moreover, a **profession** is responsible for creating the constantly increasing body of **knowledge** upon which its service depends"* (p307). With medicine's social responsibility related "to free mankind from the ills of the flesh", physicians have created over the years a large and continuously growing body of **knowledge** as a means of understanding and controlling man's bodily ills. *"They have done so by identifying, describing and explaining all manner of disorders and disturbances in man's biological being and by developing the rationale necessary to their prevention and management"* (p309).

Dyer discusses **psychiatry** as a **profession** and alludes to the original meaning of **profession** as to profess religious vows: "*one was called to the **discipline** the way disciples were called to their master for a vocation of service*". Since the Middle Ages, **professions** have been increasingly organised into guild-like fraternities, which ensure not only standards of public service, but also the economic interest of their members (Dyer, 1999: p64). "***Psychiatry** as a **profession** is caught up in our culture's attempt to rethink what is meant by a **profession** and how **professions** should be defined and regulated. As part of the medical profession, **psychiatry** faces many of the same issues of credibility faced by the rest of medicine. What defines **medicine as a profession**? Is it the technology which helps physicians to serve their patients? Or is it fundamental ethical values which define the commitment of the physician to the patients who seek **professional** help?"* He continues by describing **psychiatry** as a divided **profession**, divided in particular by competing loyalties to psychological and biological positions. He argues that **psychiatry's** future must be based on a careful understanding of the ethical principles which have always been the basis of the **professions**. *"It seems at first glance to be to **psychiatry's** advantage to identify with medicine, even with a narrow view of what medicine is. (But) to identify **psychiatry** with the reductionist aspects of medicine is to buy into the same credibility problems that beset all of medicine."* The evolution of

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professions usually involves a number of steps, including first becoming a full-time occupation, the establishing of the first training school, the first university school, the first local **professional** association and then a national **professional** association, state licensing laws and ultimately the development of a formal code of ethics. **Professions** established according to these criteria include accounting, architecture, civil engineering, dentistry, law and medicine. Developing **professions** would include librarianship, nursing, optometry, pharmacy, school teaching, social work and veterinary science. In formulating an ethical definition of a **profession**, Dyer (1999) concurs that a **profession** may be defined by its knowledge, techniques and expertise, or by its ethics and values. **Professions** attempt in one way or another to address the ethical standards of their members through "entry" (admission standards to review the character of the candidate), "education" (with the curriculum reflecting the values of the profession) and "exit" (**professional discipline** of members who do not adhere to standards). "There is often an overlap of the **knowledge-base** among **professions** with similar interests and goals. If a **profession** is conceived in terms of its **knowledge** or technical expertise, and organized to promote the economic self-interest of its members, other **professions** are rivals for a market share in so-called 'turf-battles'. If a **profession** is conceived in terms of its ethics and value of service, then other **professions** are allies in meeting a service need" (p72). **Psychiatry** of all the **professions** should be prepared to understand that one cannot understand a machine by reducing it to its parts. "*The **knowledge** that patients share of themselves is received by fellow human beings, who ideally are trained to understand not just recitations of symptoms but the meanings of symbolic communications. Nothing frustrates and angers patients more than the feeling that they are not listened to, that their stories are not being heard."* **Psychiatry** can best be understood as a **profession** seeking to apply **science**, but most accurately defined by values located in a human context (p75).

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Table 3.6 Essential and related criteria for the concept "practice and teaching of specialist psychiatry"

ESSENTIAL CRITERIA	RELATED CRITERIA (Black text – dictionary meaning, Red text – meaning from subject literature)
specialist	specialised in a medical discipline particular branch of study (e.g. psychiatry) or research distinguishing mark or feature, a special characteristic physician certified to limit his/her practice, (practising in a specialized field) (psychiatrist is a) licensed physician specially trained to practice psychiatry
psyche	soul or spirit (distinguished from body): breath, life mind as centre of thought, feeling, behaviour (consciously or unconsciously adjusting) mental process
(psychiatry)	
medical	science of diagnosing, (non-surgical) treatment and prevention (of disease and other damage)
study	pursuit of knowledge (by reading, observation, research) branch of knowledge, department of learning
diagnosis	identifying, determining (the nature of disease through examination) analysis (of nature of something) opinion (derived from such examination); conclusion (reached from analysis identifying, describing, explaining all manner of disorders and disturbances
treatment	act, behaviour toward, regard, consideration application of remedies (with objective to care) rationale necessary to the prevention and management of disorders/ disturbances
prevention	to keep from happening, avert
mental	pertaining to mind done, performed by mind relating to mind existing in mind
illness	not healthy, unsound, resulting in suffering

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profession	occupation (full-time) vocation (requiring training in e.g. sciences; advanced study in a specialised field; activity as a source of livelihood; payment in return); learned vocation body of qualified persons of one specific occupation or field organised into guild-like fraternities (ensuring standards and economic interest of members); professional association basis of ethical principles (code of ethics, e.g. Hippocratic oath) regulated entry, education and exit (discipline)
scientific	observation, identification, description, experimental investigation and theoretical explanation of natural phenomena; research (basic, applied and clinical) activity requiring study and method exact, objective, factual systematic or methodological basis theoretical body of knowledge (the aim of an academic discipline is to know) theory (descriptive, prescriptive) knowledge (through experience): familiarity, awareness, understanding through experience and study; sum or range of what has been perceived, discovered, or inferred; evidence-based (data on which a judgement or conclusion may be based, providing proof of probability); profession responsible for, and defined by, its knowledge, technology, expertise and/or ethics and values
discipline	training (expected to produce a specified characteristic or pattern of behaviour); train - to coach, to make proficient to prepare, make fit academic, professional; training school, university controlled behaviour resulting from such training state of order based upon submission to rules and authority set of rules or methods (as those regulating a branch of knowledge or of teaching)
(practice) perform	do; making a habit exercise (repeatedly in order to acquire a skill), drill to work at; to carry out in action embodies processes of research, service and education; professional disciplines directed towards practical aims observe (one's religion)
(teaching) give instruction to	to impart knowledge or skill provide knowledge to cause to learn to advocate preach, precept or doctrine mentoring

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3.2.1.4 Professional and ethical boundaries

The following element of the core concept to define is "**boundaries**". Essential and related criteria for the concept "boundaries" are summarised in Table 3.7 (p215).

(1) **Dictionary meaning**

A **boundary** in general terms refers to (AHD):

- something that indicates a border or limit;
- the border or limit so indicated;
- synonyms: border, frontier, limit, bound, end, confine;
- something that indicates or fixes a limit or extent (MWD).

This implies an inclusive territory or area (within the boundary) with a defined range, scope or limitation: **scope** (AHD): the range of one's perceptions, thoughts, or actions; breadth of opportunity to function; the area covered by a given activity or subject; the length or sweep of a mooring cable. **Boundary** thus also refers to what is beyond a certain scope, to the adjacent but distinct or exclusive space, domain, territory or expertise across the **boundary** of another country, authority, person or discipline. This approximation between two areas (or people) on either side of a **boundary** suggests that the nature of how the mutual relationship (between the two persons, authorities, or professions) is conducted is of importance and should be appropriately determined.

In terms of the core concept, the term boundary is understood to refer to the **professional** conduct of **practitioners** of a **specialist discipline**. It involves ethical principles and review, often from fellow practitioners or peers.

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Ethics according to AHD is:

- the study of the general nature of morals and of the specific moral choices to be made by the individual in his/her relationship with others; the philosophy of morals;
- also called "moral philosophy";
- the moral sciences as a whole, including moral philosophy and customary, civil and religious law; the rules and standards governing the conduct of the members of a **profession**.

A "**peer**" is a person who has equal standing with another, as in rank, class, or age; and "**review**" means: to look over, study, or examine again; to consider retrospectively; look back on; to examine with an eye to criticism or correction; to write or give a critical report on (a new work or performance).

(2) **Subject meaning**

Personal **boundaries** are physical and psychological in nature. Psychological boundaries are relevant in relationships and can be described as "soft", "rigid" of "flexible" (Personal boundaries, Date unknown). Professional and therapeutic **boundaries** are parameters in which the relationship between therapist and client occurs. In addition to safety, **boundaries** make relationships **professional**, give the client and therapist a legitimate sense of control in the relationship and result in the client gaining the maximum benefit from the therapy (Professional boundaries, Date unknown). In terms of **boundaries** in the workplace: an individual's **professional boundaries** can be defined in terms of a job description, as long as it clearly outlines basic responsibilities and reporting relationships. "***Boundaries*** *are present whenever a person or department interfaces with another person or department. The definition of a* ***boundary*** *is the ability to know where you end and where another person begins. When we talk about needing space, setting limits, determining acceptable behaviour, or creating a sense of autonomy, we are really talking about* ***boundaries****. It is a general misconception that having good* ***boundaries*** *will*

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distance you from others. However, the truth is that when you know where you end and others begin, you can then closely engage with others because you won't feel overwhelmed or unprotected. Having a sense of autonomy prevents the need to distance our self from others with a barrier." (Work place boundaries, Date unknown).

Galletly discusses **boundaries** in the context of ethical clinical conduct and highlighted the importance of **professional boundaries** in **medical practice** in Australia (Galletly, 2004). To maintain clear **professional boundaries** is an important aspect of patient care. However, according to her, **medicine** has deliberately become less formal, and doctors are increasingly urged to focus on developing just, respectful relationships with their patients, rather than rigidly adhering to rule-based systems of ethics. With this approach, doctors may cross **professional boundaries** more often. Regular **boundary** crossings may increase the risk of doctors developing inappropriate relationships with patients - **boundary** violations. The distinction between **boundary** crossings and **boundary** violations is important. Crossings are departures from usual **practice** that are not exploitative, and can sometimes be helpful to the patient, while **boundary** violations are crossings that are harmful to the patient. Preventive strategies include continuing education about ethics and the management of **professional boundaries**, along with appropriate psychological support structures for doctors.

In terms of the boundary between **psychiatry** and **religion**, Sims states that **religious** people and psychiatrists often appear to live in two different worlds (Sims, 1999). Patients are put in an uncomfortable position of vulnerability in the middle. Bhugra explains this **boundary scenario** as two next door neighbours who quarrelled about the size of their mutual fence and suggests that it is high time that commonalities are ascertained and shared and differences are put to one side (Bhugra, 1996). Patients caught in the conflict of these "turf battles" between these **spiritual professionals** and health workers are reluctant to talk to their **psychiatrists** about their **religious** beliefs and practice and to

their **ministers of religion** about their **psychiatric** symptoms and treatment (Sims, 1999). Removal of such perceived tensions between the patient's **spiritual** adviser and her/his **psychiatrist**, may in itself allow patients to be more open about matters concerning their mental health.

Table 3.7 Essential and related criteria for the concept "boundary"

ESSENTIAL CRITERIA	RELATED CRITERIA (Black text – dictionary meaning, Red text – meaning from subject literature)
parameter	border or limit (of territory, function, jurisdiction, responsibility, expertise, discipline) end confine(s) scope job description clear outline ability to know (where you end and another person begins) setting limits (crossings, violations) determining behaviour fence, barrier (next-door neighbour)
ethics	general nature of morals, specific choices by individual in relationship with others; philosophy of morals, moral sciences rules and standards governing conduct of profession rule-based system of ethics

3.2.1.5 Equal

Finally, the core concept includes the element of equal accommodation of all cultural-religious traditions and belief systems. Essential and related criteria for the concept "equal" are summarised in Table 3.8 (p218).

(1) **Dictionary meaning**

Equal according to AHD means:

- having the same capability, quantity, or effect as another; *equal strength, weight, damage*;
- *Mathematics*: related by a reflexive, symmetric, and transitive relationship;
- broadly, alike or in agreement in a specified sense with respect to specified properties;

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- having the same privileges, status, or rights; - deserving or worth: *equal before the law.*

According to MWD:

- of the same measure, quantity, amount, or number as another, identical in mathematical value or logical denotation; equivalent; like in quality, nature, or status; like for each member of a group, class, or society provide **equal** employment opportunities
- regarding or affecting all objects in the same way: impartial
- free from extremes: as tranquil in mind or mood, not showing variation in appearance, structure, or proportion
- capable of meeting the requirements of a situation or a task: suitable; bored with work not equal to his/her abilities.

(2) **Subject meaning**

In terms of **equal** education, North American legislation for example regulates that "no (American) State shall deny **equal** educational opportunity to an individual on account of his or her race, colour, sex, or national origin" (Equal Educational Opportunity Act, 20 USC Sec. 1703 – Chapter 39 – Equal Educational Opportunities), (Equal educational opportunities, Date unknown). Several not-for-profit organisations (such as the Mid-Atlantic Equity Consortium) for instance, strive "to create learning environments free of race, gender, class, ethnic and cultural biases so that students of all backgrounds have **equal** opportunities to flourish" (Equal opportunities, Date unknown). According to the Illinois State Board of Education "the laws of Illinois and the United States guarantee all students in Illinois access to a quality education. This requires every district to guarantee all students **equal** access to the full range of programs and resources. **Equal** access is influenced by admission policies adopted at the district level and implemented at the school level. By law, immigrant students are entitled to the same access as non-immigrant students" (Equal access, Date unknown).

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In terms of **equal** employment opportunity, the **Equal** Employment Opportunity Commission (EEOC) in the United States was established to enforce provisions of Title VII of the Civil Rights Act of 1964. Title VII forbids discrimination in the workplace based on race, age, handicap, religion, sex, or national origin. Title VII of the Civil Rights Act of 1964 was the first federal law designed to protect most U.S. employees from employment discrimination based upon race, colour, religion, sex, or national origin (Public Law 88-352, July 2, 1964, 78 Stat. 253, 42 U.S.C. Sec. 2000e et. seq.), (Equal employment opportunity, Date unknown).

Table 3.8 Essential and related criteria for the concept "equal"

ESSENTIAL CRITERIA	**RELATED CRITERIA** **(Black text – dictionary meaning, Red text – meaning from subject literature)**
Same	(having the same) capability, quantity, or effect as another privileges, status, or rights, deserving or worth alike in agreement identical equivalent impartial free from extremes suitable free from bias (race, age, gender, class, ethnic, cultural, handicap, religion, or national origin) non-discriminatory

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3.2.2 DEFINITION OF CORE CONCEPT

Considering the essential and related criteria identified in previous paragraphs for the definition of the concepts: "**incorporate**" (Table 3.4); "**spirituality**" (Table 3.5a and 3.5b); "practice and teaching of **specialist psychiatry**" (Table 3.6); "professional and ethical **boundaries**" (Table 3.7); and "all traditions and belief systems **equally** accommodated" (Table 3.8), the essential and related criteria to be considered in the definition of the identified core concept are summarised in Table 3.9. The essential and related criteria for the definition of the core concept are again highlighted with underlined text. Because of the interrelated nature of the concepts "spirituality" and "religion", the essential and related criteria for **religion** is also summarised here in order to inform the final definition of the central core concept from the interpreted, integrated interview and literature source data. The subsequent constructing of a model of this identified core concept will be based on this definition.

Table 3.9 Summary of essential and related criteria for definition of the core concept

ESSENTIAL CRITERIA	**RELATED CRITERIA (Black text – dictionary meaning, Red text – meaning from subject literature)**
CORE CONCEPT ELEMENT: INCORPORATE	
unite	blend, admit, merge, combine, form, give substance or form, embody, become, organise, maintain
form	grant/provide (legal) status, organise, include, unify, assimilate
CORE CONCEPT ELEMENT: SPIRITUALITY	
quality	(inner) state, fact, dimension, nature, condition
journey	process, way of life, progression, transformation, pilgrimage, search, quest, experience
relationship	involvement, connectedness/connection, evolve, interrelatedness, keep, maintain, harmony, body, society, persons, assembly, congregation, organised institution
capacity	character; tendency; instinct, being able to, being, characteristic, (intrinsic) attribute, consciousness, awareness, sense, reaching out beyond, committed, heart, foundation, faith, extent and depth, sensitivity

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(Table 3.9 Summary of essential and related criteria for definition of the core concept)	
CORE CONCEPT ELEMENT: SPIRITUAL	
concerning	relating to, having, consisting of, affecting, providing
CORE CONCEPT ELEMENT: SPIRIT	
vital principle	animating force, unseen intangible being, vital force, separate from body (soul), animating principle, fundamental emotional principle, energy, inner resources, motivating force, dynamic agency or effect
CORE CONCEPT ELEMENT: PRACTICE	
perform	do, making a habit, exercise, drill, to work at, to carry out in action, observe
CORE CONCEPT ELEMENT: TRAINING	
give instruction to	to impart knowledge or skill, provide knowledge, to cause to learn, to advocate, preach, mentor
CORE CONCEPT ELEMENT: SPECIALIST PSYCHIATRY	
particular branch (of the) medical study diagnosis treatment prevention of mental illness	certified/licensed to practice science pursuit of knowledge identifying, determining, analysis, describing, explaining act, behave, regard, consider, apply (remedies), rationale to keep from happening mind (pertaining to, performed by, relating to, existing in) not healthy, unsound, suffering
CORE CONCEPT ELEMENT: BOUNDARIES	
parameters	border or limit, end, confines, job description clear outline, ability to know (where you end and another person begins), setting limits, determining behaviour, fence
CORE CONCEPT ELEMENT: EQUAL	
same	alike, in agreement, identical, equivalent, impartial, free from extremes, suitable, free from bias, non-discriminatory

WITHDRAWN

For comparison and contrast, the essential and related criteria for the construct "religion" are:

ESSENTIAL CRITERIA	**RELATED CRITERIA** **(Black text – dictionary meaning, Red text – meaning from subject literature)**
expression	attitude, objective attended to, pursued, what is done, action behaviour, outward practice of spiritual beliefs values, codes, rituals, extrinsic, meta-narrative acted out, practicing
organized	integrated system, collection, bond, bounded systems, structured institution, a set of institutionalised beliefs or doctrines; organised system; authoritarian, official, formal, hierarchical, nature, prescribed rituals, established ways of believing
community	organised group, organised collective experiences of group, adherence in order to be accepted, preference, affiliation, like-minded believers, attendance , denomination, participation

Final definition of the construct spirituality for the purposes of this study

Considering the derived denotative and connotative meaning for the construct, as summarised in the different tables above, **spirituality** for the purposes of this study refers to:

"*individual persons' and societies' progressive inner:*

- ***quality*** *of* *transcendental awareness;*
- ***journey*** *towards understanding of ultimate questions;*
- ***relationship*** *or* *connectedness* *(with themselves, others, the natural world and a theist or atheist presence/source/principle beyond themselves); and*
- ***capacity*** *or* *consciousness* *concerning an unseen but* *vital,* *animating, life-defining* *principle*, *force* *or* *energy* *within,*

through which *meaning and purpose* *are derived."*

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It was further concluded, based on this process of derived meaning, that the identified core concept *"**incorporating** the role of defined **spirituality** into the existing bio-psycho-social approach to local **practice and teaching of specialist psychiatry** - within specific professional and ethical **boundaries** - while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society **equally**"* refers to:

> *"uniting or forming the role of defined **spirituality** into the existing bio-psycho-social approach to the local performing and instructing of the particular branch of the medical study, diagnosis, treatment and prevention of mental illness – within specific professional and ethical parameters – while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society on the same basis".*

Spirituality has been defined as a progressive process that develops and evolves as a capacity or consciousness (awareness) in degrees of involvement and deepening of related connectedness. The incorporation of the role of spirituality into psychiatric practice and training may, therefore, also be expected to be achieved progressively in steps such as: by facilitating **awareness** (mindfulness) of defined spirituality's role among interest group members, other practitioners, patients and students, and also by facilitating **awareness** (knowledge) of specialist psychiatry among patients and spiritual professionals; by informing the process of **acknowledgement** of its importance from professional, teaching and service delivery structures; and by realising appropriate **integration and review** of spirituality's role into the ongoing reality of daily professional activities of interest group members, practitioners, patients, students and spiritual workers.

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Although **religion** was not identified as a part of the core concept for the construction of the proposed model, a definition derived from denotative and connotative meaning is also to be included here for clarity and for purposes of reference. Following the same approach as for spirituality, "**religion**" can be defined as "*the practice and outward expression of spiritual beliefs with its associated activities, organised into integrated systems of doctrine and institutionalised structures, in adherence to the collective community of like-minded believers*".

With these definitions for spirituality and religion established, the essential criteria for the remaining elements of the identified core concept are defined as follows (Table 3.9):

- **Unite** refers to blend, to admit, merge, combine, form, give substance or to form, embody, become, organise, maintain; **Form** refers to grant, or to provide (legal) status, organise, include, unify or to assimilate;
- **Perform** is to do, to exercise, to drill or to work at, to carry out in action and to observe;
- **Instruct** is to impart or provide knowledge or skill, to cause to learn, to advocate, to preach or to mentor;
- **Specialist psychiatry** is defined as **"the specific branch of the medical study of the diagnosis, treatment and prevention of mental illness"**: **medical** means science or scientific; **study** means the pursuit of knowledge; **diagnosis** means identifying, determining, analysis, describing or explaining; **treatment** mean the act, or to behave, to regard, consider or to apply (remedies), the rationale of; **prevention** means to keep from happening; **mental** refers to the mind (pertaining to, performed by, relating to, existing in); and **illness** refers to not healthy, unsound, suffering;
- **Parameters** represent a border or limit, and end, the confines of and also a job description. It also refers to a clear outline, the ability to know (where

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you end and another person begins), the setting of limits which will determine behaviour, or a fence; and

- The **same** means to be alike, to be in agreement, identical, equivalent, impartial, to be free from extremes, suitable for, free from bias, or non-discriminatory.

3.2.3 MODEL CASE

In this paragraph, a model case is constructed to provide a context in which the defined core concept and the implementation of the constructed model, based on this core concept, may have to be considered. The concepts included in the model case description that correspond with the elements of the identified core concept were highlighted with underlined text.

The necessity for and importance of considering the cultural, religious and spiritual context in which patients present on a daily basis to South African psychiatrists in both the private and public sector is demonstrated by the following case scenario. Comprehensive clinical detail of the case is presented to highlight the challenge of the role that religious/spiritual factors may play in the routine presentation of symptoms and the diagnosis, treatment and prevention of mental illness. On the one hand, practitioners should be aware of how important spirituality may be in the lives of their patients and that the journey, relationships and capacity of people concerning the unseen spiritual reality beyond themselves should not erroneously be regarded as symptoms of psychopathology. On the other hand it remains essential not to overlook indications of mental illness in order to consider and advise on appropriate treatment and the prevention of disability as far as possible.

This case was devised to demonstrate the incorporation of spirituality in the routine psychiatric assessment of patients as a daily reality. The case also demonstrates the

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difficulties that may arise regarding the boundaries and scope of professional psychiatric practice and the importance of ethical parameters in which clinical decisions and recommendations have to be made.

"Dr. AM, a senior independent psychiatrist was approached by a major insurance company for an expert opinion on the merit of the following disputed medical disability claim.

- *Dr. XZ a well known black psychiatrist wrote a report to the effect that - in his professional opinion – Ms. SC, the 34 year old claimant (a personal assistant at a consulting firm) should be granted twelve months "leave of absence" from work with full benefits awarded to her. While considering the possibility of "psychosis not otherwise specified", he refrained from making a clear psychiatric diagnosis, but motivated his recommendation with a rather condescending explanation that she had to fulfil some cultural-religious obligations in preparation of her training as a traditional healer/diviner.*
- *The insurance company was also presented with another certificate from a traditional healer in Limpopo province. The healer's letter revealed that he was registered as a traditional health practitioner with the recently formed National Council for Traditional Health Practitioners. In the letter he declared that his client (the claimant) must perform certain traditional rituals as she had been called by the ancestors to undergo training as a traditional healer herself.*
- *Ms. SC has been employed by her company in Sandton, Johannesburg for the past four years. After school she obtained a diploma in human resource management and administration. She successfully held one other position prior to her appointment to this firm. Her work appraisals were consistently favourable over the past three years and she was promoted to her current salary and benefit package eight months ago. She had good interpersonal relations with other staff*

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members in the office. She was unmarried and lived in her own apartment, but had a stable relationship with her boyfriend for the past two years.

- *She had no significant medical history and no prior psychiatric history until four months previously, when she uncharacteristically reported late for work on three consecutive days. She initially told close friends that she had not slept well and that she felt stressed and anxious. By the second day her colleagues noted that she was slightly inappropriate and appeared confused and dishevelled. On the third day she was overtly restless, agitated and dysphoric. She could not concentrate and made several embarrassing judgment errors regarding company commitments. She was urged to consult her doctor.*
- *After she reported to her general practitioner that she was experiencing that her deceased grandmother was audibly communicating with her, instructing her to start training as a traditional healer, she was referred by him to Dr. XZ for a psychiatric assessment. These "voices" had started about a month prior to the presenting incident at work, but became more frequent and acute one week prior to the consultation.*
- *Ms. SC was admitted for five days to a local private medical clinic by Dr. XZ, during which she continued to be driven and agitated, while not being able to sleep without prescribed sedation. She was treated with a low dose of an atypical antipsychotic agent to which she seemed to have responded by the third day of admission. She was discharged from hospital but advised to continue the medication for another month. A medical certificate supporting a month's sick leave was submitted to her employer.*
- *She spent some time with her family in Limpopo during this month and also consulted with a traditional healer about her experience. She was not convinced that she should continue with the medication and also experienced some drowsiness after she took the tablets.*

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- *During the follow-up appointment with Dr. XZ she told him that she was now sure that she was being called to be a traditional healer/diviner and had made plans to start her training as soon as it could be arranged. According to her beliefs and cultural-religious tradition, this would be the only way to pursue her spiritual journey as she understood it, and thus to be honouring and deepening the relationship that she had with her ancestral spirits. She was not prepared to consider the suggestion of continued medication. She however, expressed concern to him about how she would be able to maintain the payments for her apartment which was purchased when she was promoted.*
- *The insurance company's initial response to the claim for the payment of benefits was to decline it on the basis that her policy did not make provision for traditional conditions, that they could not accept the certificate of a traditional healer and that no disability was implied by the specialist's report.*
- *After she obtained legal advice on the matter, the insurance company received a letter from Ms. SC's attorney, advising them that the traditional healer's certificate should be regarded as a valid document from a registered health practitioner according to the recently promulgated Traditional Health Practitioners Act. He indicated that the company's refusal to grant her the payment of benefits for this period would be challenged based on the principle that African traditional health practice was now an officially recognised alternative approach to health in parallel to the Western medical system. He further pointed out that health funders and insurance policies utilizing Western psychiatric diagnostic systems were discriminatory as they do not regard African cultural-religious conditions to be the same as medical conditions and were therefore not adequately provided for.*

Dr. AM is confronted with the following problems in his assessment of this case:

(1) Traditional cultural-religious conditions are a reality - even in young, urbanised professional people - but most medical aids and insurance

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companies do not regard traditional conditions as medically insured diagnoses.

(2) If it is a traditional cultural-religious condition that Ms. SC has experienced – best explainable by the traditional African belief system - should the case not be regarded as a spiritual or religious condition requiring clinical attention ("V-code 62.82")? In which case medical aid and insurance would also not have included benefits for this category, even if it were to be claimed under a DSM or ICD diagnostic category.

(3) While health funders and insurance institutions make allowance for the diagnoses of psychiatric conditions, Dr. AM's colleague XZ - advocating on behalf of his patient - seems to have engaged in a motivation for the payout of her benefits in terms of a psychiatric diagnosis that may be outside the parameters of ethical professional practice, in an attempt to protect her assets and enable her to continue the required monthly payments for her apartment.

(4) At the same time, reviewing Ms. SC's clinical presentation, there is also concern that she might actually have experienced a psychotic episode – albeit at first mild or limited - due to a more serious psychiatric condition such as bipolar mood disorder with psychotic elements, which may still warrant ongoing pharmacological treatment to prevent a relapse.

(5) The ethical difficulties of the case involve the claim for financial benefits based on an unclear psychiatric condition with no proven disability as yet, while the expectation remains that the patient will return to her position at work after completion of the required traditional religious-spiritual activities. Full financial benefits from the insurance pay-out were motivated for by a psychiatrist to cover the period during Ms. SC's absence. If her presentation is merely a cultural situation, to expect insurance pay-out seems to be unreasonable as no disability should be associated – unlike a

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medical condition with associated disabling complications. Yet Ms. SC's initial, mild psychotic episode may indeed be heralding a much more serious breakdown later, resulting in functional impairment and subsequent inability to resume her duties at work.

(6) The relevant professional society of psychiatrists – of whom both psychiatrists in this case are members – have not yet finalised formal guidelines that may inform the professional practice with regard to traditional African health practice, or other religious/spiritual belief systems."

Qualified specialists and psychiatrists in training need to be aware of the importance of spirituality in the clinical management of patients. They should have adequate knowledge and should be skilled in considering the presentation of problems in their cultural-religious context. They should be able to evaluate and appropriately integrate spiritual aspects in the management of patients, such as referring to a spiritual advisor in response to the patient's expressed needs. Specialist psychiatrists should, however, not be overstepping the boundaries of acceptable professional practice by engaging in unethical activity beyond the scope of the discipline's area of expertise, or in breach of personal professional boundaries of the therapeutic doctor-patient relationship.

3.2.4 CLASSIFICATION OF ELEMENTS OF CORE CONCEPT

To conclude the first Chinn and Kramer process of creating conceptual meaning (Step 1 - Concept Analysis), the elements of the defined core concept are finally categorised here according to the identified survey list of Dickoff, James and Wiedenbach (1968a). The list considers questions such as:

(1) Who or what performs the activity? – "Agent" [A];

(2) Who or what is the recipient of the activity? – "Receiver" [R];

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(3) In what context is the activity performed? – "Context" [C];

(4) What is the end point of the activity? – "Outcome" [O];

(5) What is guiding procedure, technique, or protocol of the activity? – "Procedure" [P] and;

(6) What is the energy source for the activity? – "Dynamic" [D]

Applying these principles of the survey list for fourth level (prescriptive) theory to categorise the elements of the core concept, not only one "receiver" was identified, but several (Figure 3.1). This also requires that the "procedure" have to be focused differently for each different "receiver", resulting in several "outcomes".

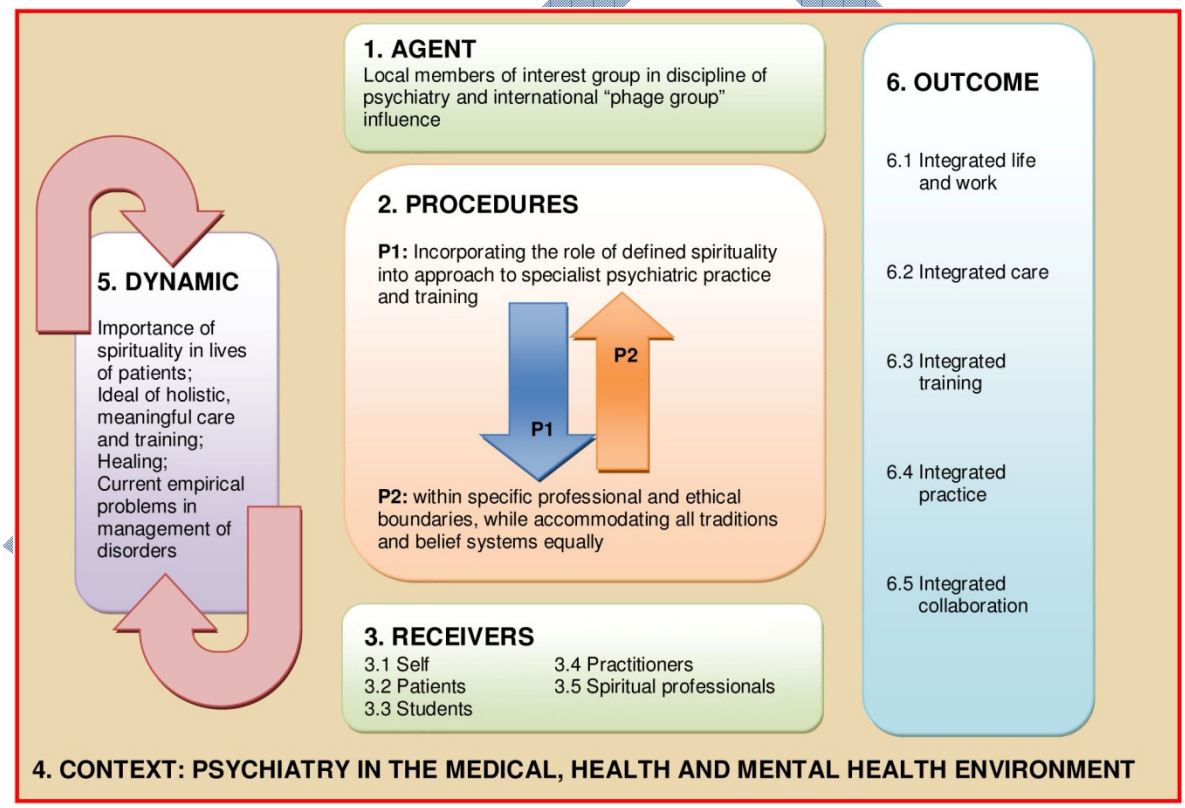

Figure 3.1 Categorisation of elements of the core concept according to survey list for fourth level theory (Dickoff et al,1968a)

3.2.4.1 Agent [A]

The agents in this model are the existing local members of the discipline who have an interest in the role of spirituality in psychiatry ("interest group") and those who are already aware of the role of defined spirituality in the practice and training of psychiatry. It also includes individual psychiatrists who will become aware (conscious) of the importance of the role of spirituality in the lives of people generally and of the impact of this for the practice of psychiatry. In addition to these local personal agents ("who") in the activity to incorporate the role of defined spirituality, is the inanimate "what" of a bigger phenomenon observed in the literature, namely the phenomenon of a growing trend in psychiatry worldwide to consider and incorporate the role of spirituality into the paradigm for psychiatric care.

This observed increased importance of spirituality in psychiatry may be referred to in similar terms as what has been described by Kuhn as occurring during bigger changes of paradigms within disciplines (Jacox & Webster, 1986), (Kuhn, 1962). He identified three stages in the development of science: the pre-paradigm stage ("immature science"); the paradigm stage ("normal science"), with rational puzzle solving on the basis of shared metaphysical and methodological assumptions; and then "revolutionary science", or the stage of abandonment (adjustment) of previously shared assumptions. He stated that existing professional education largely occurs through socialisation. The prevailing phage group (a group of frequently communicating scholars) share beliefs and goals through their network of communication. Their paradigm exerts control in a discipline, especially through the content of the teaching of the discipline, which according to Kuhn, is often largely social and political in nature rather than cognitive or rational. The existing paradigm may be rejected or adjusted in favour of a newer or competing one, when a number of anomalies or unresolved empirical problems accumulate. As a result, there is increased exploration of solutions outside of the accepted assumptions of the old

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paradigm, while a new phage group may then coalesce and come to impact on the discipline.

The idea of an international phage group influence as "co-agent" in this proposed local model may add perspective to attempts by local interest group members to come to terms with the local challenges of considering the role and appropriate definition of spirituality, as well as with the degree to which it should be incorporated into specialist psychiatric practice and training. Chibeni and Moreira-Almeida (2007) remark on the scientific exploration of "anomalous" psychiatric phenomena and reviewed Kuhn's concepts of paradigm, normal science and scientific revolution. They use Kuhn's philosophy as a background to a discussion of methodological and philosophical guidelines to the investigation of largely unexplored territories in psychiatry such as the relationship between spirituality and mental health. They argue that, while outright dogmatic rejection of the investigation of lesser explored territories may be short-sighted, at the same time hasty and careless acceptance of new hypotheses or theories may be very detrimental. They call attention to the fact that hypotheses or theories *"should stand and fall by their intrinsic scientific value of being logically consistent and empirically adequate".*

3.2.4.2 Procedures [P]

The procedural aspects in terms of the survey list of Dickoff, James and Wiedenbach (1968) for fourth level theory involve the implementation of the single identified core concept from the integrated interview and literature content, namely: "*incorporating the role of defined spirituality into the existing bio-psycho-social approach to local practice and teaching of specialist psychiatry - within specific professional and ethical boundaries - while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society equally."* Procedures are aimed at the different receivers. They refer to the strategies and activities that will be considered by the agent

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(interest group) to incorporate progressively the role of defined spirituality, into the approach to specialist psychiatry and will be focused differently upon each "receiver".

The anticipated progressive incorporation of the role of spirituality may firstly be achieved by facilitating awareness (mindfulness) of defined spirituality's role and also of awareness (knowledge) of specialist psychiatry. Secondly, it may be achieved by informing the process of formal acknowledgement of the importance of the role of defined spirituality from professional, teaching and service delivery structures. Lastly, incorporation may be achieved by realising appropriate integration and review of defined spirituality's role into the ongoing reality of daily professional activities of practitioners, patients, students and spiritual workers. Strategies and activities of the procedure aimed at different receivers may include:

- activities related to the interest group members' own incorporation of the role of defined spirituality (own skill, knowledge and attributes as person, practitioner and teacher);
- activities related to patients (e.g. inclusion of a spiritual/religious history in assessment, appropriate discussion, referral and liaison);
- activities related to students (curriculum development; selection; training and assessment of skills and knowledge);
- activities related to other practitioners (continued professional development such as conferences and lectures; peer review, practice guidelines); and
- activities related to spiritual professionals (communication, collaboration, educative forums/discussions).

3.2.4.3 Receivers [R]

Several groups of receivers of the activity of incorporating the role of defined spirituality into specialist psychiatry can be identified. These would individually and collectively

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include: practitioners from the "interest group" themselves as peers and mentors; patients; students; fellow practitioners; and lastly the identified spiritual/religious professionals to whom patients may be individually referred to in a specific geographic area. Spiritual-religious professionals will – according to the core concept - equally include the full spectrum of traditions and belief systems, such as African traditional, atheist, Buddhist, Christian, Hindu, Humanist, Islam, Jewish, "New Age".

3.2.4.4 Context [C]

The context in which the activity of incorporating of the role of defined spirituality is performed, is the importance of spirituality for people in general and that an increased importance has also been observed in secular areas such as the medical, health and mental health care environment. Local South African psychiatry as a clinical discipline operates within prevailing professional, academic and service delivery conditions, in which the current practice of, and training, in the profession occurs. Psychiatrists in this context have to provide specialist psychiatric services to a spiritually diverse, heterogeneous local population from various socio-cultural backgrounds and religious traditions.

3.2.4.5 Dynamic [D]

The dynamic (energy source) for the activity to incorporate the role of defined spirituality operates as "driver" or incentive for the strategies and activities of the Procedure [P]. The dynamic is considered to be a combination of the following factors:

- the inherent importance that people attach to cultural requirements and their religious beliefs, regardless of psychiatrists' personal decisions or positions in this regard;
- the accumulation of unresolved empirical problems within the current clinical management of serious mental disorders (such as the extent of concurrent use of

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alternative remedies/healing methods by the users of mental health care services, the extent of non-compliance with psychiatric medication due to poor insight, to side-effects and poor treatment response, the chronic and recurrent nature of many psychiatric disorders; and due to stigma related reasons);

- the ideal of holistic and integrated clinical care within a person's or community's particular socio-cultural-religious tradition;
- the objective of meaningfulness and an element of healing for patients in the treatment experience (as opposed to merely mechanically diagnosing and treating symptoms of illness); and
- the objective of continued ethical and professional practice of specialist psychiatry.

3.2.4.6 Outcomes [O]

While outcomes would be achieved according to the three progressing procedural phases that have been identified (awareness, acknowledgement and integration), different anticipated outcomes of the activity of incorporating the role of defined spirituality must be identified for the different receivers:

- integrated living and working of members of the interest group themselves (spiritual awareness, personal growth, appropriate knowledge and skill);
- integrated care of patients (spiritual awareness, personal growth, insight into mental illness, stigma reduction, improved compliance and outcome);
- integrated training of students (spiritual awareness, personal growth, knowledge/skill);
- integrated ethical and professional practice of fellow practitioners (spiritual awareness, personal growth, appropriate knowledge and skill); and
- integrated collaboration with spiritual professionals (insight into mental illness and psychiatric practice; advocacy and community support, stigma reduction).

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SUMMARY SECTION 3.2

In this section, the denotative and connotative meaning for the elements of the single core concept was established. Considering the meaning of these elements, definitions of spirituality and of the identified core concept were formulated. A model case was used to demonstrate the core concept's possible practical application. Finally, a categorisation of the elements of the core concept was made in terms of: agents(s); receivers; procedure; context; dynamic; and outcome.

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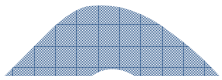
CHAPTER 4. RESULTS II: MODEL CONSTRUCTION, DESCRIPTION AND EVALUATION (STEPS 2 TO 4)





CHAPTER 4. RESULTS II: MODEL CONSTRUCTION, DESCRIPTION AND EVALUATION (STEPS 2 TO 4)

> "tree (trē) n. 1. A usually tall wooden plant, distinguished from a shrub by having comparatively greater height and characteristically, a single trunk rather than several stems; arboretum (är'bə-rē'təm) n., *pl.* – tums or –ta (-tə). A place for the scientific study and public exhibition of rare trees. [New Latin, from Latin *arborētum*, a place grown with trees, from *arbor*, tree. See arbor (shaft).]; arborescent (är'bə-rēs'-ənt) *adj*. Having the form or characteristic of a tree; treelike. [Latin *arborēscere*, to grow to be a tree]." The American Heritage Dictionary of the English Language (2003)

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INTRODUCTION TO MODEL DEVELOPMENT

The title of the proposed model described in this chapter is: *"The role of defined spirituality in local specialist psychiatric practice and training".* The chapter is divided in three sections. **Section 4.1 (Relationship statements – Step 2)** represents the second step in theory development. **Section 4.2 (Description and evaluation of model – Step 3)** represents the third step of theory development. The model is described in terms of: purpose; concepts; definitions of these concepts; relationships between concepts; the structure of the model; and the assumptions made. The chapter concludes with **Section 4.3 (Operational guidelines – Step 4)** - the final step.

4.1 RELATIONSHIP STATEMENTS (STEP 2)

This phase of theory development for the model: *"The role of defined spirituality in local specialist psychiatric practice and training"* involved the description of the linkages

STEP 2*
RELATIONSHIP STATEMENTS

(Hardy, 1986)

between and among concepts, resulting in a formal theoretical structure. In addition to the semantics (meaning of concepts) of theory that was discussed in Chapter 3, the syntax of theory discussed in this section, forms the other component and provides the structure of the model.

4.1.1 CORE CONCEPT AS PROCEDURE

The core concept identified and defined in Chapter 3 operates - in terms of the model - as the "Procedure" (paragraph 3.2.5.2), according to the categorisation of Dickoff, James and Wiedenbach (1968a). The defined core concept consists of two distinct parts (paragraph 3.2.2). The first part - "incorporating the role of defined spirituality into the existing bio-psycho-social approach to local practice and teaching of specialist psychiatry" - is very specifically counterbalanced by the other part through a distinct proviso. Only if the second part - "within specific professional and ethical boundaries, while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society equally" - is introduced, can the first part be introduced. This is a strict concurrent relationship ("If A, also B") (Hardy, 1986).

The progressive phases or steps (awareness, acknowledgement and integration) in which the counterbalanced core concept of ("incorporation..., but within...") is expected to develop, may have a number of different relationships relative to each other. It could be in time order ("If A, later B"), probabilistic ("If A, probably B") or concurrent ("If A, also B") (Hardy, 1986). For example, if awareness is achieved, acknowledgement may follow (time order). Or if awareness is achieved, acknowledgement may probably follow (probabilistic). With the eventual achievement of integration, all three (awareness,

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acknowledgement and integration) may be operating concurrently. A conditional relationship between the three can also be envisaged ("If A - awareness, then B - integration, but only if C - acknowledgement"). Acknowledgement may also be regarded as a prerequisite for integration ("If A and only A, then B").

4.1.2 DEFINED SPIRITUALITY

A very strict provisional or "necessary" relationship, ("If A and only A, then B") exists between the construct of "defined spirituality" and all the other concepts or activities (Hardy, 1986). Unless, as a first step, spirituality is clearly defined and consensus is achieved on its meaning for a particular individual, group or situation, continuation with any other activity may prove to be very challenging. The process of defining spirituality may require extended facilitation and effective communication to address anticipated disagreements.

4.1.3 ALL TRADITIONS EQUALLY

The incorporation of a spiritual element into the existing approach to psychiatry should only occur if it can accommodate all faith traditions or belief systems equally. If this can not be achieved, then the incorporation of spirituality in specialist psychiatry - whether defined or not - should not be considered in terms of this model. This would be a strictly conditional relationship: if "incorporation" (A), then "within professional scope and ethical guidelines" (B), but only if "all traditions/beliefs equal" (C). The concept of a multi-cultural, multi-religious and spirituality varied population exists in the context of the environment in which specialist psychiatry is being practised and trained. As an environmental factor it can thus also be stated, that according to the model, if all traditions and belief systems are not equally accommodated, then "Agent" (interest group), as well as the five "Receiver" groups (self, patient, student, practitioner, spiritual professional) should not have a relationship with regard to this construct.

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4.1.4 AGENT AND RECEIVERS

In order to establish the model even more clearly within the concepts derived from the interviews and literature content, in this paragraph relationships are identified between the final categories and subcategories of concepts (paragraph 3.1.2.3), and the single defined core concept that was identified from the interpretive narrative on these categories (par 3.1.3). According to the categorisation of the elements of the core concept in terms of the survey list of Dickoff, James and Wiedenbach (1968a), as summarised in Figure 3.1, the final categories of concepts relate mainly to the activity or Procedure (paragraph 3.2.4.2), that occurs between the Agent (paragraph 3.2.4.1) and Receivers (paragraph 3.2.4.3). For this reason all relationships between Agent and the different Receivers 1 to 5 will also correspond with, influence, or be influenced by, the three anticipated progressive steps (awareness, acknowledgement and integration).

4.1.4.1 Agent and Receiver 1

The first final category of concepts identified from the integrated content of the interviews and the literature was "Orientation in terms of spirituality and religion in psychiatry" consisting of five subcategories": own view and position towards spirituality: academic view of medical science and of patients; providers' perspective; and principles in practice: history and philosophy; and definition of spirituality and religion/concepts and definition (Table 3.3). These categories inform the relationship and the activities that transpire individually and collectively in and between the Agent (interest group) and themselves as Receivers (1).

The second final category "Reality of spirituality and religion for practitioners and users" relates to both Agent (interest group) and themselves as Receiver 1, and to the Agent (interest group) and Receiver 2 (patients). The second category has three subcategories: extended model of care: "bio-psycho-social-spiritual"; principles in practice: approach; and users' perspective (Table 3.3).

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4.1.4.2 Agent and Receiver 2

The Agent (interest group) and Receiver 2 (patients) relate to both the second category (see above) and the third category of concepts. The third final category (”Routine assessment of spirituality and religion in psychiatry”) consists of five subcategories: need assessment; communication and appropriate intervention; liaison and referral; presentation and symptoms; and assessment, measurement and research (Table 3.3).

4.1.4.3 Agent and Receiver 3

The Agent (interest group) and Receiver 3 (students) relate to the fourth final category of concepts. This category (”Training of spirituality in psychiatry”) has four subcategories: understanding of spirituality and its role in mental health care; didactic learning on spirituality and religious faith traditions; approach towards spirituality and religion in psychiatry; and personal growth, professional development and competency (Table 3.3).

4.1.4.4 Agent and Receiver 4

The Agent (interest group) and Receiver 4 (practitioners) relate to the fifth final category of concepts: “Scope and boundaries of spirituality in psychiatry”. The four subcategories are: ethics of spirituality in psychiatric practice; principles in practice: ethics; continued education and peer review; and psychotherapy (Table 3.3).

4.1.4.5 Agent and Receiver 5

The Agent (interest group) and Receiver 5 (spiritual professionals) relate to the sixth final category of concepts “Referral and collaboration on spirituality in psychiatry” with five subcategories: facilitating appropriate referral and intervention for individual users; information sharing and mutual awareness between disciplines; addressing stigmatization of users with psychiatric conditions; religious/spiritual traditions; and spiritual

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professionals' perspective (Table 3.3). The relationship between the Agent and Receiver 5 is probably mostly conditional: "If integration (A) - including awareness (knowledge) of specialist psychiatry by spiritual professionals - then collaboration (B), but only if on request and after discussion with patient (C)."

4.1.5 CONTEXT

The importance of spirituality and religion in the secular areas of health, mental health and psychiatry was the original phenomenon that was observed and which motivated the undertaking of this explorative, descriptive study. The relationship between the construct of specialist psychiatric practice and training (paragraph 3.2.1.3) with the medical, health and mental health environment in which it occurs (paragraph 3.2.4.4), is concurrent (If A, also B). Specialist psychiatry will therefore be consistently affected by the prevailing conditions in this environment, especially in terms of the "bridge" or boundary (gateway) position that it occupies in the topography of this environment, as discussed in paragraph 3.1.3 (p169). As constructs, the relationship between psychiatry and its medical, health and mental health environment seems to be time ordered, concurrent or even symmetrical.

4.1.6 DYNAMIC

The different dynamic factors (as identified in paragraph 3.2.4.5) drive the activity and provide incentive and energy to all relations between activities. The first factor (the essential role of spirituality in the lives of people in general and of patients and their families, irrespective of psychiatrists' personal decisions or positions in this regard) exists in the environmental context in which specialist psychiatry operates and is independent from either the interest group's (as Agent) or other practitioners' (Receiver 4) own position on spirituality and religion. This may be described as a "sufficient" relationship: "If A (the

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role of spirituality in the lives of people), then B (defined spirituality should be considered for incorporation to the current approach to psychiatry), regardless of anything else".

The second dynamic factor (the accumulation of unresolved empirical problems within the current clinical management of serious mental disorders) also exists as a reality in the context in which psychiatry operates. This may suggest a possible symmetrical relation in terms of the model's structure ("if A - incorporation of spirituality, then B - fewer unresolved empirical problems"). It may however be difficult to demonstrate and in fact, remain asymmetrical ("If A, then B; but if no A, no conclusion about B"). This could be explored through future hypotheses testing about this factor's possible relations.

The ideal of holistic and integrated clinical care within a person's or community's particular socio-cultural-religious tradition (third dynamic factor), may have a probable relationship with the incorporation of defined spirituality (If A, probably B). It may also be time ordered (if A, later B) or concurrent (if A, also B).

These different relations may also apply to the remaining two dynamic factors: the objective of meaningfulness and an element of healing for patients in the treatment experience; and the objective of ethical and professional practice of psychiatry. The latter concept of ethical standards and guidelines for practice has, however, already been discussed as part of the main concept and should therefore essentially be regarded as having a concurrent relationship with the incorporation of the role of spirituality.

4.1.7 OUTCOME

The different outcome factors were described in paragraph 3.2.4.6. The relationship that the five outcome constructs (integrated living and working, integrated care, integrated teaching, integrated practice and integrated collaboration) may have with the collective

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activities that take place in terms of the model, may be probabilistic, time ordered, symmetrical, or even conditional.

4.2 DESCRIPTION AND EVALUATION OF THE MODEL (STEP 3)

The type of model proposed in this study is an analogous model (Hardy, 1986). As discussed in the previous paragraphs, a strict concurrent relationship exists between the two parts of the model's core conceptualisation of the integrated interviews and literature content. An analogy that adequately represents this inherently counter-balanced relationship, is the metaphor of the highly sophisticated counter-balanced two-way transportation systems that plants and trees have developed to transport water, nutrients, hormones and waste products up and down from one part (the base) to another (the top part).

STEP 3 *
DESCRIPTION AND ANALYSIS OF MODEL

Analogue model (Hardy, 1986)

4.2.1 DRAFT MODEL PRESENTED TO PANEL OF EXPERTS

A draft model for *"The role of defined spirituality in local specialist psychiatric practice and training"* was presented to a panel of experts for evaluation **(Appendix 4.1 Draft model presented to evaluating panel).** This panel consisted of model building experts, as well as of invited senior academic psychiatrists.

The colours in the model, as well as full or perforated lines represent specific attributes and dynamic. The draft model consists of domes of semi-circles representing the visible ("above ground" - green) and invisible ("subterranean" - brown) parts of the activity of practising and teaching specialist psychiatry in South Africa. These semi-circles are placed within the context of blue encircling "water-cycle" arrows and an environmental space of psychiatry in the medical and health environment. The arrows which flow in a

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circular course right around the domes represent the context of spirituality that accommodates all spiritual-religious traditions equally. Through an underground permeable membrane (represented by a thicker perforated line), awareness - as the first step in the incorporation of spirituality into specialist psychiatric practice and training - is "absorbed" through the subterranean (brown) semi-circles and embodied by the members of the interest group practitioners who will act as role models, mentors and peer reviewers. This dynamic of "negative pressure" (absorption) is indicated by the absence of colour.

As spirituality is incorporated on this subterranean (awareness) level, the upward pull of the negative pressure dynamic ("water transportation") continues and the blue colour becomes more intense as the arrows reach towards the top. Five blue upwardly pointing arrows progress into and through the green "middle ground" in order to appear (visibly) on the surface above the ground. This middle (green) section represents a harder surface crust to negotiate, as this second step (acknowledgment) is anticipated to be a more challenging part of the incorporation, in particular, to obtain official acknowledgement in policy positions and documents on service delivery and content of training from relevant academic, service and professional structures. This process eventually breaks through this "meniscus" of official recognition into the third step (integration) of practical incorporation - the outer blue semi-circle, which continues within a blue encompassing context and environment towards the ongoing reality of integration in day-to-day practice and training.

At the same time - from the central core which represented the models' dynamic or driving forces (dark orange inner dome) - five orange, downward pointing arrows accumulate more colour towards the bottom, as the downward positive pressure element of the driver incentives is initiated. These driving energies include: the reality of the essential role that spirituality plays in people's lives of clients and practitioners alike; the accumulation of a

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set of unresolved empirical problems within the current clinical management of serious mental disorders; the ideal of holistic and integrated care; and the additional desired attribute to actually provide "healing". As these energies accumulate the arrows pass downwards, acting as the counter-balancing forces for the upwardly reaching blue arrows, representing the setting of appropriate ethical and professional boundaries for the concurrent process of incorporating spirituality into the current approach to specialist psychiatry.

The different tones of brown and green of the (visible) upper semi-circles account for the five different "receivers" of activities related to the procedure to incorporate spirituality. The first category is the interest group practitioners themselves, then their individual and collective patients, their students, fellow practitioners and spiritual professionals they may refer to. The expected five-fold outcome (different tones of green) of achieved incorporation of spirituality is: integrated living and working (for interest group members); integrated care of patients; integrated training and spiritual competency of undergraduate and postgraduate students; integrated ethical practice of fellow practitioners; and integrated collaboration with spiritual professionals equally across the spectrum of traditions. As indicated by the thicker blue, perforated line of the outer semi-circle (Step 3 - integration), the result of all these processes remains in a continuous communicative relationship and functions within the context and environment (medicine and health), as if continuously completing breathing cycles through a permeable pulmonary membrane to the atmosphere.

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4.2.1.1 Critique by panel members

During the discussion of the draft model, members of the evaluating panel demonstrated differences amongst themselves and discomfort about the issue of spirituality versus religion. They also engaged in exchanging different personal views and opinions about spirituality and religion, as influenced by their individual perspectives and orientation, with

roots in their own acquired subjective meaning and emotional experiences of these constructs. The discussion of the evaluating panel was transcribed **(Appendix 4.2 Transcription of evaluating panel review)**. An analysis and summary of the critique by panel members was made.

(1) **The first panel member (PM1)**

(1.1) Identified a problem with regard to the one statement (of the core concept) "that spirituality should be incorporated into specialist psychiatry", in that it was too encompassing and that it did not seem to account (in particular) for the negative and pathological aspects or problematic areas such as the practice of driving (beating) out demons or the experience of hearing the voices of one's ancestors. Some of these practices (e.g. female circumcision) may be in direct contradiction of what scientific, humane psychiatry is suppose to be about. This type of clarity must be achieved before anything can be discussed or taught formally. More themes from the interviews should be recognisable in the core concept of the model.

(2) **The second panel member (PM2)**

(2.1) Suggested that borderline case(s) of real life scenarios may be useful to demonstrate the contexts which the model tries to address.

(2.2) Acknowledged the attempt to address an increasing but marginalised discourse (the taboo of considering or discussing religion or spirituality in a clinical psychiatric setting).

(2.3) Emphasised the importance of clarifying boundaries and definitions. The view was expressed that too much emphasis was put on religion as opposed to spirituality. It appeared from the presented figure of the model, that spirituality was being equated with religion.

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(2.4) Suggested that more clarity and differentiation must be provided in describing the "agent" and "dynamic" of the model in terms of the terminology of Dickoff et al.

(2.5) Advised that participants in interviews should not be referred to in terms of their religious group.

(2.6) Suggested that literature other than medical literature could have been used as well (religious literature, popular psychological).

(2.7) Advised that open-mindedness should be central to the model.

(3) **The third panel member (PM3)**

(3.1) Identified the increasing challenge to train and teach these concepts the more one moves away from the biological to psychological concepts to socio-cultural and spiritual concepts.

(3.2) Asked how (positive) spirituality actually differs from psychotherapeutic principles that are already incorporated in current practice should be clearer.

(4) **The fourth panel member (PM4)**

(4.1) Expressed unease about the impression that what was presented did not address local African traditional diviners/healers, but in fact had a strong underlying element of a Christian agenda to it. Perceived tension was described between trying to introduce Christian ideas and values into psychiatry and dealing with African traditions. The opinion was expressed that this Christian undertone was being covered up, rather than dealing with people who have alternative faiths and how to deal with them in psychiatry.

(4.2) Suggested that links between the original interviews, their interpretation, the analogy that was used and the eventual model should be made (much) more apparent.

(4.3) Expressed more unease with the progression of the perceived argument that: first, academic psychiatrists should recognise the importance of spirituality; second, that spirituality should therefore be included in teaching and practice; and

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thirdly, that treatment will then be more holistic (with actual spiritual/religious practice part of the psychiatric treatment) and in fact, with the psychiatrist actually leading the person to religion ("through a bit of Bible-reading or maybe something else") if patients were not responding well to standard treatment, or when they were not already "struggling" with religion. This was regarded as being a normative argument, being covered up with (inadequate) scientific discourse.

(4.4) Suggested that an alternative question should rather be the focus of attention: "What does Western psychiatry have to do to deal with (spirituality) in a more holistic way?"

(5) **The fifth panel member (PM5)**

(5.1) Concluded that the reason for the apparent lack of clarity of the presented model would be addressed by excluding all references to "religion" and that all definitions and conceptualisations should focus on "spirituality" only. Attributes such as awareness, mindfulness, "living in the here and now", consciousness and internal locus of control should be central to the understanding of the construct.

(6) **The sixth panel member (PM6)**

(6.1) Concurred that in the presentation spiritually was deemed to be equated to religion, which created confusion and difference.

(7) **The seventh panel member (PM7)**

(7.1) Expressed doubt that the intent of the model (or with the study) was to attempt to hide the covert incorporation of Christianity into the practice and training of psychiatry.

(7.2) Suggested that identifying common themes from the literature on different faith traditions might achieve a solution to the perceived problem. The ascendance in neuroscience of research on the interface of (psychological) experience, stress and biology should be taken into consideration.

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4.2.1.2 Review of model

The following adjustments were made according to reviewer's comments and recommendations.

- *[Critique (2.3), (5.1) & (6.1)]:* The title of the model was changed to *"The role of **defined spirituality** in local specialist psychiatric practice and training"* due to significant procedural problems regarding the definition of spirituality. Problems with the definition of spirituality and religion and difficulties in terms of opinions and perceptions about the differences and similarities between the two constructs were experienced since the conception of this project, through the processes of assessment and review of the protocol, to the process of the assessment of the draft model by the evaluating panel. A specific relationship statement in this regard was also added (paragraph 4.1.2). In addition, the first operational guideline for the implementation of the model states that in any practice-orientated scenario where the role of spirituality may be considered, that spirituality as a construct should be defined as a first step (paragraph 4.3.1 p271, Tabel 4.1 p269, Figure 4.7 p 270).
- *[Critique (1.1), (4.2); (7.1)]*: The model was grounded more clearly to the main themes from the integrated interviews and literature content and to the identified final categories and subcategories of concepts (paragraph 4.1.4)
- More attention was given to the description and orientation of the Agent and of the Dynamic, as more subtle relationships and influences were involved (paragraphs 3.2.4.1, 3.2.4.5, 4.1.4 and 4.1.6).
- *[Critique 2.1]*: A model case was constructed to demonstrate a real life context.
- *[Critique 4.4]*: Cognisance was taken of panel member PM4's last statement and question "What does Western psychiatry have to do to deal with (spirituality) in a more holistic way?"

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4.2.2 DESCRIPTION OF FINAL MODEL

The model is described here referring to certain set guidelines (Chinn & Kramer, 1995).

4.2.2.1 Overview

How the botanical analogy of the two-fold positive and negative pressure of the transportation systems of water and nutrients of trees applies to the core concept of the model "*The role of defined spirituality in local specialist psychiatric practice and training*", is demonstrated in Figures 4.1 and 4.2. The xylem water transport system of trees consists of cells which, once they reach their predetermined size and form, die to leave a thick cellulose cell wall forming a rigid empty pipe through which water can move without interruption. Phloem also consists of distinct cells which are the principal cells through which nutrients are transported, but in contrast to xylem, has extremely thin and permeable walls.

The tree itself represents firstly the profession of specialist, evidence-based psychiatry as a clinical discipline and its existing bio-psycho-social approach to practice and training, within the environment of mental health, health in general and clinical medicine. On a subsequent level, the tree and its two-way transportation systems also represent an individual psychiatrist and his/her (individual) patient, student, peer member or the individual spiritual worker referred to. It can also represent how psychiatry is being practiced and taught in the context of a particular training or service delivery scenario or tradition (on facility, regional or national level). The "environment" (or climate) of a particular scenario (academic, service delivery or professional), may be more or less conducive to sustaining a "tree" of collectively practised psychiatry, or of an individual psychiatrist as a "tree".

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For this model, the identified two-part two-directional single core concept was equated with the Procedure [P] activities according to the Dickoff et al., (1968a) description of fourth level theory (paragraph 3.2.4.2). The first part of the model's core concept [P1] – "incorporating the role of defined spirituality into the existing bio-psycho-social approach to local practice and training of specialist psychiatry" – as the upwardly directed blue arrow, is represented by the forces and processes involved in the xylem's upwardly negative pressure transportation system (Figure 4.1). The counterbalancing part of the core concept [P2] – "within specific professional and ethical boundaries, while accommodating the knowledge of all cultural-religious traditions and belief systems equally" – as the intersecting downwardly directed orange arrow, is represented by the forces and processes involved in the phloem's downward pushing positive pressure transportation system (Figure 4.2). The fact that these two processes must be in balance and equilibrium relative to each other, is the core principle of this model. If these internal mechanisms can not be sustained through its carefully maintained counter-forces, the integrity of the tree as a living and growing organism will be by definition compromised. By implication, the absence of either one of these two essential forces (pressure systems) will render it impossible for the tree to survive in the first place. The incorporation of the roles of defined spirituality is understood to occur in progressive steps, which represent the tree's growth and reproduction in seasonal and annual time cycles: Step 1, Awareness (brown); Step 2, Acknowledgment (green); and Step, 3 Integration (blue).

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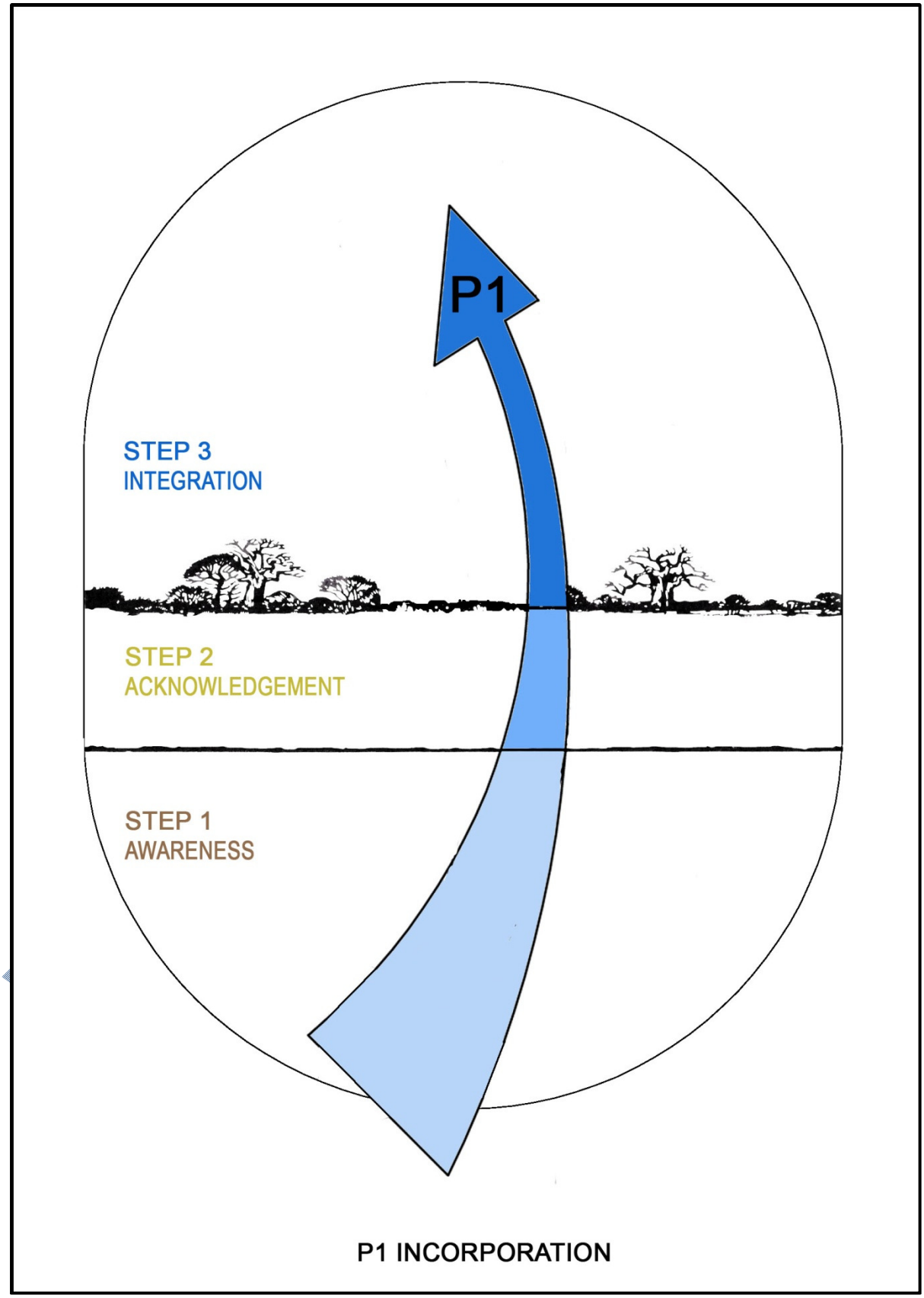

Figure 4.1 Incorporating defined spirituality into the existing approach to local specialist psychiatry

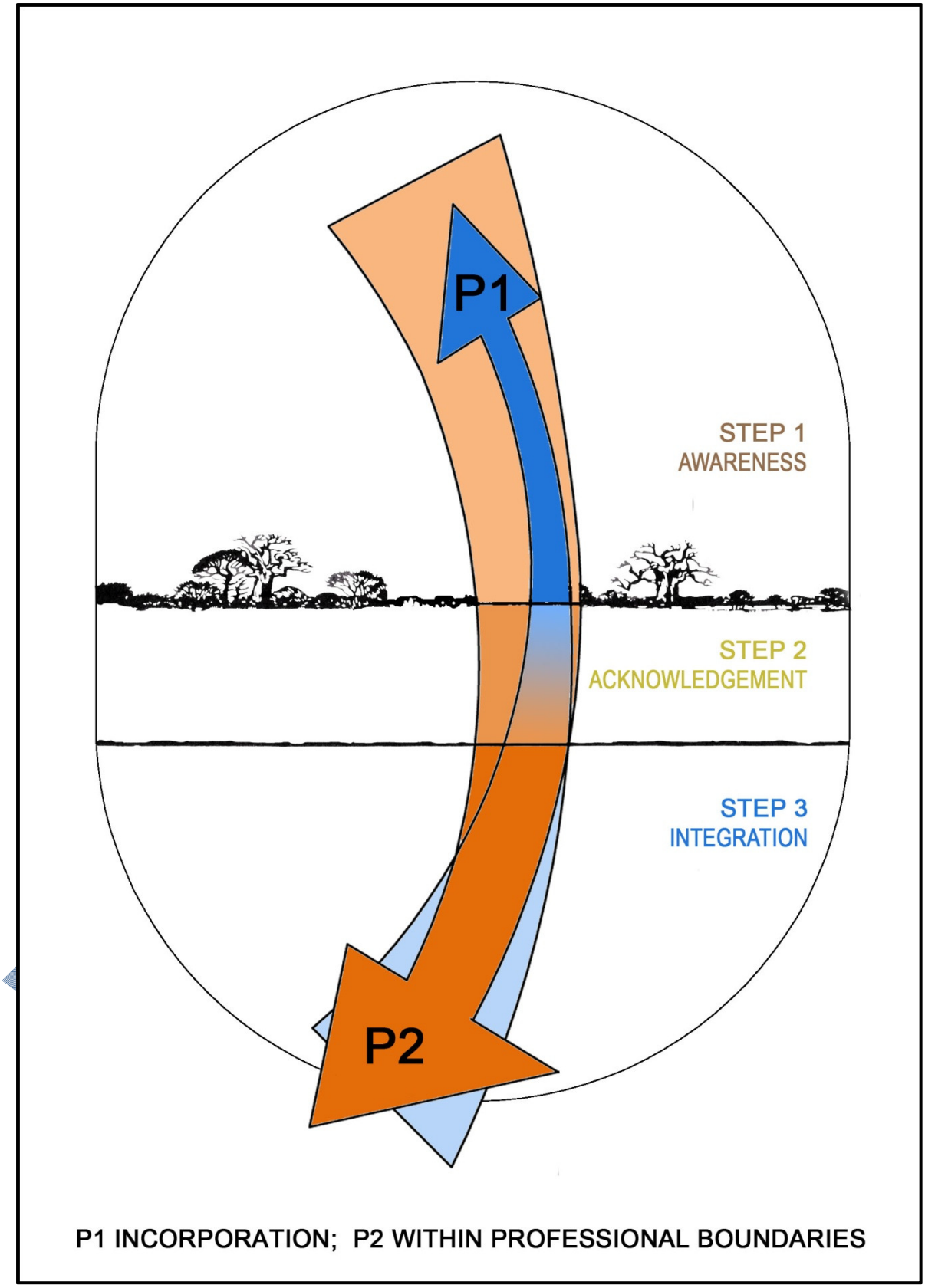

Figure 4.2 Incorporating defined spirituality into the existing approach to local specialist psychiatry, within specific professional and ethical boundaries, while accommodating all traditions equally

The progressive process of incorporation of spirituality's role from and to the Agent [A] and the Receivers [R] components of the model, involves the interest group as mentors/role models themselves (R1), as well as their patients (R2), students (R3), fellow practitioners (R4) and the spiritual professionals (R5) to whom psychiatrists may refer. The Context [C] in which the activity of incorporating the role of defined spirituality is performed (paragraph 3.2.4.4), is the importance of spirituality for people in general, and that an increased importance has also been observed in secular areas such as the medical, health and mental health care environment. The relative relationships of the identified survey list components/activity of prescriptive theory (Dickoff et al., 1968a), in context of the observed importance of spirituality in secular areas such as health, are represented in Figure 4.3. The different environmental components in this context can be described as follows.

- Water (blue encircling space) represents the different but equal spiritual-religious traditions or positions. This spectrum includes African traditional, Buddhist, Christian, Hindu, Muslim, Jewish, New Age, Shamanistic, as well as humanist and atheist/agnostic belief systems.
- Sun (Dynamic [D]) represents the dynamic energy (orange) that would animate the step-wise procedure and all activities (paragraph 3.2.4.5): the essential role of spirituality in the lives of people; accumulation of unresolved empirical problems; the ideal of providing holistic and integrated care; the objective of meaningfulness and acquiring the attribute of "healing" on personal and collective levels; and the objective of ethical and professional practice of psychiatry.
- Soil (brown) represents the allocated space and domain of psychiatry with its unique role and position, while also alluding to the physical, financial and emotional resources necessary to practise the discipline in different environments.
- Atmosphere (white and blue) represents the routine interaction in different settings with the discipline of psychiatry, as a valued and interactive part in the landscape of clinical medicine, health and mental health care provision.

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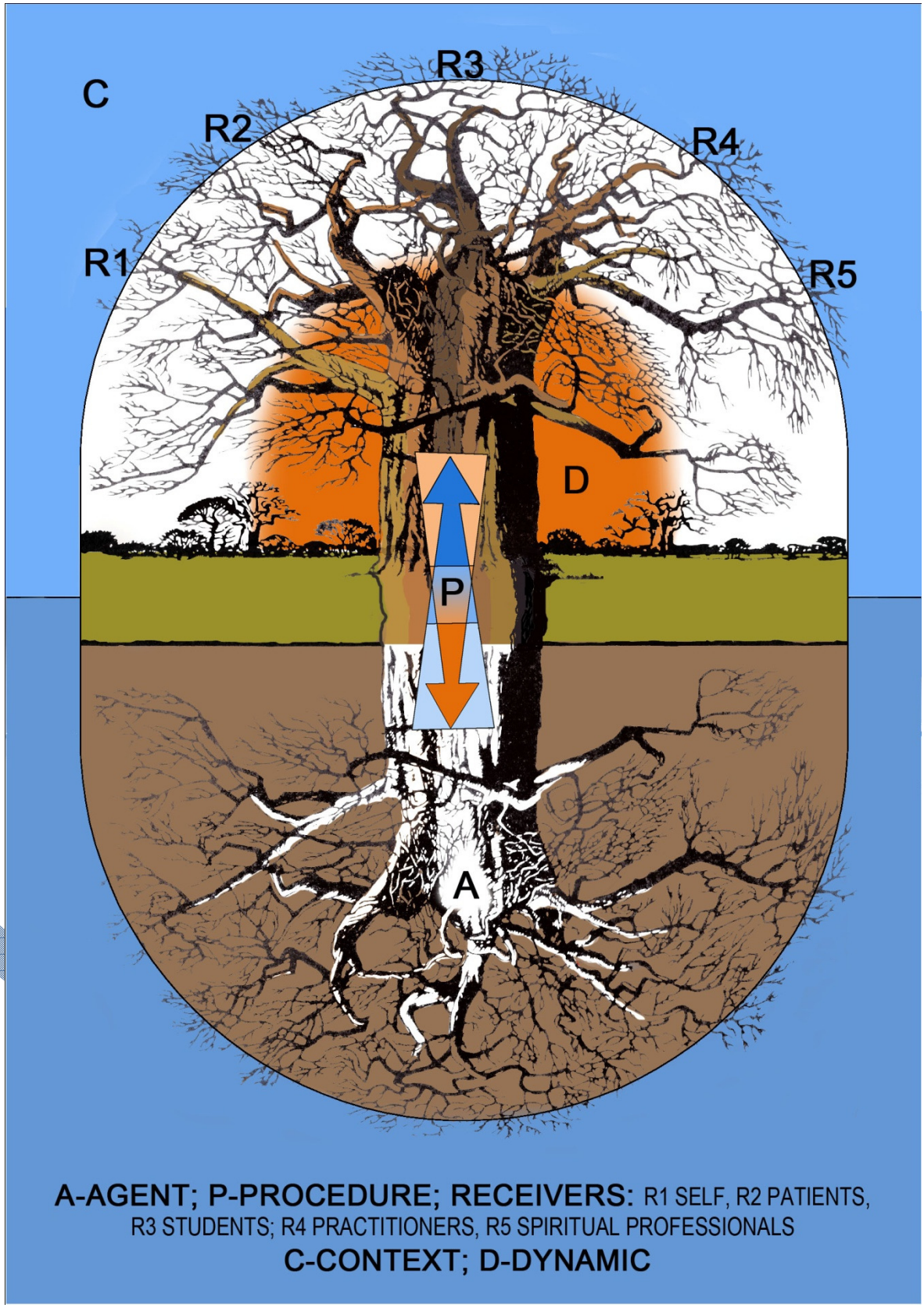

Figure 4.4 **Relative relationships of identified survey list components in context of the importance of spirituality in secular areas such as health**

The horizon and landscape represent the outcome of the incorporation of the role of spirituality into the area of "psychiatry in the medical, health and mental health environment" (outer yellow band). Through growth and reproduction - representing the three progressive steps of the two-directional counter-balanced Procedure [P] (intersecting blue and orange arrows) - the Outcome [O] of activities is accomplished when (in time) the role of defined spirituality is appropriately incorporated into the existing bio-psycho-social approach to local South African specialist psychiatric practice and training (paragraph 3.2.4.6). The changed horizon and landscape now consists of five outcomes associated with the five Receivers [R]: the integrated life and work of interest group members themselves [O1]; the integrated care of patients [O2]; the integrated training of students [O3]; the integrated practice of practitioners in general [O4]; and integrated collaboration with spiritual professionals [O5].

4.2.2.2 Description according to Chinn and Kramer guidelines

The final model *"The role of defined spirituality in local specialist psychiatric practice and training"* is represented in Figure 4.4. The guidelines of Chinn and Kramer (1995) were used to describe the model. These guidelines include the following elements: purpose, assumptions, concepts, definitions, relationships and structure which are discussed below.

(1) **Purpose**

The purpose of this practice-orientated model is to describe the achievement of appropriate incorporation of the role of defined spirituality into the existing bio-psycho-social approach to local specialist psychiatric practice and training. The outcomes of the model are regarded as being the integrated life and work for the interest group practitioners, integrated care for patients, integrated teaching for students, the integrated care for practising psychiatrists in general and integrated collaboration with spiritual

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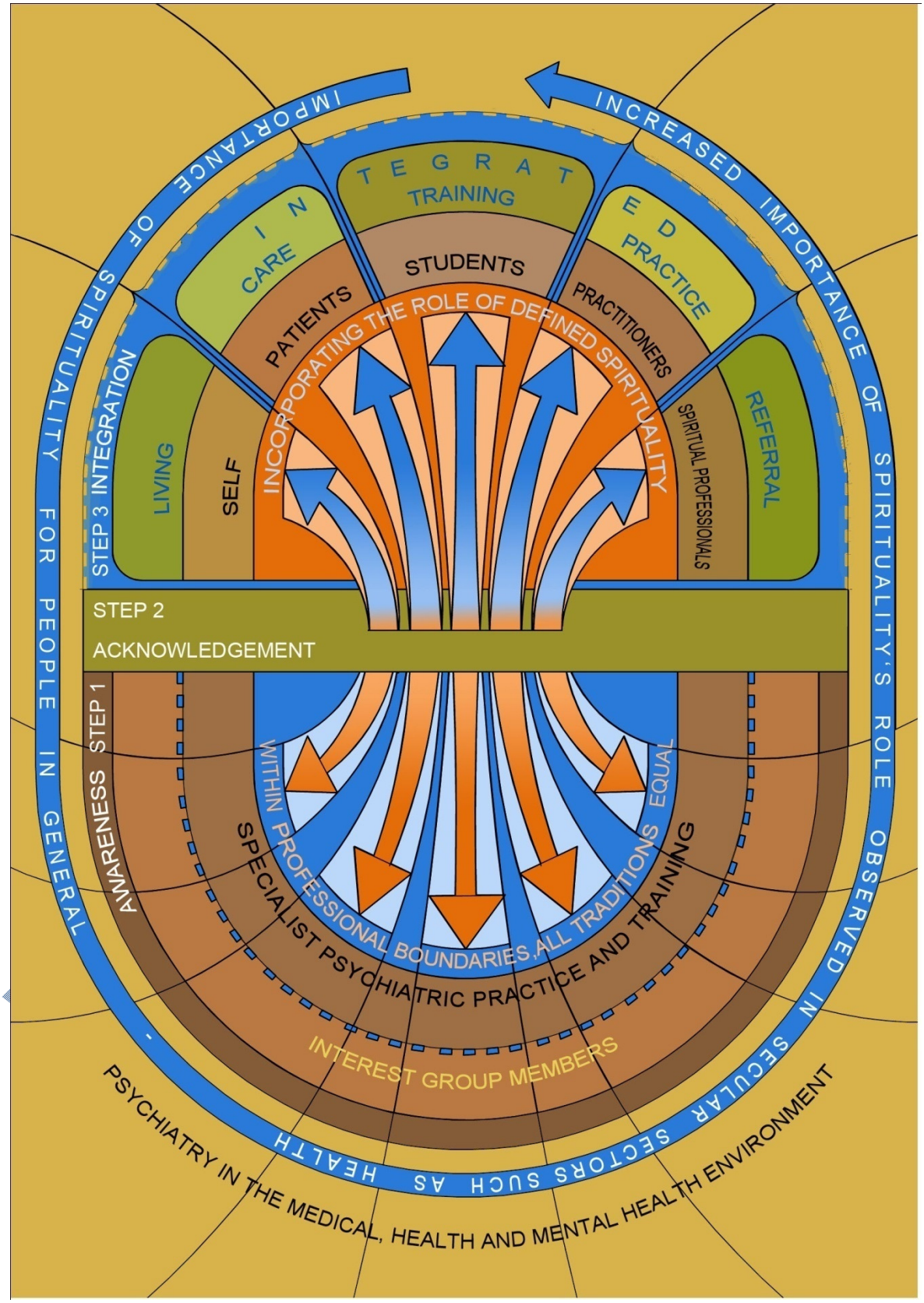

Figure 4.4 Model: "The role of defined spirituality in local specialist psychiatric practice and training"

professionals. As such, the model may initially contribute to facilitating awareness and capacity in the local discipline of psychiatry regarding the importance of the role of spirituality in the lives of people and patients in general, and currently also in the secular medical, health and mental health care environment. It may subsequently serve to inform the process of the formal acknowledgement of the role of spirituality in policy formulation by local teaching, professional and service delivery structures and to contribute to the eventual achievement of the appropriate practical integration of the role of spirituality in routine practice and training of specialist psychiatry.

Considering the Chinn and Kramer (1995) model description guidelines, it can be stated that a hierarchy of purposes may be identified for the different levels on which the model may be applicable. Examples of these are: local individual practitioners, patients, students and spiritual professionals; particular local care and training scenarios in a facility, regional or national context; and the local discipline of psychiatry as a whole. At least three separate purposes can be identified in parallel for service delivery, academic and professional structures. Within the context of these broader purposes, specific purposes can also be set for the different "receivers" of the model's activities: viz. members of the interest group, patients, students, practitioners and collaborating spiritual professionals. Purposes can thus be set more specifically according to the particular level or context in which psychiatric practice and training take place, but also more broadly in terms of local, regional and national service delivery. An important value orientation for the purpose of the model is the equal accommodation of all different religious traditions and belief systems in the process without bias or preference.

The achievement of the purpose of the model requires and inherently occurs in a clinical context, as the appropriateness of and capacity for the incorporation of spirituality into day-to-day practice and teaching must be acquired through judgment and experience and should be counter-balanced with professional and ethical guidelines to clarify boundaries

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and scope. Another purpose of addressing the role of spirituality in specialist psychiatry may revolve around creating meaning and establishing understanding and respect. One resulting hypothesis from the model generation may be that the incorporation of the role of spirituality is essential for the profession to acquire the attribute of "healing" in its activities, in addition to just diagnosing and treating symptoms of (mental) illness mechanically. The theory may cease to be applicable if the assumptions for the model are different, or when the integration of defined spirituality has successfully been achieved in the practice and teaching of the discipline.

(2) **Assumptions**

Most definitions of spirituality in the reviewed literature and in the conducted interviews have assumed that the absence of the elements or attributes considered to be indicative of positive spirituality (such as empathy, compassion, joy, meaningfulness, etc.) merely represents an absence of spirituality. Although the potential negative attributes of religion have been referred to (and often contrasted with spirituality), the notion of being spiritual but with "negative" or destructive ("evil") intent has not been the point of departure. As the model was constructed from the concepts derived from these interviews and from this selection of literature, the following assumptions about spirituality underlie the model.

- Spirituality represents a constructive concept and it is worthwhile to consider the role of spirituality in specialist psychiatric practice and training because of the important role that it plays in the lives of people generally regardless of psychiatrists' own opinion or position in this regard;
- Inclusion of spirituality and religion in the assessment and management of patients in specialist psychiatry is essential to be able to determine its role in psychopathology and destructive behaviour.

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It is also assumed that:

- all spiritual/religious traditions will be afforded equal status and accommodation – including agnostic/atheist positions - without benefiting or promoting one particular position or view; and
- practitioners and students in their routine practice and training have to consider on a daily basis how to incorporate the role of defined spirituality appropriately within the scope and confines of the discipline.

(3) **Concepts**

From the main integrated story line and the final categories of concepts derived from the interviews and from the main themes identified from the literature, the single core concept for this model was identified as: "*incorporating the role of defined spirituality into the existing bio-psycho-social approach to local practice and training of specialist psychiatry, within specific professional and ethical boundaries, while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society equally*". The six categories of concepts from the interviews (par 3.1.1.4) and the nine categories of concepts from the literature (par 3.1.2.2), were amalgamated into an integrated set of six final categories (Table 3.3, p 148) that included: (1) orientation in terms of spirituality and religion in psychiatry; (2) the reality of spirituality and religion for practitioners and users; (3) routine assessment of spirituality and religion in psychiatry; (4) training of spirituality in psychiatry; (5) the scope and boundaries of spirituality in psychiatry; and (6) referral and collaboration on spirituality in psychiatry. Each category contains a number of subcategories, totalling 25 sub-categories.

These concepts were also put in order to relate and correspond with the different Receiver components of the model. Category 1 (orientation in terms of spirituality and religion in psychiatry) relates to Receiver 1 – the interest group member him/herself. Category 2 (reality of spirituality and religion for practitioners and users) relates to

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Receivers 1 (interest group members), as well as to Receivers 2 (patients). Category 3 (routine assessment of spirituality and religion in psychiatry) relates to Receiver 2 (patients). Category 4 (training of spirituality in psychiatry) relates to Receiver 3 (students). Category 5 (the scope and boundaries of spirituality in psychiatry) relates to Receiver 4 (fellow practitioners) and Category 6 (referral and collaboration on spiritual in psychiatry) relates to Receiver 5 (spiritual professionals).

All concepts could be interrelated and, while some concepts encompass the broadest philosophical aspects of the field, other concepts are practical and empirical. Abstract concepts include - for example - practitioners "own view and position towards spirituality" and "the definition of spirituality and religion", while practical, empirical concepts included "assessment, measurement and research", "didactic learning on spirituality and faith traditions" and "information sharing and mutual awareness between disciplines". The balance between abstract and more empirical and operational concepts covered the broad scope of the field of the role of spirituality in specialist psychiatric practice and training.

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(4) **Definitions**

The definition of concepts, in particular of spirituality versus religion or religiousness, was found to be an essential and indispensable aspect of the whole project. It was the first construct that all participants in the interviews had to define and clarify for themselves. The literature emphasized the fundamental importance of clarifying terminology, both for communication purposes and for clinical and research reasons (to assess, measure and compare different spiritual/religious variables). It is anticipated that in all the activities that may potentially follow from the operationalisation of this model, the definition of concepts will always be the first aspect to address.

All concepts were firstly explicitly defined through their dictionary meaning. Implicit meaning was derived from their connotative meaning as used in the subject literature. All elements of the core concept were defined in detail, including: “incorporate”; “spirituality”; “practice and training of specialist psychiatry”; “boundaries“; and “equally” (paragraph 3.1.1). Considering the derived denotative and connotative meaning for the construct, spirituality was defined as referring to:

> “*individual persons’ and societies’ progressive inner quality of transcendental awareness, their progressive inner journey towards understanding of ultimate questions, their progressive inner relationships or connectedness (with themselves, others, the natural world and a theist or atheist presence/source/principle beyond themselves) and their progressive inner capacity or consciousness concerning an unseen but vital, animating, life-defining principle, force or energy within, through which meaning and purpose are derived.”*

It was further concluded, based on this process of derived meaning, that the identified core concept *”incorporating the role of defined spirituality into the existing bio-psycho-social approach to local practice and teaching of specialist psychiatry - within specific professional and ethical boundaries - while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society equally”* refers to:

> *“uniting or forming the role of defined spirituality into the existing bio-psycho-social approach to the local performing and instructing of the particular branch of the medical study, diagnosis, treatment and prevention of mental illness – within specific professional and ethical parameters – while accommodating all cultural-religious traditions and belief systems in the heterogenous South African society on the same basis”.*

Essential and related criteria for each core concept element were summarised in paragraph 3.2.2 and Table 3.9. In this paragraph, the essential criteria were also defined

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for “religion”, “unite”, “perform”, “instruct”, the definition of psychiatry as “the particular branch of the medical study of diagnosis, treatment and prevention of mental illness”, “parameter” and (the) “same”. Circumstantial meaning was derived from the “model case scenario” that was constructed. No concepts were defined contrary to common convention.

(5) **Relationships**

The major relationships within the model exist between:

- the two-way counter-balancing processes (incorporation but within set professional and ethical boundaries) within the “procedure” itself;
- the Agent and the five different Receivers;
- the discipline of psychiatry (as a system with its role players) and the context of academic, service delivery and professional structures (in the medical, health and mental health environment); as well as
- the discipline of psychiatry (in the medical, health and mental health environment) and the spectrum of the spiritual/religious traditions and beliefs systems in the population that it serves.

The task of psychiatry remains that of identifying and treating psychopathology. As such, the discipline of psychiatry continues to operate as a “gateway” or “gate keeper” in respect to its relation to clinical medicine on the one hand and the social disciplines and religious domain on the other. This gate-keeping position or function can vary between that of being a “permeable membrane” or an “impenetrable barrier”. The attributes of these relationships included concepts such as professional and ethical boundaries and equal accommodation (of all religious traditions/belief systems). Several concepts are included in multiple, flexible relationships and a progression of relationships exists in the three steps of the process of incorporation. All the relationships are directional, including the important two-way and counter-balancing relationship of the dual “procedure”, as well

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as cyclical (for example, the encompassing relationship of the spiritual domain – albeit in terms of different religious traditions or belief systems) impacting on the whole of the medical and health environment and on individual and communal practitioner(s).

(6) **Structure**

The two-directional nature of the central core concept is represented by a counter-balanced two-directional flow, resembling the dynamic that exists between these conceptual constructs (Figure 4.4). The overall structure of the model consists of two semi-circular domes divided by a central band, with the upper dome mirrored by the lower dome. Thin connection lines from below attached to the tails of upwardly pressing arrows, "absorb" influence from the surrounding blue contextual-arrow. The latter refers to the encircling importance of spirituality in general and the observed phenomenon of its increased importance also in secular areas such as health and mental health. In the same flow of movement, connection lines leave the (indented) upper outer dome - as if through "pores" - to re-connect again within the medical, health and mental health environment. Typical of boundary structures, the interface line of the lower dome (between the "interest group members" and the rest of the specialist psychiatric fraternity) is perforated. Likewise, the interface line of the outer (upper) dome is also perforated. These perforated lines (permeable membranes) emphasise the importance of transfer passages and of the question about "what is allowed through and what not" (definition of concepts and content, within the scope of professional and ethical boundaries). There is an overall element of flowing or "breathing" in the structure. The structure balances the focus from and towards the initiating role players and outcome activity (lower dome) towards the different outcomes of integration - integrated living and working, care, training, practice and referral (upper dome). The structure reinforces the idea of adding members to the interest group ("reproduction"), once the appropriate incorporation of the core concept of the model has been achieved, while suggesting the potential to change some of the features of the

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horizon and landscape of psychiatry in the medical, health and mental health environment.

4.3 OPERATIONAL GUIDELINES (STEP 4)

STEP 4*
OPERATIONALISA-TION OF MODEL

Definition
Objectives
Outcome activities

Following the description of the semantics and the syntax of the theory of the model "*The role of defined spirituality in local specialist psychiatric practice and training*", a schedule of guidelines for its implementation and for testing the described relationships is compiled in this section (Table 4.1, Figure 4.5).

Table 4.1 Schedule of operational guidelines

Guideline 1	**DEFINITION OF SPIRITUALITY**		
Guideline 2	Objective 1 **STEP 1** **AWARENESS**	Objective 2 **STEP 2** **ACKNOWLEDGMENT**	Objective 3 **STEP 3** **INTEGRATION**
Guideline 3	**OUTCOME-DIRECTED ACTIVITIES**		
SELF			
With regard to the final categories of concepts (Table 3.3): **Guideline 3.1** Orientation in terms of spirituality and religion in psychiatry **Guideline 3.2(1)** Reality of spirituality and religion for practitioners and users			
PATIENTS			
With regard to the final categories of concepts (Table 3.3): **Guideline 3.2(2)** Reality of spirituality and religion for practitioners and users **Guideline 3.3** Routine assessment of spirituality and religion in psychiatry			
STUDENTS			
With regard to the final categories of concepts (Table 3.3): **Guideline 3.4** Training of spirituality in psychiatry			
PRACTITIONERS			
With regard to the final categories of concepts (Table 3.3): **Guideline 3.5** Scope and boundaries of spirituality in psychiatry			
SPIRITUAL PROFESSIONALS			
With regard to the final categories of concepts (Table 3.3): **Guideline 3.6** Referral and collaboration on spirituality in psychiatry			
OUTCOMES: Integrated life and work, care, teaching, practice, collaboration			

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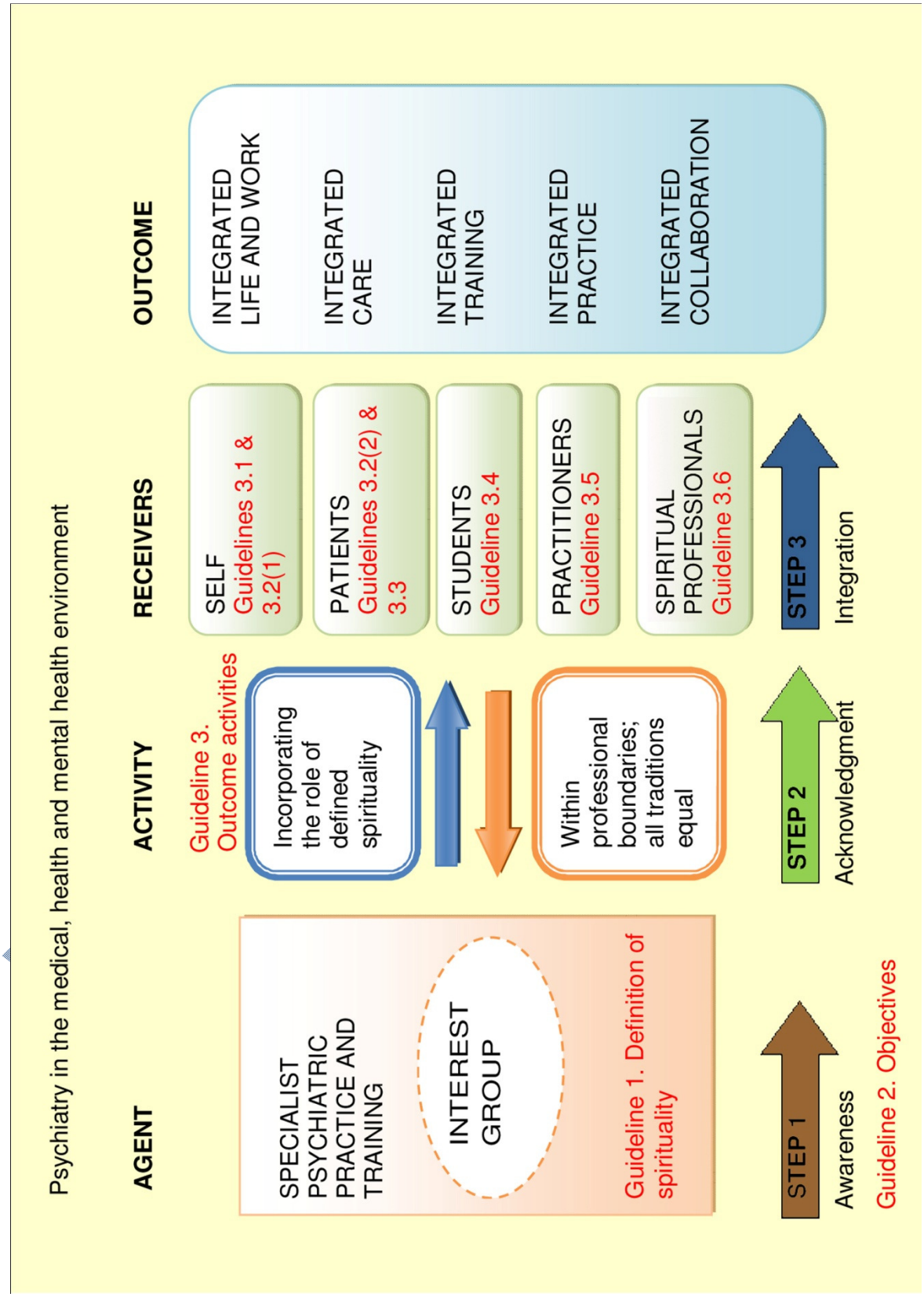

Figure 4.5 Operationalised model: "The role of defined spirituality in local specialist psychiatric practice and training"

4.3.1 DEFINITION OF SPIRITUALITY

Guideline 1. As the first step of operationalisation, spirituality versus religion must be defined in every training, service or professional situation where the incorporation of its role into the approach to specialist psychiatry may be considered. Consensus about its meaning should be achieved and the definition must be able to accommodate all traditions and belief systems equally.

The conceptual definition of spirituality according to this model is:

"**Spirituality** is *individual persons' and societies' progressive inner*

- ***quality*** *of transcendental awareness;*
- ***journey*** *towards understanding of ultimate questions;*
- ***relationship*** *or connectedness (with themselves, others, the natural world and a theist or atheist presence/source/principle beyond themselves); and*
- ***capacity*** *or consciousness concerning an unseen but vital, animating, life-defining principle, force or energy within,*

through which ***meaning and purpose*** *are derived."*

(Also see Guideline 3.1)

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4.3.2 OBJECTIVES

Guideline 2. Following the definition of meaning, objectives and outcomes for the incorporation of the role of defined spirituality in terms of awareness, acknowledgment and integration must be determined for the particular setting in which it is considered, e.g. service delivery, academic or professional.

Examples are listed below.

Example 1: To facilitate awareness about the role of defined spirituality in local specialist psychiatric practice and training.

Example 2: To inform the acknowledgement of the importance of the role of defined spirituality in local specialist psychiatric practice and training.

Example 3: To achieve the appropriate integration of the role of defined spirituality into local specialist psychiatric practice and training.

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4.3.3 OUTCOME-DIRECTED ACTIVITIES

Guideline 3. Within the set of three parallel objectives for awareness, acknowledgement and integration, outcome-directed activities must be determined in terms of the final categories and subcategories of concepts derived from the integrated interview and literature content identified by this investigation.

The final categories and subcategories of concepts identified from the integrated interview and literature data (Table 3.3) can be used to identify the outcome-directed activities for each objective.

4.3.3.1 Integrated living and working of interest group members

(1) **Guideline 3.1 Concept: Orientation in terms of spirituality and religion in psychiatry**

In the formulation of relationship statements on the structure of the model (paragraph 4.1.4.1), this concept and its subcategories were brought into relation with the interaction between the Agent (practitioners in the interest group) and Receiver 1 (the interest group members themselves). In other words, the activity of incorporating the role of defined spirituality in psychiatry occurs in this first instance in the personal life and work of an interest group member him/herself.

Activities directed towards the integrated living and working of interest group members, involve the interest group members' own incorporation of the role of defined spirituality (e.g. own skill and knowledge and attributes as person, practitioner and teacher) and may include accepted guidelines and course work on mentoring and role modelling, and research. These outcome-directed activities are identified with reference to the relevant subcategories for this main concept: own view of and position towards spirituality; academic view of medical science and of patients; providers' perspectives; principles in

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practice: history and philosophy; and concepts and definition of spirituality and religion. (In terms of "Research" see also Guidelines 3.3 and 3.5, and in terms of "Definition of spirituality", see also Guideline 1).

A framework for what to consider in the orientation in terms of spirituality and religion for interest group members may include:

- definition and terminology (concepts);
- (personal) awareness, consciousness, mindfulness;
- teaching, training and mentoring approaches; and
- practical exercises, sessions, workshops regarding personal spirituality.

(2) **Guideline 3.2 (1) Concept: Reality of spirituality and religion for practitioners and users**

In the formulation of relationship statements on the structure of the model (paragraphs 4.1.4.1 & 4.1.4.2), this concept and its subcategories were brought into relation with the interaction between the Agent (interest group) and Receiver 1 (interest group members themselves), as well as with the activity between Agent and Receiver 2 (their patients). In other words, the activity of incorporating the role of defined spirituality in psychiatry occurs in this instance in the lives and work of practitioners personally, as well as in the context of the therapeutic relationship between the doctor and patient, during which clinical assessments and interventions are made.

Activities directed towards the integrated living and working of interest group members relating to their patients (e.g. inclusion of a spiritual/religious history in assessment, appropriate discussion, referral and liaison) may include: accepted guidelines and training on clinical assessment and management; and accepted service guidelines (to health facilities) with norms and standards. These outcome-directed activities are identified with

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reference to the relevant subcategories for this concept: extended model of care: "bio-psycho-social-spiritual"; principles in practice: approach; and users' perspectives.

A framework for what to consider in terms of the reality of spirituality and religion for practitioners and users may include:

- definition and terminology;
- spiritual/religious history taking and assessment;
- cultural-religious context of clinical presentation;
- identification and management of religious/spiritual psychopathology;
- spirituality in clinical health care programmes (health promotion; curative, palliative);
- physical structures and human resources in health facilities (spaces, referral, ethical conduct); and
- resource allocation.

4.3.3.2 Integrated care of patients

(1) **Guideline 3.2 (2) Concept: Reality of spirituality and religion for practitioners and users**

In the formulation of relationship statements on the structure of the model (paragraphs 4.1.4.1 & 4.1.4.2), this concept and its subcategory were brought into relation with the interaction between the Agent (interest group) and Receiver 1 (interest group members themselves) – see Guideline 3.2(1), as well as with the activity between Agent and Receiver 2 (their patients). In other words, the activities involved in incorporating the role of defined spirituality in psychiatry occurs in this instance in the context of the therapeutic relationship between doctor and patient, during which clinical assessments and interventions are made.

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Activities directed towards integrated care of patients (e.g. inclusion of a spiritual/religious history in assessment, appropriate discussion, referral and liaison) may include user advocacy. These outcome-directed activities are identified with reference to the following relevant subcategories for this concept: definition of spirituality and religion/concepts and definition; extended model of care: "bio-psycho-social-spiritual"; principles in practice: approach; users' perspectives (See Guideline 3.6).

(2) **Guideline 3.3 Concept: Routine assessment of spirituality and religion in psychiatry**

In the formulation of relationship statements on the structure of the model (paragraph 4.1.4.2), this concept and its subcategories were brought into relation with the interaction between the Agent (the interest group) and Receiver 2 (patients). In other words, the activities involved in incorporating the role of defined spirituality in psychiatry also transpires in this instance in the context of the therapeutic relationship between the doctor and patient (See Guidelines 3.2.1 and 3.2.2).

These activities directed towards integrated care of patients (e.g. inclusion of a spiritual/religious history in assessment, appropriate discussion, referral and liaison) may include: clinical assessment and management of illness; and research. These outcome-directed activities are identified with reference to the following relevant subcategories for this concept: need assessment; communication and appropriate intervention; liaison and referral; presentation and symptoms; assessment, measurement and research (See Guidelines 3.1 and 3.5).

4.3.3.3 Integrated training of students

(1) **Guideline 3.4 Concept: Training of spirituality in psychiatry**

In the formulation of relationship statements on the structure of the model (paragraph 4.1.4.3), this category and its subcategory were brought into relation with the interaction

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between the Agent (interest group) and Receiver 3 (students). In other words, the activity of incorporating the role of defined spirituality in psychiatry transpires in this instance between the academic psychiatrists as teachers/mentors and their (undergraduate and postgraduate) students.

Activities directed towards the integrated training of students (course content, process of training, mentoring) may include: curriculum development; and selection, training and assessment (on undergraduate and postgraduate levels). These outcome-directed activities are identified with reference to the following relevant subcategories for this concept: understanding of spirituality and its role in mental health care; didactic learning on spirituality and religious faith traditions; approach towards spirituality and religion in psychiatry; and personal growth, professional development and competency.

Skills to consider for undergraduate students may include competency to: assess the role of spirituality as part of routine history taking and clinical examination; communicate bad news; and manage the scenario of the death or dying of a patient. A framework for what to consider in the training of spirituality in postgraduate psychiatry may include:

- definition and terminology;
- an overview of history and philosophy (e.g. context of the original "split" between religion and science and indications of a recent "rapprochement"; inclusion in the diagnostic systems; theories and models such as Engel's Bio-psycho-social Model, Cloninger, Vaillant, Anandarajah, Koenig; relevant philosophical schools of thought);
- the sociological and anthropological view;
- evidence of saliency of spirituality/religion and its role in psychopathology;
- a comparative overview of different faith traditions and belief systems relevant to health and mental health (e.g. African traditional, atheist, Buddhist, Christian, Hindu, Humanism, Muslim, Jewish, New Age, Shamanism);

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- clinical assessment (history taking, in-depth interviewing, diagnostic formulation, management plan);
- interventions (referral to spiritual professionals, the appropriateness of spiritual practice intervention by a clinician, psychotherapy);
- the role of the psychiatrist (practice guidelines; training requirements: knowledge, skill and competency; liaison with spiritual professionals); and
- personal growth and development (individual; teacher and mentor).

4.3.3.4 Integrated practice of practitioners

(1) **Guideline 3.5 Concept: Scope and boundaries of spirituality in psychiatry**

In the formulation of relationship statements on the structure of the model (paragraph 4.1.4.4), this concept and its subcategories were brought into relation with the categorization of interaction between the Agent (interest group) and Receiver 4 (practitioners). In other words, the activities involved in incorporating the role of defined spirituality into psychiatry transpire in this instance between the practitioners in the interest group and other practising psychiatrists generally, by maintaining and peer reviewing the scope and boundaries of spirituality in psychiatry.

Activities directed towards the integrated practice of practitioners (such as continued professional development - conferences, lectures, practice review) may include: accepted guidelines for ethical and professional practice; continued education and professional development; peer review; and research. These outcome-directed activities are identified with reference to the following relevant subcategories for this concept: ethics of spirituality in psychiatric practice/principles in practice: ethics; continued education and peer review; and psychotherapy (Also see Guidelines 3.1 and 3.3).

Setting formal guidelines for ethical practice would require continued medical education and professional development opportunities, as well as structures for peer review and

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remedial procedures. A framework for professional guidelines on spirituality in specialist psychiatric practice may include:

- definitions and terminology;
- social, cultural and spiritual competency to provide integrated care;
- spiritual practices as part of clinical intervention;
- referral to, and collaboration with, spiritual professionals;
- diagnostic formulation and categories;
- psychotherapy;
- medical aid and insurance benefits;
- peer review and remedial procedures; and
- health education of patients on evidence-based practice.

4.3.3.5 Integrated collaboration with spiritual professionals

(1) **Guideline 3.6 Concept: Referral and collaboration on spirituality in psychiatry**

In the formulation of relationship statements on the structure of the model (paragraph 4.1.4.5), this concept and its subcategories were brought into relation with the interaction between the Agent (interest group) and Receiver 5 (spiritual professionals). In other words, the activities involved in incorporating the role of defined spirituality in psychiatry in this instance transpire between practitioners in the interest group (and psychiatrists in general) and the spectrum of spiritual professionals from different faith traditions and belief systems, to whom patients may be referred.

Activities directed towards integrated collaboration with spiritual professionals (such as communication, collaboration, educative forums/discussions) may include: accepted guidelines for collaboration; referral within referral network; health education on medical and psychiatric conditions; formal liaison and advocacy. These outcome-directed activities are identified with reference to the following relevant subcategories for this concept:

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facilitating appropriate referral and intervention for individual users; information sharing and mutual awareness between disciplines; addressing stigmatisation of users with psychiatric conditions; religious/spiritual traditions; spiritual professionals' perspectives. (Also see Guideline 3.2.2). Individual pilot projects on facility or district level may be a realistic approach in initially establishing the relevant contact and structures to explore the appropriate processes for collaboration on spirituality in mental health and psychiatry in a particular area. A framework for the referral and collaboration on spirituality in psychiatry may include:

- definition and terminology (including "spiritual professional");
- role of spirituality/religion in the community;
- perspective of the particular faith tradition/belief system on health and mental health;
- evidence-based management of serious psychiatric conditions (risk factors, symptoms, diagnoses, treatment);
- compliance, stigma and outcome of psychiatric treatment; and
- integrated care.

4.3.4 TESTING OF RELATIONSHIPS (HYPOTHESES)

Further research as an outcome activity is addressed in Guidelines 3.1, 3.3 and 3.5. The proposed model "*The role of defined spirituality in local specialist psychiatric practice and training*" provides a description of the constructs and the dynamic (relationships) between them, which are involved in the observed phenomenon that spirituality is also playing an increasing role in local secular sectors (such as mental health and psychiatry). These relationships must still be empirically tested during a subsequent model/theory implementation phase. The potential positive effect of the incorporation of defined spirituality into psychiatry and how this may influence compliance with psychiatric management and the eventual treatment outcome of chronic psychiatric conditions are examples of what will be an important area for future research.

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Referring to the relationship statements discussed in paragraph 4.2, relationships in this model that may be a focus for subsequent testing include:

- the relationship between the incorporation of the role of defined spirituality and the accumulation of unresolved empirical problems within the current clinical management of serious mental disorders (such as poor compliance, excessive/inappropriate use of alternative remedies/healing methods and stigma); as well as
- the different possible relationships between awareness, acknowledgement and integration and the proposed outcomes of the incorporation of the defined role of spirituality (integrated life and work, care, teaching, practice and collaboration).

SUMMARY CHAPTER 4

In this chapter, relationship statements about the most important relationships between the concepts of this model were made. These included: the two-directional counter-balancing relationship between the two parts of the core concept; the relationship between defined spirituality and all the other concepts; the conditional relationship that all spiritual/religious traditions and belief systems should be accommodated equally; the different relationships between the interest group of practitioners with themselves, patients, students, other practitioners and spiritual professionals; the important role that spirituality plays in the lives of people and the incorporation of defined spirituality; and the incorporation of defined spirituality and the accumulation of unresolved empirical problems within current clinical management. The evaluation of the model, that included a panel of experts, was described. The final model was presented in terms of the Chinn and Kramer criteria for description and finally, operational guidelines for the operationalisation of the model were discussed.

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CHAPTER 5. DISCUSSION



CHAPTER 5. DISCUSSION

> *"Makhosi Moropodi said traditional healing is 'a religion of its kind' (sic). In previous years traditional healers were referred to as witchdoctors. This was done because the Western world could not understand the African's noble practices. The stigma was carried by traditional healers for generations. To be a traditional healer one must get that call from the ancestors and from God. One does not have to be educated to be a traditional healer."* Minutes of the South African Arts and Culture Parliamentary Portfolio Committee, 13 November 2001. (Parliamentary Portfolio Committee on Arts and Culture, 2001)

5.1 TOWARDS A LOCAL MODEL

In defining the problem statement of the study, it was initially noted that it seemed important for local psychiatrists themselves to review, from within the discipline, what role spirituality should have in specialist psychiatric practice and teaching. It also seemed necessary to revisit the scope and practice of local psychiatry as a specialist discipline and to reaffirm or - if needed - redefine its relationships and boundaries within the existing or a potentially extending multidisciplinary mental health team. To achieve the purpose of the study, a qualitative inquiry was undertaken with the researcher as instrument.

The first objective of the study was to explore, analyse and describe the views and experience of a local group of specialist psychiatrists on the role of spirituality and specialist psychiatric practice and training. To achieve this, in-depth interviews were conducted with a purposeful sample of participants, achieving data saturation after thirteen interviews. Participants held the view that awareness of spirituality, "mindfulness", or an open-minded approach towards spirituality should be facilitated in specialist psychiatric practice and training. Participants had diverse views and experiences on the role of spirituality in psychiatry, but all stated that spirituality should be considered in

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current specialist practice and training. The demands and challenges of service delivery to multi-cultural and multi-religious South African communities have been referred to by most interview participants. The content of the thirteen interviews was analysed and six provisional categories of concepts were identified: personal and professional orientation towards spirituality; spirituality and religion as a reality for practitioners and users; scope and boundaries of professional specialist psychiatric practice; spirituality and religion in routine mental state assessment and health care; awareness, knowledge and skill of trainees in psychiatry regarding spirituality; and referral and collaboration between psychiatrists and spiritual workers. A particular limitation of the study that should be mentioned is the fact that as an explorative qualitative study, its findings can't be generalised to any other setting. In addition, the fact that psychiatrists were interviewed by a colleague from the same institution, may be regarded by some reviewers to cause problems of disclosure and social desirability.

The second objective was to interpret the views and the experience of the local group of academic psychiatrists in the context of the views of authors in the international medical literature on the role of spirituality and psychiatry. When the views and experiences of this local group of teaching specialists were compared with the views of authors from a selected international literature review, strong consensus was revealed that the role of spirituality cannot be ignored, mainly because of the importance of spirituality's role in the lives of people in general. This increasingly important role of spirituality and religion was found to be in contrast with what was anticipated earlier in Western countries and alluded to in the literature, namely that the secularisation of society would rather proceed progressively over time. Final concepts from the integrated content were consistent with the six provisional categories, but in a slightly different order. While participants in the interviews, as well as authors, pointed to the negative role of religion and referred to its role in psychopathology, the single core concept that still emerged from both the interview and the integrated (interview and literature) data was that the role of defined spirituality

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has to be incorporated into the existing approach to local specialist psychiatric practice and training, but with the proviso that terminology should be defined and that the integration of spirituality should be done within the professional scope and confines of the discipline, guided by set standards for ethical practice. In addition, it was regarded as being very inappropriate for one particular view or personal conviction about spirituality to be singled out or enforced, or to allow an individual perspective to interfere with, or adversely affect, the effective clinical assessment and management of patients, or the teaching of students.

The third objective was to construct a descriptive, practice-orientated model with operational guidelines on the role of spirituality in local specialist psychiatric practice and training. The constructed model was based on the core concept identified from the views and experiences from the local interview content that were integrated with the views of international authors. The proposed model: *"The role of defined spirituality in local specialist psychiatric practice and training"*, explains how the role of defined spirituality may be incorporated into the local practice and teaching of psychiatry. It provides for three steps of incorporation: awareness of the role of spirituality; acknowledgement of .this role; and integration of this role amongst psychiatrists and their patients, students and colleagues. The local group of interested specialists who are already aware of the importance of the role of spirituality, may act as the agents of this activity of incorporation of the role of spirituality into the profession, with the different anticipated integrative outcomes of: integrated individual living and working for interest group practitioners themselves; integrated care for patients who consult psychiatrists; integrated teaching and training for undergraduate and postgraduate students in psychiatry; integrated professional practice for psychiatrists generally within ethical boundaries; and integrated referral of patients as part of appropriate collaboration between psychiatrists and spiritual professionals. The dynamic, incentive or driving energy that was identified to motivate the process of incorporation of the role of spirituality in specialist psychiatry, include: the

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knowledge of spirituality's importance in the lives of people in general; the awareness that most psychiatric conditions are chronic and recurrent in nature and that current psychiatric treatments do not offer curative options; and the endeavour to ensure that psychiatric treatments and therapeutic interventions acquire a dimension of "healing" in the reality of the bio-psycho-social-spiritual dimensions of people's lives.

Other models on related aspects in the reviewed literature during the past ten to 15 years must be considered as context for the constructed model in this study. This include: Engel's "Bio-psycho-social Model" (Engel, 1977), (Engel, 1980), which currently forms the existing approach to specialist psychiatry; and Cloninger's model for personality (Cloninger, 2006), (Cloninger & Svrakic, 2000). In addition: Lappiere's model for "Spirituality" (Lapierre, 1994); Sulmasy's "Bio-psycho-social-spiritual" model (Sulmasy, 2002); Koenig's model for "Religion and physical health" (Koenig, 2001b); Anandarajah's two models - "H3" and "BMSEST" (Anandarajah, 2008); cognitive science models of the mind (Bathgate, 2003); and models of the definition of spirituality (Koenig, 2008a). Rumbold, (2007) discussed the three major models of health in detail: the biomedical perspective; Engel's Bio-psycho-social Model; and the social-economic models of health. Engel's model proposed that illness and health were the result of an interaction between biological, psychological, and social dimensions. Sulmasy (2002) added a spiritual dimension to Engel's bio-psycho-social model, to derive a bio-psycho-social-spiritual model for the care of patients at the end of life. Katerndahl and Oyiriaru (2007) also referred to and acknowledged George Engel's Bio-psycho-social Model as a holistic alternative to the prevailing reductionistic biomedical model of the time. But referring to Sulmasy (2002) and Onarecker and Sterling (1995), they argued that in view of the growing weight of evidence in support of the impact of religion and spirituality on health behaviours, coping, physical and emotional symptoms, and quality of life, the Bio-psycho-social Model needs to be revised to include spirituality as well. Anandarajah's (2008) models: "H3" – "head, heart, hands" and "BMSEST" – "body, mind, spirit, social,

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transcendent", offer a multidimensional definition of spirituality, applicable across cultures and belief systems. Flanelly's "Evolutionary Threat Assessment Systems" model (Flannelly et al., 2007), (Flannelly et al., 2009) and Vaillant's theorem of "Spiritual Evolution" (Vaillant, 2008a&b), can also be taken into account as examples of recent more elaborate theoretical explanations of aspects of the role of spirituality in psychiatry.

5.2 THE CHALLENGE OF DEFINITION

Defining terminology - specifically what exactly "spirituality" and "religion" would mean in a discussion - proved to be one of the most critical elements of this investigation and of orientation in terms of spirituality and religion in psychiatry. This was the case for the researcher, for all participants in the interviews and it was made very clear in the literature. The necessity for definition was also evident from discussions with the study supervisors and with the independent coder, as well as from submissions and presentations to the ethics and postgraduate committees of WITS University and later in the study, to the panel of evaluating experts. It was also central when conclusions were being drawn from this investigation. It is anticipated that the importance of definition will also play a role during the assessment of the study and in all the subsequent scenarios of implementation. The reasons for this consistent experience with the introduction of the discussion of spirituality in a supposedly secular field, such as psychiatry, may be bound to each individual's own orientation and conditioned meaning attached to the phenomena of spirituality and religion. This orientation and meaning seems to lie on an intellectual/conceptual level, as well as on an emotional/experiential level. The same may be expected from individual practitioners, patients and students and from facility, academic or professional management structures. Unless space and time are scheduled to clarify what is meant by the terms used in communication, the possibility of non-engagement, or even a hostile rejection of ideas, seems to increase exponentially. Another reason for this challenge is considered to be associated with the inherent

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difficulty of finding a clear distinction and definition of terms and meaning, even if committed to doing so. Several studies, after extensive literature reviews on the definition and meaning attached to the concepts "spirituality" and "religion", remained inconclusive on a final definition or an approach to definition. The definition of spirituality that was eventually adopted for the purposes of the model building objective of this study consciously tried to avoid some of the problems of overlap between spirituality and religion, while accounting for but not limiting its meaning. It was also experienced that although spirituality was specifically the focus and concern of this study from the outset, religion would inevitably be part of the discussion. This reflects the extent to which the two terms are interrelated, intertwined and interchanged in the conceptualisation and experience of the average person, of psychiatrists and health workers and presumably also of their patients and students. Another limitation of this study is that only a particular selection (purposive sample) of the medical literature was used as subject literature to inform the connotative definition of spirituality, in the process of creating conceptual meaning. To explore the extensive literatures in nursing, psychology, social work, sociology, anthropology, religious studies and theology would have warranted several additional inquiries.

Considering the definition of terminology in a South African context, it was mentioned in the introduction to this study that in the background literature on the changing climate of the local health care scenario, the question was asked whether the practices performed by traditional healers should be regarded as a religion or as psychotherapy (Janse van Rensburg, 2009). While some authors have argued that African traditional practice is a modality of psychotherapy, Edwards et al., (1983) Griffiths and Cheetham (1982) and Cheetham and Griffiths (1982) have concluded that traditional healers are "priests before healers". They essentially act within a particular organised belief system, as intermediaries between the people and the spirits of their deceased ancestors. For the purposes of this study, "spirituality" was defined as "*individual persons' and societies'*

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progressive inner: quality of transcendental awareness; journey towards understanding; relationships or connectedness; and capacity or consciousness concerning an unseen but vital, animating, life-defining principle, force or energy within." "Religion" was defined as "*the practice and outward expression of spiritual beliefs with its associated activities, organised into integrated systems of doctrine and institutionalised structures, in adherence to a collective community of like-minded believers*". Applying these definitions to the African traditional belief system and practice, it has to be concluded that African traditional health practice - which is inherently embedded in the belief system, far more closely fits the description of a religion with spiritual contents, than that of "psychotherapy" or, for that matter, of empirical health or biomedical intervention.

In addition, Ashforth has also described attempts of local proponents of indigenous knowledge systems to provide traditional African healing with a scientific status (Ashforth 2005). For this study, "scientific" has referred to: "*observation, identification, description, experimental investigation and theoretical explanation of natural phenomena", an "exact, objective, factual systematic or methodological basis";* and *"theory"*, or a *"theoretical body of knowledge*". "Medical" has referred to "*the science of diagnosing, (non-surgical) treatment and prevention (of disease and other damage)*". "Discipline" has referred to: "*training that is expected to produce a specified characteristic or pattern of behaviour"; "controlled behaviour resulting from such training"; and "a set of rules or methods*". "Profession" has referred to: "*an occupation, trained vocation"; "advanced study in a specialized field with a basis of ethical principles (code of ethics, e.g. the Hippocratic oath) and regulated entry, education and exit*."

Applying these definitions to African traditional health practice, this faith tradition may therefore have some attributes of a religious/spiritual discipline, or even of a religious/spiritual profession. But it does not currently have the attributes of a scientific, medical discipline/profession, or the structure and acquired theoretical body of knowledge

of an allied discipline such as nursing or occupational therapy. Adherents themselves essentially identify a subjective, supernatural (divine) source for the knowledge of their knowledge system. Lastly, reference is also often made to the concept "healing" in terms of African traditional practice's objectives and the expected outcome of activities. The dictionary meaning of "healing" refers to: "*to (be) restore(d) to health; to (be) cure(d); to (be) set right; to amend ('to heal the rift between us'); to (be) rid of sin, anxiety, or the like; to become whole and sound; to (be) returned to health*" (The American Heritage Dictionary of the English Language, 2003). In the absence of scientific evidence of proven curative properties or attributes, the meaning of "healing" in this context should be understood to refer at best to the more subjective meaning of the construct encompassed by the notion of "emotional" or "spiritual" healing. Different faith traditions will therefore also have a different understanding and definition of, and approach to, how to achieve spiritual healing according to that particular tradition. African traditional beliefs should for this reason indeed - equally with all other faith traditions - be regarded as the important and recognised cultural and religious belief system of a large part of the South African population. But as an empirical health intervention, it cannot currently seriously be regarded as being on the same footing as established scientific, evidence-based bio-medical clinical disciplines.

The fact that traditional African health practice has recently been legally structured in South Africa - not only as a socio-cultural-religious entity - but as a formal alternative component of/to the formal health sector, does however challenge people (citizens, patients, health care workers and psychiatrists alike) to establish its content and scope and how it may affect clinical practice. Unless well defined, the scenario may introduce contradictions from a religious-political point of view, from a health systems' point of view and potentially also from an available health resources point of view. A question from a constitutional point of view is for example, to the extent that the South African Constitution (in terms of Section 15) establishes an equal status for all religious orientations in the

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country, what would the role and place be of all the other religious traditions and belief systems in the context of the formal health sector, considering the precedent that was set for African traditional practice and beliefs in this regard (South Africa, 1996). It seems inconsistent and – according to the findings of this investigation – inappropriate, to single out one religious tradition, albeit it the cultural-religious tradition of the majority of the population. If one tradition is acknowledged to play such a prominent role in the health environment, it must follow that the same status will potentially be afforded to other faith traditions' perspectives on health and mental health as well, such as Buddhist, Christian, Hindu, Muslim and Jewish.

5.3 A NEW APPROACH TO PRACTICE AND TRAINING

What would an appropriate response from a teaching perspective be? In the formal academic teaching environment, historically grounded in established Western philosophical tradition, the prevailing biomedical paradigm in clinical medicine has been dictating for some time that religion and spiritually have no place in the domain of objective, evidence-based biomedical science. Following the long and troubled history of numerous religious wars and of the enmeshed relationship of the Christian church and the monarchies of Western Europe up to the Renaissance, a decisive split occurred between religion and science during the period of Enlightenment in Europe. Subsequently, an established philosophical tradition grew from this position including the now traditional mind-body dualism of Descartes, and later, the fundamental influence of Freud's position on the negative effect of religion in individual psycho-dynamic development in the first half of the 20th century. This convinced the discipline of psychiatry and clinical medicine in general of the detrimental effects of religious conviction and activities and that these should not have any place in clinical assessment and management of patients. Jung on the other hand, expressed a different perspective. He referred to human beings as "*homo religiosus"* and was convinced that humans possess a primordial potential to produce

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positive spiritual religious experiences. In the South African background literature review, it was noted to what extent psycho-analytically orientated writers were advocating the collaboration between Western scientific medicine and traditional practices (Janse van Rensburg, 2009).

To argue indiscriminately from either of these two perspectives in the perceived currently changing health care environment in South Africa, still leave academic biomedicine with a paradox to negotiate in this regard. Firstly, to simply persist with strict mind-body dualism may not be adequate to address the increasing reality and prominence of, for example, African traditional beliefs and practice in the context in which clinical services are routinely being rendered. It may not be appropriate just to apply the same type of sanctioning that was previously placed on European faith traditions, historically at the time perceived to be a negative influence. Secondly, to adopt a different accommodating approach but towards one tradition only - for example to African traditional beliefs – while excluding other traditions, would not be appropriate or consistent even if this represents the majority tradition and even if it may be more politically correct to do so. It should be possible to argue that, if culture, religion and spirituality are regarded as being important factors in health for one faith tradition, in principle it should be regarded as equally important for all local faith traditions and belief constructs (including atheistic or agnostic positions). Unless equal accommodation can be considered in this regard, it is doubtful whether the exclusive incorporation of only some preferred traditions into an approach to health and illness may be advisable. It may be argued that from a teaching perspective, the approach should then rather be, to revert to the pre-existing preferred exclusion of all religions from the scientific biomedical paradigm. The large body of literature on the role of spirituality in psychiatry that has been generated over the past decades locally and internationally may now have provided adequate momentum in terms of the development and the dynamic of "revolutionary science" which Kuhn described in the 1960's (Jacox & Webster, 1986), (Kuhn, 1962). While, according to him, existing professional education largely occurs

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through socialisation, the existing paradigm that exerts control in a discipline, especially through the content of the teaching may be rejected or adjusted in favour of a newer or competing one, when a number of anomalies or unresolved empirical problems accumulate. In this case, the extent of the anomaly (resulting in unresolved clinical problems), to have thus far ignored spirituality in the official approach to specialist psychiatry, may now have provided enough incentive to adjust and extend the current incomplete bio-psycho-social paradigm to include a spiritual dimension as well. It is in this regard that psychiatry may be playing an important role in clarifying what an appropriate approach may be in the teaching of clinical medicine. Referring to what was described earlier as psychiatry's "boundary" or "gate keeping" position that the discipline seems to be occupying within clinical medicine, psychiatry is uniquely positioned in this regard. Psychiatry is on the one hand an inherent part of the scientific evidence-based fraternity of clinical medicine. On the other hand, the reality of having to consider, interpret, translate and manage scientific knowledge and interventions in the "real," lived world's socio-cultural-religious domains, has already compelled the adoption of a multi-disciplinary approach and routine liaison with disciplines with a human and social science orientation. The model constructed in this study may contribute to the process of the identification of psychiatry's role in this regard, and to the acknowledgement of the discourse on the role and place of spirituality in local psychiatry, medicine and health.

As a concluding remark, it also seemed important and appropriate to state what this study was not trying to establish. It was not trying to somehow promote the covert introduction of indiscriminate incorporation of religion of some, or of one faith tradition in particular, into the discipline of psychiatry. It was not trying to imply that, because evidence of the salient role of spirituality and religion may be claimed in a section of the literature, it should therefore uncritically be incorporated into psychiatry and clinical medicine. It was also not trying to consider or compare benefits or detriments, or the relative inherent truth value (or lack of it) of the content of any of the different belief constructs that may form

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part of the spectrum of cultural/religious groupings. The study, as a tentative, explorative, naturalistic and descriptive qualitative investigation of the phenomenon that spirituality seems to play an increasing role in secular areas, has rather attempted to contribute to a constructive discourse on the reality of the daily experience of clinicians and of practitioners and teachers of psychiatry, who contend with the extent to which religion and spirituality play a role in the lives and experiences of the people with whom they deal as patients or as family members of patients.

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CHAPTER 6. CONCLUSIONS



CHAPTER 6. CONCLUSIONS

> *"The tree itself represents firstly the profession of specialist, evidence-based psychiatry as a clinical discipline and its existing bio-psycho-social approach to practice and training, within the environment of mental health, health in general and clinical medicine."* (Paragraph 4.2.2.2 - Overview of final model, pp251-252)

At the end of this investigation, no "proof" in a quantitative sense of the word can be offered on any of the aspects of the role of spirituality in specialist psychiatric practice and training which was the interest of this study. As a qualitative inquiry, the study was expected to provide a reliable account of the views and experience of the academic psychiatrists interviewed and of the literature reviewed, as well as to provide clear identifiable links and evidence that the constructed theoretical model was adequately grounded in the content of the two data sources used. The following conclusions and recommendations may also serve to further link the experience of this investigation with practical and realistic applications for local psychiatry and clinical medicine.

One conclusion from the study is that, in this particular selection of international medical literature a surge of interest in spirituality was reported on, especially in the American context, but also in reports from the United Kingdom, Australia, Canada and some from Brazil. Being mainly from Western countries, this resulted in an emphasis on scenarios from a traditionally Christian faith tradition, although principles that were discussed and reported on can be applied to other cultural and religious backgrounds as well. One particular factor that has been widely associated with this phenomenon of the increasing importance of religion and spirituality is the influence of migration in these historically Christian countries. The extensive movement and immigration of communities of people over recent years to Europe, the United Kingdom and the United States has rendered these previously homogonous societies far more heterogenous and creolised.

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From the local literature, another conclusion is that in the South African context, considerable emphasis is currently placed on the African traditional faith tradition and practices in the health sector as compared to other local traditions such as Hindu, Muslim, Christian and Jewish traditions, not only as an alternative faith tradition with its expected associated social, cultural and religious importance, but as a distinct alternative health care practice. There seem to be indications that this development may be an element of a broader vision of elevating African traditional views and customs not only to the same recognition of other faith traditions/belief systems, but in fact for it to be regarded as having the same level of importance as Western medical practice. Complete liberation and democratisation of African spirituality is sought in all spheres of social life, with the final release from what was described as the "dominating colonial, Christian religious spirituality" which previously subjected indigenous forms of African spirituality. These aspirations may, however, be confounded by the parallel aspirations for it as a health practice equal to scientific, medical practice.

Authors in the South African medical literature over the years have often strongly called for closer collaboration between parallel African traditional practice and Western scientific medical disciplines, in particular psychiatry. As an important socio-cultural-religious component of the majority of South Africans' lives, it is surely essential to take cognisance of its influence and to understand its content, meaning and role in the local presentation of patients to the discipline of psychiatry and in the assessment of psychopathology. However, if the definitions of spirituality and religion established for this study are objectively applied to the African traditional belief system, it has to be concluded that its attributes fit the description of a religion, rather than that of a therapy or a medical intervention.

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It was also concluded that these developments leave entrenched dualistic thinking in local academic clinical practice and teaching with a challenge to respond appropriately. With the currently changing South African health care environment and observed emphasis on the promotion and liberation of local faith traditions, which has represented the tradition of the majority of members of South African communities, local academic institutions and professional structures will have to take cognisance of the extent of the importance of the role of spirituality and religion in the health sector, not only in terms of the traditional African faith tradition, but also in terms of all the different local faith traditions. The previous approaches in academic clinical medicine, rooted in Cartesian dualism and Freudian areligious conceptualisation of the mind and behaviour, may be inadequate to respond appropriately to the locally observed increasing role of spirituality in secular areas, such as health and psychiatry.

Part of an alternative response in this regard, may essentially be a health education response, including communication, dialogue and creation of awareness, about biomedical treatments aimed at patients, communities and spiritual professionals. On the other hand, it would require a response with regard to the training of primary and specialist clinicians. Adequate knowledge and skill requirements about the different socio-cultural-religious realities and contexts in which clinical medicine is practised in South Africa, should be included in the undergraduate and postgraduate curricula of local students in medicine and psychiatry.

Of the different specialist clinical disciplines, psychiatry (with family medicine) was the most likely candidate(s) to have been confronted first with the reality to have to consider and respond to the role of spirituality and religion in the lives of people and patients. Occupying a bridge position in the topography of clinical biomedicine and closely interacting with disciplines in the social and human sciences, psychiatry is uniquely

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situated and equipped to negotiate a less dualistic “either-or” approach to the observed phenomenon that spirituality is playing an increasing role in the secular area of health.

6.1 RECOMMENDATIONS

A number of recommendations followed from considering the experience with and the findings of this investigation and these are presented below.

6.1.1 CORE CONCEPT

The main message from the combined, integrated qualitative data content of this study is that the role of defined spirituality should be incorporated into the existing bio-psycho-social approach to local practice and training of specialist psychiatry. However, this will have to be done by defining terminology and within specific professional and ethical boundaries.

6.1.2 EQUAL ACCOMMODATION

As an essential principle from the interviews with local specialists and from the international literature, it is recommended, that, if the principle of incorporation of the role of spirituality is considered in the first place, all cultural-religious traditions and belief systems in the heterogenous South African society should be equally accommodated.

6.1.3 APPLICATION OF DEFINITIONS

Applying the definitions of the constructs “spirituality” and “religion” established by this study to the African traditional belief system, it has to be concluded that the system fits the description of a religion rather than that of a therapy or a medical intervention. It is recommended that the African traditional belief system should still be viewed as a religious faith tradition on par with other faith traditions and belief constructs such as Buddhism, Christianity, Hinduism, Humanism, Islam and Judaism.

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6.1.4 SIX CATEGORIES OF CONCEPTS

It can be recommended that the six final categories of concepts identified in this study should be used in the local operationalisation of the model in practice-orientated settings such as hospitals, individual practices and teaching institutions. These six main categories of concepts are: orientation in terms of spirituality and religion in psychiatry; the reality of spirituality and religion for psychiatry; routine assessment of spirituality and religion in psychiatry; training of spirituality in psychiatry; scope and boundaries of spirituality in psychiatry; and referral and collaboration on spirituality in psychiatry.

6.1.5 CLINICAL CARE AND SERVICE DELIVERY

Referring to the six final categories of concepts identified in this study, it is recommended that appropriate guidelines on the role of spirituality in specialist psychiatric practice and training should be developed for integrated clinical care and for service delivery requirements, to assist local clinicians and managers in the appropriate incorporation of the role of defined spirituality in different service delivery settings on facility and regional level.

6.1.6 TRAINING

Referring to the six final categories of concepts identified in this study, it is recommended that appropriate guidelines on the role of spirituality in specialist psychiatric practice and training should be developed for the integrated training of local undergraduate and postgraduate students in psychiatry, as well as for students in other clinical disciplines.

6.1.7 PROFESSIONAL PRACTICE

Referring to the six final categories of concepts identified in this study, it is recommended that appropriate guidelines on the role of spirituality in specialist psychiatric practice and training should be developed for the ethical integration of spirituality into the local practice

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of psychiatry within the professional scope of the discipline, in order to provide appropriate continued professional development opportunities and to structure appropriate peer review strategies.

6.1.8 REFERRAL

Referring to the six final categories of concepts identified in this study, it is recommended that appropriate guidelines on the role of spirituality in specialist psychiatric practice and training should be developed for the appropriate integrated referral of patients and collaboration between local psychiatrists or clinical psychiatric services and spiritual professionals. This would include the clarification of the application of the conceptual definition of a "spiritual professional" to all the different faith traditions and not only with regard to the more well known hospital pastoral care worker.

6.1.9 RESEARCH

It is recommended that further research should be conducted in the area of spirituality and religion in local clinical practice. As discussed in the operational guidelines (paragraph 4.3.4), further research will also be necessary to investigate the different relationships that have been described between the conceptual components of this study's proposed model. This may include, whether and how the incorporation of defined spirituality as a socio-cultural-religious factor will influence compliance with psychiatric treatment and the actual outcome of clinical treatment. Continued qualitative inquiry on aspects of spirituality and its role in psychiatry and mental health will also be needed, as perceived by practitioners in other academic or service institutions, as well as by users of mental health services and by spiritual professionals/religious workers from different faith traditions. It would also be necessary to perform more structured surveys amongst practitioners to document the local practice, views and experience of practitioners from different disciplines, as well as the trends of spirituality and religious involvement of South Africans

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communities in more detail. Further research is also suggested with regard to the possible salient effect of spirituality and religious involvement and how this may translate to all faith traditions. This may be important if more evidence of the role of spirituality may be required in the process of acknowledgement of the role of spirituality in health and medicine of a particular faith tradition. A process of standardising available measurement instruments in a South African context may in this regard be an area of research in its own right.

6.1.10 ANALOGY

Finally, returning to the tree analogy, psychiatry as a clinical discipline, and as "a tree with sophisticated counter-balanced two-way transportation systems for water and nutrients," is uniquely situated and equipped in the landscape of clinical biomedicine, while it closely interacts with disciplines from the social and human sciences. It is therefore recommended that psychiatry, from its unique position as a specialist medical discipline operating in all four bio-psycho-social-spiritual dimensions, should assume a leading role in negotiating a balanced, integrative and less dualistic approach to the observed phenomenon that spirituality is also playing an increasing role in the secular sectors of medicine and health.

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APPENDIX 1.1

Janse van Rensburg ABR. A changed climate for mental health care delivery in South Africa. African Journal of Psychiatry. May 2009; 12(2): 157-165

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APPENDIX 2.1 INTERVIEW GUIDE

Record ID
Age
Gender
Qualifications (and dates)
Practice profile and history
Current position (level)
Academic institution
Hospital
Current clinical responsibility
Current training responsibility
Religious/spiritual identification - **organisational** - **non-organisational** - **intrinsic**
Qualitative question: **"What is your experience of and view on the role of spirituality in specialist psychiatric practice and training?"**

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APPENDIX 2.2 DATA SHEET FOR THE ENTRY OF LITERATURE RECORDS

Record number	P – Practice; T – Training; U – Users; PS – Psychiatrists; SP – Spiritual workers
Type of publication	B_P - Book (popular); B_S – Book (subject); Ch – Chapter in book; JA – Journal article; EdOpR – Editorial/opinion/review; L&R – Letter and reply;
Country published	AUS – Australia; CAN – Canada; UK – United Kingdom; USA – United States of America; Other (Brazil, Europe, Africa, Middle East, India, Asia)
Year	
1st, 2nd and 3rd Author	
Title	
Journal reference	
Origin author	
Text scope	OVERV – overview; AUS; CAN; UK; USA; Other
Method	QT - Quantitative: statistical analysis; surveys - telephone, mail, personal; structured instruments (scales); structured interview QL - Qualitative: semi-structured interview; in-depth unstructured interview; focus group discussion; action research LIT - Literature review
Themes	Principles in practice (general/concepts/definition, historic/philosophic, interventions, approach, ethics, psycho- social rehabilitation, institutions); Presentation and symptoms of illness Clinical conditions (mood and anxiety, psychosis and schizophrenia, alcohol and drug abuse) Assessment and measuring Psychotherapy Providers' perspectives (psychiatrists, family medicine practitioners, other specialists, nursing, other) Users' perspectives (general, children and adolescents, elderly, end of life/terminal illness) Training (under and post graduate) Research Spiritual/religious traditions (African traditional, Buddhist, Christian, Hindu, Humanist, Islam, Jewish, New Age, Shamanism) Spiritual professionals' perspectives
Connotative meaning	Incorporation (awareness; acknowledge; integrate) Spirituality (spiritual, spirit) Religion (religious) Specialist psychiatric practice and training (*Psychiatry as the practice of a professional, specialised, medical scientific discipline)*: practice, profession, specialist, specialisation, psychiatrist, medical, mental, disease, evidence, knowledge, science, discipline, train, teach Professional and ethical boundaries Equal

WITHDRAWN

APPENDIX 2.3 PERSONAL POSITION OF RESEARCHER

Phenomenological reduction refers to the removal of impediments in order to get to the essence of the matter Botes.[1] Bracketing is identified as the first step of reduction. "*Epistemologically, only the knowledge which is obtained by reduction and bracketing reflect reality*"; where bracketing means: "*that the researcher must detach him/herself from all assumptions and must observe impartially*" (Botes, 2007).

To promote the trustworthiness of this proposed study on the role of spirituality and psychiatric practice and training, a bracketing statement about the investigator's position was included at the time when the protocol for the study was submitted to the WITS HREC and the Postgraduate Committee of the Faculty of Health Sciences:

- "*The researcher will be involved in this study as a bio-medically trained psychiatrist, assuming the intention to engage and actively participate in the debate and practice of an appropriately added religious and spiritual dimension to current South African psychiatric care and practice. The researcher is originally from an Afrikaans-speaking, Protestant Christian background, but with no current formal church or organisational affiliation or involvement.*"

In addition, the researcher is/was not in any line-function position with regard to any of the participants (e.g. supervisor/subordinate), where participants' response to the open-ended question could have been influenced by the professional relationship between the researcher and participant.

[1] Botes, A.C. (2007) Implications of philosophies of science for nursing. In: Müller, A. (ed.) [Lecture notes, pp. 59-77] Programme: Doctor of Nursing. University of Johannesburg, Department of Nursing, Faculty of Health Sciences, 28 May to 8 June.

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APPENDIX 2.4 ETHICS CLEARANCE CERTIFICATE

1. Letter from WITS Human Research Ethics Committee (Medical) dated 7 March 2007, Ref14/49 Janse van Rensburg.

2. Letter to WITS Human Research Ethics Committee (Medical) informing the committee about the change of title, dated 27 September 2007.

3. Letter from Faculty registrar dated 30 January 2008, re. approval of change of study title.

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APPENDIX 2.5 INVITATION TO PARTICIPATE IN THE STUDY AND INFORMED CONSENT

1 INFORMATION DOCUMENT: THE ROLE OF SPIRITUALITY IN SOUTH AFRICAN SPECIALIST PSYCHIATRIC PRACTICE AND TRAINING

Dear colleague

I would like to invite you to participate in this study. Most of you know me - I am currently employed as a senior specialist and senior clinical lecturer at WITS Division of Psychiatry and Helen Joseph Hospital, Auckland Park. I am also a member of SASOP's Southern Gauteng Subgroup and the local State Employee Special Interest Group representative. I have obtained approval from the WITS Human Research Ethics Committee – Medical (HREC), the Faculty of Health Sciences' Postgraduate Committee and the academic and clinical heads of the Division of Psychiatry to conduct the following study: **"THE ROLE OF SPIRITUALITY IN SOUTH AFRICAN SPECIALIST PSYCHIATRIC PRACTICE AND TRAINING"** in order to fulfill the requirements for a PhD.

1. What and who is involved – Your participation will entail taking part in one (or more if required) semi-structured interviews of one-hour duration each at a venue and time of your preference. A qualitative research question will be introduced and discussed: **"What is your view and experience on spirituality in specialist psychiatric practice and training?"** Non-directive communication techniques such as reflecting, paraphrasing, clarifying and summarizing will be used during the interview. Each interview will be audio taped and transcribed verbatim. Field notes will be compiled after each interview to describe underlying themes, dynamics and circumstances during the session, as well as my impressions of the interview. Records of the interviews (tapes and transcripts) will be securely stored within the WITS Division of Psychiatry for a period of about 6 years, after which it will be destroyed.

The primary target population for the study is the current group of consultants on the circuit of the University of the Witwatersrand's Division of Psychiatry, but determined by the saturation of data the study may be extended to a secondary group of psychiatrists on the circuits of the Universities of Pretoria and Limpopo/MEDUNSA and to practitioners/lecturers in private practice within the geographical area of Gauteng Province.

2. Information about the study – Results of the study will also be made available to you personally on request but mainly through professional meetings and submissions e.g. academic departmental or faculty meetings/structures, as well as through SASOP's regional subgroup and national meetings/conferences. Results may also be published in selected journals.

3. Risks – There are no foreseeable risks attached to the participation in this study.

4. Benefits – There are no direct benefit involved for you as participant. Benefits of the research may include the development of a model for "The Role of Spirituality In South African Specialist Psychiatric Practice And Training" and the development of guidelines for the application of the model as framework of reference. For ethical reasons, no reimbursement/remuneration for your participation in the study will be offered.

5. Voluntary participation – Although your academic head has been informed about this study, your participation is voluntary in your personal capacity and you can decide to withdraw at any time. Declining to participate on invitation or in the process of the study

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can/will in no way be used to your disadvantage. There will be no direct costs for you as a result of the study.

6. Confidentiality – All reasonable efforts will be made to keep personal information confidential. Data on general demographics and professional experience of participants needs to be documented in order to be able to contextualize the study. Research records and data analysis may however be inspected by bodies such as the HREC.

Researcher's contact detail: For any other questions, problems or queries with regards to participation please contact me on: Tel 011-489 0619; Fax 011-489-0623; Cell 082 807 8103; or email bernardj@gpg.gov.za

WITS HREC contact detail: Any problems, concerns or complaints about or as a result of this study can be directed to the WITS HUMAN RESEARCH ETHICS COMMITTEE (Medical) through the Secretary: Ms Anisa Keshav – Tel 011-717 1234; Fax 011- 339 5708; email keshava@research.wits.ac.za

THANK YOU FOR YOUR TIME AND PARTICIPATION.

Bernard van Rensburg

MBChB FCPsych MMed

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2. INFORMED CONSENT

2.1 INFORMED CONSENT TO PARTICIPATE IN INTERVIEW(S) FOR THE STUDY: "THE ROLE OF SPIRITUALITY IN SOUTH AFRICAN SPECIALIST PSYCHIATRIC PRACTICE AND TRAINING"

(1) I have read and understood the supplied INFORMATION DOCUMENT and summary of protocol for this study.
(2) I understand that the interview(s) to be conducted with me will be confidential, that I am participating in this study voluntarily in my personal capacity and that declining to participate on invitation or in the process of the study can/will in no way be used to my disadvantage.
(3) I understand and accept that no remuneration/reimbursement and no direct costs to me for participating in the study is involved.
(4) All questions about the purpose and process of and reporting on the study were answered by the researcher to my satisfaction.

NAME (PRINT) _____

SIGNATURE _____

DATE _____

PLACE _____

WITNESS _____

2.2 INFORMED CONSENT FOR THE TAPE RECORDING AND USE OF INFORMATION FROM INTERVIEWS FOR THE STUDY: "THE ROLE OF SPIRITUALITY IN SOUTH AFRICAN SPECIALIST PSYCHIATRIC PRACTICE AND TRAINING"

I hereby give my informed consent for the tape recording, transcription, analysis and reporting (including publication) by Dr. ABR Janse van Rensburg of the recorded content of the interview(s) conducted with me by him, for the purposes of this study according to the described methodology for the study.

NAME (PRINT) _____

SIGNATURE _____

DATE _____

PLACE _____

WITNESS _____

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APPENDIX 2.6 EVALUATION AND DESCRIPTION OF THEORY

GUIDELINES FOR THE EVALUATION OF THEORY – CHINN AND KRAMER (pp135-136)[2]

1. **How clear is the theory?**
   - Are major concepts defined?
   - Are significant concepts not defined? Are definitions clear? Congruous? Consistent?
   - Are words coined? Are coined words defined?
   - Are words borrowed from other disciplines and used differently in this context?
   - Is the amount of explanation appropriate? Too much? Not enough?
   - Are examples and diagrams used meaningful?
   - Are basic assumptions consistent with one another? With purposes?
   - Is the view of person and environment compatible?
   - Are the same terms defined differently?
   - Are the same terms defined similarly?
   - Are concepts used in a manner consistent with their definition?
   - Are diagrams and examples consistent with the text?
   - Are compatible and coherent structures suggested for different parts of the theory?
   - Can the theory be followed? Can an overall structure be diagrammed?
   - Where, if any, are gaps in the flow? Do all concepts fit within the theory?
   - Are there many ambiguities as a result of sequence of presentation?
   - Does the theorist accomplish what s(he) sets out to do?
2. **How simple is the theory?**
   - How many relationships are contained within the theory?
   - How are the relationships organized?
   - How many concepts are contained in the theory?
   - Are some concepts differentiated into sub concepts and other not?
   - Can concepts be combined without losing theoretic meaning?
   - Is the theory complex in some area, not in others?
   - Does the theory tend to describe, explain, or predict? Impart understanding? Create meaning?
3. **How general is the theory?**
   - How specific are the purposes of this theory? Do they apply to all or only some practice areas? When?
   - Is this theory specific to (discipline)? If not, who else could use it? Why?
   - Is the purpose justifiably a (disciplinary) purpose?
   - If sub purposes exist, do they reflect (clinical) actions? How broad are the concepts within the theory?
4. **How accessible if the theory?**
   - Are the concepts broad or narrow?

[2] Chinn PL, Kramer MK. 1995. Developing of nursing theory. In Theory and Nursing: A Systematic Approach. St. Louis, Missouri: Mosby-Year Book Inc.

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- How specific or general are definitions within the theory?
- Are the concepts' empiric indicators identifiable in reality? Are they within the realm of (clinical practice and training)?
- Do the definitions provided for the concepts adequately reflect their meanings?
- Is a very narrow definition offered for a broad concept? A broad meaning for a narrow concept?
- If words are coined, are they defined?

5. How important is the theory?

- Does the theory have potential to influence (clinical) actions? If so, to what end? Is that end desirable?
- Does the theory influence (psychiatric) education? Research? If so, to what end? Is that end desirable?
- How specific are the purposes of the theory? Do they provide a general framework within which to act or a means to predict phenomena?
- Is the theory's position about people, about (psychiatry), and about the environment consistent with (psychiatry's) philosophy?
- Given the purpose of the theory and its orientation, what of significance to (psychiatry) or health care has been omitted?
- Is the stated or implied purpose one that is important to (psychiatry)? Why?
- Will use of the theory help or hinder (psychiatry) in any way? Is so, how?
- Will application of this theory resolve any important issues in (psychiatry)? Will it resolve any problems?
- Is the theory futuristic and forward-looking?
- Will research based on the theory answer important questions?
- Are the concepts within the domain of (psychiatry)?
- Do I like this theory? Why?

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GUIDELINES FOR THE DESCRIPTION OF THEORY - CHINN AND KRAMER (pp118-119)[3]

1. **Purpose**
   - Why is this theory formulated?
   - Is there an overall purpose for the theory? A hierarchy of purposes? Separate numerous purposes?
   - Is the a purpose for the (practitioner)? The person receiving care/training? Society? Environment?
   - How broad or narrow is the purpose?
   - What is the value orientation of the purpose? Positive, negative, neutral?
   - Does achieving the theoretic purpose require a (clinical) context?
   - Does/do the purpose/purposes reflect understanding? Creation of meaning? Description, explanation, and prediction of phenomenon?
   - When would the theory cease to be applicable? What is the 'end point'?
   - What purpose not explicitly embedded in the matrix of the theory can be identified?

2. **Concepts**
   - Is there one major concept with sub concepts organized under it?
   - How many concepts are there?
   - How many major ones?
   - How many minor ones?
   - Can the concepts be ordered, related? Arranged into any configuration? Are there concepts that can not be interrelated?
   - Are concepts broad in nature? Narrow?
   - How abstract or empiric are the concepts?
   - What is the balance between highly abstract and highly empiric concepts?
   - Do concepts represent objects, properties, events? Can you say? Are there concepts that are closely related?

3. **Definitions**
   - Which concepts are defined? Which are not?
   - Which concepts are defined explicitly? Which are implied?
   - How much meaning needs to be inferred?
   - Which concepts are defined specifically? Generally?
   - Are there competing definitions for some concepts? Are the similar definitions for different concepts?
   - Do any explicitly defined concepts not need definition?
   - Are any concepts defined contrary to common convention?

4. **Relationships**
   - What are the major relationships within the theory?
   - Which relationships are obvious? Which are implied?
   - Do relationships include all concepts? Which are not included?
   - Are some concepts included in multiple relationships?

[3] Chinn PL, Kramer MK. 1995. Developing of nursing theory. In Theory and Nursing: A Systematic Approach. St. Louis, Missouri: Mosby-Year Book Inc.

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- Is there a hierarchy of relationships? Do relationships create meaning and understanding? Do they do this by describing, explaining? Predicting? What mix of each?
- Are relationships directional? What is there direction? Are they neutral?
- Are there mixed, competing, or incongruous relationships?
- Are relationships illustrated?

5. Structure

- How are overall and individual ideas organized?
- If outlined, what would the theory look like?
- Do relationships expand concepts into larger wholes or vice versa? Do they link concepts in a linear fashion?
- Does the structure move concepts away from or toward the purposes?
- Are there several structures that emerge? What is there form? Do they fit together?
- Could more than one structure represent the overall structural relationships?
- Where is there no structure?

6. Assumptions

- What assumptions underlie the theory? Are assumptions explicit, implicit, or derivable from context ad meaning?
- What are the individual, (practitioner), society, environment and health assumed to be like?
- Do assumptions have an obvious value orientation? What is it?
- Could assumptions be factually verified?
- Where are assumptions located within the structure? Prior to, within, or following theoretic reasoning?
- Can assumptions be hierarchically arranged or otherwise ordered?
- Do assumptions have any identifiable relationship to theoretic relationship or structure?
- Are there competing assumptions?

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APPENDIX 3.1 LITERATURE AND READING MATERIAL SUBMITTED BY PARTICIPANTS

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2. *3 Fabrega H. Culture, spirituality and psychiatry. Current Opinion in Psychiatry. 2000; 13:525-530

3. *6 Gallagher RE. 'A case of demonic possession.' February 2008. Faxed document, source unspecified

4. *7 Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: professional boundaries and ethics. Annals of internal medicine. Vol132:7, 2000; pp578-538

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6. *7 Mohr WK. Spiritual issues in psychiatric care. Perspectives in Psychiatric Care. Vol 42(3), 2006; p174-183

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8. *7 Annals of Family Medicine Oct 2008(6) – Editorial and articles.

*** Participant's number**

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APPENDIX 3.2 INTERVIEW QUOTATIONS

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APPENDIX 3.3 SUMMARY OF LITERATURE

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APPENDIX 4.1 DRAFT MODEL PRESENTED TO EVALUATING PANEL

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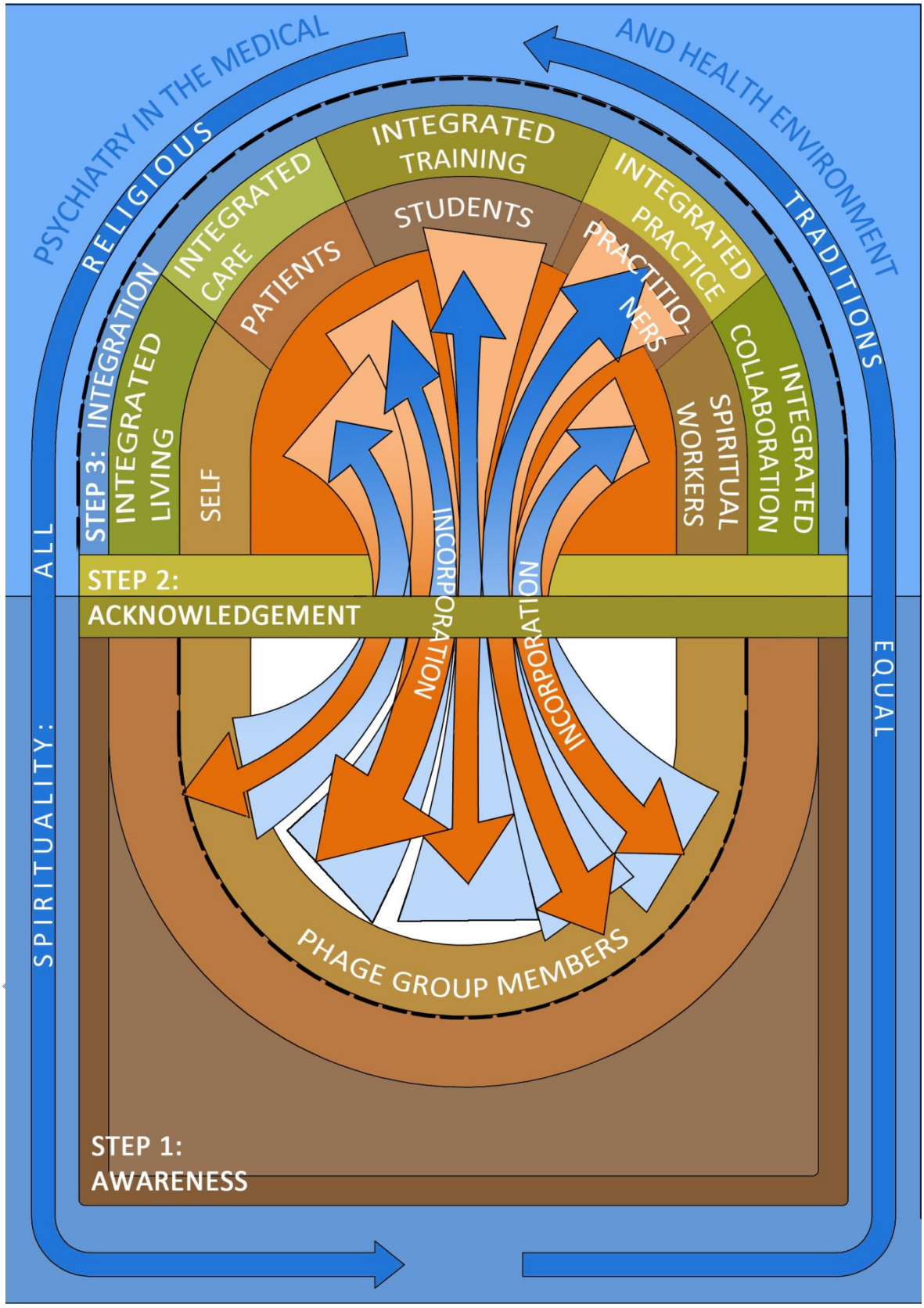

Draft model presented to evaluating panel (See paragraph 4.2.1, p245)

APPENDIX 4.2 TRANSCRIPTION OF EVALUATING PANEL REVIEW

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