Relationship between spirituality and mental illness

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Abstract: Objective: The concept of spirituality is inclusive and affects everybody. The aim of this research was Identify the relation between spirituality and mental health and illness and compare between level of spirituality in mentally ill patients and level of spirituality in mentally health persons **Methods:** The study was conducted at Tanta Mental Health Hospital. The subjects of this study classified into two groups: group I consisted of 51psychotic patients and group II consisted of 60 people with positive mental health. The data collected by using spiritual Attitude Inventory (SAI) and Mental Health Self- Assessment Questionnaire. **Results:** the majority of group I patients 84% have high score and 91.67 of the group II fall in the same category with no statistically significant relation was found between group I and group II. There is a positive significance statistical correlation between duration of mental illness and high score of NRCOPE and EWBS **Conclusion:** both group I and group II have a high score of spiritual inventory attitude. These result reflect high religious, greater locus of control, greater existential well -being, and lower levels of negative religious coping between mentally ill patient and people with positive mental health.

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1. Introduction:

Spirituality is concerned with meaning and purpose, love and harmonious relationships, forgiveness, trust, sources of hope and strength, expressions of personal beliefs and values, and the expression of the concept of God through spiritual practices. Included these aspects in his model of nursing, which demonstrates how each person has different, interconnected levels of functioning that need to be addressed in holistic nursing care.[1-2]

Spirituality is defined as feeling connected or belonging in the universe, believing in a power outside one's self, searching for a sense of meaning or purpose, experiencing transcendence, seeking one's ultimate and personal truths, knowing of the unity of visible and invisible, having an internalized relationship between the individual and the divine, encountering limitless love, and moving toward personal wholeness. Spirituality is more concerned with direct experience of latent higher consciousness within one's self, i.e. the internal space, whereas religion is an institutionalized set of beliefs, practices, and guidelines that an individual adopts and follows.[3-6]

A person's own sense of their place in the universe and how they relate to it: maybe but not always with reference to an idea of a 'higher power'. Thus people may identify themselves as 'spiritual' but not 'religious' they have not got a label or identity that neatly falls under a religious faith (and this can be a deliberate choice or because they have not yet found a religious system that fits comfortably with their own spirituality). Spirituality encompasses religion and belief, but can be broader than this. Religion – the way people organize their way of relating to what they hold to be sacred and transcendent. Thus, "spiritually healthy individuals stand in right relationship with themselves, with other people, with the world in which they live, and with the transcendent, however they conceive it. Spiritually healthy individuals build purposeful lives, develop sound relationships, and take responsibility for the world around them.[7-9]

Spirituality and the field of mental health have one common major goal; to alleviate emotional suffering, to liberate and blossom the self. A major goal of mankind since ages has been to seek liberation from suffering, both physical and mental. Every civilization, culture, and society came out with their unique solutions to deal with suffering. Almost all ancient civilizations had a strong belief in God, soul, and spirituality and well laid-down means and methods through which spiritual enlightenment could be attained.[10-12]

Since ancient times it is relentlessly believed that spiritual engagements further a sense of well-being. Researches in the contemporary psychology though in their nascent state have reached a similar conclusion. It has been found that life satisfaction correlates positively with mystical experiences and people who have had spiritual experiences report tremendous positive feelings as compared to others.[13-15]

In recent past, several neurocognitive researches have been attempted to comprehend the impact of spiritual activities on human brain. It has been found that prefrontal lobes of monks are lit even when they are not meditating and this area is responsible for positive emotions. researchers coming from a range of disciplines including psychology, psychiatry, medicine, neuroscience, theology, gerontology, and nursing have found evidence using modern scientific methods that spirituality helps in allaying various mental and physical illnesses. Overwhelming suffering that accompanies almost all mental and physical illnesses is reinterpreted within a spiritual framework as a journey or pilgrimage that fosters hope and individuals are able to locate meaning within their suffering. In modern societies where cohesive and supportive family structures are fast getting obliterated, spiritual and religious organizations provide much-needed social support which protects people from social isolation, bestows upon them a sense of belonging and self-esteem thereby equipping them to cope with stress and negative life events. (16-19)

Spirituality can affect a person's coping styles or their locus of control perceptions. It can also provide access to a network of social support and increase social capital, both of which are widely acknowledged to promote and sustain emotional and psychological wellbeing. Some expressions of spirituality affect the lifestyle and may encourage individuals to limit illness-related behaviors, such as smoking, drinking excessive alcohol and overeating, or to increase health-related behaviors such as meditation, exercise and helping others. Aspects of religious architecture and the built environment may also serve to mediate the effects of spirituality on mental health. (20, 22)

The role of spirituality in promoting mental health and alleviating mental illness is highlighted. Integrate spirituality within the mental health field albeit there are several impediments in achieving the same, which need to be worked through circumspectly. That patients' religious concerns have been taken seriously is evidenced by the fact that the American Psychiatric Association has issued practice guidelines regarding conflicts between psychiatrists' personal religious beliefs and psychiatric practice.(5,22-23)

Spiritual beliefs and practices have long been thought to have a pathological basis, and psychiatrists over a century have understood them in this light. So, many psychiatric nurses should now believe that religion and spirituality are important in the life of their patients. Spirituality is a key aspect of patient-centered, holistic care, particularly in mental health care. Although many patients express the importance of spirituality in their recovery, services and staff often neglect this area Although many staff acknowledge their role in meeting patients' spiritual needs, they often lack confidence in this area(19)

Aim:

1- Identify the relation between spirituality and mental health and illness
2- Compare between level of spirituality in mentally ill patients and level of spirituality in mentally health persons

Research question

Is their relation between spirituality and mental health and illness?

What is the relation between spirituality and mental illness?

2. Material and Method

Material:

Study design:

The design will follow in this study was descriptive cores sectional design.

Setting:

For the group I: The study was conducted at Tanta Mental Health Hospital. This hospital is under the supervision and direction of the Ministry of Health. It has a capacity of 75 beds divided as, three wards for male patients with 50 bed and two words for female patients with 25 bed and provides health care services to Gharbya, Menofia, and KafrElsheikh Governorates'.

For the group II: faculty of nursing at Tanta university, Tanta Mental Health Hospital.

Subjects:

The subjects of the present study classified into two groups: **group I** consisted of 51psychotic patients and **group II** consisted of 60 people. They were selected according to the following criteria

Criteria for group I:

1- Aged at least 18 years
2- Willing to participate in the study and able to communicate
3- Have present or past history of psychiatric disorders

Criteria for group II:

1- Aged at least 18 years
2- Willing to participate in the study and able to communicate
3- Free from mental illness
4- Both sex
5- Have positive mental health through Mental Health Self-Assessment Questionnaire (at least 6 points on **MHSAQ**)

This group involves 211 persons from patient's relatives, hospital staff and nursing students**.** The 61 person only follow the criteria of this study

Tools of the study:

The data of the study collected by using the following tools:

Tool I: Spiritual Attitude Inventory (SAI) which including two parts

Part one: A-Socio-demographic characteristics namely (age, sex, religious, and diagnosis and comorbidity)

Part two: Spiritual Attitude Inventory (SAI)[26-33]

The Spiritual Attitude Inventory (SAI) is designed to assessment of spirituality and/or to track an individual's spiritual beliefs over time as part of a comprehensive approach to wellness.

The Spiritual Attitude Inventory consists of 28-item developed by combining four currently validated measures of religion and spirituality to address the following areas:

- Religious spiritual practice was measured by the Duke Religion Index (DUREL).
- Religious/spiritual belief was measured by the Negative Religious Coping (NRCOPE) scale.
- Sense of purpose/connection was measured by the Existential Well-Being Scale (EWBS) a subscale of the Spiritual Well Being Scale (SWBS).
- Sense of hope/control measured by the internal/external subscale of the Multiple Health Locus of Control Scale (MHLC).

Higher scores on the SAI indicate greater spirituality. The SAI is classified as the following.

- DUREL: Items 1– 5 on the SAI, Each statement was rated on a 5 point Likert scale where1=definitely True, and 5= definitely not true, High scores indicate high levels of religiosity.
- EWBS: Items 6– 15 on the SAI, Each statement was rated on a 6 point Likert scale where1=strongly disagree, and 6= strongly dis agree, Higher scores indicate greater existential well-being.
- NRCOPE: Items 16–22 on the SAI, Each statement was rated on a 4 point Likert scale where1 a great deal =, and 4= not at all, higher scores indicate lower levels of negative religious coping.
- MHLC: Items 23–28 on the SAI, Each statement was rated on a 6 point Likert scale where1=strongly disagree, and 6= strongly dis agree, Higher scores indicate endorsement of an internal locus of control**.**

Tool II: Mental Health Self- Assessment Questionnaire (MHSAQ)[35]

Mental Health Self-Assessment Questionnaire consists of 14 item developed to evaluate level of mental health.

Each person can have a score ranging from 0 to 12

Total score =12 grades classified as follows:

Less than 6 = negative mental health

Above 6 = positive mental health

Method

- An official approval will be obtained from the identified hospital to collect the study data.
- Tool I Spiritual Attitude Inventory (SAI)and tool II Mental Health Self- Assessment Questionnaire (MHSAQ) will be translated by the researcher
- Tool (I) and (II) were tested for their translation and content validity by a group of 5 experts in the psychiatric nursing field from the Faculty of Nursing Tanta University. The required modifications were carried out accordingly
- A test -retest reliability will be applied on the two previously mentioned tools.
- Informed consent to participate in the study will be obtained from the study subject after explanation the purpose of the study and assurance the nurses about their privacy and confidentiality of the obtained data. The nurses will be informed that they have a right to withdraw from the study at any time if they wanted.
- A pilot study will be carried out on 10 persons after taking their approval to ascertain the clarity and applicability of the study tools. In addition, it serves to estimate the approximate time required for interviewing the study subject as well as to identify obstacles that might be faced during data collection. These persons will be excluded later from the study sample.
- Necessary modification will be done.
- All persons in group II 215 person interviewed to assess by using MHAQ to assess their mental health level,then, the researcher choose the person who have high score above6(it means positive mental health and free from any psychiatric disease) to participate in this study
- The researcher distribute the study tools to the group I and group II and ask to fill them in the presence of the researcher for more elaboration
- The data of the study collected over period of 5 months from January to May 2013
- Statistical presentation and analysis of the present study was conducted, using the mean, standard error, student t- test, Paired t-test, Chi-square, Linear Correlation Coefficient, and Analysis of variance [ANOVA] tests by SPSS V18

3. Result

Table (1) presents distribution of group I and group II regarding their socio demographic characteristics. The results revealed that all patients of the group I were Muslims, most of them are males (70%), 80%were employed and most them were from rural area (70%) with age range from 20-80. While most of group II were female (65%), all of them were Muslim, the most of them were from rural area (73.2%), the majority of them were employed, with age range 18-85.

Table (2) presents distribution of group I according to the clinical characteristics, and the most common diagnosis of the patients were schizophrenia (43%). In relation to duration of mental illness, 62% of patients have no morbidity with mental illness. The studies patients have from 1-to 30 years as duration of mental illness.

Table (3) Revealed comparison between group I and group II score of spirituality attitude inventory (SAI). The study results revealed that, in relation to Religious spiritual practice was measured by the Duke Religion (DUREL), most of the group I patients (72%) have high score, while the majority of group II (95) have high score with statistically significant deference at 0.001.

In relation to Existential Well-Being Scale (EWBS), about half of studied patients (54) have high score compared with 61.67 with no statistically significant relation, there is no statistically significant relation was found between group I and group II

In relation to Negative Religious Coping (NRCOPE), the majority of group I patients (90%) have high score while 83%fall in the same category, there is no statistically significant relation was found between group I and group II

In relation to Multiple Health Locus of Control Scale (MHLC), the majority of group I patients 94% have high score and 95%of group II have the same score, there is no statistically significant relation was found between group I and group II

Regarding to total score of SIA, the majority of group I patients 84% have high score and 91.67 of the group II fall in the same category with no statistically significant relation was found between group I and group II

Table 3 revealed Comparison between items of spirituality attitude inventory (SAI) in group I and group II by mean, one can notice that, the Existential Well-Being Scale (**EWBS)** has the highest mean of spirituality attitude inventory in group I and group II.

Table 4 reveals the Relationship between sex and item of spirituality attitude inventory**,** the result indicate that male patient have a mean total score 94.114 while female patients have 89.933 with no statistically significant relationship between patient's sex and item of spirituality attitude inventory

Table 5 reveals the Relationship between comorbidity and item of spirituality attitude inventory**,** the result indicate that no statistically significant relationship between patient's comorbidity and item of spirituality attitude inventory

Table 6 reveals the Relationship between patients' age, duration of mental illness and item of spirituality attitude inventory**,** the result indicate that there is a positive statistically significant relationship between patient's duration of mental illness and EWBS and NRCOP item of spirituality attitude inventory (increasing duration of mental illness leading to elevating of EWBS and NRCOP score)

Table 7 represents correlation between spirituality attitude inventory items and residence of group I.the study revealed that the patients in rural area have a high Mean than patient in rural area (94.133) without significant statistical relation

Table 8 revealed Relationship between spirituality attitude inventory items and employment of group I, the present study showed that employed patients have higher mean than non-employed patients (97.95)

Table 1: Socio demographic characteristic of studied patients and group II

Socio demographic characteristic		Group I (N=50)		Group II (N =60)	
		No	%	No	%
Sex	Male	35	70%	21	35%
	Female	15	30%	39	65%
Residence	Rural	35	70%	44	73.2%
	Urban	15	30%	16	26.8
Employment	Employed	40	80%	50	82.2%
	Non employed	10	20%	10	16.8%
Age	Range	20-86		18-85	
	Mean+ SD	41.540±14.282		28.950±11.553	

Table 2: clinical characteristic of studied patients (group II)

Clinical characteristic		No (50)	%
Diagnosis	Depression	7	14%
	Schizophrenia	32	64%
	Obsessive compulsive disorders	3	6%
	Substance abuse	1	2%
	Mania	4	8%
	Schizoaffective	3	6%
Comorbidity	Present	19	38%
	Not present	31	62%
Recurrence of mental illness			
Duration	Range	1-30	
	Mean+ SD	10.878±8.652	

Table 3: Comparison between items of spirituality attitude inventory (SAI) in group I and group II

		Patients N= 50		Controls N= 60		Total N=110		Chi-square	
		N	%	N	%	N	%	X^2	*P*-value
DUREL%	Low	14	28.00	3	5.00	17	15.45	11.042	0.001*
	High	36	72.00	57	95.00	93	84.55		
EWBS%	Low	23	46.00	23	38.33	46	41.82	0.659	0.417
	High	27	54.00	37	61.67	64	58.18		
NRCOPE%	Low	5	10.00	10	16.67	15	13.64	1.029	0.310
	High	45	90.00	50	83.33	95	86.36		
MHLC%	Low	3	6.00	3	5.00	6	5.45	0.053	0.818
	High	47	94.00	57	95.00	104	94.55		
Total%	Low	8	16.00	5	8.33	13	11.82	1.538	0.215
	High	42	84.00	55	91.67	97	88.18		

Table 3: Comparison between items of spirituality attitude inventory (SAI) in group I and group IIs by the Mean

	Patients			Controls			T-test	
	Mean	±	SD	Mean	±	SD	T	*P*-value
DUREL	16.700	±	4.062	19.950	±	2.873	-4.901	0.000
EWBS	31.020	±	10.090	32.200	±	9.719	-0.623	0.535
NRCOPE	21.140	±	6.682	18.183	±	5.101	2.630	0.010
MHLC	24.000	±	4.682	24.800	±	3.952	-0.972	0.333
Total	92.860	±	17.914	95.133	±	13.892	-0.749	0.455

Table 4: Relationship between group I patient's sex and item of spirituality attitude inventory

	Sex (N =50)							
	Male			Female			T-test	
	Mean	±	SD	Mean	±	SD	T	*P*-value
DUREL	17.257	±	4.348	15.400	±	3.043	1.500	0.140
EWBS	31.914	±	9.769	28.933	±	10.859	0.956	0.344
NRCOPE	20.629	±	6.371	22.333	±	7.451	-0.824	0.414
MHLC	24.314	±	4.670	23.267	±	4.788	0.722	0.474
Total	94.114	±	19.020	89.933	±	15.215	0.753	0.455

Table 5: Comparison between comorbidity and item of spirituality attitude inventory

	Comorbidity. (N=50)							
	Present			**Not present**			**T-test**	
	Mean	±	SD	Mean	±	SD	T	*P*-value
DUREL	16.056	±	3.857	17.065	±	4.258	-0.827	0.412
EWBS	34.556	±	9.787	29.645	±	9.372	1.740	0.088
NRCOPE	23.611	±	5.627	19.935	±	6.938	1.910	0.062
MHLC	23.833	±	5.639	24.097	±	4.214	-0.186	0.853
Total	98.056	±	15.976	90.742	±	18.243	1.414	0.164

Table 6: Relationship between group I patients' age, duration of mental illness and item of spirituality

	Age (N =50)		**Duration**	
	R	***P*-value**	**R**	***P*-value**
DUREL	0.218	0.127	-0.001	0.995
EWBS	0.203	0.157	0.316	0.044*
NRCOPE	0.198	0.167	0.366	0.019*
MHLC	0.063	0.663	-0.080	0.617

Table7: Correlation between spirituality attitude inventory items and residence of group I

	Rural			Urban			T-test	
	Mean	±	**SD**	**Mean**	±	**SD**	**t**	***P*-value**
DUREL	17.029	±	3.952	15.933	±	4.350	0.872	0.388
EWBS	30.943	±	10.773	31.200	±	8.629	-0.082	0.935
NRCOPE	20.771	±	6.826	22.000	±	6.481	-0.592	0.557
MHLC	23.571	±	4.182	25.000	±	5.720	-0.989	0.328
Total	92.314	±	19.828	94.133	±	12.878	-0.326	0.746

Table 8: Relationship between spirituality attitude inventory items and employment of group I

	Employed			Non employed			T-test	
	Mean	±	SD	Mean	±	SD	t	*P*-value
DUREL	18.100	±	4.105	16.350	±	3.755	-1.225	0.227
EWBS	31.550	±	9.966	28.900	±	10.847	0.739	0.463
NRCOPE	21.200	±	6.521	20.900	±	7.666	0.126	0.900
MHLC	27.100	±	3.846	23.225	±	6.471	-2.459	0.018
Total	97.95	±	17.003	89.375	±	22.091	-0.419	0.677

4. Discussion

Spirituality can play an important role in helping people live with or recover from mental health problems. Spirituality is not tied to any particular religious belief or tradition. Although culture and beliefs can play a part in spirituality, every person has their own unique experience of spirituality - it can be a personal experience for anyone, with or without a religious belief. It's there for anyone.

Spirituality can also help people deal with mental distress or mental illness. Spirituality can bring a feeling of being connected to something bigger than yourself and it can provide a way of coping in addition to your own mental resilience. It can help people make sense of what they are experiencing. Interest in the relationship between spirituality and mental health is being explored in a number of ways.

The present study revealed that, most of the studied patients in group I had high score of Duke Religion Index (DUREL) and the majority of group II fall in the same category. This result indicate that both group I and group II have high level of religious, this result means that the majority of group I and group II attend to the church or mosques many times, spend a lot of time in private religious activity, experience the presence of Allah, religious belief effects on their approaches in life, and carry religious over into all other dealing in life. This may be probably due to the all participant are Egyptian, and the Egyptian are spend a lot of time in religious activities and their religious effects on their approaches in life, also, this result may be due to that

the majority group I and group II are of Muslims and live in rural area, and the people in this era are religious so much.

The study also reveals that about half of group I and group II have greater existential well-being(EWBS), this may be probably due to that the most of both groups are employed and feel that the life is a positive experience, fell satisfied with life, and the believe that there is real purpose of life

The majority of both groups have low level of negative religious coping(NRCOPE) and have endorsement of an internal locus of control this may be probably due to, more of Egyptian society have strong religion and certain value and Allah even they are healthy or in the period of illness. Group I patient feel that the diseases are the mercy from Allah and have a lot of reward and they feel attached to Allah and feel satisfied with everything comes from Allah, in Islam, the period of illness are the chance to repentance.Those people believe in the power of Allah.

There is a positive significance statistical correlation between duration of mental illness and high score of NRCOPE and EWBS. This is may be due to when the length of period of disease increase, the patient become more close to Allah, coping positively with his disease and have greater extensile well being

Regarding to MHLC the majority of the group I and group II have greater locus of control, this probably due to Egyptian people also have sense of that their action and behaviors are responsible about their condition and if they change their behavior they can still healthy. For the some mentally ill patients they think that their illness result from their flutes and mistakes, and other patients think that Allah love him so much so, Allah give him this chance to be attached to him

In this respect ***Young*** (2012)[36] mentioned that high spirituality has positive effect on mental illness and quality of life Attachment theory, originally introduced by Bowlby, has been adopted and modified by Kirkpatrick to explain the ways of spirituality in enhancing individual's general well-being. According to the attachment theory, the Transcendent or God can become an important attachment figure for people. People will turn to the God for comfort and security during stressful circumstances as if a child asks for the protection from his parents during stressful circumstances. People who experience a secure connection with God would experience greater strength, confidence, and comfort.

This results contradict with ***Jong-Ik, Jin Pyo Hong***[37] this study revealed two important associations between mental disorders and spirituality. We confirmed that attaching high importance to spiritual values was associated with a higher prevalence of current depression, irrespective of causality. In contrast, a higher importance placed on spiritual values was also associated with less current alcohol use disorder. However, this study did not confirm any associations between spirituality/religion and past mental disorders or indicate any significant relationship between anxiety disorder and spiritual values

In the study for ***Jansen et al,, 2009***[38], he examined the existing models religion and spirituality with the specific purposes of a determining how religious commitment, spiritual awareness, religious quest, and extrinsic religious correlate with depression and anxiety, examining meaning in life as a mediator between religiosity/spirituality and mental health. The main the result Religious quest was the only variable of religiosity/spirituality that showed a negative correlation with depression and anxiety and was the only variable of religiosity that supported a mediating effect of meaning in life. All variables of religiosity and spirituality reported a significant positive relationship with meaning in life, and meaning in life was significantly negatively correlated with depressive symptoms and symptoms of anxiety. Significant indirect effects were found between all measures of religiosity/spirituality, meaning in life, and depression/anxiety symptoms. These significant indirect effects showed that there are significant implications for the role that meaning in life plays in the relationship between religiosity/spirituality and mental health. The results of the present study reflect the possibility that a mental illness motivate people to search for spiritual meaning or the power of God.

In general, results of the present study are in accordance with the literature and prove that spirituality can improve mental health. Also, mentally ill patients have high level of spirituality. It is also importance to nurses to assure the importance of the involvement of spiritual activities in patients nursing care plan.

Conclusion and recommendations

According to the findings of the present study, it can be concluded that both group I and group II have a high score of spiritual inventory attitude. These result reflect high religious, greater locus of control, greater existential well -being, and lower levels of negative religious coping. There is a positive significance statistical correlation between duration of mental illness and high score of NRCOPE and EWBS. So, that spirituality in all items has great importance to psychiatric patients. It is also importance to nurses to assure the importance of the

involvement of spiritual activities in patients nursing care plan

The followings are the main recommendations yielded by the present study:

1. The patient with mental illness should be continuously and regularly submitted to spirituality program and counseling
2. Involve religious activity in daily schedule of patient, because it's very important to him.
3. In-services training programs and workshops need to be implemented for hospital staff to provide information about importance of spirituality for mentally ill patients.
4. Develop new program for psychiatric patients about new ways of coping with daily disappointments
5. Establish this study to large number of psychiatric patient in different settings to confirm the result or elaborate it.

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