Purpose of the document:

These spiritual guidelines support the work of Mental Health and Addiction Professionals (MH&AP) at Vancouver Community Mental Health and Addiction Services. MH&AP are required to engage in spirituality conversations with clients unless clinically contraindicated. This document intends to expand professionals’ knowledge and skill in engaging in their own understanding of spirituality and that of their clients. We acknowledge and honour the fact that MH&AP in the system vary in their understanding of, use of, and comfort with, spirituality.

The need for spirituality conversation:

From the perspective of consumers of mental health services, spirituality, despite its complexity, is viewed as a one of the nine most important components for recovery (Schrank & Slade, 2007). At least 79% of mental health consumers in Canada consider themselves spiritual and/or religious and have suggested the importance of incorporating their spiritual values with their care (Baetz et al. 2004).

It is important to recognise that many individuals and groups that are newcomers to Canada access their religious and/or spiritual leader as their first line of help seeking when experiencing mental health problems (The Mental Health Commission of Canada, 2009). This further indicates the need for MH&AP to be open to engage with an individual’s spirituality and their spiritual community.

MH&AP role in spiritual conversation:

Although MH&AP are not trained to give professional spiritual care of the kind provided by spiritual care professionals, MH&AP can integrate spirituality into care within the boundaries of mental health and addiction services in the following ways:

- treat each person with dignity and respect;
- acknowledge spirituality that supports mental health recovery;
- network with spiritual services that are part of a client’s support system; and
- refer to and network with spiritual care professionals where necessary.
VCH affirms the place for spiritual care professionals as part of a client’s interdisciplinary team (see Appendix 1 for types of spiritual care professionals).

**Tool: Spirituality for wellness and recovery: A Clinical Tool for Engaging Clients’ Spirituality**

Spirituality is a personal and individualised concept. Instead of providing a definition, a conversational framework is offered (see Appendix 2). This includes four conversation areas (meaning making, spiritual experience, spiritual activities, and community engagement), broad exploratory questions, and a sampling of spiritual ideas. A mini poster is available with this framework.

**Navigating spiritual conversations with clients:**

In order to support MH&AP in their process of engaging in spiritual conversation the authors have developed a decision-making algorithm (Figure 1) that shows when to:

- engage in spiritual conversation;
- refer to another professional; and
- become familiar with the clients spirituality.
Figure 1: Decision Making Algorithm
Important considerations (These are indicated with an * in Figure 1):

(a) Consider possible contraindications and timing:

Spiritual beliefs may play a role in how the client understands or explains their condition. These beliefs may affect a client’s treatment expectations and choices. Engaging spiritual beliefs that negatively impact mental health recovery may be very difficult to negotiate particularly during active psychosis or severe mood disturbances.

Here are some specific issues to consider:

1. **Depression**: Spiritual and/or religious practices are an important factor that may enable people to cope with stressful life circumstances. However, this may not be true in all populations, e.g. pregnant unmarried teens (Koenig, 2009).

2. **Suicide**: There is evidence that spiritual and/or religious beliefs may be a protective factor for suicide through coping, religious condemnation of suicide, and life meaning. However there is also evidence to suggest that beliefs can be a risk factor (i.e as an incentive to be with a higher power by dying, anger at ‘god’, to live another life after death, the mystical experience of death, breaking with a spiritual community) (Huguelet et al. 2007).

3. **Anxiety**: Studies report a mix of religious/spiritual beliefs provide both comfort that reduces anxiety and have the potential to exacerbate guilt and fear that reduces the quality of life and interferes with functioning (Koenig, 2009).

4. **Psychotic disorders**: Religious delusions may be very difficult to distinguish from acceptable, more widely held cultural and spiritual beliefs. In recent studies the thought form, quality of belief and the individual’s context has been used as an indicator for a delusion (Drinnan & Lavendar, 2006). It is crucial to consider the timing of conversations about visual and auditory hallucinatory experiences that may have spiritual meaning. Jackson and Fulford (2005) suggest that over time, an individual can decide whether a psychotic process has spiritual significance experience was spiritual or part of a psychotic process by the ‘fruit’ of the experience. They found that individuals in their study perceived spiritual experiences as life enhancing and empowered them toward positive action.

5. **Substance Abuse**: While religious and spiritual influences on substance abuse tend to be positive (discouraging use of substances), this is not always the case. When complete abstinence is promoted by a community, individuals who are living with SUD may
completely withdraw from these communities and face increased guilt and recalcitrant use (Koenig, 2009).

Case Study 1:
Ms S. is a 19 year-old college student who is a practicing Muslim. She was born and raised in Canada to parents of Pakistani origin and was an honor student in high school. Ms S. began feeling depressed a few weeks after arriving at University and did poorly in the first semester, failing three of her four courses. She developed a strong sense of guilt and shame over her failure. One of her close friends insisted that she should see a psychiatrist, but she refused to see anyone who was not a Muslim. By the time she first saw a Muslim psychiatrist (3 months later) she was severely depressed and isolated and had lost more that 15 of her original 115 lbs. Early in the interview she denied any suicidal or homicidal ideation, as well as any personal or family history of psychiatric illness. Toward the end of the first conversation with the psychiatrist, however she burst into tears and expressed overwhelming guilt over suicidal thoughts about throwing herself into the river. She questioned the strength of her faith and whether she was a good Muslim. She was aware that Islam does not allow suicide, but she felt worthless and considered her depression a punishment from God.
(Adapted from, Cook, Powell and Simms (2009) Spirituality and Psychiatry).

Considerations:
- On initial assessment, a question could be asked: “What are your beliefs about suicide?”, however if these are accompanied by a sense of shame, it may not prompt a totally honest response.
- Suicide is always in some sense an existential/spiritual question.
- When working with clients that are suicidal it is important to understand their beliefs and values and to learn how they may impact the client’s thoughts and actions, particularly with respect to protecting life and promoting wellbeing.
- Suicide is also connected with concerns about meaning/purpose in and of life.
- Conversations about meaning/purpose should be occurring throughout a therapeutic relationship in a context that is safe, respectful, trauma informed, kind, compassionate, caring and attuned.
- When developing a safety plan with a client, the MH&AP may ask: “Are you connected with a faith community or a religious or spiritual adviser that could provide support to you when you are feeling overwhelmed?”
- The timing to move into more direct discussion about spirituality/religion will make sense to both MH&AP and client in a conversation that occurs when a trusting therapeutic relationship has been developed.
- In order to build on protective factors a MH&AP can ask what makes a life worth living. If no Muslim MH&AP is available, talking to someone from the same cultural and spiritual context (a cultural broker) may be helpful for the MH&AP to become familiar with the client’s view of the world.
In this case Ms. S could not kill herself because it would go against her spiritual or religious convictions. Though protective, this thinking also presents a challenge if she is constantly thinking about suicide and her thinking may easily flip into thoughts of deserving to die because she has sinned or will sin against God’s laws.

- A MH&AP needs to be comfortable to respectfully have an exploratory conversation about spirituality and/or religion; always taking action on the side of preserving life.

(b) **Referral:**

**To another MH&AP:**
While working with a client, a MH&AP may note differences in culture, religion/spirituality and social status that may create a barrier for working well with the client. (see Arnault et al, 2011).

Exploratory questions a MH&AP may ask:
- Does the difference influence my ability to understand this client’s suffering?
- Are there topics that I cannot fully address or explore due to the difference?
- What is the impact of transference and counter-transference?
- Can I remain respectful and maintain essential professional integrity? (see Winslow et al., 2007).

**To a spiritual care professional:**
As a MH&AP our role is to acknowledge and support a client’s spirituality (meaning making, activities and community engagement). If a conversation about spirituality is beyond our scope, referral to a spiritual care professional may be necessary. There are a variety of different spiritual care professionals available to us (Appendix 1).

Reasons to refer a client to a spiritual care professional (see Appendix 3 for a more detailed list):
1. If religious/spiritual beliefs contribute to suffering:
   - client’s spirituality is an active stressor;
   - client is using spiritual language that is a barrier to emotional health (e.g. If I pray, God will cure me. I don’t need the help of professionals);
   - client’s use of religious practices is leading to further impairment and suffering.
2. Client is experiencing grief, loss or isolation;
3. Client needs to make an important value-guided, ethical decision; and
4. Client desires to develop healthy spiritual rituals and practices.

(c) **Becoming familiar with client’s spiritual beliefs/practices:**
1. Online Resources: [http://www.interfaithcalendar.org/](http://www.interfaithcalendar.org/) provides a resource on the major faith traditions in the world, their days of celebration and provides links to international sites representing these traditions;

2. Connect with a colleague who may have a similar worldview/spiritual belief/practice as your client: your colleague can serve as a cultural bridge/broker – giving a general ‘lay of the land’ in which a client’s particular spirituality rests;

3. Connect with client’s peers who practice or are familiar with their spirituality; this may mean engaging with a client’s spiritual community (Plante, 2007).

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**Case Study 2:**

Jim was referred to the mental health team on two occasions, once by the manager of the hotel where he lives and, the second time, by a medical practitioner at the Downtown Clinic where he had presented seeking treatment for an ear infection. On other occasions Jim had dropped by the mental health team on his own volition to request help. In June 2010, Jim came to the team requesting help. He had swallowed 21 feet of surgical twine as part of a yoga practice. At some point he had decided not to swallow further and attempted to pull the twine back out and there was 7 feet of twine that he had swallowed that would not come out. String was hanging from the side of his mouth down his chin with the end of it hidden in his jacket.

The case manager’s initial response was to have Jim seen by one of the physicians at the team. In an interview with the physician, Jim revealed that swallowing the twine is a yoga practice used for cleansing. He stated he had done this several times in the past without incident. Jim was calm throughout the interview and was agreeable to the advice of the physician to go to the hospital. Transport to the hospital was arranged. As he had come to the team on his bicycle, it was arranged that his bike would be stored at the team while he was in hospital. After Jim was taken to the hospital, the physician and case manager searched the internet for further information on this yoga practice.

When Jim was discharged from hospital, he came to pick up his bike. The case manager took this opportunity to try to engage Jim in discussion about other yoga practices that would be safer practiced under the guidance of a teacher. Jim listened but did not show any interest in pursuing other methods, even though he did admit that he was concerned in the future he might accidentally cause serious injury to himself as a result of these practices. The case manager was not able to engage Jim further.
Annotated Bibliography:


The authors provide sample questions and case studies to elaborate on the cultural formulation of distress and help seeking outlined in the DSM. Asking questions about meaning and spiritual explanatory models of illness are part of the assessment.


Participants from a range of religious backgrounds were asked about their religious experiences and beliefs, family background and experiences of psychosis. Through qualitative analysis the authors found that whilst religious background affected the content of delusions, the nature of delusions appeared to be influenced by other factors. Individuals often used a religious framework to understand unusual experiences, and there seemed to be a role for the process of identification and wish fulfilment in influencing delusional content. Whilst this research is clearly limited by its exploratory nature, it offers a possible framework of understanding which helps make sense of religious delusions, and suggests approaches which may be helpful in recovery.


A review of the research on spirituality, religion and mental health as applied to the Canadian population. Specific evidence for individuals diagnosed with depression, suicide, anxiety, psychosis and substance abuse. Koenig comments on beliefs and practices that may be important resources for coping and those that may contribute to mental pathology.


Outpatients with schizophrenia or schizoaffective disorder and inpatients without psychotic symptoms were interviewed assessing religiousness/spirituality. Their past suicide attempts were examined. Additionally, they were asked about the role (protective or incentive) of religion in their decision to commit suicide. Religiousness was not associated with the rate of patients who attempted suicide. Twenty-five percent of all subjects acknowledged a protective role of religion, mostly through ethical condemnation of suicide and religious coping. One out of ten patients reported an incentive role of religion, not only due to negatively connoted issues but also to the hope for something better after death. The authors found that religion may play a specific role in the decisions patients make about suicide, both in psychotic and non-psychotic patients. This role may be protective, a finding particularly important for patients with psychosis who are known to be at high risk of severe suicide attempts.
*Psyche and Geloof, 16*(1), 9-33.

In this paper, the authors use three detailed case histories to illustrate that psychotic phenomena could occur in the context of spiritual experiences rather than mental illness. Its implications are then explored for psychopathology, for psychiatric classification, and for our understanding of the concept of mental illness. It is argued that pathological and spiritual psychotic phenomena cannot be distinguished by 1) form and content alone (as in traditional psychopathology), 2) by their relationship either with other symptoms or with pathological causes (as in psychiatric classification), or 3) by reference to the descriptive criteria of mental illness. The distinction is shown to depend, rather, on the way in which psychotic phenomena themselves are embedded in the values and beliefs of the person concerned.


Plante uses the American Psychological Association Code of Ethics to analyse the integration of spirituality and psychotherapy. This article clearly highlights the possible traversing of mental health professional boundaries in the area of spirituality. Plante gives some clear guidelines how to engage with spiritual care professionals.


Puchalski is interviewed and describes the development of the FICA as a tool for spiritual assessment (Faith, Importance, Community and Address. This tool is helpful to ascertain how a client may want their spirituality addressed in the context of health care.


Winslow outlines the importance of respectful care that seeks a basic understanding of clients spiritual needs, resources and preferences; follows the clients expressed wishes regarding spiritual care; and does not prescribe spiritual pratices/beliefs. Winslow also outlines the importance for professionals to understand their own spirituality and uphold their professional integrity.

**Online recourses:**

5. Suicide and spirituality:
Appendix 1: **Types of Spiritual care professionals:**


(1) **Institution-based spiritual care**: Most hospitals, prisons, military installations etc have a spiritual care professional. These individuals are trained to work individually and in groups with clients assisting them in finding meaning, purpose, and values that are critical to their movement forward toward health and healing. They are familiar with most traditional spiritual and religious belief systems, are trained in bio-medical ethics, psychological and other interdisciplinary aspects to the integration of spiritual care and healing. They are usually well networked in the community.

(2) **Community Clergy**: These spiritual care professionals are trained in a specific tradition (a degree is required from a seminary and/or college). They oversee the spiritual wellbeing of a particular community. They can be helpful in giving insight to the big picture of a client or family’s life. They can bring information, support and community resources.

(3) **Community Spiritual Leaders**: Some faith traditions use terms like visitation minister, elder, medicine woman, shaman or lay leader. These individuals are usually trained by their community to provide care for someone going through a health crisis.

(4) **Community support**: Spiritual communities are often well structured to provide home-based care when someone is in a time of health crisis. They can be a vital partner for health professionals. These efforts may be coordinated by a Care Minister/Pastor or Parish Nurse.

(5) **Other Spiritual Resources**: Other intentional support groups such as AA, grief support, creative art group, may provide support for someone as they face recovery and beyond.
Appendix 3: What Spiritual Care Professionals can provide for clients:

**Assessment**

Spiritual care professionals (SCP) will assess the nature of the client’s struggle from the perspective of their own discipline within the context of the psychiatric diagnosis. They will then assess what level of spiritual care is appropriate.

**Assisting clients in coping with thought disorder issues**

Clients having troublesome religious/spiritual delusions may be open to spiritual support even when they reject other sources of help. SCP can help to differentiate thought disorders of a religious nature from the standard teachings of religious communities or integrating personal theologies. Clients with delusions or voices that are not religious in content may also be open to the support that relying on a higher power may provide for them in coping with such disturbing phenomenon.

**Normalization and learning healthy means of coping spiritually**

Due to the emotional alienation that can attend severe or chronic mental illness a client may have anthropologised the spiritual dimension of their self and thereby become alienated from much that is life giving and normal about them. SCP affirm the normalcy of the human desire to explore the spiritual dimension of the human condition while affirming good mental health practices regarding choices of avenues that are within the client’s ability to synthesize and integrate. For example, while everyone has the human right to attend silent retreats such an experience is likely too demanding and counterproductive for a person with schizophrenia who is hearing voices. SCP assist clients with recognizing that everyone needs to somehow face and cope with the human condition that involves a simultaneous sense of our separateness as well a sense of being connected and inter-related. Sorting out how some degree of alienation or loneliness is common to most of us from time to time and learning to self soothe through practices that are consistent with one’s own spiritual beliefs can be very comforting.

**Cooperation/Concordance**

By forming a therapeutic spiritual alliance with clients SCP explore questions of treatment concordance and cooperation with integrity through simultaneously respecting the client’s autonomy while affirming the intentions of the treatment team to foster healing.

**Emotional Struggles**

Clients who are emotionally distraught, anxious, depressed or fearful are frequently open to exploring their own spirituality as a source of comfort and solace. Similarly clients are often interested in exploring questions of meaning and existence but are not sure how to proceed without some skilled guidance by someone versed in spirituality and mental health.
Personality Disorders or troublesome traits
Clients who are caught in a cycle of self-defeating behaviours and interpretations are at times open to how their own understanding of a higher power may assist in their recovery. These clients can benefit from developing a spiritual focus as a means of interrupting the negative pattern and thereby experiencing enough hope, acceptance and courage to honestly look at themselves.

Self Esteem
Clients open to spirituality can find in it a wealth of affirmations about their value as human beings. The primary core of this affirmation is simply about being accepted as one is and as such it is not dependent upon performance, yet through primary acceptance persons are also affirmed in their sense of becoming and growing into a fuller maturity.

Exploration/Healing of Loss
Clients who have experienced a recent loss or have unresolved grief may benefit from intentional spiritually focused exploration through counselling and/or a spiritual practice. Unresolved grief can frequently be a major factor in some mood disorders.

Assisting with Addictions
Spirituality is a part of many addictions programs and an understanding of how to access one’s higher power can be most helpful to someone caught in a loop of feeling powerless by them self.

Developing Healthy Spiritual Practices
Some clients need assistance in finding or developing individual practices or communal practices such as attendance at worship services.