FULYA AKGÜL GÖK
Ankara University, Turkey

EZGI ARSLAN
Ankara University, Turkey

VELI DUYAN
Ankara University, Turkey

SPIRITUALITY AS A COPING MECHANISM FOR PROBLEMS RELATED TO MENTAL HEALTH

Abstract:

Emerging of the disease, accepting the disease and whole this process especially affect the life of the mental health patient's family. Parents shape and change their lives according the disease of the children and they cannot perform same activities before the disease. Parent's spare time decrease and creates some emotional problems as well as economic and social difficulties cause important effects in their lives. These individuals develop some coping strategies in order to overcome these problems. This study aims to explain and be understood the spirituality, one of these strategies.

This study aims to explain and determine the importance of spirituality as a coping mechanism while dealing with every psychosocial, physical and economic problems attached to families of the individuals with mental illnesses.

This study aims to explain and determine how the spirituality as a coping mechanism is used by families of the individuals with mental illnesses. Spirituality is wrongly understand as a religious term but it involves personal and intra-personal power of individuals. Its multidimensional term with the believing of some higher power than the individual's his/herself. Therefore it is really significant coping mechanism.

Keywords:

Spirituality; coping mechanism; mental health; social work; family

Caregiving Process and Spirituality

Psychiatric disorders are deeply affecting the lives of individuals who have mental diseases, as well as the lives of other family members. The socio-economic, physical and psychological effects, troubles and difficulties the caregiver have experienced conceptualized as "burden" in the literature. As a matter of fact, Zarit et al. (1980) refers to the concept of care load as a concept used without expressing the psycho-social and economic effects experienced while providing care; Platt has identified (Platt, 1985 as cited in Lowyck et al., 2004, 395) the existence of negative situations, difficulties or problems that affect the lives of caregiving individuals.

The presence of a mental illness in the family leads to the emergence of some forms of interaction in response to the illness. This results in a sense of burden as the other members of the family begin to deal with the disease (Levene et al., 1996).

The emergence of the disease, its acceptance, reactions to the symptoms of the disease, the regular use of medicines and the regular medical controls can affect the caregiver and the life of the family. In addition to this, the caregiver constantly needs to stay with the patient to take care of his / her needs, because of that the usual daily life activities of the caregiver and special hours reserved for him / herself decrease. Also the emotional troubles, the economic and social problems that the caregiver have experienced causes serious problems in family life. In a study carried out in Turkey, Karancı (1995) investigated the causal attributions, burdens and expectations of health personnel of patients' relatives. They found that the relatives of patients also deal with financial burdens of the care and treatment as well as emotional problems and conflicts in family life.

Psychiatric illness is a burden that goes beyond the medical dimension of the disease, both for the family of the person, and for the spiritual sense. Institutionalization has encouraged families of schizophrenic patients to take responsibility for providing informal care (Caqueo-Urizar et al., 2011). Foldemo et al. (2005) reported that the family of an individual with schizophrenia experienced deep anger, anxiety, guilt, fear, sadness.

Giving care to schizophrenic patients has a significant impact on family well-being, health and family behavior (Caqueo-Urizar and Gutierrez-Maldonado, 2006). In these difficult life events, family members, and especially caregiving individuals, develop some coping mechanisms to reduce the suffering they experience.

When we look at the situation in our country, it seems that the burden of the families is increasing because of the gradual disappearance of the large families where the patient's care can be shared, into nuclear families and because of the traditional structures of the society begins to dissolve (Gülseren et al., 2010). This has led to a shift in mental health services into the understanding that the needs of caregivers should also be met, as well as the treatment needs of the patient (Hughes, 1996). Chronic diseases cause families to experience stress, and families are developing a number of coping mechanisms to deal with this (Scazufca and Kuipers, 1999). Coping

mechanisms are a way of minimizing the problems of caregivers and raising their quality of life.

As A Coping Mechanism: Spirituality

Mental illness not only affects the patient but also deeply affects the family and social environment of the patient and the family. Apart from the patient affected at the primary level from the disease process, the individual giving them primary care is also directly affected by the disease process. The emergence of mental illness, which is very unknown by society, in their own children is a source of sadness for the families themselves. Besides, the fact that mental illnesses are among the least known diseases as their cause and symptoms are not widely known by the society causes the families to live in a feeling of uncertainty.

In the disease process, severe symptoms and treatment of the disease cause the lives of families and caregivers to change. The individuals under the burden of the disease process are beginning to question themselves, their lives and their environment at this stage. The inquiries that started with the question "Why did it happened to me/us?" can continue with such as "It's Allah's admonition", "This is the test of my life", "This is my destiny". These individuals use a number of coping mechanisms to relieve the burden of their lives and to reduce their distress to the lowest level.

The coping mechanisms are the cognitive and behavioral struggles that individuals use to control specific demanding situation (Caqueo-Urizar et al., 2011). The coping mechanisms adopted by caregivers are shaped by the personal characteristics of the caregiver, personal self-assessments and available support resources (Huang et al., 2007). One of the coping mechanisms used by caregivers of mental disease patients is spirituality.

Health is not only physical, psychological, mental and social, but also a spiritual well-being. Spirituality is the power beyond the individual and his being. So it is personal awareness that covers both the physical field and beyond. The place where the individual seizes the meaning and purpose of life is its spiritual space. This may be the subjective and latent relationship established by the supreme power of believing, or the relationship between the individual and nature, art, music, family, and social environment. As the love, acceptance and awareness of the individual increases, the state of well-being in the spiritual area also shows a positive development (Tuncay, 2007).

Advocates of the holistic health model emphasize the importance of spiritual dimension in health. Burns (1991: 142) stated that the spiritual dimension includes the level of harmony between intellect and soul, and the self-realization of one's self. Watson (1985)'s theory of self-maintenance differs from other theories related to the subject in a number of ways. The purpose of his theory is to discover the mental-spiritual development of the individual and others, to find meaning in one's own existence and experience, internal power and control (as cited in Burns, 1991).

Although spirituality and religion may seem like two similar concepts, spirituality is a broader concept including religious meanings (Mueller et al., 2001). Spirituality is a concept involving people's beliefs, feelings, values and attitudes (Elkins et al., 1988). Religion is a very complex structure that includes practices, rules, rituals and beliefs. Spirituality is a concept involving religion, emotions, thoughts and experiences of individuals (Rumbold, 2003). Spirituality includes both believers and non-believers.

Questioning the meaning and purpose of the life threatening illness and the life of the individual; (Prince-Paul, 2008; Baldacchino et al., 2012) make the person thinks about herself/himself by increasing the spiritual awareness of the individual through relationships with God and through some spiritual coping. On the contrary, the illness can lead to negative emotions such as hopelessness, uncertainty, and inadequate feelings about individuals' future (Bowman et al., 2006). Spirituality can increase the satisfaction of life and the level of adoption of the disease by affecting the individual's perception of the disease (Delgado, 2007).

The spiritual coping strategy includes existential and religious coping methods (Koenig, 2009). Existential coping mechanisms include finding the meaning and purpose of disease and life and knowing the individual's self, his family, his friends, his relationship with nature and art, and also his powers and boundaries (Baldacchino & Buhagiar, 2003). Individuals can also experience spirituality in the context of religion (such as continuing to relate to God and praying) (Vivat, 2008). In addition, negative perceptions about spirituality can lead decreasing the belief in and can cause a sense of hopelessness, but it can also increase the adaptation to disease and cope with it (Penman et al., 2009; Schneider, 2007).

Spirituality influences well-being by playing an important role on individuals' lives, thoughts and behaviors (Hadzic, 2011). Spirituality can be defined as something that gives hope, that strengthens the individual, and something to rely on (Coyle, 2002). The state of spiritual well-being is described as one's own coherent relationship with others, with nature and with the great / supreme power (Hunglemann et al., 1996). The spiritual well-being of an individual also affects the condition of physical and psychological well-being (Sullivan, 1993). Hill et al. (2000) found that there is an important relationship between spirituality and mental health status. The relationship with Ultimate Other includes belief in the supreme, trust in God, expression of God's love, ritual communication with God such as prayer, and religious practice. The relationship with others / nature involves accepting differences and accepting tolerance, mutual love, mutual forgiveness, helpfulness and being thankful for nature. The individual's self can help to accept the life situations and to accept the individual's self, his love for himself, his control over his own life, his positive thoughts and life satisfaction (Hunglemann et al., 1996). Persons' understanding of sickness is influenced by a number of religious and cultural beliefs and practices and life experiences (Penmann et al., 2009).

According to Baldacchino et al. (2012), praying alone or with others is an instrument of strengthening the individual's connection to God as a source of strength and hope, and at the same time strengthening the individual.

Some research suggests that spirituality and religion are an important source of coping mechanisms for traumatic events such as loss of a loved one, disease, and also there is a positive relationship between spirituality and health status (Shaw et al., 2005, Mueller et al. 2001).

In a study by Yeh and Bull (2009), it was concluded that caregivers' spiritual well-being is related to mental health status and positive coping. Again, in the same study, mental health scores of caregivers with better spiritual well-being were found to be better. Spirituality is an empowering element for people who are caregivers of a mental disease patients. Spirituality, while increasing the well-being of these individuals in difficult processes, also increases their adaptation to the disease process.

Conclusion

Psychiatric disorders affect the individual patient, the caregiver and the family. Many families are struggling to cope with this process by isolating themselves from society, not taking time for themselves and instead of expressing their feelings hiding them from the immediate vicinity. In this case, the individuals who come to the point of breaking apart from their own selves are increasingly starting to distaste from life and themselves and they become alienated.

Mental health caregivers develop a range of coping mechanisms to reduce the stress caused by the disease process and the symptoms of the illness. Individuals with strong coping mechanisms are able to overcome from the troubles brought by disease and care. One of the coping mechanisms used by caregivers is spirituality.

Until recently, health professionals have adopted and followed a medical model that often gives less importance to beliefs and destiny, ignores the patient doctor relationship or does not care too much, and instead treats patients through medication and surgery. This mechanical vision, which only saw patients as material bodies, began to become unsatisfactory. Patients and doctors have begun to notice the value of elements such as faith, hope and love during the recovery process. The value of these spiritual elements on health and quality of life has led to the conduct of research area that advocates a more holistic view that includes a non-material dimension in this area (WHO, 1998, Akt Drazenovich and Kourie, 2010).

Healthcare providers should encourage caregivers to seek adequate social support from the right source. This is a factor that will help meet the needs of caregivers. At the same time, health professionals should guide caregivers to manage the patient's incompatible behavior and provide accurate and sufficient information about the patient's current situation. In addition, clinicians should encourage caregivers to practice more religious and spiritual practices. These practices can help caregivers improve their functionality (Kate et al., 2014).

Having an extremely important place in the lives of individuals, spirituality generally has a positive effect on the well-being of individual caregivers. At the same time, spirituality also helps to bring out the strengths of these individuals. Individuals' lives become difficult and divergent with the disease process and the care-giving process that starts simultaneously with this process.

References

Baldacchino, D. R., Borg, J., Muscat, C., & Sturgeon, C. (2012). Psychology and theology meet: illness appraisal and spiritual coping. *Western journal of nursing research*, *34*(6), 818-847.

Baldacchino, D. R., & Buhagiar, A. (2003). Psychometric evaluation of the Spiritual Coping Strategies scale in English, Maltese, back-translation and bilingual versions. *Journal of Advanced Nursing*, *42*(6), 558-570.

Bowman, G., Watson, R., & Trotman-Beasty, A. (2006). Primary emotions in patients after myocardial infarction. *Journal of advanced nursing*, *53*(6), 636-645.

Burns, P. (1991). Elements of spirituality and watson"s theory of transpersonal caring: Expansion of focus. In *P. L. Chinn* (Ed.), *Anthology in Caring*. New York: National League for Nursing.

Caqueo-Urízar, A., Gutiérrez-Maldonado, J., Ferrer-García, M., & Miranda-Castillo, C. (2012). Coping strategies in Aymara caregivers of patients with schizophrenia. *Journal of Immigrant and Minority Health*, *14*(3), 497-501.

Caqueo-Urízar, A., & Gutiérrez-Maldonado, J. (2006). Burden of care in families of patients with schizophrenia. *Quality of Life Research*, *15*(4), 719-724.

Delgado, C. (2007). Sense of coherence, spirituality, stress and quality of life in chronic illness. *Journal of Nursing Scholarship, 39*(3), 229-234.

Drazenovich, G., & Kourie, C. (2010). Mysticism and mental health: A critical dialogue. *HTS Theological Studies*, *66*(2), 1-8.

Elkins, D. N., Hedstrom, L. J., Hughes, L. L., Leaf, J. A., & Saunders, C. (1988). Toward a humanistic-phenomenological spirituality: Definition, description, and measurement. *Journal of humanistic Psychology*, *28*(4), 5-18.

Foldemo, A., Gullberg, M., Ek, A. C., & Bogren, L. (2005). Quality of life and burden in parents of outpatients with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, *40*(2), 133-138.

Gülseren, L., Çam, B., Karakoç, B., Yiğit, T., Danacı, A. E., Çubukçuoğlu, Z., Taş, C., Gülseren, Ş. ve Mete, L. (2010). Şizofrenide ailenin yükünü etkileyen etmenler. *Türk Psikiyatri Dergisi*, *21*, 203-212.

Hadzic, M. (2011). Spirituality and mental health: Current research and future directions. *Journal of Spirituality in Mental Health*, *13*(4), 223-235.

Hill, P. C., Pargament, K. I., Hood, R. W., McCullough Jr, M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour*, *30*(1), 51-77.

Hughes, I. (1996). Developing a family intervention service for serious mental illness: clinical observations and experiences. *Journal of Mental Health*, *5*(2), 145-160.

Hungelmann, J., Kenkel-Rossi, E., Klassen, L., & Stollenwerk, R. (1996). Focus on Spiritual Well-Being: Harmonious interconnectedness of mind-body-spirit—Use of the JAREL Spiritual Well-Being Scale: Assessment of spiritual well-being is essential to the health of individuals. *Geriatric Nursing*, *17*(6), 262-266.

Karanci, A. N. (1995). Caregivers of Turkish schizophrenic patients: causal attributions, burdens and attitudes to help from the health professionals. *Social Psychiatry and Psychiatric Epidemiology*, *30*(6), 261-268.

Kate, N., Grover, S., Kulhara, P., & Nehra, R. (2014). Relationship of quality of life with coping and burden in primary caregivers of patients with schizophrenia. *International Journal of Social Psychiatry*, *60*(2), 107-116.

Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *The Canadian Journal of Psychiatry*, *54*(5), 283-291.

Lazarus, R.S. (1993). Coping theory and research: Past, present and future. *Psychosomatic Medicine,* 55, 234-247

Levene, J. E., Lancee, W. J., ve Seeman, M. V. (1996). The perceived family burden scale: measurement and validation. *Schizophrenia research*, *22*(2), 151-157.

Lowyck, B., De Hert, M., Peeters, E., Wampers, M., Gilis, P. ve Peuskens, J. (2004). A study of the family burden of 150 family members of schizophrenic patients. *European Psychiatry*, 19, 395-401.

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious involvement, spirituality, and medicine: implications for clinical practice. *Mayo Clinic Proceedings,* 76(12), 1225-1235.

Penman, J., Oliver, M., & Harrington, A. (2009). Spirituality and spiritual engagement as perceived by palliative care clients and caregivers. *Australian Journal of Advanced Nursing, The*, *26*(4), 29.

Prince-Paul, M. (2008). Relationships among communicative acts, social well-being and spiritual well-being on the quality of life at the end of life in clients with cancer enrolled in hospice. *Journal of Palliative Medicine, 11*, 20-25.

Rumbold, B. D. (2003). Caring for the spirit: lessons from working with the dying. *Medical Journal of Australia*, *179*(6), 11-13.

Scazufca, M., & Kuipers, E. (1999). Coping strategies in relatives of people with schizophrenia before and after psychiatric admission. *The British Journal of Psychiatry*, *174*(2), 154-158.

Schneider, M. A. (2007). Broadening our perspective on spirituality and coping among women with breast cancer and their families: Implications for practice. *Indian Journal of Palliative Care, 13*, 25-31

Shaw, A., Joseph, S., & Linley, P. A. (2005). Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture*, *8*(1), 1-11.

Sullivan, E. M. (1993). The Importance of the Human Spirit in Self-Care for Older Adults. *Generations*, *17*(3), 33-36.

Tuncay, T. (2007). Spirituality in coping with HIV/AIDS. *HIV & AIDS Review*, *6*(3), 10-15.

Vivat, B. (2008). Measures of spiritual issues for palliative care patients: a literature review. *Palliative Medicine*, *22*(7), 859-868.

Zarit, S.H., Reever, K.E., Bath-Peterson, J. (1980). Relatives of the impared elderly: Corralates of feelings of burden. *Gerontologist,* 20, 649-655.