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March 2006 Articles of the Month

This month's article selection is by Chaplain John Ehman,
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Michalak, E. E., Yatham, L. N., Kolesar, S. and Lam, R. W. "**Bipolar disorder and quality of life: a patient-centered perspective**." *Quality of Life Research* 15, no. 1 (February 2006): 25-37.

Mitchell, L. and Romans, S. "**Spiritual beliefs in bipolar affective disorder: their relevance for illness management**." *Journal of Affective Disorders* 75, no. 3 (August 2003): 247-257.

COMMENTS and SUMMARIES: The prospect of research with a psychiatric population may be daunting to many chaplains, because of special procedural requirements mandated by Institutional Review Boards or because of basic ethical concerns (--see Related Items of Interest, below). However, the experience and perspective of chaplains may be a significant asset for the study of the complex relation of spirituality to mental health. It is worth remembering, too, that the history of Clinical Pastoral Education is rooted largely in work with psychiatric patients, and in recent years many ACPE supervisors have expressed a desire to reemphasize that connection. The two articles this month report intriguing findings about patients with bipolar affective disorder, but they also raise a host of questions to inspire pastoral care research.

The recent qualitative study [n=59] by **Michalak, et al.** at the University of British Columbia, considers spirituality only in part, but it reveals four important issues. First, patients with bipolar disorder (BD) may "struggle to disentangle ‘real’ spiritual experience from hyper-religiosity, a symptom of BD, when hypo/manic" [p. 33]. In the words of one man:

> So, my dilemma is how do I know when my…transcendence is real, or when is it part of my disease? So, I have a tendency to try to avoid, you know, fellowship, or whatever you want to call it, because I get confused whether I’m getting, you know, overly emotional due to my disorder or whether this is a normal religious experience, because I can’t differentiate the two. [p. 33]

Second, these patients may have trouble talking about their spirituality for fear that this will be misinterpreted by others. As one woman put it:

> ...[A]nytime you talk about spirituality then you’re deemed as having a psychotic episode. And… and that’s horrific because now I’m afraid to say anything. [p. 34]

Third, BD may have a profound impact upon individuals’ involvement with their religious communities. The illustration offered by one participant:

> ...[I]t makes it difficult to maintain a steady relationship in a spiritual community. So, you know, participating and then being depressed and not being there at all, and then being manic and coming

back and sort of doing all these kind of slightly embarrassing things and then being sort of mortified. [p. 34]

And fourth, many BD patients may find, in their periods of depression, that their faith--or need of faith--increases. As one participant described it:

> [Depression] makes me lean on my Lord more or when I was depressed religion and spirituality was this, like it sort of held out this promise of God, if, you know, if actually religion and spirituality could do what it was supposed to do then maybe I'd be better…. [p. 34]

The authors report that spirituality was discussed in about a third of the interviews, but in a prioritization exercise that asked participants to list and rank "the 3 things they considered to be most important in determining their QoL [quality-of-life]," [p. 34] spirituality per se was hardly mentioned [--see Table 2, p. 35]. However, the interviews did not explicitly raise spiritual issues but rather began with the general question, "What do you need to have good quality of life?" [p. 27]. Chaplains might pursue in further research the relationship between spirituality and BD more explicitly, working out of the four spirituality-related themes here. Also, it would be interesting to investigate the effect of a spirituality-focused interview on patients' prioritizations of quality-of-life themes.

The slightly older study by **Mitchell and Romans**, from the University of Otago (New Zealand), focuses precisely on spirituality and BD. This quantitative research (n=81 out of a total 147 questionnaires) used the Royal Free Interview for Religious and Spiritual Beliefs (--see Related Items of Interest, below), with the addition of several items (described on pp. 249-250). The purpose of the study was "to elucidate the religio-spiritual characteristics of a population of people with bipolar depression," with particular attention to "clinical facets and implications of religious coping" [p. 249].

Among the findings, the following suggest good questions for potential follow-up by chaplain researchers:

> *Findings:* "Those who had been more unwell in the last 5 years (>25% of the time on self-report) were significantly more likely than those who had been more well to report that their beliefs had not helped the management of their illness..." [p. 252]. "Those who practiced their faith in an organizational way had been more unwell in the past 5 years" [p. 255]. "People who practice their faith non-organizationally were significantly more likely than others to find their beliefs had helped them manage their bipolar illness" [p. 253].
>
> > *Potential research questions:* Do people with BD tend to see the value of their religious beliefs in light of their practical experience of illness? To what extent are relationships between BD and communal worship a function of the qualities of religious communal activity or of the mere logistical interference of BD to attending those activities?
>
> *Findings:* "The degree to which subjects found their beliefs helpful to the management of the their illness was strongly and positively associated with...whether the subjects had sought spiritual healing for their bipolar illness..." [p. 252]. "Certain forms of spiritual healing, such as meditation, group prayer and physical actions, were significantly more likely than other forms to be associated with the opinion that beliefs helped their illness management. Those who had used meditation were significantly more likely to say that their beliefs helped them manage their bipolar illness than those who had not...and that their beliefs helped them recognize early warning signs... [p. 252].
>
> > *Potential research questions:* How salient are spiritual/religious resources to patients seeking help with BD, and do patients tend to think of these resources in terms of private activity, small group activity, or broad congregational activity? How does a chaplain figure in to a patient's sense of resources? How might spiritual/religious resources help patients become more self-aware of warning signs of their disease?
>
> *Findings:* "Those who had used group prayer for their spiritual healing were significantly more likely to say that their beliefs helped them take their medication" [p. 253]. However, "those with

greater strength of belief were significantly less compliant with their medication than those with a weak belief system" [p. 253].

Potential research question: How do patients with DB see connections between their spiritual/religious beliefs and resources and their use of medications?

Findings: "One quarter...of all respondents rated the problem of medical staff having a different illness paradigm from their beliefs as being stronger than a 5/10. Similarly, 19%...of all respondents indicated that they had encountered problems with conflicting advice between spiritual and medical advisors frequently.... One third...of the examples volunteered of conflict between the advice of their spiritual leader and their doctor related to a spiritual leader telling an individual that they did not need their medications anymore as they had been cured" [p. 253].

Potential research questions: In what ways do religious authorities conflict with medical authorities in the management of BD, and do these conflicts tend to be greater during manic or depressive periods? Are conflicts between religious and medical authorities for patients with BD greater than--or different from--such conflicts in relation to other forms of mental illness (e.g., schizophrenia)?

Findings: "Greater activity of faith (i.e., greater frequency, greater importance of practice) was associated with a greater frequency of a doctor's advice conflicting with that of a spiritual leader. ...Denomination was important in this regard; those from an evangelistic group were more likely to report experiencing conflicting advice" [p. 255]. However, "People belonging to an evangelistic denomination were more likely than those in a conservative/traditional/liberal denomination to say that their beliefs helped them seek clinical help early" [p. 253].

Potential research questions: Do patients with BD experience "mixed messages" from their spiritual/religious resources: such as helping them seek early medical intervention but then creating tension in the medical management of their disease? For patients who experience conflict between their beliefs or religious authorities and the medical management of BD, what is the perceived position of chaplains? Are chaplains associated with medical authorities or religious authorities?

Finding: "[Patients] experiencing their religio-spiritual power influencing their lives was associated with receiving conflicting advice and problems with conflicting illness paradigms" [p. 255].

Potential research questions: How do beliefs of God's involvement/providence in patients' lives play into the management of BD, and do patients understand this differently during manic or depressive periods?

There are many possible directions for chaplaincy research here, and much opportunity for *qualitative research* (which many chaplains find more appealing than quantitative research). One of the findings by Mitchell & Romans was that 40% of participants "indicated that they would have preferred an interview format...to the questionnaire method that was used" [p. 254]. The interpersonal skills honed through CPE, especially the ability to *be a non-anxious presence*, may be crucial to good data collection from patients who must contend not only with mental illness itself but with complex social tensions (from such factors as differing illness paradigms, conflicting authorities, or societal stigma) that can inhibit self-disclosure.

Suggestions for the Use of the Articles for Discussion in CPE:

The articles together lend themselves to CPE discussion in two ways. First, the study by Michalak, et al., could be used as a general introduction to patients' experiences of bipolar disorder, as part of a disease-based didactic series. The relatively small section addressing spirituality [pp. 33-34] could then lead into a larger discussion of spirituality and BD, with the study by Mitchell & Romans offered for further reading. The second, and more research-oriented strategy for using the articles would focus on the Mitchell & Romans article, augmented by

only the pertinent excerpt from pp. 33-34 from the work of Michalak, et al. This latter approach would take advantage of Mitchell & Romans' good introduction to research on spirituality and health [pp. 247-249], which some students seem to need even after they have been reading in the area for a while. Neither article specifically addresses the role of chaplains, so discussion in either case could turn on students' thoughts about how a chaplain may be a special resource for psychiatric patients, helping patients with tensions that can spring up between spiritual and health issues. Also, it is worth noting that both articles are easily readable, and many of their individual findings are in and of themselves good discussion-starters.

Related Items of Interest:

I. For more on the ethics and practice of research with patients suffering from bipolar disorder or mental illness in general, especially with regard to issues of consent, see the following articles:

Appelbaum, P. S., Grisso, T., Frank, E., O'Donnell, S. and Kupfer, D. J. "**Competence of depressed patients for consent to research**." *American Journal of Psychiatry* 156, no. 9 (September 1999): 1380-1384.

Cohen, B. J., McGarvey, E. L., Pinkerton, R. C. and Kryzhanivska, L. "**Willingness and competence of depressed and schizophrenic inpatients to consent to research**." *Journal of the American Academy of Psychiatry and the Law* 32, no. 2 (2004): 134-143.

Misra, S. and Ganzini, L. "**Capacity to consent to research among patients with bipolar disorder**." *Journal of Affective Disorders* 80, nos. 2-3 (June 2004): 115-123.

Roberts, L. W. "**Ethics and mental illness research**." *Psychiatric Clinics of North America* 25, no. 3 (September 2002): 525-545.

NOTE: All four of the articles above make reference to the MacArthur Competence Assessment Tool (MacCAT). For more on this particular instrument, see:

Grisso, T., Appelbaum, P. S. and Hill-Fotouhi, C. "**The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions**." *Psychiatric Services* 48, no. 11 (November 1997): 1415-1419.

Wong, J. "**MacCAT-CR: MacArthur Competence Tool for Clinical Research**." *Psychological Medicine* 32, no. 5 (July 2002): 946-947.

Also, you may visit the web site for the MacArthur Research Network at http://macarthur.virginia.edu, and especially the page for the MacArthur Treatment Competence Study.

II. For more on the Royal Free Interview for Religious and Spiritual Beliefs, used by Mitchell and Romans, see the following articles:

King, M., Speck, P. and Thomas, A. "**The Royal Free Interview for Religious and Spiritual Beliefs: development and standardization**." *Psychological Medicine* 25, no. 6 (November 1995): 1125-1134.

King, M., Speck, P. and Thomas, A. "**The Royal Free Interview for Spiritual and Religious Beliefs: development and validation of a self-report version**." *Psychological Medicine* 31, no. 6 (August 2001): 1015-1023.

The original instrument (not the self-report version) is also available on pp. 351-357 of Hill, P. C. and Hood, R. W., eds., ***Measures of Religiosity*** (Birmingham: Religious Education Press, 1999).

III. For other studies that touch in one way or another on spirituality and bipolar disorder, see the following articles:

[ADDED 5/5/10]: Cruz, M., Pincus, H. A., Welsh, D. E., Greenwald, D., Lasky, E. and Kilbourne, A. M. "**The relationship between religious involvement and clinical status of patients with bipolar disorder**." *Bipolar Disorders* 12, no. 1 (February 2010): 68-76.

[ADDED 5/5/10]: D"Souza, R. F. and Sundram, S. "**Evidence for the Need to Foster Spiritual Values and Well-Being in Management of Bipolar Disorders**." *Bipolar Disorders* 10 Suppl. 1 (February 2008): 22. [(Poster Report:) Objective: The increasing awareness of the basic need of all human beings for a source of meaning that is greater than one's self. To study the ability to achieve well-being for the bipolar patients in remission. Method: The spiritually augmented well-being cognitive behavior therapy which uses the exercising of the self transcendence character trait by adding the important dimension of existential, spiritual resources and positive emotions is applied to a randomly allocated group of bipolar patients in remission and compared with a control group who receive conventional case management. The demoralization scale and personal well-being scale are instruments used. Results: Evidence from RCT in recovered bipolar disorder patients receiving an adjunct spiritually augmented well-being CBT demonstrated evidence of significant reduced demoralization improved well-being and inter-episodal function compared with the control group. The particular exercising of the self transcendence character trait by adding the important dimension of existential, spiritual resources and positive emotions reduces demoralization enhancing well being and function. Conclusions: Fostering of spiritual values and well-being is crucial for management of bipolar disorders in order that patients are able to achieve new meaning and purpose beyond the catastrophic affects of the illness and in order that they might maximize their reintegration in life's journey with in the constrains that the disorder might impose on them. It is thus important to achieve the development of health & happiness also as a treatment objective than merely fighting disease and distress.]

Fitchett, G., Burton, L. A. and Sivan, A. B. "**The religious needs and resources of psychiatric inpatients**." *Journal of Nervous & Mental Disease* 185, no. 5 (May 1997): 320-326.

Murphy, P. E., Ciarrocchi, J. W., Piedmont, R. L., Cheston, S., Peyrot, M. and Fitchett, G. "**The relation of religious belief and practices, depression, and hopelessness in persons with clinical depression**." *Journal of Consulting & Clinical Psychology* 68, no. 6 (December 2000): 1102-1106.

Perlick, D. A., Hohenstein, J. M., Clarkin, J. F., Kaczynski, R. and Rosenheck, R. A. "**Use of mental health and primary care services by caregivers of patients with bipolar disorder: a preliminary study**." *Bipolar Disorders* 7, no. 2 (2005): 126-135.

Sheehan, W. and Kroll, J. "**Psychiatric patients' belief in general health factors and sin as causes of illness**." *American Journal of Psychiatry* 147, no. 1 (January 1990): 112-113.

Sivan, A. B., Fitchett, G. A. and Burton, L. A. "**Hospitalized psychiatric and medical patients and the clergy**." *Journal of Religion and Health* 35, no. 1 (Spring 1996): 11-19.

Wilding, C., May, E. and Muir-Cochrane, E. "**Experience of spirituality, mental illness and occupation: a life-sustaining phenomenon**." *Australian Occupational Therapy Journal* 52, no. 1 (March 2005): 2-9.

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .

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