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An exploration of attitudes towards spiritual care for the recovery from post-traumatic stress disorder

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ABSTRACT

Spiritual-based care has been increasingly explored and investigated for its effectiveness in assisting the recovery from mental illness, such as post-traumatic stress disorder (PTSD) in the United States of America (Harris et al., 2018). Although research studies have attempted to explore attitudes towards spiritual care and the effectiveness of spiritual-based care for PTSD, few have explored attitudes regarding spiritual care for recovery from PTSD, especially from Undergraduate Allied Health students. This paper explores the attitudes towards spiritual care for the recovery from PTSD, from Undergraduate Allied Health students. The study adopted an interpretivist approach that deployed qualitative methods. The data collection method used for the study was semi-structured interviews. In total, four participants participated in the interviews, and reflexive thematic analysis was utilised to examine the datasets from the interviews. The research revealed that the majority of participants had negative opinions regarding traditional medical treatment for PTSD and mental illness recovery. This led to the identification of barriers, such as stigma and cultural barriers, for seeking treatment for mental illness. The participants expressed positive opinions regarding spiritual care for assisting PTSD recovery, with the recommendation that religious and spiritual needs must be assessed before the allocation of spiritual-based care to prevent any conflict with patients' religious or cultural beliefs.

Introduction

Most mental health services in the United Kingdom (UK) are provided by the National Health Service (NHS). They currently use the traditional bio-psycho-social model that was implemented in 1977 by Engel (Engel, 1977; Raffay et al., 2016). This model involves separate but interacting elements of the biological, psychological and social dimensions of illness, health and wellbeing (Engel, 1977). Initially, the medical model was applied to the understanding of mental illness.

Although traditional care models may appear positive, they have, however, been heavily criticised (Benning, 2015; McDermott et al., 2016; Pilgrim, 2015). For instance, Ghaemi (2011) criticised the bio-psycho-social model for lacking attention to subjective matters, such as personal meaning and spirituality, which in turn fails to accommodate patients' preferences and other dimensions of health, such as spirituality. Furthermore, Bartz (1999) criticised the model from a cross-cultural perspective. Bartz (1999) examined the transcripts from a clinic between health professionals and native American patients and found that there were frequent misunderstandings and distrust from the patients towards the health professionals. Thus, illustrating that the bio-psycho-social model is not culturally sensitive.

PTSD affects 4.4 in 100 people in the UK every week (McManus et al., 2016). PTSD is defined by the American Psychiatric Association (2021, para. 1): 'a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, such as a natural disaster, a serious accident, a terrorist act, war/combat, or who have been threatened with death, sexual violence or serious injury'.

Furthermore, researchers have proved that alternative therapies, such as spiritual care, are just as effective as traditional medical treatments in assisting the recovery from PTSD (Davis et al., 2018; Niles et al., 2018). The NHS University hospital Southampton (2010, para. 1) define spiritual care as: 'care that recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayers or sacrament, or simply for a sensitive listener'.

Consequently, American psychologists have been investigating the effectiveness of spiritual therapies and have found a positive relationship between spirituality and PTSD (Bormann et al., 2012; Harris et al., 2018; Pearce et al., 2018).
Despite this significant progress, there has been very little awareness of the effectiveness of spirituality in reducing PTSD symptoms. This is important because the recovery for individuals who suffer from PTSD is being delayed because spirituality is not being taken seriously in mental health services in the UK (Forrester-Jones et al., 2018). Additionally, there has been little discussion about spiritual care for PTSD, especially from Undergraduate Allied Health students.

Rationale

The rationale for this piece of research was aimed at a gap in the existing literature that takes into account Undergraduate Allied Health students' perceptions about spiritual care for PTSD. Currently, there is a lack of studies that provide this group with a voice. Thus, for the purposes of this project the interest focused on what students thought about the role of spiritual care where PTSD was concerned. Finally, the existing literature lacks discussion of attitudes towards both spiritual care and PTSD.

Research aims

The aims of this study were to obtain a greater understanding of the relationship between spiritual care and PTSD recovery by collecting information regarding the attitudes from Undergraduate Allied Health students. Specifically, the study aimed to:

- Explore the meaning of spiritual care among Undergraduate Allied Health students
- Identify attitudes towards traditional medical care for PTSD
- Examine attitudes towards integrating spiritual care to assist PTSD recovery

Literature review

Attitudes towards spiritual care

Regarding healthcare professionals, McSherry and Jamieson (2013) conducted an online survey that focused on examining the perceptions towards spiritual care among members of the Royal College of Nursing (RCN). A total of 4054 RCN members responded to the online survey. Of that 4054, 2327 members provided qualitative comments. McSherry and Jamieson (2013, p. 3176) found that most RCN members had positive perceptions towards spiritual care and that '40.4 strongly agreed and 43% agreed that spiritual care is a fundamental aspect of nursing'. This was supported by the qualitative comments provided by over half of respondents. McSherry and Jamieson (2013, p. 3176) reported that 'respondent 333 stated that "spiritual care and spirituality is a fundamental need of humanity and implicit within our identity as humans. If we neglect the spiritual, we impoverish ourselves, our work and our patients'. This single perspective could suggest that the healthcare professionals value spiritual care

for patient-centred care. However, this study does not include the opinions from service users receiving spiritual-based care. Thus, it is also important to explore the importance of spiritual care for service users.

In comparison to McSherry and Jamieson (2013), Raffay et al. (2016) explored the NHS service users' perceptions of spiritual care and pastoral care. Raffay et al. (2016) used a qualitative approach and conducted 22 semi-structured interviews. Raffay et al. (2016) found that the majority of the participants had positive opinions of the integration of spirituality in mental health treatments and that they believed that spiritual care played an important role in delivering holistic care to service users. Additionally, Raffay et al. (2016) found that the participants felt that spirituality was missing from the bio-psycho-social model. As a result, Raffay et al. (2016, p. 8) proposed a revised version that included spirituality called 'bio-psycho-social-spiritual model of care'. This suggests that spirituality is becoming increasingly recognised by not only health professionals but also service users with mental illness.

To expand on this further, Forrester-Jones et al. (2018) conducted a Spiritual Support Group (SSG) in the UK for people recovering from mental illness. The aim of the study was to examine the participants' experiences of spiritual care. Nine participants with mental illness were recruited for this study (five female; four male). Forrester-Jones et al. (2018, p. 400) found that 'the subjective views of participants about the SSG were that it was helping them in their rehabilitation. In particular, individuals felt that the SSG sparked emotions often flattened by medication. Additionally, the participants collectively agreed that the spirit groups were important for assisting their recovery from mental illness and that spirituality should be more common within psychiatric services in the UK. The participants also highlighted that they felt as though the psychiatric staff did not fully understand the importance of spirituality. These findings could suggest that service users with mental illness do value spiritual-based care therapies in the UK. However, it also suggests that healthcare professionals, such as psychiatrists, may not fully prioritise spiritual dimensions, and that psychiatric services in the UK should consider spirituality.

To add to these findings, Rogers et al. (2019) explored health and social care workers' attitudes towards spirituality in the UK. The survey was distributed online through a local mental health trust and had a sample size of 104 participants. Rogers et al. (2019, p. 1170) found that: '47 participants agreed that spirituality is integral to clinical practice and care, whereas 24 participants were uncertain'. Additionally, '64 participants agreed that an awareness of spirituality is part of the healthcare process'; while '39 participants strongly agreed, and 37 participants agreed that spirituality can be distinguished from religion' and lastly '19 strongly disagreed and 41 disagreed that spirituality was integrated within their pre-registration training or clinical education'.

These findings could suggest that health and social care workers place high value on spirituality in healthcare and that they are able to differentiate between spirituality and religion. However, Rogers et al.'s (2019) findings raise concerns that health and social care workers are not receiving efficient training in spirituality.

The effectiveness of spiritual care and therapies for the recovery of PTSD

Although the reviewed literature highlights a positive relationship between spiritual care and attitudes from healthcare professionals and service users, it is important to identify the effectiveness of spiritual care in assisting PTSD recovery.

Recently, psychologists have been investigating the importance and the effectiveness of spirituality in assisting the recovery from mental illnesses. Harris et al. (2018) explored the effectiveness of spiritual care in reducing PTSD symptoms among US veterans. In total, 56 veterans were recruited and randomised into two groups; 28 veterans were

placed into the Building Spiritual Strength (BSS) intervention that lasted eight weeks and focused on meditation, belonging and spiritual coping mechanisms. The remaining 28 veterans were placed in a traditional, validated psychological therapy called Present Centred Group therapy (PCGT) that also lasted eight weeks and focused on psychoeducation. Harris et al. (2018) used a Clinical Administered PTSD Scale (CAPS). At the follow-up two months after the completion of both interventions they found that the 28 participants in the BSS group had a 68.3% reduction in PTSD symptoms, whereas the 28 participants in the PCGT group had a 70% reduction in PTSD symptoms. This illustrates that there is not a significant difference between the effectiveness of BSS and PCGT, and therefore suggests that alternative therapies can be just as effective as medical treatments for PTSD. However, due to the small sample size, additional research is warranted.
In another study, Pearce et al. (2018) explored spirituality and PTSD. However, unlike Harris et al. (2018), Pearce et al. (2018) integrated spirituality into an existing validated psychological therapy, CPT. Pearce et al. (2018) named the intervention Spiritually Integrated Cognitive Processing Therapy (SICPT) that aimed at tackling moral injury and PTSD by using the participants' spiritual resources. The experimental study was conducted in the US and involved 12 sessions that consisted of: challenging spiritual distress, and awareness of spiritual resources that took place over a six-to-twelve-week period; each session lasted an hour. Furthermore, the researchers measured the participants' PTSD symptoms pre- and post-intervention using the PTSD checklist-DSM 5. The sample frame for this study was not provided because Pearce et al. (2018, p. 5) presented the research findings as a 'compilation of several patients to protect confidentiality'.

In the case study, 'James' had a pre-Post-traumatic Stress Disorder Checklist (PCL-5) score of 57 and by the end of the 12 sessions he had a post-intervention score of 31. This is a significant decrease in PTSD symptoms as his score fell below the cut-off point of 35 for a probable diagnosis of PTSD. This could suggest that spirituality is an important element when treating PTSD. Conversely, with the absence of a sample frame, the experimental study lacks reliability because it does not provide statistics on how many participants had truly benefitted from SICPT. Thus, it is difficult to fully ascertain the effectiveness of SICPT.

Although the sample sizes were limited in all these studies, collectively the studies demonstrate that there is evidently a positive and crucial relationship between spirituality and PTSD. Therefore, this could suggest that spirituality needs to be taken more seriously and that more research is required to fully understand the effectiveness of spiritual-based therapies. However, the reviewed literature highlights a gap in current knowledge as it does not cover the perceptions towards spiritual care from Undergraduate Allied Health students. Therefore, this study aimed to explore Undergraduate Allied Health students' attitudes towards the use of spiritual care for recovery from PTSD.

Methodology

This study adopted an interpretivist approach that utilised qualitative research methods and techniques. Qualitative research methods are often associated with the interpretivist paradigm (Howitt, 2019).

Conversely, a positivist approach was not appropriate because quantitative methods produce objective and statistical data. Thus, it would not allow the researcher to explore perceptions or meaning in-depth (Queirós et al., 2017).

Recruitment and sampling

An opportunistic sampling strategy was adopted to recruit Undergraduate Allied Health students who met the research requirements. The sample was drawn from the population of Undergraduate Allied Health students at a northern, post-92 university. All participants had to be undertaking undergraduate degrees, including BSc (Hons) Nursing, Mental Health Nursing and Occupational

Therapy. Additionally, due to recruitment issues the strategy was extended to include students from BSc (Hons) Sociology with Psychology and Sociology with Criminology who had an interest in spirituality as a theoretical concept.

Data collection

Online semi-structured interviews were used for the data collection for this research. Online semi-structured interviews were deemed to be in the best interests of all participants due to the importance of complying with the British government guidelines on social distancing and travel due to the on-going COVID-19 pandemic (GOV.UK, 2021). The interviews were conducted online using Microsoft Teams and were audio recorded using an electronic handheld device. Each interview lasted for one hour. Furthermore, an interview guide was emailed to the participants prior to the interview to allow them to prepare.

Data analysis

Reflexive thematic analysis (Braun & Clarke, 2019) was used to identify, analyse and report the patterns within the datasets from the semi-structured interviews. Specifically, Braun and Clarke's (2019, p. 87) six-phase process for doing reflexive thematic analysis was used:

1. Familiarisation with the data
2. Coding
3. Generating initial themes
4. Reviewing themes
5. Defining themes
6. Producing the report

Firstly, the audio recordings of each interview were listened to twice prior to transcription. Once each interview had been transcribed, they were read through at least twice. The second step involved identifying important features within the datasets. Next, the important features and learning aims were used to generate initial themes. The remaining steps included reviewing and defining the themes from all the interviews and ensuring that each theme was representative of the codes identified and linked with the research aims. The themes that emerged from this process were spiritual care, views on traditional medical treatment, alternative therapies and spiritual care for PTSD.

Research ethics

Ethical approval was granted prior to the commencement of the recruitment and the data collection. This research complied with the guidelines set out by the British Psychological Society (BPS) statement of ethical practice (BPS, 2017). Due to the sensitive nature of the topic, this study excluded those who have been affected by PTSD or low mood to prevent the risk of causing any psychological distress to participants (BPS, 2017).

Prior to the commencement of the interviews, participants were emailed an information sheet, consent form, interview guide and a debrief form, which outlined the aims and purpose of the study and how their information would be utilised and stored. All the participants were informed that the interview would be audio recorded, and consent forms were returned prior to conducting the interviews. To protect the participants' identities, their names were replaced with pseudonyms. Furthermore, their personal information was only accessible to the researcher and was stored electronically with password protection.

Findings

The reflexive thematic analysis helped to identify the patterns in the data and to define the themes and sub-themes (Braun & Clarke, 2019).
The following four themes are the focus of this article: spiritual care, views on traditional medical treatment, alternative therapies and spiritual care for PTSD. Each theme has two-to-three sub-themes that will be discussed.

Spiritual care

The participants were asked to explain their understanding of spiritual care in the UK. Two sub-themes were identified: the role of spiritual care and

the meaning of spiritual care (see Figure 1).

Figure 1: A diagrammatic representation of spiritual care theme and sub-themes.

The role of spiritual care

The participants shared their understanding of spiritual care, but some also mentioned its role in the National Health Service in the UK:

> "Um, it is really not that prevalent in mental health settings. It, however, is prevalent in hospital settings when people like cancer sufferers or people who may die soon, normally there the hospitals will ask the person about their beliefs and spiritualism, and if they do say yes then they would allocate a priest to help the patient through their last parts of their life." (Participant 2)

> "I think in the UK people use spiritual care when they are grieving so for example, someone that has lost a family member or friend. I also think spiritual care is more dominantly used in palliative care where an individual is coming to their end stages in life and would like to talk to a priest about their religious and spiritual needs." (Participant 4)

These findings illustrate that spiritual care is more commonly used in palliative care in comparison to mental health care and that there is uncertainty regarding its role. These findings are similar to those identified in the literature review from Forrester-Jones et al. (2018) and Raffay et al. (2016). For instance, they found that their participants were uncertain regarding the role of spiritual care in mental health programmes and that it was strongly associated with chaplaincy services and palliative care.

The meaning of spiritual care

The meaning of spiritual care was a dominant sub-theme throughout the interviews. However, there was uncertainty over the terminology of spiritual care:

> "To be honest I do not really understand spiritual care in the United Kingdom. Other than I suppose it is kind of under the radar. I mean someone getting spiritual care it is kind of like the black market." (Participant 3)

> "Yeah, I do not really know how to define that to be honest. I suppose that it is just care that has considerations of a person's values and beliefs, and that sense of faith and hope. Um… yeah and values that and motivating that person and encouraging positive change. Make that person feel connected to something bigger and I think you have more chance helping that person by empowering them to heal." (Participant 1)

Similarly, Participant 4 stated:

> "I think in the UK people use spiritual care when they are grieving so for example, someone that has lost a family member or friend. I also think spiritual care is more dominantly used in palliative care where an

> individual is coming to their end stages in life and would like to talk to a priest about their religious and spiritual needs. I do think spiritual care would be beneficial for individuals with mental health illness such as PTSD, especially for spiritual coping mechanisms as it can reduce stress and anxiety." (Participant 4)

It would appear from the findings that there is uncertainty over the terminology among Undergraduate Allied Health students. The role and the meaning of spiritual care have been reported in previous studies. Raffay et al. (2016) found that spiritual care was closely linked with religious practices and suggested that spirituality and religion could be perhaps blurred. Thus, suggesting that there is a lack of awareness or perhaps clinical education surrounding spiritual care and the spiritual dimension of health in the UK.

Views on traditional medical treatment

Views on traditional medical treatment was another dominant theme to emerge from the interviews. Three sub-themes emerged from the data: the importance of medical treatment, limitations of medical treatment and barriers to medical treatment (see Figure 2).

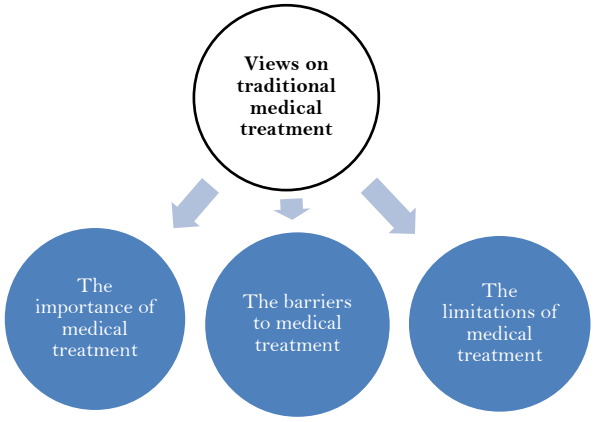

Figure 2: A diagrammatic representation of the views on traditional medical treatment theme and sub-themes.

The importance of medical treatment

Two participants highlighted how medical treatment can have a positive effect on an individual's life:

> "I think the medication prepares the individuals in getting ready to be able to go and complete holistic therapies. Because I know with my own mental health struggles if that drug treatment had not been in place, then I would not have the frame of mind to go anywhere set alone try holistic therapies." (Participant 3)

> "Um, the other treatment that is used a lot is medication. This is where in the brain, different parts of the brain are more active than others, so the medicines actually make those parts of the brain that are not that active become more active, so they are actually using the brain itself to give medication to stop brain disorders from happening." (Participant 2)

These findings could suggest that the participants recognise the importance of medical treatment for the recovery from mental illness. It also suggests that traditional medical treatment may be a useful intervention to prevent individuals' particular conditions from deteriorating further. The comments made by the participants are aligned with the aims of traditional care models, such as Engel's (1977) bio-psycho-social model that offered a holistic approach to treating mental illness. Additionally, Murphy et al. (2015) and Forbes et al. (2012) also highlighted the effectiveness of traditional medical treatment, such as Cognitive Behavioural Therapy and Cognitive Processing Therapy for assisting PTSD recovery. Thus, illustrating that traditional medical treatment is still highly valued and effective in the treatment or prevention of mental illness.

The limitations of medical treatment

Not only did the participants address the importance of traditional medical treatment, but two participants also highlighted the limitations:

> "I think there has been a growing level of mental health issues in the UK but yet the provisions are not matching that. For example, there are long waiting lists to reach support or treatment from mental health services in the UK. [...] But in the UK, it is just not good enough and I feel as though there is a lack of practitioners to carry out the treatment." (Participant 3)

Participant 3 went on to say:

> "I think overall the side effects that these drugs cause actually decreases your quality of life, so it is a weighing up of those factors." (Participant 3)

While one participant said that they felt as though medical treatment was not enough for recovery from mental illness:

> "From my perspective I felt like it really was not a long-term solution, and they were just fighting short-term solutions really and I felt like it was not looking holistically at that person, and they were just trying to cope kind of with that environment for the short term before they got back out into the community." (Participant 1)

These findings show that there are a broad range of limitations regarding medical treatment, ranging from the delivery of services made available, side effects of the medication and that treatments lack a holistic approach. These findings are similar to those found by Forrester-Jones et al. (2018). For example, participants in Forrester-Jones et al.'s (2018) study mentioned how medication would often flatten their emotions and lead to low mood.

Barriers to medical treatment

The participants addressed a broad range of barriers to medical treatment, ranging from stigma, limitations of services and religious/cultural beliefs:

> "I think there is still so much stigma attached to mental health that people are not accessing services because of that stigma or not fully wanting to acknowledge that they have a problem." (Participant 1)

> "I think the stigmatisation um is about you know in this country we have this 'stiff upper lip'; you know they would not talk about these kind of problems." (Participant 2)

Not only this, another participant mentioned how long waiting lists can also act as a barrier to seeking medical treatment for mental health:

> "Another barrier is waiting lists; the UK tends to have a long waiting list for not only therapies for mental illness but also for physiological appointments. So, I think that can put people off and by the time the appointment comes about, the individual may no longer feel comfortable about receiving treatment as their mental and emotional wellbeing would have deteriorated in that sense." (Participant 4)

Two participants mentioned the challenges that ethnic minority communities face in relation to mental health and seeking medical treatment:

> "I also think it is to do with accessibility as well and what they have a right to because, a lot of

> people from ethnic minority backgrounds are not aware of this help for mental health issues. I will give you an example, um one of my close family friends they had a mental health issue from post-traumatic stress disorder after childbirth basically so what happened was the mental health nurse came to visit them in their home, it was a community visit and they sat and spoke very briefly about what had happened and they just recommended that they actually go to Pakistan." (Participant 2)

> "There is a stigma about being mentally affected by mental illness. Especially in certain ethnic communities that having a mental illness is a sign of an individual not worshipping their god or being faithful to their religion. So, mental illness can be considered as a punishment. So, I think that religion and cultures that believe in such thing, that can act as a barrier for that individual seeking help as they do not want to be separated from their community, family and faith." (Participant 4)

The findings illustrate the barriers that individuals could face when attempting to seek medical treatment for mental illness. Participants also addressed the greater challenges that ethnic minority communities may face when seeking support because of stigma, accessibility issues and, potentially, racism. Similar points have been highlighted by Murphy and Busuttil (2015) as they also discussed the implications of stigma and institutional racism experienced by individuals seeking support.

Alternative therapies

Alternative therapies were identified as a highly common theme across all interviews. Although the theme may not be entirely linked with the research objectives, it is, however, linked with why individuals are turning to more holistic or spiritual options for support in comparison to seeking traditional medical treatment. The sub-themes are as followed: change in attitudes and awareness of alternative therapies (see Figure 3).

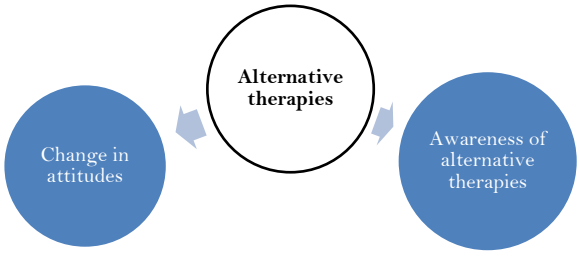

Figure 3: A diagrammatic representation of alternative therapies theme and sub-themes.

Change in attitudes

Alternative therapies were discussed in the interviews, and the participants highlighted the change in attitudes as being the main contributor to the growth in popularity towards alternative therapies:

> "I think people are becoming more open-minded and those who are already religious and spiritual I feel as though they turn to those practices more so than medication and are therefore more open to alternative therapies." (Participant 4)

Two participants mentioned that individuals are taking greater interest in self-care:

> "I feel as though more people are taking responsibility for their own health and they are not thinking that this doctor is going to fix me but thinking I am alive in this body, how can I look after my body to my best ability, you know to prevent myself from getting ill." (Participant 1)

> "There has been a growing interest in what we, ourselves can do to control our own bodies without external influences, such as medication or invasive therapies. Also, the thought of invasive therapies scares a lot of people, so alternative therapies for mental illness and even physiological illness have become more accepted and acknowledged due to fear of invasive treatments and potentially the negative side effects of medication." (Participant 3)

It would appear from the findings that participants have identified and recognised the shift towards alternative therapies and the causes behind the change. This movement towards alternative therapies has become increasingly acknowledged by health professionals (Gale, 2014). For example, the NHS now offers Mindfulness-Based Cognitive Therapy (NHS Solent Trust, 2021) as a treatment for mental illness.

Awareness of alternative therapies

Awareness of alternative therapies was another sub-theme identified in the data. Two out of four participants explained how they perceived that the increase in awareness was due to the limitations of prescribed medication, which was, in part, causing individuals to turn to alternative therapies:

> "I think sometimes medication is not helping or it is causing other problems as there is so many side effects of taking medication that I think people are now realising that sometimes medication long-term for chronic things is not the answer." (Participant 1)

> "I think as science improves and our medication expands, there is more release of information about medical treatment in comparison to the past. I always think about the contraceptive pill, and you receive this massive instruction leaflet that lists all the side effects and that is pretty scary for a lot of people. So, I think they are more open now to not just only spiritual based therapies but just alternatives to those harmful side effects of medication." (Participant 3)

Similarly, Participant 4 observed:

> "People are more aware of the side effects of medication, and I feel as though people fear having those side effects. Also, there is more access to information about certain medical treatments and people are becoming more aware that they can cause more negative side effects than positive effects." (Participant 4)

These findings illustrate only some of the reasons behind the transition to alternative therapies and that the participants have recognised changes in attitudes towards alternative therapies. Forrester-Jones et al. (2018) reported similar findings that participants often struggled with the side effects of prescribed medication, particularly on their emotions. Additionally, both Forrester-Jones et al. (2018) and Raffay et al. (2016) found that service users had positive opinions regarding alternative therapies. Thus, suggesting that individuals are perhaps becoming more open to trying alternative therapies to assist them with their health and wellbeing.

Spiritual care for PTSD

Spiritual care for PTSD was the last theme to be identified in the data during the analytical process. This theme had two sub-themes which are: the advantages of spiritual care and the limitations (see Figure 4).

Figure 4: A diagrammatic representation of spiritual care for PTSD recovery theme and sub-themes.

Advantages of spiritual care

In the study, the participants expressed that spiritual care could be beneficial for individuals with PTSD and that care models should incorporate spirituality:

> "It should definitely consider spirituality […] I mean being an ethnic minority person myself there is a belief amongst a lot of the Asian people in the UK that um if somebody suffered from a mental health problem that person themselves is to blame for that illness. The reason for that is because spiritually that person has not been spiritual or have not prayed or believed in god or went against the teachings of god. So basically, a lot of the religions, such as Judaism, Christianity and Islam, mental illness is a source of guilt and shame for that person that is at the receiving end of it. Also, this gives them problems forgiving themselves and others as well and that actually complicates the problem […] they will only get more PTSD symptoms […] The only way they are going to stop that is by having a spiritual based treatment that aids spiritual healing." (Participant 2)

When the participants were asked whether they thought that spiritual care would be a helpful approach for PTSD one participant commented

> "Yes, I do. From my own journey I had a lot of talking therapies and they were not helpful to me. Um, not that there is anything wrong with the therapies. I just felt the process I was going through was not getting to the trauma in the right way and needed some sort of movement to access where it was being held in my body. I feel like if you engage in with other holistic therapies you can access things in a different way, and it can work better for some people." (Participant 1)

While Participant 4 said:

> "I think it would definitely be an approach if they were introduced to it and what the benefits and limitations would be. I also think it would be an approach that could be more beneficial for ethnic minority groups as they are more likely to believe in spirituality and if they can use their own knowledge of spirituality in that treatment then I think that in itself can boost their independence." (Participant 4)

These findings show that the participants had positive views towards spiritual care for PTSD

recovery with some mentioning its potential to help individuals. This is similar to the findings reported by Forrester-Jones et al. (2018) where individuals claimed that spiritual care benefited their mental health recovery. Additionally, Harris et al. (2018) found spiritual-based therapies to be effective in reducing symptoms of PTSD.

The limitations of using spirituality

Furthermore, two participants illustrated that spiritual care may not be helpful for everyone with PTSD due to the risk of spirituality interfering with religion, cultural beliefs and personal preferences:

> "Well, you see it would not help me as I do not believe in spirituality so there would be a mental block there whether I thought it was having an effect. Whereas somebody who is open to it then yes it would help aid recovery from mental illness. But it does depend on the person, which is the same with any treatment." (Participant 3)

> "I think in western culture spirituality would definitely be good but obviously in some other cultures that people are in and living in the UK it could have a negative effect." (Participant 4)

These findings are important because participants highlight the possibilities that spiritual care could perhaps interfere with patients' religious or cultural beliefs, which could cause unnecessary anxiety. This concern had been highlighted by Harris et al. (2018) and many psychologists, that spiritual therapies may not be beneficial for everyone.

Discussion

Views towards traditional medical treatment

In the UK, the NHS currently treat mental illness with the bio-psycho-social model developed by Engel (1977). In this study the majority of participants criticised Engel's (1977) care model and felt that spirituality should be included in treatment plans when assisting recovery from mental illness, particularly PTSD. The participants also spoke about the importance of acknowledging an individual's spiritual wellbeing when creating treatment plans, particularly for ethnic minority groups, taking into consideration their cultural or religious beliefs. Furthermore, the findings of this study are similar to the findings presented by Raffay et al. (2016). Raffay et al. (2016) found that both professionals and service users felt that spiritual care is important for mental health. Based on the findings from the study and from the existing literature, Raffay et al. (2016) proposed a new model of care that consisted of three separate but interacting dimensions: biological, psychological and social but with an additional element, spirituality, which contains those three dimensions (see Figure 5).

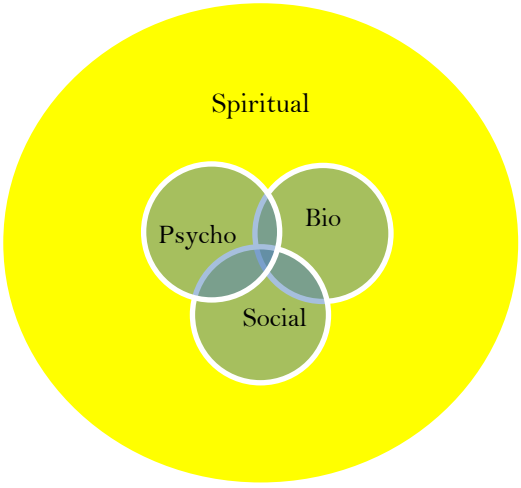

Figure 5: A diagrammatic representation of the revised bio-psycho-social model.
Source: (Raffay et al., 2016, p. 8).

The spiritual dimension in the model is highlighted in yellow, and this colour can change if spirituality is less salient in an individual's life. For instance, for some patients the yellow could be paler or clearer depending on the individual's spiritual needs (Raffey et al., 2016). In line with this study's findings, participants felt that spiritual care was underused or uncommon in existing mental health services in the UK and that it could have a potential

role in the recovery of mental illness, such as PTSD. However, the participants emphasised concerns regarding spiritual care for individuals with particular religious or cultural beliefs as it could cause conflict. In relation to Raffay et al.'s (2016) proposed care model it could ease this concern due to its flexibility, especially with the spiritual element being assessed and matched to everyone's care needs. Overall, it is evident that spirituality and spiritual care are highly valued among a broad range of demographic groups.

Cultural competence

Cultural competence is a set of skills, behaviours and policies that collectively enables mental health professionals and services to deliver high-quality care to patients from diverse cultural backgrounds (Kirmayer, 2012). In this study all the participants illustrated awareness of the cultural barriers to seeking mental health treatment and the problems surrounding cultural competence in training and in care models. The participants identified issues ranging from the awareness of available treatments, accessibility, racism, and that mental health treatments lack cultural considerations (see findings). Additionally, external research suggests that cultural competency training primarily focuses on communication, empathy, cultural knowledge, and accessibility, rather than on treatment plans or care models (Bassey & Melluish, 2013; Kirmayer, 2012; Lie et al., 2011). The issue of care models lacking cultural competence was an important issue highlighted in this study's findings and that the participants felt that spirituality, religious beliefs, and preferences were not considered in treatment plans. Thus, imposing concerns over the effectiveness of such care models for individuals recovering from mental illness. Whitley (2012) also expressed similar opinions to those identified in this study and claimed that if attention is given to religion and spirituality, it could aid the development of culturally competent and accessible services.

Study limitations

The main limitation of this research is the low number of participants, which is due to the COVID-19 pandemic. The majority of the Undergraduate Allied Health students were recruited in the fight against the COVID-19 pandemic and therefore did not have the time to attend interviews. In addition to this, it was not possible to extend the time to try to increase recruitment to the study.

Recommendations for future research

For future research, it is recommended that researchers test the effectiveness of the inclusion of spirituality in treatment plans for patient outcomes and to examine attitudes from the general patient population regarding the inclusion of spirituality in assisting recovery from PTSD.

Recommendations for treatment

It is recommended that mental health services in the UK adopt and implement care models that include spirituality, such as Raffay et al.'s (2016) revised care model. Furthermore, treatment providers must improve cultural competence training within their mental health services and their treatment plans must meet religious, cultural and spiritual needs of patients. Failing that, ethnic minority communities will continue to be placed at a greater risk of health inequalities.

Conclusion

The findings of this study have several important practical implications. Perhaps the most important finding is that participants identified that ethnic minority groups are struggling to access and receive adequate quality care for mental illness, despite the emergence of cultural competence training in treatment provision. Thus, suggesting that cultural disparities in mental health care are still as evident as ever.

Another important finding is that the participants expressed concerns over traditional medical treatment for mental illness, with the participants

emphasising that traditional medication is not enough to solve mental illness and that it only fulfils short-term solutions. In regard to spiritual care and spirituality, the participants had positive views regarding the integration of spirituality to assist with PTSD recovery, with some stating that it would offer a more holistic approach to patient-centred care. Additionally, the participants made recommendations that spiritual, cultural and religious needs must be assessed before receiving spiritual care to avoid any interference with cultural or religious beliefs.

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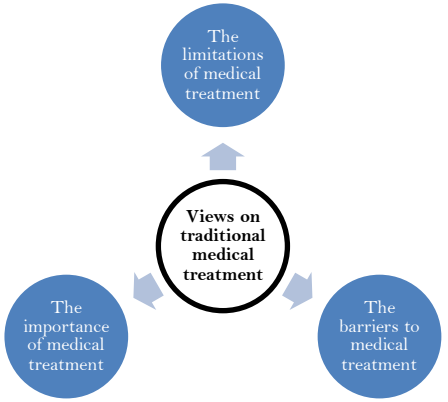
Appendix A: Coding framework/reflexive thematic analysis

Examples of the codes and themes identified from the reflexive thematic analysis of the semi-structured interviews in relation to the research objectives.

1. Research objective: Explore the meaning of spiritual care among allied Undergraduate Human and Health Sciences students		**2.** Research objective: Identify attitudes towards traditional medical care for PTSD			**3.** Research objective: Examine the attitudes towards integrating spiritual care to assist PTSD recovery	
Code: Factors of spiritual care	Code: Role of spiritual care	Code: Importance of medical treatment	Code: Limitations of medical treatment	Code: Challenges to accessing medical treatment	Code: Advantages of spiritual care for PTSD	Code: Disadvantages of spiritual care for PTSD

Refined themes and sub-themes from the reflexive thematic analysis:

			
Figure 1: A diagrammatic representation of spiritual care theme and sub-themes	Figure 2: A diagrammatic representation of the views on traditional medical treatment theme and sub-themes	Figure 3: A diagrammatic representation of alternative therapies theme and sub-themes	Figure 4: A diagrammatic representation of spiritual care for PTSD theme and sub-themes