The role of spirituality in recovery from mental illness has gained increased attention in recent years. In this article, the authors present an update on previous work exploring the role and function of religion/spirituality in the lives of people participating in a psychiatric rehabilitation program (Bussema & Bussema, 2000). Fifty-eight (58) participants age 18 to 64 completed a spirituality survey based on Pargament’s five coping functions of religion. Chi-square tests for independence and independent groups t-tests were performed. Seventy-one percent of the respondents reported that their spiritual life has played a significant role in their recovery. Reported religious coping strategies are discussed within the framework of a recovery model of service delivery.

Keywords: recovery, religion, mental illness, coping
Christian agency providing an array of rehabilitation services for nearly 40 years) explored through extensive interviews the impact of serious mental illness on faith lives and the role that spirituality played in helping people cope with their disabilities. This initial work employed a faith development model (Fowler, 1984) to engage the participants in an analysis of their religious experiences and understanding relative to their attempts to cope with their illness. The findings suggested that faith stage placement does not seem to influence the role of faith in coping; however, there was clear support for the role religious belief functioned in the lives of the participants. Pargament (1997) suggests that religion, as a coping mechanism, serves five essential purposes: spiritual (a sense of personal closeness with God, as well as meaning, purpose, and hope), self-development (help in feeling good about self and being more in control), resolve (self-efficacy and a sense of peace and comfort), sharing (closeness, connectedness to a community, meeting intimacy needs), and restraint (help in keeping emotion and behavior under control; p. 184).

These coping aspects of religion provided a helpful framework to understand what they were learning in their participants’ descriptions of how individuals used religious beliefs and practices to cope. The authors found clear evidence in these interviews for all of Pargament’s (1997) suggested coping functions of religion.

More recent investigations have continued to demonstrate the salience and efficacy of spiritual and religious resources in recovery (Falliot, 2001). Reger and Rogers (2002) found that religion serves as a highly prevalent and salient coping mechanism for individuals with mental illness. Rogers et al. (2002) found that more than 81% of their sample of 379 persons with mental illness reported using religious beliefs and activities to cope and 65% perceived religious coping strategies to be effective. In their phenomenological investigation of spirituality with six persons who have experienced mental illness, Wilding, May and Muir-Cochrane (2005) observed that spirituality sustained mental health and well-being and provided a deep sense of peace, calm and awareness that one is not alone. Although these studies and others support the positive role of religion and spirituality in coping, little is known about the differences in religious coping in this population (Reger & Rogers, 2002). Further, there is little specific information about particular religious practices and their relationship to adaptive and nonadaptive coping (Rogers et al., 2002).

Building on the authors’ initial work and the observations reported by other researchers, the second phase of research began to examine more closely specific ways that spirituality and faith impacted the coping and recovery efforts of persons with serious mental illnesses. The goal was to explore more closely the specific functions of religion in coping with mental illness with a larger group of people in recovery in order to investigate identifiable patterns in coping efforts and to explore the both adaptive and non-adaptive aspects of religious coping.

Method

Participants

All 61 individuals receiving psychiatric rehabilitation services offered by Hope Haven, Inc. at the time of this study were invited to participate. Hope Haven is a faith-based agency providing psychiatric rehabilitation services to people referred by various state and county providers. Fifty-eight persons, 32 women and 26 men, completed the survey. One participant was African American, one was Hispanic and the remaining 56 participants were non-Hispanic Caucasians. The participants all met the eligibility requirements for severe and persistent mental illness set by various agencies and funding sources. By virtue of age requirements for program eligibility, the participants ranged in age from 18 to 64. Eleven participants were between 18 and 29 years old; 18 were age 30 to 39; 17 participants were age 40 to 49; and 12 were 50 years old or over. While participants were not asked to identify their religious affiliation for the survey, service records indicate that the persons served in Hope Haven’s mental health services at the time of the survey self-identified as follows: Protestant (67%), Catholic (13%), other (11%), and none (9%).

Survey

Religious coping was explored through a survey constructed by the authors based on Pargament’s (1997) coping functions of religion and observations gained from the original in-depth interviews (Bussema & Bussema, 2000). The survey included four items each representing the self-development, interpersonal sharing, restraint and resolve coping functions of religion. Five items were included for the spiritual function. Four additional items, which did not fit a specific coping function, were used to evaluate the effectiveness and availability of religious activities. The participants rated these 25 items using a 5-point scale ranging from strongly agree to strongly disagree. Four of the 25 items were written in the negative direction (disagreement indicated support for the coping function) to avoid potential response bias. Opportunity was provided for written comments following each item. In addition, five open-ended questions were asked regarding participation in agency sponsored religious
activities. These were not included in the analysis of coping functions.

The surveys were administered by one of the authors in a number of group settings. Participants were informed that their responses would remain anonymous and would have no impact on services. Statistical analysis of the survey responses included frequency summaries of the responses of all participants as well as for those who indicated that spirituality played an important role in their recovery. Chi-square tests for independence were performed to determine whether there were any significant differences in patterns of responses across the four age groups and between those indicating that spirituality played an important role in their recovery and those who did not. An independent groups t-test was used to test for gender differences.

**Results**

71% of the participants reported that their spiritual lives played a significant role in their recovery, giving them a definite sense of purpose, peace and comfort. Regular participants in religious activities reported that fellowship and worship were an important part of their lives and were more likely to agree that they felt fulfilled and satisfied with life. In summary, the majority (70% or more) of study participants agreed that: faith gives them a definite sense of purpose (71%); they think about religious/spiritual matters daily and they have opportunities to read and discuss spiritual concerns regularly (71%); they experience joy in their faith lives (71%); they hold fast to beliefs even when opposed (76%); difficult times bring them closer to God and they believe that their faith helps them cope with the hard times (78%); and their faith gives them peace and comfort (78%).

**Group Differences in Role of Religious Coping**

There were no significant differences in patterns of survey responses by age; however, the gender of the respondents did yield several significant differences. Women were more likely to report that spirituality played an important role in recovery ($t = -2.652, 56df, p = .014$) and that they received encouragement and support from fellow believers ($t = -2.926, 56df, p = .005$). The women also reported thinking about religious matters more often ($t = -3.606, 56df, p = .000$) and were more persistent in holding fast to their beliefs in the face of opposition ($t = -2.131, 56df, p = .037$). Men, on the other hand, reported feeling angrier and more disappointed in God ($t = 2.071, 56df, p = .040$).

**Coping Functions**

Analysis of the responses of participants who reported that religion and spirituality played a significant role in their recovery clearly suggested that at least four of Pargament’s (1997) coping functions of religion were utilized in their recovery efforts.

**Spiritual Purpose**

It was evident in the survey responses that religious faith provided a sense of meaning and purpose that gave the participants hope for the future and a source of comfort in the present. The experience that one is not alone and that life can have coherence and purpose was clearly evident across the majority of the respondents. Those participants who affirmed “spirituality plays a significant role in my recovery” reported a significantly greater sense of purpose ($\chi^2 = 36.231, 12df, p = .006$) and felt more spiritually alive ($\chi^2 = 42.505, 16df, p = .002$). They were also more likely to experience joy in their faith lives ($\chi^2 = 50.376, 16df, p = .002$) and spent more time in spiritual practices ($\chi^2 = 33.807, 16df, p = .006$). Interestingly, the individuals who reported that believing plays a significant role in their recovery were also more likely to try to bargain with God to make things better ($\chi^2 = 25.761, 16df, p = .05$). God was experienced as approachable and caring; and although they often had trouble accepting it, they recognized that belief does not necessarily eliminate symptoms and struggles. It just makes it easier to cope.

**Self-Development**

Those reporting that spirituality plays a significant role in their recovery were significantly more likely to report feeling fulfilled and spiritually alive ($\chi^2 = 42.504, 16df, p = .000$) and had a stronger sense that God loves and cares for them ($\chi^2 = 50.376, 16df, p = .014$). The belief that their religious conviction brings joy and that they enjoy a personal connection with a spiritual being was significantly more evident among those reporting that spirituality plays an important role in their recovery ($\chi^2 = 50.703, 16df, p = .000$).

**Resolve**

The majority of the participants employing religious coping strategies also indicated that their faith gives them a sense of self-efficacy. They expressed confidence that difficulties draw them closer to God and that He guides them through their struggles ($\chi^2 = 112.890, 16df, p = .014$). They reported that their faith definitely gives them a sense of peace and comfort ($\chi^2 = 59.755, 16df, p = .000$). Additionally, those who indicated that spirituality plays an important role in their recovery responded that they did not feel spirituality abandoned when difficulties arose ($\chi^2 = 21.501, 12df, p = .044$). The participants’ reports suggest that a strong faith commitment can serve as an important buffer against despair.
Interpersonal Sharing
Participants affirming that their church community played a positive role in their coping consistently reported a greater sense of peace and comfort and less loneliness than those who were disappointed with their church communities ($\chi^2 = 59.755, 16$ df, $p = .013$). They were also more likely to report that fellowship was an important part of their lives ($\chi^2 = 33.420, 16$ df, $p = .000$) and that fellow believers take their spiritual needs seriously ($\chi^2 = 31.207, 16$ df, $p = .012$). These participants were also more likely to be encouraged by others who share their beliefs ($\chi^2 = 34.138, 16$ df, $p = .005$).

Sadly, the potential positive contribution of community was significantly limited as only half of the participants reported that their religious beliefs and faith commitments led to the experience of support from a religious community (e.g., the organized church). Additionally, a significant number in our study expressed a deep sense of estrangement from their religious communities. Many expressed a very individualized sense of spirituality, a personal commitment isolated and unsupported by fellow believers.

Restraint
Fewer participants reported that their beliefs helped to keep them from undesirable actions. While the religious coping group was significantly more likely to assert that they looked to God for guidance ($\chi^2 = 112.890, 16$ df, $p = .000$) and they were also more likely to report taking an avoidance approach by attempting to just let God take care of things ($\chi^2 = 33.207, 16$ df, $p = .007$). For the most part, however, there was less indication that the restraint function, as described by Pargament, played a significant role in recovery. Only 25% of the entire sample of participants reported that their faith could at times assist them in managing symptoms. For most, however, the relationship was in the opposite direction with symptoms of mental illness at times interfering with their spiritual lives.

Conversely, about half of the participants reported that at times their religious beliefs and practices hindered their efforts to manage negative symptoms. These negative experiences fit into two categories. First, the presence of a strong personal sense of inadequacy (e.g., “I feel condemned for wanting to end my life,” “I feel inadequate when I can’t pray”) seemed to engender feelings of guilt and hopelessness. Secondly, in situations where others in the religious community appeared to ignore, judge or condemn them because of their symptoms, religious coping seemed less effective. In the absence of fellowship, faith and hope were difficult to sustain.

Discussion
For the majority of the participants in this study there is strong evidence of the positive role religion plays in coping with severe and persistent mental illness. The religious coping strategies reported and the extent to which these coping efforts were found to be effective are consistent with the findings of other investigators (Fallot, 2001; Reger & Rogers, 2002, Rogers et al., 2002, Wilding, May and Muir-Cochrane, 2005). The efficacy of religious coping fits well within a recovery model. Anthony (1993) suggests a core component of a recovery model is pursuing new meaning and purpose in life despite the presence of symptoms and negative consequences associated with psychiatric disabilities. Religious coping, as reported by the survey participants, offers a frame of reference to facilitate understanding of one’s difficulties, especially those associated with the loss of control and endured meaning (Rogers et al., 2002).

Religious belief and practice provides a paradigm for interpretation and decision making related to illness (Curlin et al., 2005).

Recovery first person narratives (Ridgeway 2001) inform us that recovery entails a reawakening of hope, reclaiming a positive sense of self, and developing a sense of meaning and purpose, all accomplished with the support of other people and resources. The participants in this study suggest that their faith and religious practices offered an important resource for acquiring these key aspects of recovery. Wilding, May and Muir-Cochrane (2005) suggest that religion or spirituality also offers persons in recovery a way of seeing self outside of a “sick role” that so often follows someone who has spent time within the traditional psychiatric system. Seeing oneself as a person whose meaning, worth and purpose are larger than and more essential than a person with an illness is perhaps one of the greatest assets religious faith has to offer. Furthermore, relying on religion or spirituality to find clarity and direction in life, a coping function used by people in multiple difficult circumstances, further normalizes the recovery experience.

Religious coping not only provides a frame of reference for understanding one’s predicament, religious practice can also provide a community in which illness and recovery are experienced and endured. Unlike our earlier findings (Bussema & Bussema, 2000), the participants in this study were much more positive about their experiences within the church community. Over half reported that their church community played a positive role in their coping. Efforts to find ways to build collaboration with faith communities in providing recovery support and ongoing fellowship (Kehoe, 1998) should be
maintained and increased. Most importantly, our participants continued to remind us, as we found so clearly in our initial work, the critical importance of being part of a caring community.

In addition to the limitations of a relatively small sample, the authors are also sensitive to the concern that by virtue of affiliation with a faith-based agency, the participants in this sample might be more inclined to respond positively to the effectiveness of religious coping in their lives. Given that referrals come primarily from case management, that most participants in the psychiatric rehabilitation program received additional support services from non-faith-based providers, and four items were written in a reverse direction, we feel that the potential for a positive response bias is decreased.

While this study gives evidence for the positive role religion and spirituality can play in coping, many participants also reported that at times faith also interferes with or hinders coping. Belief systems can complicate recovery. Expecting improvement, feelings of anger towards God and guilt and shame targeted toward self were commonly reported. People in recovery who take their faith seriously frequently wrestle with questions about God’s interest in them and whether faith is real. While these feelings may also be common for believers who do not have a mental illness, people in recovery reported feeling, to varying degrees, isolation from a caring religious community, resulting in receiving a lesser degree of affirmation that these feelings are normal human experiences. This isolation can lead to more prolonged and intense periods of doubt.

Even though this study demonstrated strong evidence for the positive role spirituality can play, the negative cannot be dismissed. Further investigations exploring specific recovery situations, or symptom patterns where religious coping seems non-adaptive would be helpful to more fully understand the benefits and limits of religious coping strategies.

References


