

## Spirituality and religion in psychiatric rehabilitation and recovery from mental illness

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### Summary

*While mental health professionals frequently express concerns about the function of spirituality and religion in the lives of people diagnosed with severe mental disorders, there are both clinical and research bases for the increased acceptance of spirituality's potentially positive role in psychiatric rehabilitation and recovery. This paper first addresses issues of religious experience in diagnosis, including the importance of religiocultural context and overall functioning in diagnostic assessments. It then examines the roles of spirituality in recovery, exploring both positive and negative relationships between religion and consumers' well-being. Finally, it describes several specific ways in which spiritual and religious concerns may be integrated into psychosocial rehabilitation services: conducting spiritual assessments; offering spiritually-informed discussion groups; incorporating spiritual dimensions of psychotherapy; and facilitating linkages to faith communities and spiritual resources.*

### Introduction

Mental health professionals frequently express concerns about the role of spirituality or religion in the lives of people diagnosed with severe mental illness—including schizophrenia, major depression, bipolar and schizoaffective disorders. These concerns flow from a number of sources: the not infrequent religious content of delusions and hallucinations; a sense that the metaphoric nature of spiritual ideation may have a negative impact on symptoms of disorganization and confusion; the involvement of religious language in self-injury (e.g. taking literally the injunction to pluck out the eye if it offends) or violence to others (e.g. killing demons seen in another person); and the perceived rigidity of religious beliefs and rituals, rigidity that may worsen symptoms and preclude acceptance of treatment recommendations. At the same time, there are increasing grounds for the acceptance of spirituality's potentially positive role in rehabilitation and recovery from severe mental disorders: a growing recognition of the importance of religion in health and in coping with stress; greater emphasis on cultural competence in service provision; increased differentiation between spirituality and religion; more holistic approaches in many training programs; and increased attention to the voices of consumers and their understandings of recovery (Fallot, 1998c).

This article will address three areas of special significance for rehabilitative work with people with severe mental illnesses: diagnosis; roles of spirituality in recovery; and the place of spirituality in

rehabilitative services. I will use the terms spirituality and religion in ways that reflect both *experience* and *institution*. Experientially, spirituality and religion can be considered virtually synonymous. They both may involve a sense of ultimate purpose, meaning, and values; a sense of the holy or sacred; and/or a relationship with transcendent reality or higher power. Religion, in addition, involves a stronger institutional context; a shared set of beliefs, rituals, or practice; and a more or less identifiable community of believers. When spiritual group experience becomes formal and structured, then, it becomes increasingly difficult to distinguish from institutional religion. I will also use the term psychiatric or psychosocial *rehabilitation* in its broader sense to emphasize services provided to individuals with severe mental disorders, services that draw on community resources and consumer abilities to support people in meeting their chosen goals. *Recovery* will refer primarily to the experiences of consumers themselves and secondarily to a goal of rehabilitation.

### Spirituality and religion in diagnostic assessment of people with severe mental disorders

#### *Spirituality and religion in psychiatric categories*

In psychiatric rehabilitation programs, arriving at a DSM-IV diagnosis often involves the assessment of religious experiences. DSM-IV (American Psychiatric Association, 1994) is a symptom-oriented

nosological system and therefore focuses on those instances when spiritual or religious behavior is considered problematic. DSM-IV offers two alternatives in relation to psychiatric disorder and spiritual experience.

First, religious concerns may be deemed problematic and also attributable to a mental disorder. In severe mental illnesses, this means that the psychiatric disorder is considered primary and the spiritual expressions secondary. The individual's cultural context often contributes significantly to the content of severe symptoms, including delusions and hallucinations. While intense distress may attend the particular thoughts, perceptions, or behaviors involved (e.g. the conviction that one is sinful beyond redemption), this diagnostic assessment would accord well with those times when religious experiences virtually disappear or diminish markedly in intensity when the primary disorder is adequately treated.

In the second alternative offered by DSM-IV, the religious issue is considered problematic and worthy of clinical attention but not attributable to a mental disorder. For these instances, the V Code section of DSM-IV includes V62.89, 'Religious or Spiritual Problem' (American Psychiatric Association, 1994, p. 685). People with severe mental illnesses may indeed present the same kind of spiritual or religious concerns as those with no diagnosed mental disorder: struggles with finding a sense of meaning in life; with conflictful or confusing relationships with the divine; or with challenges to long-held beliefs. They may also bring spiritual concerns secondarily related ('not attributable') to prolonged psychiatric difficulties: problems understanding religious experiences that were part of psychotic states; demoralization and a loss of hope; or stigma and exclusion in faith communities. Diagnostic decisions in both of these alternatives rest heavily on the clinician's understanding of the cultural contexts involved (Turner *et al.*, 1995).

#### *The importance of religiocultural contexts in assessment*

In many cultures, spirituality and religion figure prominently in an understanding of personal difficulties and of the boundaries between 'normal' and 'abnormal' or between usual and problematic. Religious experiences and language are often part and parcel of the expression of these difficulties. Understanding both the individual's *cultural context* and the context of one's own practice, then, is essential in making judgments about religious or spiritual experiences that may be associated with subjective distress or observed symptoms. In one culture, an individual who attributes his fears and suffering to the threatening or intrusive actions of invisible spirits may be well within the range of cultural acceptability while in others it may clearly violate cultural expectations. Religious and spiritual

modes of expression not only vary widely from one culture to another but from one religious group to another within heterogeneous cultures. For those professionals offering psychiatric rehabilitation services, there is value in attaining religiocultural competence, that is, the ability to understand and work effectively with individuals from a range of spiritual backgrounds. This competence requires the capacity to maintain multiple perspectives simultaneously, including that of the consumer's culture as well as that of secular Western diagnostic formulations.

But understanding the spiritual dimensions and often fluid boundaries of an individual's cultural context is not the only important factor in making judgments about the diagnostic implications of religious experience. The person's *overall functioning* is also a key to discerning the diagnostic significance of spiritual ideation, emotion, or behavior. A comprehensive approach to assessment requires that any specific belief or behavior be placed in the context of the person's ability to function in social, educational, familial, and vocational roles; of overall psychological organization; and of physical or biological findings. In this way, the spiritual is brought into relationship with other arenas of functioning and, taking these domains together, the clinician may make more adequate judgments about categories of psychopathology and well-being. Alonso & Jeffrey (1988), for example, describe several individuals whose religious beliefs included elements of santeria, including spirit possession, and whose belief in possession played a role in their mental illness. Only by taking into account the person's ability to carry out usual activities and by accounting for the individual's overall belief system, the authors assert, could an adequate diagnosis be made. In a similar vein, Lukoff *et al.* (1995) propose several criteria for distinguishing between psychopathology and 'authentic' spiritual experiences. Good pre-episode functioning, stressful precipitants and acute onset, and a positive exploratory attitude toward the experience indicate less psychopathology and better prognoses. Understanding both the religiocultural context and the person's overall life functioning in that context is necessary, then, in making informed diagnostic decisions about religious experience and mental disorders.

#### **Spirituality and religion in recovery from mental illness**

##### *The salience of spirituality and religion as recovery resources*

In both the US (Fitchett *et al.*, 1997; Kroll & Sheehan, 1989) and the UK (Neeleman & Lewis, 1994), the religious commitments, beliefs, and practices of psychiatric patients have been found to be similar to, or stronger than, those of non-

psychiatric populations. Not surprisingly, then, many consumers turn to religious resources for help in response to mental health problems. Only 5% of Fitchett *et al.*'s (1997) psychiatric patient group said that religion was *not* a source of strength and comfort for them. Neeleman & Lewis (1994) refer to some of the beliefs strongly endorsed by their study participants as 'comfort beliefs', because they reflect religion's capacity to reassure and offer solace. In Lindgren & Coursey's (1995) interviews with people in psychosocial rehabilitation programs, 80% said that spirituality/religion had been helpful to them. And over 60% of the interviewees in a UK study reported that they had used religion for coping with their psychotic disorder (Kirov *et al.*, 1998).

#### *Positive and negative religious coping*

On the whole, there is increasingly convincing evidence that people with mental disorders not only turn to religion or spirituality as a significant resource, but that such coping is indeed helpful to many (Koenig *et al.*, 1998). A number of possible mechanisms have been proposed for the positive impact of religion on health (Ellison & Levin, 1998) and for the value of religious coping with particular stressors (Pargament & Brant, 1998).

As both Ellison & Levin (1998) and Pargament & Brant (1998) point out, though, religion may at times be related to negative health and mental health outcomes. Clinicians often point to the difficulties of religious experiences in relationship to mental illness. For example, major depression may appear deepened by rigidly self-deprecating religious beliefs about sinfulness, guilt, or unattainable ideals. Grandiosity may seem fueled by over-identification with saviors or groups with salvation missions. Delusions and hallucinations may take on religious content. Faith communities or religious leaders may disagree with mental health professionals about the value of medication or psychotherapy. While it is difficult to establish causality in these observations, religion may function in ways that conflict with the recovery goals of both consumers and clinicians. Psychosocial rehabilitation staff are especially interested in this question of whether any particular religious experience or belief supports, undermines, or is irrelevant to the person's overall well-being. It becomes crucial to clarify the values by which this judgment may be made whether the emphasis is on the process or outcome of religious coping (Fallot, 1998a).

#### *First-person and qualitative reports of spirituality in recovery*

While the research literature illuminates certain functions of religion in sustaining and enhancing psychological well-being, first-person and qualitative reports enrich our understanding of the

phenomenology of spirituality in the process of recovery from mental illness. As one leader in the consumer movement succinctly summarized his own experiences of recovery, 'For me it has been a spiritual journey. Regardless of what anyone else chooses to call it, that's what it's been for me' (Mahler in Weisburd, 1997, p. 1). The journeys described by consumers include numerous examples of the complex relationships between their experiences of mental illness and of spirituality. At times, painful religious experiences are part of psychotic episodes. One man described his terror at feeling caught in the center of an apocalyptic battle between the invisible but pervasive and powerful forces of good and evil. Others recounted living with the voices of demons and the unresponsiveness of God. And a woman had difficulty distinguishing her obsessional and depressive symptoms from her religious faith, deepening not only a mental health crisis but a spiritual one (Hammock, 1997). Active rejection by some faith communities and concern with stigma and marginalization have kept other individuals from participating in religious activities. That religious coping does not always enhance well-being would not surprise many consumers.

However, most consumers emphasize the ways in which spirituality has contributed positively to their recovery. Sullivan (1998) and Fallot (1997, 1998b) have summarized some of the key themes in these consumer accounts. Sullivan (1998) interviewed people diagnosed with severe and persistent mental illnesses who had not been hospitalized for over 2 years, lived at least semi-independently, and were involved in some form of vocational activity. He talked with them about the factors contributing to their success in dealing with their psychiatric problems and reported three findings relevant to spirituality. First, spirituality played a positive role in coping with stress and in decision-making. Prayer, avoidance of negative activities such as drug use, and reliance on religious role models were mentioned prominently. In addition, religious involvement enhanced social support, both tangible and emotional. And relationships with a higher power contributed a unique, often reinforcing dimension to this experience of support. Third, spirituality often strengthened a sense of personal coherence, of being a 'whole person'.

The importance of narrative approaches in the social sciences informed Fallot's (1998b) treatment of the spiritual dimensions of consumers' recovery stories. He identified several themes: 'whole-person' spiritual language that resists reducing the self to symptoms or diagnostic labels; faith-based perseverance in the long and often arduous journey of recovery; the assurance of hope; the power of loving relationships, both divine and human; the experience of serenity; genuineness and authenticity as existential goals; and spiritually-informed activities that express core beliefs.

In many ways, these consumer accounts fit readily with, and expand on the substance of, research findings that spirituality may play a positive role in coping with mental health problems. While religious content may at times be central in the expression of psychiatric distress and while religion may not consistently serve a strengthening function, for many consumers spirituality and religion are core elements of their journey of recovery.

### **Spirituality and religion in psychiatric rehabilitation services**

There are many ways to incorporate spirituality and religion more fully in psychiatric rehabilitation services (Fallot, 1998c). Four of them are most generally applicable: making spiritual assessments a routine part of service planning; developing group interventions that address spiritual and religious issues; incorporating spirituality in psychotherapy; and facilitating relationships with community resources for spiritual support.

#### *Spiritual assessment*

Spiritual assessment refers to an understanding of the content and functions of a person's religious or spiritual beliefs and practice. Many models have been proposed for organizing such an assessment, ranging from formal and structured inventories to brief sets of questions for exploration. Fitchett (1993) organizes his assessment approach along seven dimensions: beliefs and meanings (how the person develops a sense of purpose and meaning in life); vocations and consequences (how the person understands obligations and the results of fulfilling/not fulfilling them); experience and emotion (the affective tone of the person's spiritual life); courage and growth (how the person faces change and doubt); rituals and practice (how the person enacts key beliefs); community (how the person participates in formal or informal groups of shared practice); and authority and guidance (where authority for core beliefs resides).

This approach to spiritual assessment offers several strengths for programs serving people with severe mental illnesses. Because it focuses more on the *functions* of beliefs than the *content*, it is especially useful in settings where there are diverse religious experiences and cultures. Its definition of spirituality is intentionally broad and inclusive. Since it assumes a spiritual dimension to each person's life, it can be used helpfully whether or not respondents identify themselves as religious or spiritual. While this method can certainly be used with great sophistication by religious professionals, it does not necessarily require that the person doing the assessment have extensive religious training or background. It does expect the interviewer to take seriously the consumer's spiritual experiences and to understand them empathically.

Fallot (1998a) describes a somewhat simplified version of Fitchett's approach adapted specifically for work with people who have severe mental disorders. It includes four steps. First, in an open-ended conversation, the interviewer gains an understanding of four spiritual domains: beliefs and meaning, experience and emotion, rituals and practice, and community. Second, the interviewer rates how explicitly the consumer uses religious language to express experiences in each domain. Third is a rating of the role each domain's experiences play in the person's overall well-being (do they play a positive or negative function in recovery?). Fourth, based on the information gathered, the interviewer discusses with the consumer whether and how spiritual issues should be included in the service plan—as part of the consumer's *resources*, *problems*, or *goals*.

Koenig & Pritchett (1998) propose an even less formal set of questions: Is religious faith an important part of your life? How has your faith influenced your life (past and present)? Are you a part of a religious or spiritual community? Are there any spiritual needs that you would like to me to address? Even a brief exploration of these questions provides the clinician with an important perspective to enrich planned services.

Regardless of its degree of formality or structure, a spiritual assessment has considerable value in psychiatric rehabilitation settings. Simply asking about religious or spiritual issues communicates the program's interest in more than a symptom-oriented evaluation and opens the door for an exploration of an area of potential significance in the consumer's recovery.

#### *Spiritually informed groups*

Because spirituality can play such a diversity of roles in recovery, some clinicians have offered opportunities to discuss spiritual issues in group settings. Kehoe (1998) has described a 'religious-issues group therapy' model for people with severe mental illnesses. The Spiritual Beliefs and Values Group provides a therapeutic context for an examination of consumers' religious beliefs and traditions (and those of their families) and an exploration of concerns and feelings members may have about their religious or spiritual beliefs. The open-ended groups are psychodynamically oriented and do not include didactic content; leaders often ask what theme the group would like to discuss that day. Part of the leaders' task is to facilitate connections between group members' comments about religion or spirituality and the members' current lives and circumstances. Kehoe (1998) states that among the positive outcomes of the group are the members' relating their beliefs to their life situations and discovering the common search for meaning and purpose that is shared by people in spite of religious diversity. Rather than exacerbating psychiatric symptoms, the discussion

of spirituality supports clarity about the role of one's own and others' beliefs.

Lindgren & Coursey (1995) describe a very different kind of spiritually focused group for people diagnosed with severe mental disorders. In four sessions of one and one-half hours each, this structured psychoeducational group addresses how spiritual themes may enhance self-worth and a sense of social support. The first session focuses on self-esteem and spirituality, including the role of societal values. The next session deals with the spiritual meanings individuals have connected with their illness and the implications of these for self-worth; the content also includes education about the biology of mental illness. The third meeting focuses on forgiving self for failures and celebrating successes and also explores the qualities group members think they have to offer others. The final session addresses the impact of spiritual experiences and social support in spirituality. No significant differences were found between group participants and wait-list controls on mental health or spirituality outcome measures. But the small number of participants in the study made this lack of statistical significance unsurprising. For programs in which consumers prefer time-limited and at least semi-structured groups, this model offers interesting possibilities.

In a program of services for women abuse survivors diagnosed with co-occurring mental and substance use disorders, Fallot & Newburn (2000) developed a nine-session spirituality group with specific topics and goals for each session. Less didactic than traditional psychoeducational approaches and more structured than open-ended group discussions, this model helps group members deal with areas of spiritual struggle as well as identify spiritual resources for recovery. The first three sessions invite reflection on and discussion of participants' spiritual histories; spiritual gifts; and spiritual coping strategies. The middle sessions focus more on experiences which often lead to spiritual struggles and call for spiritual responses: fear and powerlessness, anger and resentment, and despair and hopelessness. The final meetings move toward members' views of the future and address the possibilities of forgiveness; hope and vision; and continuing the journey of healing. Each session is built around a set of questions and an exercise designed to clarify ways in which members may choose to use the discussion in their spiritual lives. While some of the questions are most relevant to the needs of trauma survivors diagnosed with mental illness, the group's goals, structure, and process also provide an appropriate setting for people who may not identify themselves as victims of abuse.

Interventions such as the three mentioned here indicate only some of the possible ways to address spiritual and religious issues in group contexts. Clinical reports support the value of these groups as avenues for discussing topics often avoided in mental

health settings, for dealing with spiritual problems, for identifying helpful spiritual resources, and for placing one's own spiritual experiences in the perspective offered by leaders and other group members.

### *Individual psychotherapy*

Though long-term intensive psychotherapy has become less prevalent in psychosocial rehabilitation programs, individual counseling remains highly valued by many consumers and professionals in these settings. Several research studies have demonstrated the potential effectiveness of religiously-oriented psychotherapy and the effective and ethical integration of spirituality in therapeutic work has been a central topic in several recent books (Koenig, 1998; Miller, 1999; Richards & Bergin, 2000). While few of these works deal directly with unique concerns of people with more severe mental disorders, most of them are highly relevant to core counseling issues and the therapeutic skills needed regardless of the severity of the client's mental health problems. Koenig (1998) and Richards & Bergin (2000) deal extensively with the unique needs of religious persons from different traditions. Their edited collections devote several chapters to key themes in, and recommendations for, spiritually sensitive therapeutic work with people from particular religious backgrounds, including various Christian traditions, Judaism, Islam, Buddhism, Hinduism, and Unity groups. Psychotherapeutic approaches attuned to the spiritual and religious traditions of various ethnic and cultural groups (African American, Latino/Latina, Asian American, and Native American) are also described (Richards & Bergin, 2000). Individual chapters in these two volumes address not only an overview of religious interventions in therapy but in-depth treatments of the appropriate roles of meditation and mindfulness; prayer; and spiritually-informed cognitive-behavioral techniques as well. These broad-ranging works offer thoughtful avenues for integrating spirituality into the counseling relationship.

### *Relationships with faith communities and other sources of spiritual support*

Community-based psychiatric rehabilitation programs usually devote considerable effort to working with consumers toward renewing or developing needed and wanted social supports and relationships. Faith communities have long been recognized as powerful sources of such support (Shifrin, 1998). Religious organizations can offer significant antidotes to the stigma often connected to mental illness. Consumers describe the empowerment that attends a sense of acceptance and belonging in valued faith communities (Fallot, 1997). But, as with other forms of religious coping, attempts

to affiliate with religious groups do not always yield the desired outcome. Many consumers have felt rejected by these communities, especially those that attribute mental health problems to sinfulness or inadequate faith and those that have a narrow range of acceptable appearance and behavior. Conflicts between the recommendations of mental health professionals and religious groups can leave consumers with a painful dilemma in which following the urgings of either authority jeopardizes a relationship with the other.

Representatives of both the mental health and religious communities have explored possibilities for joint programs of support for people with mental disorders (Shifrin, 1998; Walters & Neugeboren, 1995). Models and guidelines for developing these programs reflect the necessity of attention to the interests, values, and needs of both the mental health and faith communities.

For clinicians in psychosocial rehabilitation programs, several implications emerge from this literature. First, collaborating with religious professionals or traditional healers may be a fruitful way to assist consumers. In communities where there is an especially close association of religious involvement and well-being, these collaborations may be particularly valuable and important. Ruiz (1998) describes the effectiveness of creatively working with a Roman Catholic priest in providing care for a Hispanic American woman with major depression. Second, it is important for rehabilitation staff to have a clear and comprehensive view of the religious and spiritual organizations in their area. An inclusive understanding of resources, one that reflects the consumers involved, is important. In some communities, this will mean focusing primarily on traditional religious groups while in others it will involve a full range of spiritual resources associated with New Age movements, mind-body relationships, unique ethnic groups, etc. So a comprehensive approach includes not only a general sense of available resources but detailed knowledge of particular faith communities and their leadership, including how people with mental illnesses are understood and received. Third, for consumers who wish to renew or initiate a relationship with a faith community, information from a spiritual assessment and from the provider's understanding of local possibilities may help in developing a plan for finding a community responsive to the consumer's spiritual and mental health needs. Faith communities and other community spiritual resources may offer a great deal to people with mental illness. They may foster a sense of belonging; sustain shared meaning; mitigate the effects of stress; provide both tangible and emotional support in difficult times; and offer practices and rituals that structure and give purpose to life. Paying close attention to, and evaluating the likelihood of, these outcomes for each consumer significantly strengthens psychosocial rehabilitation services.

## Conclusion

While religious experiences and coping mechanisms can complicate and at times undermine the well-being of people with mental illnesses, reports from consumers, researchers, and clinicians all point to the potentially strengthening role of spiritual and religious resources in recovery. Research directed at more specific questions is necessary, addressing unique concerns related to severe mental disorders: How is spiritual or religious involvement related to long-term and short-term coping; potential subpopulation (e.g. demographic, religious, diagnostic group) differences; severity and type of psychiatric symptoms; other potential interactions with mental health problems (e.g. trauma and substance abuse)? Similarly, while clinical reports suggest that rehabilitation services can integrate attention to spirituality in a number of ways and thereby respond more helpfully to the full range of consumer concerns and strengths, research is needed to examine more systematically the effectiveness of these spiritually-informed interventions. Drawing spirituality and religion more fully into rehabilitation practice and research takes seriously the voiced needs and preferences of consumers, the necessity of offering culturally competent services, and the potentially positive roles of spirituality in recovery.

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