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ARTICLE

Spirituality and Psychosocial Rehabilitation: Empowering Persons with Serious Psychiatric Disabilities at an Inner-City Community Program

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Of 48 persons in a psychosocial rehabilitation program, 20 participated in an optional spirituality group (SG), while the other 28 did not. The recovery progress based on treatment goal attainment is compared between those participating and those not participating in the SG. Within 6 months, all of the SG participants (100%) achieved their goals, compared to 16 of the 28 individuals (57%) not in the SG. The difference between the two groups is statistically significant. The role that spirituality played in the SG participants' recovery process is discussed in light of their self-reports.

Keywords: spirituality, recovery, goals, faith

Empirical findings in the last two decades have fairly consistently reflected the beneficial effects of spirituality and religion on mental and physical health. In general, people who are more spiritually devout report better physical health, psychological adjustment, and lower rates of problematic social behavior (Miller & Thoresen, 1999; Mulligan & Mulligan, 1999; Richards & Bergin, 2000; Seybold & Hill, 2001). Many persons with psychiatric disabilities view spiritual activities as an integral part of their recovery processes. They believe that spiritual concerns should be discussed with mental health service providers (Mulligan & Mulligan, 1999; Quackenbos, Privette, & Klentz, 1985; Rose, Westefeld, & Ansley, 2001; Tepper, Rogers, Coleman, & Malony, 2001; Worthington, Kurusu, McCullough, & Sanders, 1996). However, the incorporation of spirituality in clinical practice is still at its infancy, and its inclusion in psychiatric rehabilitation is in need of additional attention (Lecomte, Wallace, Perreault, & Caron, 2005; Longo & Peterson, 2002; Miller & Thoresen, 2003).

Persons who utilize psychiatric rehabilitation services are often diagnosed with serious psychiatric disabilities and some may have co-occurring disorders (e.g., substance abuse and psychiatric disorders). A review of literature may shed some light on the impact of spirituality on the recovery process of persons diagnosed with depression, anxiety, substance abuse,

and schizophrenia. Spirituality is associated with decreased levels of depression (Catipovic, Ilakovac, Durjancek, & Amidzc, 1995; Cosar, Kocal, Arikan, & Isik, 1997; Plante & Boccaccini, 1997), especially among people with intrinsic spirituality or faith based on internal beliefs (Mickley, Carson, & Soeken, 1995; Watson, Milliron, Morris, & Hood, 1994). Positive outcomes are noted for individuals who cope with anxiety using spiritual methods (Jahangir, 1995), and lower levels of general anxiety are associated with intrinsic spirituality (Bergin, Masters, & Richards, 1987; Lotufo-Neto, 1996; Mickley et al., 1995; Richards & Bergin, 2000). Moreover, higher levels of spirituality among individuals recovering from substance abuse are related to better coping, resiliency to stress, and optimism (Pardini, Plante, & Sherman, 2001). Finally, spiritual coping methods are found to have positive effects for persons diagnosed with schizophrenia (Walsh, 1995), and participation in spiritual or religious activities helps to integrate these individuals with their families and with the community when they feel isolated (MacGreen, 1997). For persons diagnosed with serious psychiatric disabilities, spirituality has been found to be beneficial for those who wish to incorporate it into their recovery processes (Mulligan & Mulligan, 1999; Richards & Bergin, 2000; Seybold & Hill, 2001).

The current study examines the results of a spirituality group that was offered at a psychosocial rehabilitation (psych rehab) program at an inner-city community mental health center. It is anticipated that, along with proper medication and psychiatric rehabilitation, the inclusion of spirituality as a therapeutic component would enhance the recovery of persons who wish to incorporate it as a part of their treatment services.

Table 1—Participant Characteristics

Demographics	Spirituality Group (SG)	Not in SG
Number of participants (*N*)	20	28
Sex		
Females	11 (55%)	15 (54%)
Males	9 (45%)	13 (46%)
Years of Age	*M* = 43.95 (*SD* = 9.18)	*M* = 43.18 (*SD* = 14.25)
Years of Education	*M* = 12.65 (*SD* = 1.49)	*M* = 12.54 (*SD* = 2.46)
Attendance	*M* = 72.97% (*SD* = 15.88%)	*M* = 72.52% (*SD* = 16.12%)
Ethnicity		
African Americans	2 (10 %)	6 (22%)
Asian Americans	3 (15%)	4 (14%)
Caucasians	11 (55%)	9 (32%)
Latinos	4 (20%)	7 (25%)
Other	0 (0%)	2 (7%)
Primary Diagnosis		
Bipolar Disorder[1]	5 (25%)	6 (21%)
Major Depression[1]	7 (35%)	6 (21%)
Panic Anxiety[2]	2 (10%)	1 (4%)
Schizoaffective Disorder[3]	0 (0%)	3 (11%)
Schizophrenia	6 (30%)	12 (43%)

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Method

Participants

From April 8, 2003 to April 7, 2006, 75 individuals participated in the psych rehab program. For purposes of the study, only individuals who had participated with at least 50% attendance for a minimum of 3 months are included. Three months is the approximate time period for completion of a skills-training module (For a discussion of the evidence-based Liberman modules, see Liberman, Wallace, Blackwell, Eckman, Vaccaro, & Kuehnel, 1993; Liberman Wallace, Blackwell, Kopelowicz, Vaccaro, & Mintz, 1998). Twenty-seven people were not included in the research, having been in psych rehab for less than 3 months for various reasons, including having joined the program recently, insufficient attendance, relocating, being referred to another program, or gaining outside employment. Of the 48 individuals included in the study, 20 attended the spirituality group and psych rehab regularly, and 28 participated in psych rehab (but not the SG) on a weekly basis.

TABLE 1—PARTICIPANT CHARACTERISTICS *CONTINUED*

Demographics	Spirituality Group (SG)	Not in SG
History of Substance Abuse	5 (25%)	9 (32%)
Unemployed	20 (100%)	28 (100%)
Type of Goals		
Vocational	5 (25%)	12 (43%)
Socialization	7 (35%)	8 (29%)
Wellness	8 (40%)	8 (29%)
Living Arrangements		
Alone in apartment	7 (35%)	9 (32%)
Homeless	1 (5%)	0 (0%)
Managed facility[4]	4 (20%)	5 (18%)
Shares an apartment	1 (5%)	2 (7%)
With family members	7 (35%)	12 (43%)

Notes:

[1] All of the clients with Bipolar Disorder were severe with psychotic features. One client in the SG with Bipolar Disorder also has a secondary diagnosis of panic anxiety.

[2] In the SG, 2 clients with panic anxiety had secondary diagnoses of Major Depression.

[3] One client with Schizoaffective Disorder in the not SG group also had a secondary diagnosis of panic anxiety.

[4] Board and care homes or shelters.

Characteristics of the 48 participants are presented in Table 1.

All of the participants in the SG indicated that spiritual issues are important in their lives and that they wish to discuss them in the group. Eighteen participants profess to adhere to some form of Judeo-Christian faith, while 2 indicated that they are open to all faiths. All of them described spirituality as very important in their lives. Verbatim accounts of their definitions of spirituality include: "Belief in a higher power, in this case God and Jesus Christ, as the source of all things and my being"; "I believe in one God, who is waiting for the human race to make the world good enough for him to come back"; "Spirituality is having faith in a higher authority. It gives you hope"; "Belief in God and all that has to do with God" and "Your religious beliefs and your personal actions as a result of your faith." Common among their definitions is a belief in a higher power. When group members were surveyed regarding the topics they desired to discuss in the SG, they indicated the following issues as pertinent in their recovery: Finding hope again, dealing with depression, fear and anxiety, negative thoughts, self-doubt and self-worth, emotional healing, and forgiveness.

Interventions

A psychosocial rehabilitation program is conducted 2 days per week, 5 hours on each of the days, at an outpatient community mental health center, emphasizing skills training, psychoeducation, community integration, and cognitive behavioral treatment for persons diagnosed with serious mental disabilities. (For a full description of this award-winning psych rehab program, see Reger, Wong-McDonald, & Liberman, 2003.) In April 2003, a spirituality group (SG) was offered as a 60-minute optional weekly session in the same time slot as another group, enabling individuals in psych rehab to choose in which group they would participate. The SG is open-ended (i.e., ongoing) and persons in the program may participate whenever it is held. Individuals decide how long they remain in the group and they may attend the alternate skills-training group whenever they wish. Conducted with the participants' informed consent, the SG is approached from the group members' definitions of spirituality to empower participants toward recovery through spiritual pathways. Consistent with their definitions, spiritual music and writings are sometimes utilized. Periodic surveys are utilized to determine topics of discussion that are salient to the participants. Each session focuses on one topic of interest (e.g., forgiveness). The role that spirituality plays in the recovery processes of persons is emphasized pursuant to the requests and desires of the participants.

Spiritual interventions (Richards & Bergin, 1997) utilized are consistent with the participants' definition of spirituality and include discussing spiritual concepts (e.g., raising awareness of God's promises of peace, love, and faith, and helping participants to see their self-worth based on God's promises), encouraging forgiveness (e.g., discussing the relationship between spiritual well-being and forgiving others), referring to spiritual writings (e.g., encouraging participants to read the story of the prodigal son in understanding God's love and forgiveness),

listening to spiritual music (e.g., listening to songs that inspire hope), and encouraging spiritual and emotional support among the SG members (e.g., praying for one another, telephoning each other for support).

The general purposes of the interventions were to help participants understand their problems from an eternal, spiritual perspective, to gain a greater sense of hope, to emotionally forgive and heal from past pain, to accept responsibility for their own actions, and to experience and affirm their sense of identity and self-worth. Participants were also encouraged to connect with their faith communities for social and spiritual support and to widen their spiritual understandings by accessing their clergy and by participating in worship services.

At the time of entry into psych rehab and at 6-month intervals thereafter, participants set treatment goals for symptom management, community integration, and improvement in their overall quality of life. Examples of goals include health-related wellness (such as lowering the frequency of panic attacks, losing weight, decreasing cigarette smoking, lowering the number of hospitalizations, and overcoming agoraphobia), socialization goals (such as making at least one new friend, going out on a date, or saving money to go on vacation with friends), and vocational and educational goals (such as obtaining a driver's license, maintaining a car, earning a high school diploma, obtaining a volunteer job, returning to college to obtain a bachelor's degree, or transitioning from a volunteer job to paid employment).

Results

All 20 participants (100%) in the spirituality group achieved their treatment goals, compared to 16 out of 28 people (57%) not in SG who attained their goals. For persons not in SG, 7 (25%) achieved vocational goals, 5 (18%) attained socialization goals, and 4 (14%) accomplished wellness goals. The difference in goal attainment between the two groups is significant with Fisher exact test, one-tailed, $p = .0001$.

To determine if there is a difference in goal attainment and the type of goals, 3 separate Fisher exact tests, one-tailed, were computed for each kind of goal. Results were not significant for vocational and socialization goals ($p = .13$ and .12 respectively). Significance was found for the wellness goal ($p = .04$).

Due to the small sample, multivariate tests were not utilized. A chi square test was computed to determine whether there was any significant relationship between ethnicity and goal attainment. Results were not significant (with $\chi^2 = 8.25$, $df = 4$, and $p = .08$). To test whether the initial choice of the type of goal (vocational, socialization, or wellness) was related to the choice of the group (SG or not SG), a chi square was calculated. Results were not significant (with $\chi^2 = 1.66$, $df = 2$, $p > .5$). To see if there was a significant difference in attendance between participants in the SG and those not in the SG, a chi square was computed ($\chi^2 = .01$, $df = 1$), and it was not significant. As a final check to see whether goal attainment was related to other variables such as years of education, diagnosis, type of goal, history of substance use, age, and housing arrangements, individual chi square tests were calculated and all of them were not significant.

Individual examples of how spirituality may enhance recovery may speak to its role in psychiatric rehabilitation. One participant with a 30-year history of agoraphobia and daily panic attacks shared that she was able to "push away" the symptoms by utilizing a combination of prayer and relaxation techniques. Subsequently, by using both spiritual and psychological interventions, she overcame her disabilities by being able to walk down crowded streets and by being able to control the symptoms of panic, which subsided to about once every other month. Another SG member, with bipolar disorder and a history of risky sexual behaviors, shared that by returning to God, he has stopped these behaviors for over a year. Instead, he channeled his energies into attending a community college and by focusing on what God wants him to do. Yet another participant said that her hope in Christ empowered her to journey through her depression. Subsequently, she graduated from the psych rehab program and maintained full-time employment.

Finally, a participant who was homeless and suicidal told of God sending people to reach him when he was living on the street. He responded by going to a church nightly for meals and accepted assistance to obtain housing. At that time, his depression caused him to overeat in an effort to harm his body. As a result, he weighed over 300 lbs. He spoke of God removing the suicidal urge from his heart and replacing it with the will to live. Subsequently, he lost over 100 pounds over a 1-year period, kept his weight at 185 lbs. through daily exercise, maintained independent living in his own apartment, adopted a pet, graduated from psych rehab, and maintained volunteer work. He attributed his accomplishments to the interventions of God. He said, "By remembering that Jesus suffered more than I ever did kept me from self-pity and on the course to getting better."

Participants in the SG found spirituality to be a very important part of their recovery. They stated that sensing God's presence helps to lessen feelings of

sadness, their spirituality enables them to feel calmer from fears and anxieties and helps in dealing with forgiveness, they feel more confident in their recovery with the use of spiritual interventions such as prayer, they are more able to resolve daily problems from a spiritual perspective, and they know there is always hope because God is always there. Some have returned to participate in their communities of faith. Some have decided to study spiritual literature amongst themselves outside the spirituality group. Furthermore, some have indicated that focusing on spirituality has been their "lifeline" from relapse.

Discussion and Conclusion

When persons in recovery begin to conceptualize various aspects of life within a spiritual context, they often find a new orientation to the world and a new motivation and direction for living. Many aspects of life (e.g., health, work, service to the community) take on a sacred meaning, and people may be more likely to treat them with greater respect and care. The connection to the transcendent may be a source of strength, meaning, and hope. People are empowered to hold on to their sense of ultimate purpose and meaning even in the midst of debilitating disabilities and disturbing life events. Moreover, persons who are more spiritually devout may have access to a wider array of spiritual coping methods (e.g., prayer, meditation, spiritual support) in dealing with stressful situations. Finally, in their pursuit of spiritual growth or a relationship with the transcendent, individuals may be more likely to avoid harmful behaviors (e.g., gluttony, lust) and engage in healthy ones (e.g., forgiveness, perseverance, hope) that have been associated with better mental and physical health (Hill & Pargament, 2003).

The journey of incorporating spirituality into psychiatric rehabilitation begins with raising awareness and sensitivity among providers of mental health services. As service providers take into account age, gender, gender identity, race, ethnicity, culture, national origin, sexual orientation, disability, language or socioeconomic status (APA, 2002) in the delivery of services, they must also respect and take into consideration the spiritual, religious, and faith beliefs of people with psychiatric disabilities. This sensitivity can be expressed by 1) a nonjudgmental, accepting, and empathic relationship toward participants, 2) an openness and willingness to take time to understand the participants' spirituality as it may relate to health issues, 3) cultivating familiarity with cultural and spiritual values, beliefs, and practices that are common among the participant populations, 4) comfort in asking and discussing spiritual issues with participants, and 5) a willingness to seek information from appropriate spiritual professions and coordinate care concerning the participants' spiritual traditions (Miller & Thoresen, 1999).

Mental health service providers may seek additional training and consultation on incorporating spiritual interventions in clinical practice. Several excellent books on the topic have been published in recent years which may assist in this endeavor (Miller, 1999; Plante & Sherman, 2001; Richards & Bergin, 1997; Shafranske, 1996). It is important to note that clinicians must practice within the scope of their training and competence. Honesty and genuiness are essential in relating to people with psychiatric disabilities. If service providers are not familiar with the spiritual practices of the participants such that appropriate interventions cannot be utilized, they should inform the participants, encourage them to seek assistance from their communities of faith, and provide appropriate referral.

Unfortunately, spirituality has long been a neglected area in psychiatric rehabilitation (Lecomte, Wallace, Perreault, & Caron, 2005; Longo & Peterson, 2002; Miller & Thoresen, 2003). If service providers are not open to discussing spirituality with individuals who wish to incorporate it as part of their recovery processes, contraindications may result. These may include increased absenteeism, decreased willingness on the part of the participant to disclose deeper issues, keeping the alliance with the service provider at a superficial level, and an increased resistance to fully participate in treatment interventions (Dueck, 2001). The concept of acceptance in psychiatric rehabilitation must be extended to mean accepting what is important to the participants, which may include spirituality.

The findings of the current study may point to the inclusion of spirituality in psychiatric rehabilitation as a promising approach. Consistent with research in the last two decades (Hill & Pargament, 2003; Miller & Thoresen, 2003; Mulligan & Mulligan, 1999; Richards & Bergin, 2000; Seybold & Hill, 2001), the participants' self-reports and goal-attainment outcome point to the positive effects that spirituality has for people in recovery. Due to the non-randomized design and small power ($n = 48$), however, the validity and generalizability of the current report may be limited. Moreover, most of the participants in the SG (90%) profess to adhere to some Judeo-Christian faith. Studies on diverse groups of spiritual orientations are needed for a more complete picture on the effects of spirituality on mental health.

Furthermore, longitudinal studies are needed to examine the longer-term effects of spiritual interventions. Future studies may also speak to the effects of spirituality on specific types of treatment goals. Nevertheless, the results of the spirituality group over a 3-year period point to the beneficial effects of spirituality on the recovery of its participants. By encouraging those who desire to utilize a spiritual framework in treatment to do so, their recovery processes and well-being may be greatly enhanced.

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