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ARTICLE

Spirituality and Religion in Recovery: Some Current Issues

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This paper addresses current perspectives on the roles of spirituality and religion in recovery from serious mental health problems. Drawing on a variety of discussion groups and consultations in addition to the published literature, consumer perceptions as well as those of mental health and religious professionals are reviewed. Consumers note both potentially supportive and burdensome roles of religion and spirituality in recovery. Professionals report both hope for, and discomfort with, these domains in the context of mental health services. From each perspective emerge key recommendations regarding the appropriate place of spirituality and religion in psychiatric rehabilitation and related supports.

Keywords: spirituality, religion, recovery, severe mental disorder

Recent years have seen a growing emphasis on the importance of spirituality and religion in recovery from mental disorders (Bussema & Bussema, 2000; Fallot, 1998, 2001; Tepper, Rogers, Coleman, & Malony, 2001; Longo & Peterson, 2002; Corrigan, McCorkle, Schell, & Kidder, 2003); from substance use disorders (Pardini, Plante, Sherman, & Stump, 2000; Arnold, Avants, Margolin, & Marcotte, 2002); from violence and trauma (Drescher & Foy, 1995; Fallot, 1997; Fontana & Rosenheck, 2004); and from physical illness (Levin, 2001; Koenig, 2001). People in recovery, service providers, and researchers have all contributed to a growing conversation about the role of spirituality in recovery and, consequently, in the delivery of behavioral health services. I will focus in this paper on spirituality in recovery from serious mental health problems; offer a summary of certain key issues in this discussion; and make recommendations regarding the place of spirituality and religion in psychiatric rehabilitation and related services.

This paper draws on several sources in addition to the published literature and formal research or evaluation projects. Consumer perspectives, for example, are drawn in part from several structured spirituality discussion groups, ranging in length from 10 to more than 30 sessions, that I have conducted at an urban mental health agency serving people diagnosed with severe mental

disorders. Focused discussions with consumers regarding spirituality have also taken place in meetings to plan a "Spirituality in Trauma Recovery" group for women trauma survivors with co-occurring mental health and substance use problems and to plan a related research project. Similarly, discussions with mental health professionals have occurred in a variety of contexts over the past 10 years: numerous presentations and workshops at professional meetings; supervision and teaching in interdisciplinary graduate programs engaging psychology and religion; committee meetings of a 5-year multi-site research project examining recovery among women with co-occurring disorders and trauma histories; and both formal and informal consultation with clinicians providing publicly funded mental health services.

Defining spirituality and religion is a complex task; the social science literature has offered a wide range of alternative approaches (see, e.g., Zinnbauer, Pargament, & Scott, 1999). I will draw primarily on those frameworks that emphasize the personal nature of spirituality and the organizational or community aspects of religion. Hence, I will consider *spirituality* as that dimension of personal experience related to the sacred, ultimate, or transcendent. *Religion*, by contrast, carries an organizational dimension, involving a community of believers with a shared set of doctrines or beliefs and ritual activities. Religion may thus provide one avenue or context for spiritual experience but is not necessary to spirituality.

The Voices of People in Recovery: Resources and Dangers in Religion and Spirituality

Religion and spirituality as supportive resources. In first-person reports (e.g., Weisburd, 1997), in qualitative summaries (Sullivan, 1993; Fallot, 1998; Bussema & Bussema, 2000; Longo & Peterson, 2002), and in structured surveys yielding quantitative data (Tepper et al., 2001; Corrigan et al., 2003; Fallot & Heckman, 2005), consumers have consistently indicated that religion and spirituality can serve as major resources in recovery. For many people served by the public mental health and substance abuse systems, religion and spirituality may be reported as among the most salient sources of help. For example, in a Los Angeles area survey of people diagnosed with severe mental disorders, more than 80% indicated that they used religious beliefs or activities to cope with daily difficulties, a number greater than that found in many surveys of the general population, and 65% reported that religion was helpful (to a moderate or large extent) in dealing with their psychiatric symptoms (Tepper et al., 2001). For 30% of the respondents, such religious activities were considered the "most important things that kept [them] going" (p. 662).

In a District of Columbia survey completed as part of a project serving predominantly African American urban women with multiple vulnerabilities (trauma, mental health, and substance use problems), respondents reported the extent to which they thought a number of possible "ways to get help" had been or would be useful to them (Fallot & Flournoy, 2000). This group of over 175 women rated "religious or spiritual activities you do by yourself" (e.g., prayer or meditation, reading scripture or devotional materials, watching or listening to religious programs on TV or radio) as most helpful, followed by assistance from formal service providers (e.g., mental health or substance abuse centers, hospitals), and then by "religious or spiritual activities you do with others" (e.g., going to church or other spiritually oriented groups, talking to a spiritual leader or counselor, singing in a religious group). (Other categories of help included friends or family members, community agencies, informal support groups, and police/lawyers/courts/legal advocacy.)

Fitchett, Burton, and Sivan (1997) found that only 5% of the psychiatric inpatient participants in their survey reported that religion was *not* a source of strength and comfort, a pattern consistent with Neeleman and Lewis's (1994) report on the prevalence of religiously-based "comfort beliefs" among consumers. Lindgren and Coursey (1995) interviewed participants in a psycho social rehabilitation program, 80% of whom said that spirituality or religion had been helpful to them.

Some recent studies have begun to assess more formally the relationships between specific aspects of religiousness or spirituality and mental health indices. Tepper et al. (2001) found that participants experiencing greater symptom severity and lower overall functioning were more likely to use certain religious activities (prayer and Bible reading, e.g.) as part of their coping. Further, those individuals who reported a greater reliance on religious coping when their symptoms worsened had fewer hospitalizations in the previous year. The authors suggest that symptom-related stress may, for some participants, lead to greater use of religious coping methods and, over the longer term, to less symptom severity as reflected in fewer hospitalizations. Among psychiatric inpatients surveyed by Baetz, Larson, Marcoux, Bowen, and Griffin (2002), both public religion (worship attendance) and private spirituality were associated with less severe depressive symptoms. In comparison with less frequent or non-attenders, those who attended worship frequently also had shorter current lengths of stay in the hospital and higher life satisfaction. People in re-

covery who self-identified as spiritual or religious individuals reported higher levels of psychological well-being and fewer psychiatric symptoms (Corrigan et al., 2003).

These latter studies are more similar to the large body of research examining relationships between spirituality and well-being in community samples and among people with medical illnesses. Though not without controversy (Sloan, Bagiella, & Powell, 1999), there is an emerging consensus that many dimensions of religion and spirituality are positively related to indicators of well-being. Because this research has addressed links between certain aspects of spirituality and mental health functioning, it may provide indirect evidence useful in work with people who have been diagnosed with severe, persistent mental disorders. Findings regarding affective symptoms may be especially pertinent. Koenig, George, and Peterson (1998), for instance, followed medically ill older persons who were diagnosed with a depressive disorder and found that intrinsic religiousness (following religion "for its own sake" rather than for its provision of social or emotional support) was predictive of shorter time to remission of depressive symptoms, after controlling for demographic, physical health, and other factors. Other studies have similarly reported relationships between some form of religiousness and fewer depressive symptoms (Musick, Koenig, Hays, & Cohen, 1998). Pargament (1997, 2002) has studied extensively the role of religious coping methods in dealing with stress. His work has demonstrated consistent connections between *positive* styles of religious coping and better mental health outcomes. After controlling for demographic factors, such activities and beliefs as perceived collaboration with God, seeking spiritual support from God or religious communities, and benevolent religious appraisals of negative situations have been related to less depression (Koenig et al., 1998); to less depression and anxiety (Pargament, Koenig, & Perez, 2000); and to more positive affect (Bush et al., 1999).

In consumer spirituality discussion groups as well as the published literature, a number of content themes emerge as central in consumers' perceptions of the mechanisms that may account for spirituality's potentially positive impact on their lives. First, spirituality may strengthen a *sense of self and self-esteem* (Sullivan, 1998; Longo & Peterson, 2002; Fallot, 1998). Feeling more like a "whole person"; being valued by the divine (e.g., as a part of a world created as "good" or as a "child of God"); or being connected with a "higher power," are a few of the ways in which consumers have expressed the experience of enhanced personhood or empowerment that attends particular spiritual or religious beliefs. Especially important for countering stigma and shame, these more positive self-attributions are often bolstered by connection to ultimate values, sanctioned by a transcendent reality.

In addition, religion or spirituality may involve distinctive *coping responses,* behaviors and activities that mitigate distress (Bussema & Bussema, 2000; Longo & Peterson, 2002; Tepper et al., 2001). In Tepper et al.'s (2001) study, consumers reported on the extent and perceived helpfulness of such religious "coping strategies" as prayer, attendance at religious services, worship, and meditation. While 65% of consumers diagnosed with persistent mental illness said that these activities had helped them in coping with symptom severity, nearly half said that religion became even more important when their symptoms worsened. Other positive religious coping strategies may be more cognitive (cf. Pargament, 1997), involving reminding oneself of God's support and care in the midst of difficult times.

Third, spirituality or religion may be connected to important sources of *social support* and community (Sullivan, 1998; Longo & Peterson, 2002). Not only are there instrumental and emotional dimensions to the support activities of many religiously or spiritually-based groups but the impact of this support may be enhanced by the perception that it is validating in a moral or transcendent sense. Belonging to, and finding acceptance in, a community that understands itself as grounded in a relationship to the divine, may have special importance for people often rejected, isolated, or stigmatized (Fallot, 1997). And, even if they do not directly involve an identified religious community, many spiritual experiences and beliefs emphasize and facilitate the development of a fundamental sense of *connectedness*—to oneself, to other people, and to the ultimate or sacred.

Finally, consumers frequently report that spirituality is basic to their sense of *hope* (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Sullivan, 1998; Fallot, 1998). Recovery rests on the experienced possibility that the future may contain opportunities for growth and positive change. A sense of purpose or a "reason for being" may sustain a person's daily efforts to live more positively. Holding particular religious beliefs and/or participating in spiritual activities may help to develop or strengthen this sense of hopefulness and optimism. If a divine or higher power is experienced as an actively collaborating ally in recovery, hope for success in meeting important goals may increase substantially. From the perspective of consumers, then, beliefs, activities, and relationships in

the religious or spiritual domain may all contribute positively to the recovery process.

Religion and spirituality as burdens and dangers. Corrigan et al.'s survey (2003) indicated the range of religious and spiritual self-identifications among people in recovery from psychiatric disabilities. Although over 60% of the respondents identified themselves as both "religious" and "spiritual," others reported that they were spiritual but not religious (21.6%), religious but not spiritual (4.1%), or neither spiritual nor religious (10.8%). This diversity of experience demonstrates that, in spite of the large number of people in recovery who endorse the value of religion or spirituality, such affirmation is by no means universal: over 30% of the respondents did not consider themselves to be "religious" individuals.

Engagement with religion or spirituality may be diverse in a second important way as well. In addition to the positive roles described above, religion and spirituality may play distinctly *negative* roles in relation to well-being. Pargament (1997, 2002), for example, has summarized some of the differences between positive and negative religious coping. Negative religious coping methods involve such beliefs and activities as expressing anger at God, questioning God's power, attributing negative events to God's punishment, and discontent with religious communities and their leadership. In contrast to the more benign outcomes associated with positive religious coping noted above, negative religious coping in community samples has been linked to greater affective distress, including greater anxiety and depression and lower self-esteem (Exline, Yali, & Lobel, 1999) and more PTSD symptoms (Pargament, Smith, Koenig, & Perez, 1998). Exline (2002) has also detailed some potentially problematic ways in which religion may function: by increasing interpersonal strain (rather than providing social support); by conflicts with God (rather than perceived collaboration and support); by struggles with belief (rather than clear meaning and coherence); and by difficulties related to imperfect striving after virtue. These kinds of "religious strain" have been linked to higher levels of depression and suicidality (Exline et al., 2000). Some elements of this pattern are consistent with the experiences of rejection and marginalization many consumers report in some religious settings (e.g., Bussema & Bussema, 2000). Others, such as confusion about beliefs or faith, may be especially problematic for those diagnosed with severe mental disorders when this confusion is intertwined with symptoms of cognitive disorganization. Siddle, Haddock, Tarrier, and Farragher (2002) found that, among individuals diagnosed with schizophrenia, those with religious delusions had higher symptom scores and lower overall functioning than those with other delusional content. Given the positive and negative outcomes related to religiousness, it is not surprising that religious involvement has been found to buffer depression related to stress in some life domains but exacerbate it in others (Strawbridge, Shema, Cohen, Roberts, & Kaplan, 1998).

Consumers participating in spirituality discussion groups describe many of these negative possibilities as nearly polar opposites of the resources described above. For example, just as religious beliefs may enhance self-esteem, they may *denigrate the self*. Excesses of self-blame and perceptions of unredeemable sinfulness can be rooted in religious conviction. When such beliefs are woven into obsessive and/or depressive symptom patterns, they are all the more distressing. Consumers also report that self-blame may be reinforced by religious communities who see mental disorders as signs of moral or spiritual weakness or failure. These groups sometimes tell consumers that their symptoms would be alleviated if the consumers only had adequate faith or strong enough commitments to moral probity.

Similarly, religious or spiritual practices that are positive coping resources for some consumers may have *negative coping* consequences for others. Prayer or other religious rituals may become compulsive and interfere with overall daily functioning. Tepper et al. (2001) reported some cross-sectional evidence for this kind of negative impact of religious activity among consumers whose prayer and Bible reading was associated with greater impairment. Some consumers express precisely the kind of negative religious coping that Pargament (2002) has found related to poor health outcomes: anger at God for causing a disability, for example (Bussema & Bussema, 2000).

Third, the social support available in many religious contexts can be especially painful when it turns to *rejection* or *estrangement*. In their interviews with 17 individuals in a psychosocial rehabilitation program, Bussema and Bussema (2000) found that only five experienced significant support from a religious community and that interviewees were more likely to express estrangement. The same factors of divine sanction and ultimate meaning that strengthen positive social engagement with religious groups can deepen the isolation that accompanies marginalization. In addition to experiences of rejection by religious organizations, consumers who are also trauma survivors sometimes report *abuses of power*, in which the group or its representatives are either directly abusive (physically, sexually, or emotionally) or

indirectly sanction abuse by minimizing, denying, or rationalizing it in self-justifying ways. Such abuses are part of the ironic reports of some consumers that they are "in recovery" from religion or from a particular religious orientation. It is not surprising, then, that many consumers report themselves to be more "spiritual" than "religious," when organized religion can be associated with such dangers.

Finally, in contrast to hope, religious or spiritual experiences may carry connotations of *despair*. Beliefs involving themes of divine abandonment or condemnation, unrelenting rejection, or powerful retribution may make recovery seem unattainable or unimportant (compare Exline, 2002).

Recommendations based on consumer perspectives. Consumers' hopes and concerns lead to some specific recommendations about the place of spirituality and religion in mental health service contexts. First, mental health programs should adopt a *holistic* approach to both assessment and intervention, an approach that includes the spiritual dimension of life in an explicit way. Addressing spirituality directly; inquiring about the consumer's own understanding of spirituality and about whether religion or spirituality is important to the consumer; asking about spiritual or religious histories; asking whether and how the consumer would like to have spiritual concerns or goals included in their work; and developing structured ways to discuss spirituality in group or individual meetings are some possible responses to consumer requests for greater attention to spirituality and religion.

Second, it is important for service providers and programs to have an *open* and *inclusive* understanding of spirituality and religion, sensitive to the many differences of experience and conviction among consumers. Most consumers want providers to address spiritual and religious issues (compare D'Souza, 2002); they do not generally want providers to "push" either religion in general or a particular expression of spirituality or religion. Further, for some consumers, the experience of spirituality is profoundly personal, private, and meaningful. Many are wary of discussing it with providers (Lindgren & Coursey, 1995). Some fear that clinicians will "reduce" or trivialize it as simply another item in a long list of assessment domains or that they will see it as a sign of pathology (especially if spiritual practice or language differs from the so-called mainstream religions). This requires clinicians to take a *respectful* and *individualized* approach to spiritual and religious realities, attuned to the varying needs of individual consumers over time and across situations.

An individualized approach means that clinicians need to be aware of the *multiple* and *complex* ways spirituality can function in the lives of consumers with mental health problems. The roles of spirituality and religion may be tremendously variable at different times, in different situations, and in coping with different kinds of difficulties and stressors (Pargament, 2002). Providers may be helpfully informed by questions such as the following: *How* is the person drawing on the religious or spiritual dimension of experience? To deal with what stressors or problem(s)? To achieve what goals? In what situation or context? With what impact? According to what criteria of health and well-being? Discussions of whether and how an individual may wish to include attention to spirituality in service delivery must take into account the specific needs and preferences of a particular person at a particular time. Consumers are as leery of a "one size fits all" approach to spirituality as they are of similarly overgeneralized models of pharmacological or psychosocial interventions.

Clinician and Professional Voices: Hope and Discomfort Regarding Religion and Spirituality

Religion and spirituality among mental health professionals. Numerous surveys have addressed the religious and spiritual commitments of mental health professionals. Most have pointed to the relatively lower levels of religious beliefs and activities among these service providers in comparison to the general population (Bergin & Jensen, 1990; Shafranske, 2000). Some surveys suggest that such patterns vary by professional discipline with psychiatrists and psychologists reporting lower levels of religiousness than social workers, professional counselors, or marriage and family therapists (e.g., Bergin & Jensen, 1990; Myers & Truluck, 1998; Carlson, Kirkpatrick, Hecker, & Killmer, 2002). Even when overall similarities between mental health professionals and the general public are noted, there may be noteworthy differences at a more specific level. For example, psychiatrists and psychologists affirm the importance of *spirituality* to a much greater degree than they do religion, suggesting that they may draw a sharper distinction between these realms than the general population does (Shafranske, 2000).

Religion and spirituality as personal and professional resources. These differences raise the important question of cultural competence or, perhaps more accurately in this case, "spiritual competence": to what extent are providers skilled in understanding and taking into account the spiritual and religious realities of the people receiving services? Surveys of professionals' attitudes toward the inclusion of spirituality and religion in service delivery have been equivocal. Although many providers express openness to the in-

clusion of attention to spirituality in mental health services (e.g., Carlson et al., 2002), some studies have reported noteworthy differences between clinicians and consumers in their perceptions of the value and relevance of attention to spirituality. For example, Goldfarb, Galanter, McDowell, Lifshutz, and Dermatis (1996) found that medical students significantly underestimated the extent to which consumers diagnosed with co-occurring disorders rated the importance of spiritual factors in recovery. In a survey conducted in a Montreal psychiatric rehabilitation program, consumers reported that, among their various recovery goals, the services they received were *least* helpful in achieving goals in the spiritual and religious domain (LeComte, Wallace, Perreault, & Caron, 2005).

In focus groups, trainings and consultations, and clinical case conferences, providers have clarified some of the reasons they are both supportive and skeptical about including increased attention to spirituality in psychiatric rehabilitation services. To a significant degree, many of the clinicians' positive responses overlap with those noted by consumers. Clinicians, too, often recognize the ways in which spiritual beliefs and activities may facilitate recovery: through a stronger sense of self; through specific beliefs and activities that enhance coping with life stressors; through supportive relationships and a sense of belonging and attachment; and through a sense of purpose that sustains hopefulness.

Clinicians are especially aware of the value of addressing spirituality and religion from three additional perspectives. First, they often strive to place spiritual factors in the larger context of, and in direct relation to, consumers' overall life and functioning. Spirituality becomes a key to a more holistic approach to assessment and service planning. Clinicians frequently state that discussions of spirituality or religion open the door to more "whole person" approaches, reinforcing an emphasis on consumer skills, strengths, and community integration. For some clinicians, a spiritual perspective is inherently *integrative*; it serves as a reminder to address core issues of meaning and purpose, connectedness to other people, and a sense of transcendence and ultimacy in individuals' lives. Biopsychosocial formulations are enriched, in this view, by the addition of the spiritual domain.

Further, clinicians and program administrators are aware of the increasing inclusion of spirituality and religion in *professional standards* guidelines. Some accreditation standards in health and human services now require that providers address consumers' spirituality in assessment, service planning, and delivery. Similarly, the importance of cultural competence in the provision of services has become well-established as a professional and ethical requirement. And, in many cultures, it is difficult to develop and deliver services sensitive to the uniqueness of that culture without understanding the centrality of religion and spirituality.

Third, many clinicians recognize the importance of spirituality or religion in sustaining their own professional work. In talking about how they deal with experiences of burnout, vicarious or secondary traumatization, or simple fatigue growing out of their clinical work, providers not infrequently refer to spiritual or religious sources for *personal sustenance* and renewal. For some clinicians, then, spiritual and religious realities prompt them to remember not only the fundamental humanity of the consumers with whom they work but the fundamental needs they both share for a grounded sense of purpose and an encompassing source of understanding and perspective about their time together.

Religion and spirituality as a confusing morass. Although many clinicians are decidedly positive about a potentially expanded and explicit role for spirituality in mental health services, there remain significant concerns among providers who are supportive as well as among those who are skeptical about spirituality in general. The doubts of some mental health professionals are certainly not surprising, given the longstanding mutual skepticism, if not outright hostility, between religion and some psychological theorists. Religious and spiritual worldviews and experiences are, according to certain frameworks, inherently dysfunctional, reflecting shared neuroses and an inability to face harsh realities (Freud, 1950, 1964) or rigid, irrational belief systems (Ellis, 1980). But even among clinicians who take more neutral or positive stances toward religion—including Ellis's own more recently differentiated views on this subject (2000)—there are many questions about whether and how to give spirituality a more prominent place in service delivery.

Several factors underlie these concerns. Many clinicians indicate that dealing with spirituality and religion is beyond their range of expertise or professional competence. They describe either a lack of necessary knowledge, or a lack of confidence in their knowledge, about how to address spirituality helpfully with consumers. This concern is compounded by the popular proliferation of "spiritual" movements and ideas. As spirituality, especially as distinct from traditional religious groups and activities, has become increasingly prominent in the last decade and increasingly publicized in popular media, some clinicians feel confused by the tremendous array of beliefs, practices,

and organizations identified as "spiritual." The spiritual or religious "marketplace" (Finke & Stark, 1992) is full to overflowing with options for both individual and group commitments, options that include, of course, many mutually exclusive and contradictory paths. Sociologists of religion have described the increasing tendency of people to draw on elements from many traditions, to meld these with their own unique experiences, and thereby to develop highly individualized spiritual expressions (Bellah, Sullivan, Swidler, & Tipton, 1985). These idiosyncratic blendings may be confusing to clinicians who are unfamiliar with many of the elements involved and who have limited time to explore their subtleties.

The burgeoning range of spiritual options and the seemingly endless possibilities for amalgamation, then, are often confusing in their own right. That they offer clinicians, implicitly or explicitly, a parallel range of tools and approaches to *understanding* spirituality frequently seems to add to the confusion. The more popular literature in spirituality often differs markedly from that based in traditional religious communities and these may in turn be quite different from those of mental health professionals interested in religion. Further, the religious and social scientific communities bring very diverse and not easily reconcilable positions to bear on this discussion as well. So even for the clinician positively disposed to include spiritual issues in mental health services, there is often considerable confusion about the great diversity of spiritual expressions and the equally great diversity of sources for reflecting on and utilizing spiritual resources.

A final factor related to clinicians' reluctance to address spirituality parallels consumers' concerns with protecting their privacy. For some clinicians, the spiritual domain is not only an arena of great privacy but one that should remain separate from the mental health realm. This concern is voiced more frequently by public mental system clinicians who associate discussions of spirituality with a metaphorical, if not actual, violation of the separation of church and state.

A separate group of professionals, those from religious communities, have raised certain questions about the inclusion of spirituality in health care generally and these concerns are also relevant to this discussion of mental health, especially as they affect relationships between mental health providers and representatives of faith-based organizations. Some religious professionals (i.e., some clergy, theologians, and chaplains) voice concern about the way in which mental health practitioners, often reflecting their roots in the medical and social scientific community, are sometimes *reductionistic* in their treatment of religion and spirituality. Providers may often functionally reduce religious realities to secular concepts, either positive or negative ones. Thus, religion may be *no more than* a positive "coping mechanism" or a "source of social support." Or, negatively, religion may be reducible to its function as a socially numbing opiate or psychological illusion. In either case, religious professionals serve as reminders that religion and spirituality are defined in, and have important consequences in, their own terms that are not identical to the concepts of social or behavioral science. In a related vein, representatives of the religious community are sometimes concerned that mental health practitioners treat spirituality from a purely *instrumental* perspective (e.g., Shuman & Meador, 2003). That is, religion may be seen as only a means to an end, a way to accomplish certain other worthwhile goals (e.g., self-esteem or social support). From the religionists' viewpoint, this inverts key spiritual values by making religion a tool for the achievement of other non-religious objectives rather than a self-validating journey that may also yield healthful byproducts.

Recommendations based on professional perspectives. The most obvious recommendation growing from these concerns is the need for more extensive training and education for human service providers in spirituality, training that is pertinent to the particular service setting in which staff and consumers work together. In some areas of pre-professional training (e.g., psychiatry, social work, medicine), there are organized movements to expand the educational emphasis on spirituality. In-service and continuing education opportunities have the additional potential to tailor educational offerings more closely to the actual work of clinicians with a specific population.

Such training needs to address several topic areas. First, clinicians are concerned with how to understand and evaluate the ways in which spirituality relates to consumers' overall well-being. Is a particular expression of spirituality helpful or harmful to an individual's recovery? Educational programs should offer a framework for answering this question by examining key criteria of mental health that often remain implicit in clinical judgments. Clinicians who are able to understand spiritual experiences in the context of a consumer's overall functioning as well as in their religious-cultural milieu have one of the skills necessary to exploring spiritual realities in a helpful way. A second, related assessment skill is the ability to talk with consumers about spirituality in a manner that is neither intrusive nor reductionistic but communicates respectful openness to the consumer's unique

spiritual experiences, both positive and negative. There are many models for spiritual assessment available; examining them and choosing or developing an appropriate approach for the specific services and consumer population is a key step for mental health programs.

Adequate assessment flows naturally into service planning and delivery. As clinicians develop a clearer understanding of spiritual aspects of consumers' lives, there may be opportunities to expand the connections between religious or spiritual activities in the community and in the mental health program itself. "Automatic" referrals (e.g., encouraging a consumer to talk to the leader of his or her religious or spiritual group without a thorough discussion of the implications of participating in this group) should be avoided. Consumers clearly report that involvement in some religious groups may undermine recovery or even be directly harmful. Referrals to religious professionals, to faith-based programs, or to centers of spiritual activity may, however, all be appropriate based on an adequate *shared understanding* of and *collaborative response* to the consumer's needs and preferences.

Some programs may wish to add their own services that address explicitly the role of spirituality in relationship to mental health problems and recovery. Several group models have been proposed to structure this process. They range from very short-term psychoeducational groups designed to explore ways in which spirituality may enhance self-esteem and social support (Lindgren & Coursey, 1995) to open-ended discussions of "religious issues" as they relate to mental health concerns (Kehoe, 1999). Other groups have combined elements of both more and less structured approaches. Like the religious issues groups, they discuss both spiritual resources and struggles; like the psychoeducational groups, the discussions are focused on specific topics and have session-specific goals in a time-limited setting (Phillips, Lakin, & Pargament, 2002; Fallot & The Trauma and Spirituality Working Group, 2001). As with other group interventions, these groups often facilitate a sense of belonging and the possibility of learning from others' experiences, whether similar or different with regard to spirituality. Individual therapy may also provide opportunities for exploration of spirituality in recovery and has the advantage of more intensive focus on the historical, current, and future roles of spirituality in coping with mental health problems. All of these assessment and service possibilities, however, rest on the foundation of expanded education for clinicians about the various roles of spirituality in consumers' recovery.

Conclusion

In responding to a growing awareness of the prevalence and impact of trauma in the lives of people receiving human services, we have made a distinction between "trauma-specific" and "trauma-informed" services (Harris & Fallot, 2001). Trauma-specific services, such as trauma recovery groups and individual therapies like EMDR, focus directly on the impact of trauma and the process of recovery. Trauma-informed services, by contrast, may address any of a wide range of human problems as their primary task but they are offered in a way that draws on our knowledge of trauma to make the services more hospitable, engaging, and helpful to trauma survivors. There is a useful parallel here for addressing spirituality and religion. The first task of mental health services organizations is to become "spiritually-informed." That is, both staff and the services they provide need to take into account the place of spirituality in the lives of consumers, building on our growing understanding of the various roles spirituality may play in recovery from mental health problems. This includes, at minimum, communicating to consumers that the program staff are interested in and responsive to the spiritual dimension of consumers' experiences and that they are willing to talk about including this attention in service planning, referral, and coordination if the consumer wishes to do so. Some programs may, in addition, wish to take on more "spiritually-specific" interventions, developing structured, optional ways to explore with interested consumers how their spirituality has functioned, positively and/or negatively, in relationship to their recovery and how it may find expression in the future. In groups or in individual settings, this explicit attunement to the possibilities embedded in the spiritual domain offers promise for the enrichment of consumers' lives and for the enhanced quality of mental health services.

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