Critical Social Work

School of Social Work
University of Windsor
401 Sunset Avenue
Windsor, Ont.
Canada N9B 3P4
cswedit@uwindsor.ca

Publication details, including instructions for authors and subscription information can be found at: <http://uwindsor.ca/criticalsocialwork>

Link to article:

<http://www.uwindsor.ca/criticalsocialwork/exploring-spirituality-in-mental-health-social-worker-and-psychiatrist-viewpoints>

Critical Social Work, 2009 Vol. 10, No. 1

Exploring Spirituality in Mental Health: Social Worker and Psychiatrist Viewpoints

Critical Social Work 10(1)

Jan-Stella Metheany¹ and Diana Coholic²

¹ Community Mental Health Program and ² Laurentian University School Social Work

Abstract

This paper discusses the viewpoints of four psychiatrists and four social workers practicing in mental health. These participants were individually interviewed for the purposes of understanding how spirituality was being incorporated into helping/health practice with people who have serious mental illnesses. Overall, the qualitative analysis demonstrated that the participants' perspectives were consistent with the literature in social work and spirituality. For example, participants advocated for a diverse conceptualization of spirituality and believed that an incorporation of spirituality into helping/health practices led to more effective processes. One finding that may be specific to mental health practice was the usefulness of understanding a client's spiritual beliefs and practices in order to better understand their mental illness. Given many mental health consumers/survivors' desire for a greater integration of their spirituality in their recovery process, practitioners and researchers are encouraged to consider how the incorporation of spirituality into mental health practices may be fostered.

Introduction

Knowledge regarding spiritually-sensitive social work practice continues to develop and demonstrates the usefulness of holistic practice methods (Graham, Coholic & Coates, 2006). Social workers practicing in various fields and with a myriad of populations have reported on this usefulness (Dane & Moore, 2005; Furman, Benson, Grimwood & Canda, 2004; Northcut, 2000). However, within the mental health field and specifically in work with people who suffer serious mental illnesses, there is a lack of discussion concerning the incorporation of spirituality and spiritually-sensitive methods. Serious mental illness refers to mental disorders categorized by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) as Axis I diagnoses, for example, schizophrenia, bi-polar disorder, and major depression; severe and persistent illnesses that cause significant functional disability (Corrigan, McCorkle, Schell & Kidder, 2003). In this paper, we discuss a few practitioners' perspectives

regarding the incorporation of spirituality in mental health practice with people who have serious mental illnesses.

The discussion is based on research that was completed for a master of social work degree. The first author individually interviewed four social workers and four psychiatrists in order to explore their viewpoints on the incorporation of spirituality in their mental health practices. A decision was made to interview an equal number of social workers and psychiatrists as both professions are key players in the mental health field although psychiatrists have typically held important positions of authority, influence, and knowledge. Certainly, social work has provided important contributions to the multidisciplinary field of the mental health care system (Carpenter, 2002), and more social workers are employed by community mental health support programs for people with mental health illness than any other profession (Rapp, Shera & Kisthardt, 1993). We were interested in exploring any convergences and differences that might arise between the two professions regarding their perspectives about spiritually-sensitive practices. Before discussing these findings, we situate the research within the current literature and describe the research process.

Current Literature and Research in Mental Health and Spirituality

A transition from the long-standing view that mental illness is chronic and fixed to one that recovery from mental illness is possible has been incorporated within the mental health field, particularly in the last decade (Yangarber-Hicks, 2004). This recovery movement has been largely driven by mental health consumers/survivors (Carpenter, 2002). The recovery model emerged from personal narratives about recovery written by these consumers, as well as empirical data that demonstrated the feasibility of positive outcomes to mental illness. Recovery is defined as a process of transformation, adaptation and self-discovery involving one's illness (Anthony, 2000).

Many personal accounts of recovery highlight the role of spirituality (Sullivan, 1999), and some studies report that religiosity/spirituality is an important dimension in mental health recovery (Phillips & Stein, 2007; Wilding, May & Muir-Cochrane, 2005). Furthermore, recent literature reveals that a majority of individuals suffering serious mental illnesses want their spiritual beliefs, values and practices to be considered and included in their overall treatment planning and recovery process (Baetz, Griffin, Bowen & Marcoux, 2004; Coyle, 2001). For example, D' Souza (2002) surveyed 79 patients diagnosed with a psychiatric illness and found that 79% rated spirituality as being very important in their lives with 67% reporting that their spirituality helped them cope with their psychological pain - 69% of these people also reported that their spiritual needs should be considered by the therapist treating their psychiatric illness.

However, as Curlin et al. (2007) argue, psychiatry has a history of dismissing or labeling spiritual experiences as neuroses, obsessions, ego regressions, emotional imbalances or pathological thinking. This being said, the decision to include psycho-religious and psycho-spiritual concerns within the DSM-IV represents an effort to address this important aspect of health (Coyle, 2001). In fact, these changes may have helped to create an important conceptual shift in current mental health practices to more holistic perspectives. The initial impetus for the addition of a new diagnostic category in the DSM-IV was largely driven by the transpersonal

movement which grew out of humanistic psychology and psychotherapists and researchers who wanted to acknowledge the role of spirituality and/or religion in human development (Lukoff, Lu & Turner, 1997). This change also grew from the recognition that necessary innovations were needed to better facilitate usage of the DSM with culturally diverse populations for whom spirituality can be intimately linked with spirituality and/or religion (Turner, Lukoff, Barnhouse & Lu, 1995). In addition, it might be argued that the consumer-driven recovery movement, which integrates empowerment and a strengths perspective (Ruscinova, 1999), has also provided a suitable context for the consideration of spirituality as an aspect of good health and well-being, and a person's coping resources and resiliency.

Studies that have explored psychiatric viewpoints on spirituality/religion and mental health practices have relied primarily on quantitative methods in the form of surveys. For example, two studies, one Canadian (Baetz et al., 2004) and one American (Curlin et al., 2007), utilized surveys to investigate the roles of spiritual and religious beliefs, practices, and attitudes in psychiatric practice. In the Canadian study, 50% of the psychiatrists surveyed reported that they always or often inquire about spirituality and religiosity. However, only 17% of patients (in the same survey) reported that their psychiatrist had addressed this issue with them. The American study found that psychiatrists were more likely than other physicians to address religion and spirituality.

Mental health social workers have been prominent among those who challenge the medical model where too frequently focus has been on symptoms and deficits, and failures to recognize or engage the whole person (Rapp, 1998). One of the most important contributions has been the incorporation of a strengths perspective in the development of case management models (Carpenter, 2002). Social workers have also made significant contributions to literature regarding consumer/survivor empowerment and mental health recovery (see Borg & Kristiansen, 2004; Carpenter, 2002; Stormwall & Hurdle, 2003). However, while social workers have also contributed to a significant body of literature in spiritually-sensitive practice as was noted in the introduction, there is a lack of social work literature that specifically explores spiritually-sensitive practice with people diagnosed with serious mental illnesses [see Miller & McCormack (2006) for an exception].

The Research Process

The objective of the research described herein was to explore in-depth the viewpoints of mental health social workers and psychiatrists concerning the incorporation (or not) of spirituality in helping practice with individuals diagnosed with serious mental illness. Given the lack of previous study in this area, a qualitative exploratory method was used in order to develop a more thorough understanding of how these practitioners conceptualized spirituality, and how they incorporated it (or not) in their work. The qualitative thrust of this project was guided by a grounded theory strategy. Although Glaser and Strauss (1967) originally developed grounded theory, these methods have evolved and now there is no one correct way to conduct grounded theory research (Dey, 1999). In general, grounded theory methods are inductive approaches that involve a continuous process of defining and redefining concepts, and relationships between concepts (Gilgun, 1994). This process is termed "constant comparison" by Glaser and Strauss

(1967). Practice professions such as social work have made considerable use of grounded theory methods in their quest to conduct research that is relevant for practice (Gilgun, 1994).

The study took place in an urban community in northeastern Ontario. A grounded theory strategy begins with a purposive sampling method and, as the coding becomes more refined, sampling becomes more discriminate. Typically, the researcher continues to gather information until the categories are saturated and no new knowledge is emerging from the ongoing analysis (Creswell, 1998). Invitations to participate in this study were mailed to all of the practicing psychiatrists at local and regional psychiatric hospital units as well as psychiatric outpatient clinics in the northeast (22 invitations in total). The invitations explained the purpose of the study, which was to explore the incorporation of spirituality in mental health practice. The same invitations to participate were also sent to the 25 social workers working within acute and long-term psychiatric units in northeast Ontario, as well as the community mental health programs in the region. Five psychiatrists and seven social workers responded to these invitations. Four psychiatrists and four social workers were eventually interviewed due to factors such as summer holidays and other issues related to availability. After completion of the eighth interview, it was evident that theoretical saturation was emerging in many of the categories. However, collection of data stopped after the eighth interview because of the nature of the project, that is, the study was a master's thesis project and reaching complete theoretical saturation was not feasible given time constraints and the expectations of a master's thesis study.

The eight participants were two registered psychiatrists (one male and one female), two physician-psychiatric associates (two males practicing solely in psychiatry), and four registered social workers (three females and one male). The social workers ranged in age from 40-51 years old and the psychiatrists ranged in age from 38-66 years old. The psychiatrists' years in practice ranged from two to 34 years and the social workers' ranged from five to 17 years. Two social workers practiced in a hospital setting and two provided services in the community. All four psychiatrists practiced in both in-patient and out-patient settings. Of the eight participants, four considered themselves both religious and spiritual, three were non-religious but spiritual, and one participant reported being neither religious nor spiritual.

A semi-structured interview guide was used. The individual interviews began with questions about spirituality (How would you define spirituality?), and then included questions about the participants' experiences with spirituality in their work (Have you ever discussed spirituality with your clients? Why or why not?), and their thoughts about the incorporation of spirituality in mental health practice (Do you think spiritual dimensions of care are important in supporting individuals suffering serious mental illness?). A semi-structured format provided a guide but enabled the exploration of responses in more depth. The length of interviews averaged 55 minutes and they were transcribed verbatim by the first author. Each participant received a transcribed copy of their individual interview, which allowed them to check for accuracy of the transcription as well as to add further comment if so desired.

Briefly, a grounded theory method constructs knowledge from the analysis of the individual interviews, which were all audio-recorded and then transcribed for the purposes of the analysis. Research data (transcribed interviews) are converted into systematic schema for examining its meaning, discovering themes, and making connections among concepts. First, the data is coded

and organized into categories. As more data are reviewed they are compared with existing categories, and data that is different is assigned a new label. This process of constant comparison allows for the ongoing refinement of categories, which can produce the richness that is typical of a grounded theory analysis (Kennedy & Lingard, 2006). Memo-writing (making notes about your own thinking process during analysis) was also used as the analysis progressed (Strauss & Corbin, 1990). Final integration of research data follows this process but it is done at a higher, more abstract analytical level (Glaser & Strauss, 1967); making links between categories/themes is a means of putting conceptual order on the mass of data. For one brief example, discussions about spirituality as a resource for wellness, recovery, and coping, and as an aspect of whole person care were all related to rationales for the incorporation of spirituality into mental health practices; that is, participants thought that the incorporation of spirituality in practice contributed to a more effective and successful helping/health process.

Overall, the analysis demonstrates movement towards incorporating spirituality and spiritually-sensitive methods and processes into mental health practices; this is certainly consistent with other areas of social work practice and other helping/health professions. The participants' perspectives were convergent between the two professions and with the literature in this area (see Nortcut, 2000; Phillips & Stein, 2007). In the following section we present and discuss the findings. We begin by briefly describing how the participants conceptualized spirituality and then the discussion focuses on how spirituality is becoming a part of a more holistic mental health practice, at least for these participants. Challenges to this incorporation are also briefly explored.

Spirituality in Mental Health Practices

Conceptualizations of spirituality

We note that much of the research in social work and spirituality conceptualizes spirituality and spiritually-sensitive practices as distinct from religion and religiously-based practices such as prayer or attending church (Graham et al., 2006; Corrigan et al., 2003). Social workers have typically embraced definitions of spirituality that are inclusive of a variety of experiences, embrace a diversity of beliefs and experiences, and reflect the complexity of spirituality (Canada & Furman, 1999). Consistent with this literature, all of the participants held diverse definitions of spirituality and discussed their awareness of spiritual and religious diversity, a respect for individual beliefs, and an understanding of spirituality as a more inclusive construct than religion. As one participant stated, I think about [spirituality] in terms of connection of self to bigger than self...so beyond just a relationship to another individual...how do you connect with the whole...some feeling that there is some plan for you...fate...or that kind of thing. Another participant explained that there is no generic form of spirituality. And a third participant noted that spirituality and religion are different but overlapping...so I think people can be very religious but not very spiritual or spiritual but not necessarily religious.

Rationales and methods for incorporating spirituality into mental health practices

In general, the participants' viewpoints reflect the literature that discusses the incorporation of spirituality into health/helping practices (Curlin et al., 2007; Handzo & Koenig, 2004; Hodge,

2005), including psychiatry (Dein, 2005; Turbott, 2004). Within the social work literature, spirituality is often incorporated into practice by way of assessment (asking about the importance of spirituality in a client's life), because of a client's culture and the links between the cultural worldview and spirituality, and spirituality is linked with making meaning and developing understanding of some trauma or difficult life event, or it is connected with coping resources and a person's resiliency (Graham et al., 2006). Overall, the participants' rationales for incorporating spirituality into mental health practice were consistent with the literature, which includes first, care of the whole person, second, the relevance of spirituality for wellness and recovery, and third, spirituality as a possible diagnostic clue related to symptoms of illnesses (all of which can be connected with beliefs in the usefulness and/or effectiveness of holistic practice). One social worker explained care of the whole person: Their own stuff is so important to their care...it's the physical...the emotional...the mental...the social...the spiritual...it's the whole person...you can't help people if you look at them in pieces. Spirituality can be important in healing and recovery, which is summarized by the following psychiatrist: *Mental health patients that have some kind of spirituality or faith...it seems to me that they always do better, meaning they always improve faster...they stay well longer and they can deal with issues or difficulties better even though they are very sick.*

These comments demonstrate beliefs that sensitivity to clients' spirituality contributes to a more effective helping/health process and methods. While this belief is evidenced by many other researchers and practitioners, we require more studies that will examine the effectiveness of spiritually-sensitive methods for client change and wellness (see Coholic, Cadell & Nichols, 2008). Along these lines a social worker described how mental health clients may have prior experience with spiritually-sensitive approaches in other areas such as addictions: *I think addictions have come a lot further than we have in mental health as far as spirituality...that's you know...a huge part of recovery...and lots of our clients come from that.*

Identifying a client's spirituality as a coping resource was also discussed by the participants, for example, I ask...how does that work into your life and what do you find about this spirituality or religion that you use...what do you use out of that when you're coping with stress? Helping clients reconnect with spiritual resources and supports was deemed important. Indeed, for many clients, spirituality is a strength and resource from which to draw. It has been argued that to not acknowledge a client's spirituality impedes the provision of optimal support (Cascio, 1998) and creation of opportunities (Canda & Furman, 1999). As Corrigan et al. (2003) suggest, spirituality and/or religion may offer a framework for understanding one's mental illness and for adding meaning to one's life – that these are fundamental foundations for hope, which is an important coping resource for anyone trying to regain control over his life when struggling with psychiatric illness. One social worker expressed this concept well: In the past...as a system...*I don't think we gave a lot of hope...but it's so important...it's at the root of what we're doing...the best thing we can do for our clients is give them hope...and I think hope is very much spiritual.*

The third issue regarding changes in a client's spirituality or religion as a possible diagnostic clue has not been discussed as much in the literature (Breakey, 2001; Coyle, 2001; Keks & D'Souza, 2003), and certainly not in the social work and spirituality literature as social workers are not often charged with diagnosing serious mental health disorders (although they may play an important role in the assessment process). The following psychiatrist's statement demonstrates

the idea that shifts in an individual's spiritual viewpoints, behaviours or beliefs can indicate changes in symptomology related to that individual's illness:

Spiritual practices...particularly if they shift... gives me lots of diagnostic clues...I become very concerned when I find someone who's been faithful for a long time who's lost their faith because of mental illness...or because of a tragedy...It can indicate the severity of the mental disorder and it can give me some clue as to the prognosis.

Similarly, one of the social workers discussed how healthy spiritual practices can change to reflect a mental illness: *religious or spiritual preoccupation...its painful for them...it's not a good thing...it's not contributing to their well being...it's actually disturbing them and I think it's the illness that skews that for them.* As Coyle (2001) suggests, sometimes clients will manifest spiritual or religious content during active stages of psychiatric illness, which he argues would be expected in light of the strongly held and deeply ingrained nature of religious and spiritual beliefs. The participants in this study agreed that having information about a client's spiritual perspectives is important in that this knowledge could help one understand how the mental illness may be shaping the client's beliefs and behaviours.

In terms of how spirituality can be a part of assessment, the participants stressed the use of open ended language to explore whether spirituality is important to the client: I think introducing it is important because we allow the opportunity for the client to address it as being relevant or not in their life. As Crossley and Salter (2005) argue, a benefit of raising the topic of spirituality is that it informs clients that discussion about this area is sanctioned, which may be particularly important in clinical settings where spirituality has not been rigorously engaged and may be avoided. D'Souza (2003) warns that there is a need to encourage the building of trust before taking a spiritual history, particularly by a mental health clinician, as clients may be suspicious that sharing their spiritual experiences will be viewed as pathological. However, as Fallot (2001) suggests, spiritual assessment has important value in psychiatric rehabilitation settings as it communicates an interest in more than symptom-oriented evaluation and may open the door for exploration of areas of possible significance in the individual's recovery process. The participants believed that the model for mental health, which has traditionally been based on a medical perspective, was shifting to include a more holistic emphasis, for example, I think that's the trouble with the medical model although it's improving...you only looked at the physical. Indeed, across helping/health professions, shifts are occurring from a biopsychosocial model of health to a model that includes a spiritual dimension (Handzo & Koenig, 2004; Gall et al., 2005). There is a growing body of psychiatric literature calling for this movement [see Dein (2005) and Turbott (2004)]. As one psychiatrist noted, If [spirituality] is important to the person...or it's a problem for them, then it's important or a problem for the team...*if we're not sure we should talk about it...how does the patient know it's safe to talk about it?*

Finally, another way that helping practitioners have reported the incorporation of spirituality in their practices is by way of the relationship with the client. Some of the participants thought that their own spirituality helped them to be fully present with the client, for example, So it's in that space...it's a spiritual thing...and they know that when I am sitting with them that I care...it's that presence that I bring in with me. Another participant explained that it's that human interaction...in the sense that I try and help patients heal and they realize that I'm not

encouraging that out of any personal benefit but out of a sense love for them as a fellow human being. This finding is consistent with other research in the area (Weingarten, 1999). Coholic (2003) also found that social workers believed that their relationships with clients can be spiritual in that it may involve the sharing of life stories, deep connection and feelings of compassion and caring. Not unsurprisingly, the participant who described himself as neither spiritual nor religious did not express these viewpoints.

Challenges regarding the incorporation of spirituality

While the participants discussed their viewpoints regarding how mental health practices were changing, this process was not without its challenges. Three of the participants (one social worker and two psychiatrists) shared some difficulties concerning this shift even though they were incorporating spirituality into their own practices. For instance, one psychiatrist explained how he did not share the insights gained from clients in talking about their spirituality with colleagues noting that he felt inhibited about that because it's not part of the traditional discourse...it's not part of the professionalization in psychiatry. Indeed, although spiritually-sensitive helping is gaining some acceptance within health care and helping professions, it remains on the margins of mainstream helping practices. This marginalization continues for various reasons. Some helping professionals are concerned with blurring professional and personal boundaries with clients. A lack of clarity surrounding definitions of spirituality and religion creates confusion and can lead to fears of proselytizing. Others, such as the participants in this study, are concerned about colleagues' opinions (Dudley & Helfgott 1990; Early, 1998).

These are all important points to consider but the drive to work from more holistic models of health continues to grow and over time the continued development of knowledge, including research that proves the effectiveness of spiritually-sensitive interventions, may lead to increased comfort in discussing spirituality within professional contexts. Continued growth in knowledge development should also expose more helping/health students to this knowledge in their education. In fact, the three participants who discussed their discomfort in talking about spirituality with their colleagues were the most senior practitioners. Perhaps this difference that is related to years since professionalization accounts for some of their discomfort as some more recently trained psychiatrists and social workers have had access to training on spirituality and religion (Canda, 2005; McCarthy & Peteet, 2003).

Another factor/challenge that has been identified in both the literature and in this study regarding the incorporation of spirituality into helping/health practices is a practitioner's beliefs in their competency (or lack thereof) in this area (Hodge & McGrew, 2006; McCarthy & Peteet, 2003). All of the participants stated that inquiries about spirituality should be performed in a competent manner and they linked this competency with an ability to demonstrate spiritual sensitivity by way of engaging in personal reflection about spirituality; having experience and/or training in the area; and using supervision and other experts such as chaplains for consultation. For example, one participant argued that some practitioners don't feel comfortable with some spiritual issues because they haven't resolved them for themselves. Certainly, there are increasing resources within the burgeoning knowledge base in this area that could be helpful for practitioners interested in understanding their own spiritual viewpoints and how they might raise spirituality with their clients [a good example is Canda and Furman's (1999) book]. There are also numerous

conferences and workshops available to practitioners such as the Annual Canadian or North American Conference in Spirituality and Social Work at which this paper was originally presented. This being said, development of practice competencies in the area of spirituality and social work, and specifically in the field of mental health, might help to guide practitioners in their work.

Discussion and Conclusion

The goal of this study was to explore psychiatrist and social worker viewpoints on spirituality and the spiritual dimensions of care in mental health work. It was hoped that qualitative study in this area would help us begin to understand how spirituality is included in mental health practice and/or how it is avoided. In this study, the participants' professions and their spiritual and/or religious beliefs did not seem to contribute to divergent responses, and this included the participant who identified as neither religious nor spiritual, for all but one of the areas – the incorporation of spirituality into practice by way of relationship with a client. While this latter participant did not express personal spiritual or religious beliefs, he explained that he has respect for the role that spirituality and religion can play in many clients' lives, its importance for wellness and recovery, and that he always takes a spiritual history and encourages the use of spirituality and/or religion as a coping mechanism. These viewpoints likely explain his participation in this study despite the lack of personal identification with spirituality.

It is evident throughout this paper that the participants' viewpoints and practices concerning spirituality are in line with and reflect the current literature in spiritually-sensitive social work and other helping/health practices; for example, spirituality was part of assessment processes and used to foster coping skills in clients (see Furman et al., 2004). As such, the results seem to demonstrate that helping/health practices with people who have serious mental health problems are keeping with the trends towards the development of more holistic practices across helping/health professions (Dien, 2005). Certainly, the current recovery paradigm (Borg & Kristiansen, 2004) with its emphases on strengths and resiliency provides a good context within which spiritually-sensitive methods might gain greater acceptance and can be further developed.

One finding that emerged in this study that may be specific to work in mental health was the usefulness of understanding a client's spiritual beliefs, practices and behaviours in order to better understand their mental illness. Both the social workers and the psychiatrists highlighted that a person's religiosity or spirituality could be affected by their illness rather than advocating a viewpoint in which spiritual or religious beliefs are pathologized. These viewpoints are consistent with current models focusing on wellness and recovery rather than deficit and disease (Kruger, 2000). Clearly these perspectives are more conducive for the incorporation of spirituality in mental health care practices. Providing psychiatrists and mental health social workers training on spiritual sensitivity, the use of formal spiritual assessment tools, and holistic theoretical frameworks could assist this incorporation even more.

One of the obvious limitations of this study is that it is based on the perspectives of eight participants. Continuing to interview more participants might have enriched the findings. However, the participants had varied years of practice experience and spiritual perspectives, and we can use their viewpoints to help us contemplate the issues discussed herein. Certainly, the

study is useful as a pilot research project where this initial exploration could be used as a jumping off point for future study in the field of mental health illnesses and spirituality, an area within the social work and spirituality literature that requires more attention. Indeed, this direction is reinforced by a recent article by Steve Lurie, which was published in the Ontario Association of Social Workers (November 2008) journal. Lurie currently chairs the Service System Advisory Committee for the new Mental Health Commission of Canada. The article identifies his top ten strategies that include increasing research funding to investigate the causes of, and treatment for, mental illness. Spirituality should be included in these future investigations particularly since many people with mental illness desire the incorporation of spirituality in their recovery process/treatment. Lurie also stresses the need for cultural competence given that there is evidence that immigrants' physical and mental health declines proportionately to the amount of time they stay in Canada due to migration stress, racism and employment difficulties. As well, many refugees are victims of trauma. Spirituality is highly relevant for many cultures and has been linked to the treatment of trauma [see Tan (2006) for just one example]. Thus, we also argue for the relevance of spirituality in studying and developing cultural competencies for mental health practice and research.

Finally, the recovery process has been defined as a process of transformation, adaptation and self-discovery involving one's illness (Anthony, 2000). Integration of the spiritual dimensions of care into mental health care practices may help to further conceptualize and operationalize the phenomenon of recovery of people suffering mental illness. Given many consumers/survivors' desire for a greater integration of their spirituality in their recovery process, this may be an area in which practitioners along with consumers could begin to develop more holistic practice methods and processes. Indeed, consumer and practitioner demands for the incorporation of spirituality in social work form the impetus for many of the developments in this field (Graham et al., 2006). Thus, it would also be informative to know more about how people with serious mental illnesses rely on spirituality in their recovery and in coping with their disorders. This is clearly one of the numerous research directions for future projects in the mental health field that are concerned with developing more holistic methods and approaches.

References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.
- Anthony, W.A. (2000). A recovery oriented service system: setting some system level standards. *Psychiatric Rehabilitation Journal*, 24, 159-168.
- Baetz, M., Griffin, R., Bowen, R., & Marcoux, G., (2004). Spirituality and psychiatry in Canada: Psychiatric practice compared with patient expectations. *Canadian Journal of Psychiatry*, 49(4), 265-271.
- Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health*, 13(5), 493-505.
- Breakey, W.R. (2001). Psychiatry, spirituality and religion. *International Review of Psychiatry*, 13, 61-66.
- Canda, E.R. (2005). Integrating religion and social work in dual degree programs. *Journal of Religion and Spirituality in Social Work*, 24(1/2), 79-91.
- Canda, E.R., & Furman, L.D. (1999). *Spiritual diversity in social work practice*. New York: Free Press.
- Carpenter, J. (2002). Mental health recovery paradigm: implications for social work. *Health and Social Work*, 27(2), 86-94.
- Cascio, T. (1998). Incorporating spirituality into social work practice: a review of what to do. *Families in Society*, 79, 523-532.
- Coholic, D. (2003). Incorporating spirituality in feminist social work perspectives. *Affilia – Journal of Women and Social Work*, 18 (1), 49-67.
- Coholic, D., Cadell, S. & Nichols, A.W. (Eds.). (2008). Special Issue of the *Journal of Religion, Spirituality and Social Work – Social Thought*, 27 (1-2).
- Corrigan, P., McCorkle, B., Schell, B., & Kidder, K. (2003). Religion and spirituality in the lives of people with serious mental illness. *Community Mental Health Journal*, 39 (6), 487-499.
- Coyle, B.R. (2001). Twelve myths of religion and psychiatry: lessons for training psychiatrists in spiritually sensitive treatments. *Mental Health, Religion & Culture*, 4(2), 149-174.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks, CA: Sage.

Crossley, J., & Salter, D. (2005). A question of finding harmony: a grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 295-313

Curlin, F. A., Lawrence, R.E., Odell, S., Chin, M.H., Lantos, J.D., Koenig, H.G., Meador, K.G. (2007). Religion, spirituality and medicine: psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *American Journal of Psychiatry*, 164 (12), 1825- 1831.

Dane, B., & Moore, R. (2005). Social workers' use of spiritual practices in palliative care. *Journal of Social Work in End of Life & Palliative Care*, 1(4), 63-82.

Dein, S. (2005). Spirituality, psychiatry and participation: a cultural analysis. *Transcultural Psychiatry*, 42(4), 526- 656.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. California: Academic Press.

D'Souza, R. (2002). Do patients expect psychiatrists to be interested in spiritual issues? *Australian Psychiatry*, 10 (1), 44-47.

D'Souza, R. (2003). Incorporating a spiritual assessment into psychiatric assessment. *Australian Psychiatry*, 11(1), 12-15.

Dudley, J., & Helfgott, C. (1990). Exploring a place for spirituality in the social work curriculum. *Journal of Social Work Education*, 26 (3), 287-294.

Early, P. (1998). Between two worlds: The psychospiritual crisis of a dying adolescent. *Social Thought*, 18 (2), 67-80.

Fallot, R.D. (2001). Spirituality and religion in psychiatric rehabilitation and recovery from mental illness. *International Review of Psychiatry*, 13, 110-116.

Furman, L.D., Benson, P.W., Grimwood, C., & Canda, E. (2004). Religion and spirituality in social work education and direct practice at the millennium: A survey of UK social workers. *British Journal of Social Work*, 34, 767-792.

Gall, T.L., Charbonneau, C., Clarke, N.H., Grant, K., Joseph, A., & Shouldice, L. (2005). Understanding the nature and role of spirituality in relation to coping and health: a conceptual framework. *Canadian Psychology*, 46(2), 88-104.

Gilgun, J. (1994). Hand into glove: The grounded theory approach and social work practice research. In E. Sherman & W. Reid (Eds.), *Qualitative research in social work* (pp.115-125). New York: Columbia University Press.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. New York: Aldine.

- Graham, J., Coholic, D. & Coates, J. (2006). Spirituality as a guiding construct in the development of Canadian social work: past and present considerations. *Critical Social Work*, 7 (1). Available at: <http://criticalsocialwork.com/>
- Handzo, G., & Koenig, H.G., (2004). Spiritual care: whose job is it anyway? *Southern Medical Journal*, 97(12), 1242-1244.
- Hodge, D.R. (2005). Developing a spiritual assessment toolbox: a discussion of the strengths and limitations of five different assessment methods. *Health & Social Work*, 30(4), 314-323.
- Hodge, D.R., & McGrew, C.C. (2006). Spirituality, religion, and the interrelationship: A nationally representative study. *Journal of Social Work Education*, 42(3), 637- 654.
- Keks, N, & D' Souza, R. (2003). Spirituality and psychosis. *Australian Psychiatry*, 11(2), 170-171.
- Kennedy, T.J.T., & Lingard, L.A. (2006). Making sense of grounded theory in medical education. *Medical Education*, 40, 101-108.
- Kruger, A. (2000). Schizophrenia: recovery and hope. *Psychiatric Rehabilitation Journal*, 24, 29-37.
- Lukoff, D., Lu, F.G., & Turner, R.P. (1997). Commentary on spiritual experience and psychopathology. *Philosophy, Psychiatry, & Psychology*, 4(1), 75-77.
- Lurie, S. (2008 November). Toward a mental health strategy for Canada. *OASW NewsMagazine. The Journal of the Ontario Association of Social Workers*, 34(4).
- McCarthy, M.K., & Peteet, J.R. (2003). Teaching residents about religion and spirituality. *Harvard Review of Psychiatry*, 11(4), 225-228.
- Miller, R., & McCormack, J. (2006). Faith and religious delusions in first episode schizophrenia. *Social Work in Mental Health*, 4(4), 37-50.
- Northcut, T.B. (2000). Constructing a place for religion and spirituality in psychodynamic practice. *Clinical Social Work Journal*, 28(2), 155-169.
- Phillips, R.E., & Stein, C.H. (2007). God's will, God's punishment, or God's limitations? Religious coping strategies reported by young adults living with serious mental illness. *Journal of Clinical Psychology*, 63(6), 529-540.
- Rapp, C. A. (1998). *The strengths model: case management with people suffering from severe and persistent mental health illness*. New York: Oxford University Press.
- Rapp, C. A., Shera, W., & Kisthardt, W. (1993). Research strategies for consumer empowerment of people with severe mental illness. *Social Work*, 38, 727-735.

Russinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation outcomes. *Journal of Rehabilitation*, Oct/Nov/Dec, 50-57.

Stromwall, L.K. & Hurdle, D. (2003). Psychiatric rehabilitation: an empowerment- based approach to mental health services. *Health & Social Work*, 28(3), 206-213.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. London: Sage Publications.

Sullivan, W.P. (1999). Recoiling, regrouping, and recovering: first-person accounts of the role of spirituality in the course of serious mental illness. *New Directions for Mental Health Services*, 80, 97-101.

Tan, P. (2006). Survivors of the killing fields: Spirituality and religious faith as protective factors against the impact of trauma. *Arete*, 30 (1), 112-123.

Turbott, J. (2004). Religion, spirituality and psychiatry: Steps towards rapprochement. *Australian Psychiatry*, 12(2), 145-147.

Turner, R., Lukoff, D., Barnhouse, T., & Lu, F. (1995). Religious or spiritual problems: A culturally sensitive diagnostic category in the DSM-IV. *Journal of Nervous & Mental Diseases*, 182, 435-444.

Yangarber-Hicks, N. (2004). Religious coping styles and recovery from mental illness. *Journal of Psychology and Theology*, 32(4), 305-317.

Weingarten, K. (1999). Stretching to meet what's given: Opportunities for a spiritual practice. In F. Walsh (Ed.), *Spiritual resources in family therapy* (pp.240-255). New York: The Guilford Press.

Wilding, C., May, E., & Muir-Cochrane, E., (2005). Experience of spirituality, mental illness and occupation: a life-sustaining phenomenon. *Australian Occupational Therapy Journal*, 52, 2-9.