



**California Mental Health & Spirituality Initiative**

***PROGRESS REPORT***

***August 2009***



The **California Mental Health & Spirituality Initiative** was established in June 2008 at the Center for Multicultural Development of the California Institute for Mental Health. It developed out of a grassroots movement founded in 2006 by Jay Mahler and other consumers, family members, and service providers.

We are deeply grateful to the 51 California counties that have supported us financially to date and for the multitude of in-kind contributions from our collaborators. We are committed to providing useful, practical, and timely technical assistance to all of our partners in California's public/private mental health system.

The goals of the Initiative are:

- To increase awareness of spirituality as a potential resource in mental health prevention, intervention, and recovery;
- To advance the capacity of mental health service providers in California to prevent mental health problems and to support individuals and families in recovery by including spirituality as an aspect of cultural competency and natural community supports;
- To encourage collaboration among faith-based organizations, mental health service providers, clients, and families in combating stigma and reducing disparities in access to services for diverse populations; and
- To provide technical assistance to mental health service providers on how to utilize spirituality as a resource for prevention, early intervention and recovery while preserving client/family choice and respecting the separation of church & state.

Please see the attached "Values Statement" which describes our approach.

The remainder of this document provides a status report on the Initiative's progress in our first fourteen months of operation.

## **FORMING RELATIONSHIPS**

- The Initiative is guided by a dedicated team of eight work group (Steering Committee) members:
  - Patty Blum, PhD, CPRP, Crestwood & Dreamcatchers
  - C. Rocco Cheng, Ph.D., Corporate Director of Prevention and Early Intervention Services, Pacific Clinics
  - David Lukoff, PhD, Professor of Psychology, Institute for Transpersonal Psychology and Founder, Spiritual Competency Resource Center
  - Jay Mahler, Consumer Relations Manager, Alameda County Behavioral Healthcare Services
  - Kumar Menon, MSPA, Chief, Community & Government Relations, Office of the Director, Los Angeles County Department of Mental Health
  - Alice J. Washington, Training, Policy, and Research Associate, California Institute for Mental Health
  - Khani Gustafson, MSW, Center for Multicultural Development, California Institute for Mental Health (Project Manager), and

- Rev. Laura Mancuso, MS, CRC, Goleta, CA (Director).
- o Most County Behavioral Health Directors have identified a primary point of contact to serve as the liaison between their agency and the Initiative.
- o Major statewide client, family, and provider organizations have designated official liaisons to the Initiative (California Network of Mental Health Clients, NAMI California, Racial & Ethnic Mental Health Disparities Coalition, United Advocates for Children & Families, California Alliance of Child & Family Services, California Association of Social Rehabilitation Agencies, California Council Of Community Mental Health Agencies, and California Mental Health Directors' Association).
- o We have compiled a distribution list of 1,000 people interested in the topic of mental health & spirituality, to whom we send periodic email updates.

### **ONLINE ANNOTATED RESOURCE DATABASE**

- o The Initiative hosts a website at [www.mhspirit.org](http://www.mhspirit.org) with lists of books, websites, journal articles, and online audio and video resources on the topic of mental health & spirituality. It may be viewed by anyone with access to the Internet. Viewers who create a Google Account and register with the site can comment on what they find there, participate in online discussion forums, and contribute examples of resources they have found helpful.

### **CONFERENCES ON MENTAL HEALTH & SPIRITUALITY WITH OVER 1,000 PARTICIPANTS**

- o Unquestionably a highlight of the Initiative's activities to date, two major conferences on Mental Health & Spirituality were held in Oakland and Los Angeles in June 2009. We were delighted with the turnout: **1,111** total participants, including speakers and volunteers. This is an outstanding result, especially given the difficult economic circumstances that have resulted in travel restrictions for many. The audiences included people with mental health issues of all ages; their family members; mental health service providers; and individuals from faith communities (both lay people and clergy). We are very grateful to the local planning committee in Alameda County for hosting the first Northern California conference, and Los Angeles County for their ongoing commitment to the topic and their willingness to collaborate with us to expand their audience in 2009. Video recordings of the keynote speeches and selected workshops have been compiled into a three-DVD set. Complimentary copies were sent to our Organizational Liaisons, and each of the County Behavioral Health Authorities that supported the Initiative. Additional copies are for sale at cost at [www.mhspirit.org](http://www.mhspirit.org).

### **SURVEY OF INDIVIDUALS & FAMILIES RECEIVING MENTAL HEALTH SERVICES AND COUNTY BEHAVIORAL HEALTH DIRECTORS**

- o A brief written survey was recently conducted to assess the needs, preferences, and experiences of individuals and families receiving public mental health services. The survey was refined with extensive input and assistance from a dedicated group of individuals from our network, including consumers, service providers, and County Liaisons. The survey was translated from English into seven key statewide threshold languages (Spanish, Vietnamese, Hmong, Tagalog, Chinese (Cantonese), Farsi, and Russian). We are especially grateful to Alameda, Los Angeles, Riverside, Butte, and Santa Clara Counties for providing the translation services. Survey results will be posted online at our website in late September.
- o Since the opinions of some service recipients are more effectively ascertained through a dialogue process, we are also developing a template for a facilitated dialogue regarding mental health and spirituality. Counties, community-based organizations, and client & family advocacy

groups will have the choice of utilizing the survey form or the community dialogue process or both to gather information. The results will be collected, compiled, and reported by the Initiative.

- The Initiative also conducted structured phone interviews with over 50 County Behavioral Health Directors in Winter 2009 to gather their opinions about spirituality as a potential resource in mental health wellness, recovery, and multicultural competency. The survey interview team included David Lukoff, Kathy Cramer, Elvia McGuire – courtesy of Placer County, Khani Gustafson, and Laura Mancuso. An initial summary of the findings was released at the June 09 conferences and is available online at [www.mhspirit.org](http://www.mhspirit.org).

## **FUTURE PLANS**

- Due to the economic downturn, some Counties who wished to make a financial contribution to the Initiative have been unable to do so. We have modified our approach to and timeline for completion of the deliverables accordingly. We are also encouraged by the potential for achieving our goals through in-kind contributions and collaborative arrangements with other organizations. At this point, the Initiative is only fully funded through September 2009, although we are optimistic that we will obtain funding to sustain our activities beyond that date. One of our highest priorities for the future is the development of face-to-face and online training curricula utilizing video footage captured at the June 2009 conferences.

## **ABOUT CiMH & THE CENTER FOR MULTICULTURAL DEVELOPMENT**

The California Institute for Mental Health (CiMH) is a non-profit organization established in 1993 to promote excellence in mental health services through training, technical assistance, research, and policy development. The Center for Multicultural Development (CMD) is a division of CiMH. CMD's goals are to eliminate health/mental health disparities and to promote cultural competence in public mental and behavioral health systems.

## **FOR FURTHER INFORMATION ABOUT THE CALIFORNIA MENTAL HEALTH & SPIRITUALITY INITIATIVE, PLEASE CONTACT:**

Rev. Laura L. Mancuso, MS, CRC, Director, [mancuso@west.net](mailto:mancuso@west.net), 805-886-9193,  
Khani Gustafson, MSW, Project Manager, [kgustafson@cimh.org](mailto:kgustafson@cimh.org), 916-317-6230,  
or visit [www.mhspirit.org](http://www.mhspirit.org)



## **VALUES STATEMENT**

***“...a greater appreciation of the whole person is emerging in the mental health field...”***

The California Mental Health & Spirituality Initiative was established in June 2008 at the Center for Multicultural Development of the California Institute for Mental Health. It developed out of a grassroots movement founded in 2006 by Jay Mahler and other consumers, family members, and service providers. The purpose of this document is to state the values that guided the formation, and now operation, of this initiative.

**RESPECT FOR ETHICAL AND LEGAL BOUNDARIES.** We advocate for the inclusion of spirituality as a potential resource in mental health services. None of our work should be construed as advocating that mental health providers should “push religion” on the people they serve. There are barriers (including political, legal, and cultural) between the public mental health system and spirituality/religion that need to be addressed carefully and respectfully. We are committed to helping service providers understand these barriers so that they can make informed choices about policy and practice. In particular, we believe that mental health providers should never promote a particular religion or proselytize. They should, however, be receptive and responsive to the expressed interests of their clients and potential clients, including their requests for support with the spiritual aspects of their wellness and recovery.

**SPIRITUALITY INCLUDES, BUT IS NOT LIMITED TO, RELIGION** – There are many ways to define “spirituality” and “religion.” We utilize the following definitions: Spirituality is a person’s deepest sense of belonging and connection to a higher power or life philosophy which may not necessarily be related to a religious institution. A religion is an organization that is guided by a codified set of beliefs and practices held by a community, whose members adhere to a worldview of the holy and sacred that is supported by religious rituals.

**SPIRITUALITY IS A CORE COMPONENT OF CULTURAL COMPETENCY** – The public/private mental health system in California recognizes that cultural competency, including the ability to understand different worldviews, is necessary for effective practice. Spirituality represents a core value within many ethnic and cultural communities and is often considered a primary resource. Faith-based organizations are a vital source of community leadership for individuals, families, and neighborhoods. Therefore, spirituality can be regarded as an essential connector for ethnic and cultural communities and for understanding wellness, illness, intervention, and recovery. We are committed to the inclusion of multicultural voices that represent California’s broad array of faith traditions and practices.

**SPIRITUALITY IS PART OF A HOLISTIC APPROACH TO MENTAL HEALTH** -- We know that physical health can influence an individual’s mental health. The same is true for spirituality. Understanding spirituality as an element in wellness promotion and mental health recovery brings us closer to dealing with the whole person. Many persons from diverse, multicultural communities utilize spiritual and/or faith-based organizations as a source of social support and hope in their wellness promotion and healing process. Spirituality can be a powerful tool to inspire hope, create motivation,

and promote healing. By integrating spirituality and multicultural factors into prevention and treatment, a greater appreciation of the “whole person” is emerging in the mental health field.

**SPIRITUAL EXPERIENCES CAN OCCUR DURING ALTERED STATES** -- Some people experience altered states with a spiritual component that can support the journey toward wellness and recovery. For some, this can be a life-changing event. Too often, this spiritual component has been ignored, labeled, or confused with delusions or other symptoms. Providers should respond respectfully and appropriately when clients ask for assistance with these experiences.

**ENGAGEMENT OF FAITH-BASED ORGANIZATIONS** – Faith communities and spirituality can be a source of coping and social support for those struggling with the impact of mental health issues: poverty, homelessness, loss of meaning and purpose, stigma, isolation, etc. Some faith communities have become “welcoming congregations” to people with mental health issues, and others have adopted mental health advocacy as part of their social justice agendas. Mental health agencies are better able to reach unserved, underserved, and inappropriately served populations when they invite collaboration with local faith-based organizations.

We acknowledge that some individuals and families have experienced traumatic interactions with religious communities. In these instances, it is important to provide a safe environment for talking about these experiences in an open and accepting way.

**THE PARAMOUNT IMPORTANCE OF CLIENT CHOICE** – We are passionate about choice – including individuals’ and families’ choice *not* to engage with spirituality and/or religion. Mental health services are enriched by an open, welcoming, and non-judgmental stance toward spiritual, religious, and cultural beliefs, practices, rituals, values, theologies, and philosophies – including non-belief or non-practice -- that may be different from one’s own. We welcome the opportunity to be enriched by the wisdom that others have gleaned from their own spiritual path and/or life experience.

**NEED FOR NETWORKING AND TECHNICAL ASSISTANCE** -- County mental health authorities and community-based organizations already interact with spirituality and faith-based organizations in numerous ways. We believe they can benefit from knowing more about what other individuals, agencies, and systems are already doing and what results they have had. It is the role of the California Mental Health & Spirituality Initiative to facilitate this technical assistance.

This values statement was revised and adopted by the Work Group on January 20, 2009. Because we are always learning, this values statement will be updated over time as needed.

**FOR FURTHER INFORMATION ABOUT THE CALIFORNIA MENTAL HEALTH & SPIRITUALITY INITIATIVE, PLEASE CONTACT:**

Rev. Laura L. Mancuso, MS, CRC, Director, [mancuso@west.net](mailto:mancuso@west.net), 805-886-9193 or  
Khani Gustafson, MSW, Project Manager, [kgustafson@cimh.org](mailto:kgustafson@cimh.org), 916-317-6230 or  
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## **A sample of preliminary findings on innovative practices from the Initiative's "Survey of California Counties"**

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### **MADERA COUNTY**

The Cultural Competency Coordinator publishes a monthly calendar that includes, but is not limited to, religious holidays for various cultures. Within her Division, staff celebrate a different ethnic culture each quarter: staff bring food from that culture, and educate themselves about the celebrations associated with the holiday.

Contact: Debbie C. DiNoto, LMFT, Madera County Department of Behavioral Health, (559) 675-7850, [debbie.dinoto@madera-county.com](mailto:debbie.dinoto@madera-county.com)

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### **MODOC COUNTY**

Lloyd Powell is an enrolled member of the Chickasaw Nation who practices the Red Road path to wellness, a form of Native American spirituality focused on maintaining sobriety. He brings this perspective into his work with young adults participating in a juvenile justice diversion program in Modoc County. The youth that come into the diversion program can choose to participate in the Native American program or use a more traditional treatment approach.

One of the core concepts used in the Native approach is that of the medicine wheel. The wheel incorporates the four directions (mental, spiritual, physical and emotional). Lloyd uses this as a wheel of wellness and teaches the participants in the program that every action or lack of action has a reaction, as all of our actions are connected. In order for a person to be well (maintain sobriety, be a responsible citizen, be respectful, etc.), they need to live in balance between all four directions. Another important aspect of the program is for youth to understand and connect to their Native culture. Lloyd believes that if youth understand their connection to their culture and traditions, they will have a greater chance of success. His focus is a spiritual one, not religious. Part of understanding the traditions is to participate in sweat lodge and other native ceremonies. It is through ceremony that they learn to respect others, listen to authority, develop socially appropriate behavior and foster self-awareness and self-esteem.

As the youth develop responsible behavior, they have the opportunity to become a fire keeper. The position of fire keeper is a privilege. In order to be a fire keeper, the individual needs to stay sober and to live up to standards of honor. At each sweat lodge, the youth are asked if they have lived up to these standards. They are very honest and willingly omit to any infractions. They know that they will have another opportunity at the next lodge.

Lloyd also maintains an ongoing relationship with the tribes in the area. This also includes Indian Health Services, Resources for Indian Student Education and similar organizations. Lloyd states that the Director of Health Services, Karen Stockton, has “been very open to the program and allowed me a lot of flexibility to try out different things.” The program is open to Native and non-Native youth and is showing promising outcomes and is growing in its popularity.

Contact: Karen Stockton, PhD, MSW, Director, Modoc County Mental Health Services, (530) 233-6312, [karen\\_stockton@modocounty.us](mailto:karen_stockton@modocounty.us)

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## **MONTEREY COUNTY**

Four years ago, the Behavioral Health Division sponsored a Dia de los Muertos display at the administrative offices in late October/early November. This was so well-received that it has now expanded to all clinic sites, and other displays of culture and spirituality are featured throughout the year.

Contact: Jesse Herrera, LCSW, Monterey County Health Dept - Behavioral Health Division, (831) 755-4510, [herreraj@co.monterey.ca.us](mailto:herreraj@co.monterey.ca.us)

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## **PLACER COUNTY**

The “Faith and Health in Action Council” was recently launched in Placer County. Members include faith and service organizations. Its mission is, “Linking people to services and each other,” to improve services through collaboration. Initial project ideas include a community health fair.

Additionally, the Placer Collaborative Network consists of health and social service agencies (non-profit, for profit and county) and cities. The Collaborative recently hosted a forum with a panel of Faith-Based organizations focused on describing the services of the panel representatives and ways to improve coordination. Several faith-based agencies providing drug and alcohol services, shelter for women and children, and a collaborative of churches that sponsor a nomadic homeless shelter.

Contact: Elvia McGuire, Administrative Social Work Intern, Placer County System of Care, (530) 889-7244, [emcquire@placer.ca.gov](mailto:emcquire@placer.ca.gov)

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## **SAN BENITO COUNTY**

In San Benito County they have a long standing commitment to promoting cultural competence throughout their system. This helps create a foundation for being open to different spiritual beliefs.

In their intake assessment,(Cross Cultural Assessment) they ask about people’s religious or spiritual views. If they are affiliated with a particular faith or practice, there are some follow-up questions:

1. How often do you pray?
2. Do you have an altar at home?

3. Do you believe people can heal with the help of spirits or saints?
4. Have you ever consulted such a person (espiritista, curandero or santero)
5. Are you currently consulting such a person, if yes has the treatment helped?
6. Have you or your family consulted a religious leader/healer about your health problems?
7. Does your religion have any beliefs which might affect your treatment (regarding certain medications, transfusions, etc)

Dr. Lynda Yoshikawa, the ethnic services manager for San Benito county explains how this helps inform treatment: "This information is necessary to see how they view mental health and how they view healing--how do they see mainstream services in addition to any cultural beliefs. By asking these questions we convey that we are interested in these issues. Also if they have strong religious beliefs then part of the treatment could be making sure that they are praying or following up with their connections to church, or other practices."

Contact: Lynda M. Yoshikawa, PhD, Quality Improvement Supervisor & Ethnic Services Manager, San Benito County Behavioral Health, (831) 636-4020 x322, [lyoshikawa@sbcmh.org](mailto:lyoshikawa@sbcmh.org)

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## **SACRAMENTO COUNTY**

The Department provides a four-day training for provider agencies. Many of the exercises in the training specifically relate to spirituality and how providers are addressing spirituality in their work with consumers.

Contact: Pat Mangan, MSW, Chief, System Development, Support and Oversight, Sacramento County Division of Mental Health, 916-875-4830, [manganp@saccounty.net](mailto:manganp@saccounty.net) or JoAnn Johnson, Cultural Competence/Ethnic Services Program Manager, LCSW, Sacramento County Division of Mental Health, 916-875-3861, [johnsonj@saccounty.net](mailto:johnsonj@saccounty.net)

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## **SAN BERNARDINO COUNTY**

San Bernardino County offers a unique series of groups for consumers and family members at their Clubhouse locations. The Clubhouses serve as wellness and recovery centers and are operated by consumers and family members. The series includes spirituality, meditation and yoga groups which meet once per week. The groups are voluntarily and open to anyone who would like to attend.

Contact: David Miller, Peer Family Advocate, San Bernardino County Behavioral Health, 909-579-8157, [millerd@dbh.sbcounty.gov](mailto:millerd@dbh.sbcounty.gov)

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## **STANISLAUS COUNTY**

Stanislaus County offers a one day training entitled, "Spirituality and Wisdom," for staff, consumers, family members and partner organizations. The training, facilitated by a multicultural/multi faith training body, encourages participants to consider and better understand the role of spirituality and faith in the

work they do as providers or volunteers in the mental health field. Through dialogue and interactive processes participants can enhance exploration and inquiry about mental health and spirituality.

This program will be the featured topic of the Initiative's next training teleconference on May 1, 2009.

Contact: Jim Hurley MFT, Manager Workforce, Education Training, Stanislaus County Behavioral Health and Recovery Services, 209-525-5324, [HurleyJ@stancounty.com](mailto:HurleyJ@stancounty.com)

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**See also the description of CBO activities by Casa Pacifica Centers for Children & Families and Crestwood Behavioral Health Inc. on the following pages.**



## **SURVEY OF INDIVIDUALS RECEIVING MENTAL HEALTH SERVICES AND THEIR FAMILIES**

### **PURPOSE**

This survey is being conducted by the California Mental Health & Spirituality Initiative at the California Institute for Mental Health. The purpose of the survey is to document the interests, needs, and experiences of service recipients of the mental health system in California regarding spirituality.

The California Mental Health & Spirituality Initiative has several goals including:

- To increase awareness of spirituality as a potential resource in mental health prevention, intervention, and recovery
- To advance the capacity of mental health service providers in California to prevent mental health problems and to support individuals and families in recovery by including spirituality as an aspect of cultural competency and natural community supports
- To encourage collaboration among faith-based organizations, mental health service providers, clients, and families in combating stigma and reducing disparities in access to services for diverse populations
- To provide technical assistance to mental health service providers on how to utilize spirituality as a resource for prevention, early intervention and recovery while preserving client/family choice and respecting the separation of church & state

For more information about the Initiative or to fill this survey out online, go to [www.mhspirit.com](http://www.mhspirit.com). Results from this survey will be online September 2009.

Return by ~~August 10~~ **Postmark by Friday August 14, 2009** and mail forms to:

David Lukoff, PhD  
CiMH Survey Research Consultant  
1035 B St., Petaluma CA 94952  
[mentalhealthandspirituality@gmail.com](mailto:mentalhealthandspirituality@gmail.com)

**Surveys may also be completed online at [www.mhspirit.org](http://www.mhspirit.org) until 5 pm on 8/17/09.**

## **DEFINITIONS**

This survey uses the term “spirituality” a lot, so let’s take a minute to clarify what we mean.

**Spirituality** is an individual’s internal sense of meaning, purpose, and connection to something beyond oneself (which could be, for example, nature, humanity as a whole, or a higher power).

A **religion** is an organization that is guided by shared beliefs and practices, whose members adhere to a particular understanding of the holy and participate in religious rituals.

Some people’s **spirituality** is deeply informed by participation in organized **religion**, while others describe themselves as “spiritual but not religious.” So, **spirituality** is a broader term than includes but is not limited to **religion**. Most of the questions in this survey will pertain to spirituality.

A **religious professional** is a person who is recognized by a faith tradition (or practice tradition) as a spiritual leader/teacher and is authorized by that community to conduct religious rituals. The preparation and rites of passage required to become a religious professional vary widely. The term does not apply to lay people who are followers of the tradition. Some examples include elders, pastors, imans, shamans, rabbis, gurus, ministers, priests, nuns, monks, or spiritual teachers.

If you are both receiving mental health services and a family member of a person receiving mental health services, please answer all questions as one or the other in the survey.

I am taking this survey as a person who receives mental health services directly.

I am taking this survey as a *FAMILY MEMBER* of a person who receives mental health services.

**SURVEY QUESTIONS (19 QUESTIONS)**

Please indicate to what extent you agree or disagree with the following statements:

ITEM	RATING	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1) "Spirituality is important to me"/Spirituality is important to my family member."		0	0	0	0	0
2) "Spirituality is important to my mental health"/"Spirituality is important to my family member's mental health."		0	0	0	0	0
3) "Mental health care providers should be willing to discuss spiritual concerns with me or my family if I request it."		0	0	0	0	0
4) Have you or your family member ever talked to a mental health care provider about spirituality?		0	0	0	0	0
4a) If yes, "When I/my family have spoken with mental health care providers about spirituality, their responses have been helpful to me."		0	0	0	0	0
5) "The mental health care providers I/my family have seen have demonstrated respect for my spiritual life."		0	0	0	0	0
6) "The mental health care providers I/my family have seen have demonstrated respect for my spiritual life even when it is different from theirs."		0	0	0	0	0
7) "It is appropriate for the public mental health system to address spirituality as part of my/my family's mental health care."		0	0	0	0	0

8) "The public mental health system in California should do more to support clients and families in utilizing their spirituality as a wellness and recovery resource."

9) Do you consider yourself

- Religious but not spiritual
- Both spiritual and religious
- Spiritual but not religious
- Neither spiritual or religious

10) Do you identify with any of the following? (check all that apply)

- Buddhism
- Christianity (Catholic)
- Christianity (Protestant/Non-Catholic)
- Hinduism
- Islam
- Judaism
- Native American Spirituality
- Pagan or Earth-Based Religion
- Shamanism
- Sikh
- Agnostic
- Atheist
- Nothing in particular
- Other: Please specify \_\_\_\_\_

11) Do you practice your spirituality in a group setting (e.g., church, temple, synagogue, mosque, sangha, meditation center, etc.)?

yes  no

11a) If YES,

How often do you practice your spirituality in a group setting, on average? (check one)

- daily
- weekly
- monthly
- annually
- less than once a year

ITEM	RATING	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
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11b) Please indicate the extent to which you agree with the following statement: "My/my family's involvement with this spiritual community has been helpful to my/my family's mental health."

**12) Have you/your family member ever turned to a faith-based community or spiritual advisor for help with mental health concerns (e.g., a minister, pastor, rabbi, imam, shaman, elder, spiritual teacher, guru, etc.)?**

yes  no

<b>ITEM</b>	<b>RATING</b>	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<b>12a) If yes, please indicate the extent to which you agree with the following statement, "When I have spoken with a faith-based community or spiritual advisor about my/my family member's mental health issues, their responses have been helpful to me."</b>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**12b) When I/my family member have spoken with a faith-based community or spiritual advisor about mental health issues, the connection helped me/my family member: (circle as many as apply)**

- a) develop more hope about my wellness and recovery
- b) do things I want to
- c) cope with daily life better
- d) more satisfied with life in general
- e) better able to cope with my symptoms
- f) more comfortable talking to and reaching out to others about my problems

<b>ITEM</b>	<b>RATING</b>	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<b>12c) Please indicate the extent to which you agree with the following statement, "It would be helpful if my faith-based community or spiritual advisor was more aware of mental health issues."</b>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**13) Which of the following spiritual practices, if any, have been helpful to your/your family member's mental health? (check all that apply.)**

- |   |   |
|---|---|
| <input type="checkbox"/> prayer   | <input type="checkbox"/> dancing  |
| <input type="checkbox"/> meditation   | <input type="checkbox"/> singing  |
| <input type="checkbox"/> attending religious services                       | <input type="checkbox"/> chanting   |
| <input type="checkbox"/> attending Bible study groups                       | <input type="checkbox"/> attending a prayer vigil   |
| <input type="checkbox"/> yoga   | <input type="checkbox"/> participating in Talking Circles   |
| <input type="checkbox"/> 12-step groups                                     | <input type="checkbox"/> participating in Sweat Lodge ( <i>temazcal</i> )   |
| <input type="checkbox"/> attending a spirituality support group             | <input type="checkbox"/> receiving healing/advice from a medicine man ( <i>curandero</i> ) or medicine woman ( <i>curandera</i> ) |
| <input type="checkbox"/> participating in spiritual community social events | <input type="checkbox"/> drumming   |
| <input type="checkbox"/> reading sacred texts or spiritual self-help books  | <input type="checkbox"/> making crafts  |
| <input type="checkbox"/> spending time in nature                            | <input type="checkbox"/> participating in ritual ceremonies   |
| <input type="checkbox"/> volunteering to serve the community                | <input type="checkbox"/> other: _____   |
| <input type="checkbox"/> journal writing                                    | <input type="checkbox"/> not applicable or none   |

**14) Additional comments are welcomed. Is there anything else you want to add?**

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**14a) Do we have your permission to publish your answer to Question 14 as an anonymous direct quote without your name?**

- yes  no

**DEMOGRAPHIC INFORMATION** (Optional-skip to question 18 if not answering)

*The following questions will help us learn more about the group of people completing the survey as a whole. The answers will only reported as group data.*

**15) What year were you/your family member born? \_\_\_\_\_**

**16) Have you/your family member ever been diagnosed with a psychiatric condition?**

- yes  no

**16a) If yes, please check all that apply:**

- Schizophrenia/Schizoaffective
- Bipolar Disorder
- Depression
- Post-Traumatic Stress Disorder (PTSD)
- Problems With Alcohol Or Other Drug Use
- Anxiety Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Other – Please describe \_\_\_\_\_

**17) How do you describe your/your family member's race/ethnicity? (check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Middle Eastern         |
| <input type="checkbox"/> Armenian                         | <input type="checkbox"/> Mien                   |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Cambodian                        | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Persian                |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Russian                |
| <input type="checkbox"/> Guamanian                        | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Hispanic/Latino                  | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Hmong                            | <input type="checkbox"/> Unknown                |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> White or Caucasian     |
| <input type="checkbox"/> Korean                           | <input type="checkbox"/> Self-identify as       |
| <input type="checkbox"/> Laotian                          | _____   |

**18) Do you/your family member live in California?**

yes  no

**17a) IF YES**

**Which California county do you/your family member live in**

\_\_\_\_\_ **County**

19) Please select one

- I/my family member CURRENTLY receive services in the public mental health system (either at County Mental Health and/or a community-based agency)
- I/my family member PREVIOUSLY received services in the public mental health system (either at County Mental Health and/or a community-based agency)
- I/my family member have NEVER received services in the public mental health system (either at County Mental Health and/or a community-based agency)

**FOLLOW-UP**

20) Would you be willing to be contacted to respond to additional questions?  
(Check one)

yes  no

20a) If YES,

Please provide your name, phone number, and email address (if you have one) below. This personal information will not be used for any other purpose. PLEASE WRITE CLEARLY.

Name

Phone #

Email address

21) The final report from this survey will be available online beginning in September 2009 at [www.mhspirit.com](http://www.mhspirit.com).

Would you like us to send you a copy of the final report from this survey in September 2009?

yes  no

21a) If YES,

Please provide your email address (preferred) or mailing address. This personal information will not be used for any other purpose. PLEASE WRITE CLEARLY

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## Spirituality and Mental Health: A Consumer-driven Holistic Approach to Recovery

David Lukoff, PhD, Jay Mahler and Rev. Laura L. Mancuso, MS, CRC

**M**ental health systems throughout the U.S. are undergoing a quiet revolution as former patients, families, and other advocates work with service providers to incorporate spirituality into mental health care. A recent achievement is the California Mental Health & Spirituality Initiative that began in June 2008 with funding from 40 of the 58 county mental health authorities.

The therapeutic value of spirituality is widely recognized in substance abuse treatment due, in large part, to the success of 12-step programs since the founding of Alcoholics Anonymous in 1935. Similarly, the more recent incorporation of spirituality provides a holistic approach to the treatment of serious mental health problems such as bipolar disorder, depression, PTSD, and schizophrenia.

### The Consumer Movement and Spirituality

The recognition of spirituality as an important component of recovery has been driven by consumer and family grassroots advocacy. In the late 1950s, with the advent of the civil rights movement, people began organizing to fight against inequality and social injustice. The women's movement, gay rights movement, and disabilities rights movement soon followed. In this context, in 1975, former mental health patients across the country began what was first known as the anti-psychiatry movement with groups such as the Network Against Psychiatric Assault. As a result, ex-mental health patients organized drop-in centers, artistic endeavors, and businesses.

Sally Clay, a pioneer of this movement and founder of the Portland Coalition for the Psychiatrically Labeled, wrote a seminal article in 1987 on spirituality and stigma that illustrated consumer concerns about the neglect of spirituality in their treatment. In reviewing her written psychiatric records from the Yale-affiliated Hartford Institute of Living, she found no mention of the spiritual crisis that triggered her episode or the role that attending religious services at the hospital had played in her recovery (Clay, 1987). This corroborated her recollection that the mental health providers involved in her treatment had never addressed these issues. Clay (1994) described how the lack of sensitivity to the spiritual dimensions of her experience was detrimental to her recovery: "Finding a spiritual model of recovery was a question of life or death...My experiences were, and always had been, a spiritual journey—not sick, shameful, or evil."

The anti-psychiatry activities of the 1970s have transformed into a movement of consumers who are taking an active role in shaping a spiritually-sensitive vision of recovery that is influencing the mental health system. Frank Leonard and Jay Mahler organized a spiritual support group in the San Francisco Bay area as early as 1978. However, conferences beginning in the 1980s provided a forum where consumers and mental health providers began dialogues to address spirituality in recovery more effectively. Among the many events funded by NIMH was the 1993 Alternatives Conference, "A Celebration of Our Spirit" organized by the National Empowerment Center ([www.power2u.org](http://www.power2u.org)). In 2002, The California Association of Social Rehabilitation Agencies had at their conference a keynote a talk on "The Spiritual Journey in Recovery" (with author DL). Another important event building momentum for this movement was the 2004 SAMSHA Conference *Building Bridges: Mental Health Consumers and Members of Faith-Based and Community Organizations in Dialogue* which brought together academic researchers such

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## AWARDS OF HONOR

CPA annually honors psychologists and others for their commitment to the betterment of the association, the profession and public mental health. These awards were presented at the CPA Annual Convention on April 16, 2009.

### **Lifetime Achievement Award**

Mae Billet-Ziskin, PhD

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Elsa Salguero, PhD

### **Outstanding Chapter**

San Diego Psychological Association Under The Leadership Of Sallie Hildebrandt, PhD

### **Outstanding Newsletter**

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### **Division Of Education And Training (II) – Distinguished Service To Division II**

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### **Division Of Industrial/Organizational Psychology (III) – Distinguished Service To Industrial/Organizational Psychology**

David B. Peterson, PhD

### **Division Of Public Service Psychology (IV) – Distinguished Contribution To Psychology**

Sharon Rippner, PhD

### **Division Of Clinical Psychopharmacology (V) – Distinguished Service Award**

Jarline Ketola, PhD, MSCP

as Harold Koenig, MD, consumers (including author JM), and religious professionals.

A grassroots network of family members of consumers also organized and formed The National Alliance for the Mentally Ill (NAMI). Since 1998, their FaithNet network ([www.faithnet.nami.org](http://www.faithnet.nami.org)), founded by California physician Guannar Christiansen, has published a newsletter on outreach and engagement of faith communities with mental health concerns. In addition, NAMI's national conventions have featured many programs on spirituality.

### **Launch of the Mental Health and Spirituality Initiative**

In November 2004, the passage of Proposition 63, the Mental Health Services Act (MHSA), provided the California Department of Mental Health with increased funding, personnel and other resources to support county mental health programs. Jay Mahler saw this as an opportunity to develop a systematic approach to remediating the neglect of spirituality in the public mental health system. In August 2006 Mahler invited a diverse group of about 20 consumers, family members and service providers, including the other two authors of this article to form a "spirituality workgroup" which met at Alameda County Behavioral Health Care Services. This group convened monthly in its first year for the purpose of sharing knowledge about diverse spiritual practices, religious traditions, and ethnic and cultural experiences. This dialogue led to the development of a concept paper for a state-wide project. Its goal was to "find effective, collaborative means to lead the public mental health system in California to inquire about, embrace, and support the spiritual lives of the people it serves or desires to serve" (p. 1). The concept paper (available at [www.mhspirit.com](http://www.mhspirit.com)) and Value Statement (see Table 1) formed the foundation for the California Mental Health & Spirituality Initiative. Specific activities of the initiative include conferences on mental health & spirituality, a website, community dialogues, teleconferences, development of online and face-to-face curricula, as well as surveys of mental health service recipients (individuals and families), provider agencies, and county mental health directors. The Initiative is housed in the Center for Multicultural Development at the California Institute for Mental Health CiMH ([www.cimh.org](http://www.cimh.org)). Currently, the Initiative is co-sponsoring two conferences in California. Information on this conference and a guide to scientific literature, spiritual practices, and books and other resources on spirituality and mental health are available on the Initiative's website.

### **Research on Recovery and Spirituality**

Studies have found that people with serious mental issues place a value on religion similar to that of the general population and they turn even more to religion during crises. In one study, 94 percent of people with serious mental health problems indicated a belief in God or higher power and 70 percent reported they were "moderately," "considerably," or "very" religious (Kroll & Sheehan, 1989). People with serious mental health problems also had lower spiritual well-being scores and were less likely to have talked with clergy than community sample groups. Thus they had not experienced the emotional and social support typically gained from religious communities (Fitchett, Burton, & Sivan, 1997).

Many people report using religious and spiritual practices during their recovery. In one study, 50 percent reported using religious/

## Values Statement of the California Mental Health & Spirituality Initiative

- An appreciation for the significance of spirituality in personal growth, recovery and wellness
- A desire to reduce the suffering of people in recovery whose spiritual experiences have been denied and whose spiritual journeys have been impeded by their interactions with service systems
- An open, welcoming, and non-judgmental stance toward spiritual, religious, and cultural beliefs, practices, rituals, values, theologies, and philosophies – including non-belief or non-practice
- A clear commitment to the inclusion of voices that reflect the diversity of our state – including racial/ethnic diversity and a wide variety of faith traditions or practices
- A passion for choice – including the choice by individuals not to engage with spirituality and/or religion
- A holistic view of recovery that includes mind, body, and spirit

Table 1

spiritual readings, 31 percent meditation, and 20 percent yoga (El-lison, Anthony, & Sheets, 2002). Another study of 74 people with psychotic disorders, 30 percent reported an increase in religious faith after the onset of the illness and over 60 percent reported they used religion to cope with their illness (Lukoff, 2007).

To respond to these needs identified in research, the Initiative plans to create face-to-face and e-learning courses to improve the spiritual competency of mental health providers in addressing religious and spiritual needs and to support the spiritual journeys of consumers and families.

### Altered State Experiences as Part of the Spiritual Journey

A goal of this initiative is to change the way in which religious and spiritual experiences that occur during acute episodes are viewed by mental health and religious professionals. Studies have shown that religious content occurs in 22 to 39 percent of psychotic symptoms (Siddle, Haddock, Tarrier, & Faragher, 2002). In people with bipolar disorder, religious delusions were present in 25 percent and over half of the hallucinations had religious content (Goodwin & Jamison, 1990). Deegan (2004) found that distress, even the distress associated with psychosis, can be hallowed ground upon which one can meet God and receive spiritual teaching. Additionally, Deegan found that those of us who are diagnosed can have authentic encounters with God and that these spiritual teachings can help to guide and encourage the healing process that is recovery.

Father Jerome Stack (1997), a Catholic chaplain for 25 years at Metropolitan State Hospital in Norwalk, California, has observed that people with psychotic disorders often do have genuine religious experiences:

Many patients over the years have spoken to me of their religious experience and I have found their stories to be quite genuine, quite believable. Their experience of the divine, the spiritual, is healthy and life giving...It is important not to presume that certain kinds of religious experience or behavior are simply 'part of the illness.' (p. 23)

The first author has published case studies and an account of how his own spiritual experiences during a psychotic episode helped him to find strength, hope and support during recovery (Lukoff, 1991; Lukoff & Lu, 2005). An episode of mental problems can be a genuine route to spirituality.

### How Spiritual Competency Can Aid Psychologists in Supporting Consumers

Conducting a spiritual assessment offers a way to help consumers connect to social and spiritual support networks and aids in uncovering healthy and dysfunctional forms of religious coping (Pargament, Koenig, Tarakeshwar, & Hahn, 2004). The brief Faith and Interest Importance Community Address (FICA) in care interview, now taught at over two-thirds of medical schools, includes four questions and can be administered in three to five minutes (Puchalski & Romer, 2000). The list below includes some additional approaches that must be used in a culturally sensitive manner, but are additional ways to support the spirituality of consumers and their family members.

1. Educate consumers about recovery as a spiritual journey with a potentially positive outcome.
2. Encourage consumers' involvement with a spiritual path or religious community that is consistent with their experiences and values.
3. Encourage consumers to seek support from appropriate religious or spiritual advisors.
4. Encourage consumers to engage in religious and spiritual practices consistent with their beliefs (e.g., prayer, meditation, reading spiritual books, acts of worship, ritual, forgiveness and service).
5. Actively support a consumer during the learning process to explore various methods by sharing the experience of practicing together (e.g., meditation, silence, or prayer).
6. Model one's own spirituality including a sense of purpose and meaning, along with hope and faith in something transcendent.



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### **See page 25**

## Spirituality in the Recovery from Persistent Mental Disorders

David Lukoff, PhD

Mental health systems in this country are undergoing a quiet revolution. Former patients and other advocates are working with mental health providers and government agencies to incorporate spirituality into mental healthcare. While the significance of spirituality in substance abuse treatment has been acknowledged for many years due to widespread recognition of the therapeutic value of 12-step programs, this is a new development in the treatment of serious mental disorders such as bipolar disorder and schizophrenia. The incorporation of spirituality into treatment is part of the recovery model which has become widely accepted in the US and around the world. In 1999, the Surgeon General, in a landmark report on mental health, urged that *all* mental health systems adopt the recovery model.<sup>1</sup>

What distinguishes the recovery model from prior approaches in the mental health field is the perspective that people can fully recover from even the most severe forms of mental disorders. Services and research are being reoriented toward recovery from severe or long-term mental illnesses.<sup>2</sup> This creates an orientation of hope rather than the “kiss of death” that diagnoses like schizophrenia once held. One hundred years ago, Emil Kraepelin identified the disorder now known as schizophrenia as dementia praecox, a chronic, unremitting, gradually deteriorating condition, having a progressive downhill course with an end state of dementia and incompetence.<sup>3</sup> However, researchers have established that people diagnosed with schizophrenia and other serious mental disorders are capable of regaining significant roles in society and of running their own lives. There is strong evidence that most persons, even with long-term and disabling forms of schizophrenia, do “recover,” that is, enjoy lengthy periods of time free of psychotic symptoms and partake of community life as independent citizens.<sup>4</sup> Daniel Fisher, a former patient, now a psychiatrist and internationally renowned advocate for the recovery model, maintains that

“Believing you can recover is vital to recovery from mental illness. Recovery involves self-assessment and personal growth from a prior baseline, regardless of where that baseline was. Growth may take the overt form of skill development and resocialization, but it is essentially a spiritual



David Lukoff, PhD

revaluing of oneself, a gradually developed respect for one's own worth as a human being. Often when people are healing from an episode of mental disorder, their hopeful beliefs about the future are intertwined with their spiritual lives, including praying, reading sacred texts, attending devotional services, and following a spiritual practice.”<sup>5</sup>

### Recovery versus Medical Model

The medical model tends to define recovery in negative terms (eg, symptoms and complaints that need to be eliminated, disorders that need to be cured or removed). Mark Ragins observed that focusing on recovery does not discount the seriousness of the conditions<sup>6</sup>:

“For severe mental illness it may seem almost dishonest to talk about recovery. After all, the conditions are likely to persist, in at least some form, indefinitely. . . . The way out of this dilemma is by realizing that, whereas the illness is the object of curative treatment efforts, it is the persons themselves who are the objects of recovery efforts.”

Drawing on the 12-step approach to recovery from addictions, Ragins outlines an alternative to the medical model approach that he helped to develop for individuals at Village Integrated Services Agency<sup>6</sup>:

1. Accepting having a chronic, incurable disorder, that is a permanent part of them, without guilt or shame, without fault or blame;
2. Avoiding complications of the condition (eg, by staying sober);
3. Participating in an ongoing support system both as a recipient and a provider;
4. Changing many aspects of their lives including emotions, interpersonal relationships, and spirituality both to accommodate their disorder and grow through overcoming it.

In the recovery model, healthcare professionals act as coaches helping to design a rehabilitation plan which supports the patient's efforts to achieve a series of functional

From the Spiritual Competency Resource Center, Peta Luma, CA.

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goals. Their relationship often focuses on motivating and focusing the patient's own efforts to help themselves. What is important, particularly during the initial stages of interaction, is that professionals afford dignity and respect to those in their care. Respecting and supporting a patient's spiritual journey, as described later in this article, is often an important component of their recovery. In the words of one recovery center, "Recovery has so much to do with quality of life. And that may not necessarily mean going back to work or going back to school. It may mean developing friendships, belonging to a church, having a healthy body and a healthy mind."<sup>7</sup>

## History of the Consumer Movement

The increasing adoption of the recovery model has evolved from the growing movement throughout the United States and the world of people calling themselves consumers, survivors, or ex-patients who have been diagnosed with mental disorders and are working together with mental health professionals to make changes in the mental health system and in society. The consumer movement grew out of the idea that individuals who have experienced similar problems, life situations, or crises can effectively provide support to one another. According to Sally Clay, one of the leaders of this movement,

"The Consumer/Survivor Communities began 25 [now 45] years ago with the anti-psychiatry movement. In the 1980s, ex-mental patients began to organize drop-in centers, artistic endeavors, and businesses. Now hundreds of such groups are flourishing throughout the country. Our conferences (many sponsored by NIMH) have been attended by thousands of people. More and more, consumers participate in the rest of the mental health system as members of policy-making boards and agencies."<sup>8</sup>

## Case Examples

Frederick Frese, PhD is a vocal example of the recovery model. Forty years ago, he was locked up in an Ohio psychiatric hospital, dazed and delusional, with paranoid schizophrenia:

"In March of 1966, I was a young Marine Corps security officer. I was responsible for guarding atomic weapons at a large naval air base and had just been selected for promotion to the rank of Captain. One day, during a particularly stressful period, I made a "discovery" that certain high-ranking American officials had been hypnotized by our Communist enemies and were attempting to compromise this country's nuclear capabilities. Shortly after deciding to reveal my discovery, I found myself locked away in the seclusion room of the base's psychiatric ward, diagnosed with schizophrenia."<sup>9</sup>

During the following ten years he was involuntarily hospitalized at a variety of psychiatric facilities around the country. Twelve years later, he had become the chief psychologist

for the very mental hospital system that had confined him. Despite 10 hospitalizations, he married, had four children and earned a master's degree and doctorate. He is currently a prominent advocate for the recovery model.

In *The Day the Voices Stopped*, Ken Steele reports that staying medication compliant, having a therapist, having good friends and family, and working with the consumer movement were paramount in his recovery from mental illness. Ken's recovery began when he and his doctor discovered a medicine that softened the voices, and he was able to reconnect with his family, his faith, and to begin working for Fountain House.<sup>10</sup>

## Recovery from Mental Disorder as a Spiritual Journey

Recovery from a mental disorder is experienced by many people as part of their spiritual journey. This was eloquently expressed by Jay Mahler, Program Director of the Mental Health Division of Contra Costa County:

"The whole medical vocabulary puts us in the role of a 'labeled' diagnosed victim. . . . But as they go through trial and error to control your symptoms, it doesn't take a genius to realize they haven't got the answers. No clue about cures! And oh boy, those side effects! I don't say medications can't help, or that treatments won't have value.

But, what I do say is that my being aware that I'm on a spiritual journey empowers me to deal with the big, human 'spiritual' questions, like: 'Why is this happening to me? Will I ever be the same again? Is there a place for me in this world? Can my experience of life be made livable? If I can't be cured can I be recovering, even somewhat? Has my God abandoned me?' We who have it have to wonder whether what remains constitutes a life worth living. That's my spiritual journey, that wondering. That's my search."<sup>11</sup>

Sally Clay, who was hospitalized at the Hartford Institute of Living with schizophrenia, writes: "My recovery had nothing to do with the talk therapy, the drugs, or the electroshock treatments I had received; more likely, it happened in spite of these things. My recovery did have something to do with the devotional services I had been attending. . . . I was cured instantly—healed if you will—as a direct result of a spiritual experience."<sup>8</sup>

## Mental Disorder and Genuine Spiritual Experience

Many years later Clay went back to the Institute of Living to review her case records and found herself described as having "decompensated with grandiose delusions with spiritual preoccupations."<sup>8</sup> She complains that her spiritual experience, neither its difficulties nor its healing, was "recognized as legitimate." Clay makes the case that, in addition to the disabling effects she experienced as part of her illness, there was also a profound spiritual component that was ignored.

She describes how the lack of sensitivity to the spiritual dimensions of her experience on the part of mental health and religious professionals was detrimental to her recovery. Clay considers her mental illness to have been a “spiritual crisis” for which “finding a spiritual model of recovery was a question of life or death. . . . My experiences were, and always had been, a spiritual journey—not sick, shameful, or evil.”<sup>12</sup>

Pat Deegan also makes the point that psychosis can be a genuine route to spirituality:

“Distress, even the distress associated with psychosis, can be hallowed ground upon which one can meet God and receive spiritual teaching. When we set aside neurobiological reductionism, then it is conceivable that during the passage that is madness, during that passage of tomb becoming womb, those of us who are diagnosed can have authentic encounters with God. These spiritual teachings can help to guide and encourage the healing process that is recovery.”<sup>13</sup>

Studies have shown that religious content occurs in 22 to 39% of psychotic symptoms.<sup>14,15</sup> One study of hospitalized bipolar patients found that religious delusions were present in 25% and over half of the hallucinations were brief, grandiose, and usually religious.<sup>16</sup> Goodwin and Jamison suggest that there “have been many mystics who may well have suffered from manic-depressive illness—for example, St. Theresa, St. Francis, St. John.”<sup>16</sup> During manic episodes in particular, people have experiences similar to those of the great mystics.<sup>17</sup>

Jerome Stack, a Catholic Chaplain at Metropolitan State Hospital in Norwalk, California for 25 years, has observed that many people with psychotic disorders do have genuine religious experiences:

“Many patients over the years have spoken to me of their religious experience and I have found their stories to be quite genuine, quite believable. Their experience of the divine, the spiritual, is healthy and life giving. Of course, discernment is important, but it is important not to presume that certain kinds of religious experience or behavior are simply ‘part of the illness.’”<sup>18</sup>

Psychotic experiences which have religious/spiritual content can be explored to find sources of strength, hope and belief that can provide spiritual support.

## Research on Spirituality and Recovery from Mental Illness

A number of studies show that spirituality plays an important role in the recovery process for many. Fallot analyzed the key religious and spiritual themes in recovery narratives drawn from spiritual discussion groups, trauma recovery groups and other clinical groups at Community Connections, a mental health facility for people diagnosed with severe mental illness.<sup>19,20</sup> He found that although organized religion had been experienced as stigmatizing and rejecting on some occasions, on the whole a personal, spiritual experience of a relationship with God helped build hope, a sense of divine

support and love, the courage to change and to accept what cannot be changed, connection with faith communities, and supported calming practices such as prayer, meditation, religious ritual, religious reading, and listening to religious music.

The authors found three key themes. First, spirituality played a positive role in coping with stressful situations, and helped adherents to avoid drug use and negative activities. Second, church attendance and a belief in a higher power provided social and emotional support. Third, spirituality enhanced the sense of being whole. Sullivan conducted a qualitative study<sup>21</sup> involving 40 participants which sought to uncover factors associated with the successful adjustment of former and current consumers of mental health services. In it, 48% of participants found that spiritual beliefs and practices were identified as essential.

Jacobson (2001) applied the technique of dimensional analysis to 30 recovery narratives.<sup>22</sup> She identified a spiritual or philosophical crisis as destroying and then recreating the self:

“The crisis is an altered state of being. ‘Mental illness’ is the label society gives to these crises, but such designations don’t represent reality. Standard interventions by the system—especially medication—hinder the individual’s ability to seek and find the truth that can end the ordeal. Other people can be helpful only to the extent that they themselves have been through similar experiences or are willing to acknowledge the ineffable nature of the crisis. The greatest help comes when individuals are able to connect with some source of enlightenment; a community of practicing Buddhists, the Bible, treatises of philosophy or physics. Recovery is about enduring and coming out the other side. Coming back to life, in a recreated and enlightened self, the individual discovers new ‘wisdom and compassion’. Those who have recovered, then, are obligated to demonstrate this wisdom and to practice compassion by reaching out to others who are in the midst of their own crises.”<sup>22</sup>

Several studies document that patients with serious mental disorders use religion to cope with their illness,<sup>23</sup> and that the intensity of religious beliefs is not associated with psychopathology.<sup>24</sup> In many cases, religious practices (such as worship and prayer) appear to protect against severity of psychiatric symptoms and hospitalization, and enhance life satisfaction and speed recovery in mental disorders.<sup>25</sup>

However, many patients have been found to hold dysfunctional beliefs about their disorder. One study of 52 psychiatric inpatients found that 23% believed that sin-related factors, such as sinful thoughts or acts, were related to the development of their illness.<sup>26</sup> This is clearly a guilt-inducing belief for which there is no evidence, and one that the vast majority of religious professionals would challenge.

Studies have found that psychiatric patients are as religious as the general population and they turn more to religion during such crises.<sup>27</sup> In a study of the religious needs and resources of psychiatric inpatients, Fitchett et al found that 88% of the psychiatric patients reported three or more current religious needs. Psychiatric patients had lower spiritual well-

being scores and were less likely to have talked with their clergy. They concluded that religion is important for the psychiatric patients, but they may need assistance to find resources to address their religious needs.

Many patients make use of religious and spiritual practices during their recovery. Among a sample of 157 patients, 86% of whom were on psychotropic medications, 50% reported using religious/spiritual reading, 31% meditation, and 20% yoga.<sup>28</sup> Another study of 74 patients with acute psychotic symptoms followed up every 6 months for 2 years found that 30.2% of these patients reported an increase in religious faith after the onset of the illness, and 61.2% reported they used religion to cope with their illness and to get better.<sup>29</sup> Eighty-three per cent of psychiatric patients in a different study felt that spiritual beliefs had a positive impact on their illness through the comfort it provided, and the feelings of being cared for and not being alone it engendered.<sup>30</sup>

## Providing Spiritual Support

For many people, having a relationship with a higher power is the foundation of their psychological well-being. Providing spiritual support involves supporting the patient's sense of connection to a higher power that actively supports, protects, guides, teaches, helps, and heals. Some researchers have suggested that the subjective experience of spiritual support may form the core of the spirituality-health connection.<sup>31</sup> There is evidence that indicates that persons with mental disorders utilize their spiritual resources to improve functioning, reduce isolation, and facilitate healing; nonetheless, "mental health professions have a long history of ignoring and pathologizing religion."<sup>25</sup>

Spirituality is an important coping mechanism because individuals seek meaning when experiencing severe illnesses. Therefore promoting religious and spiritual beliefs and practices is appropriate with patients who are open to accepting that approach. Studies consistently show that at least two-thirds of people are open to such discussions with their physicians. For example, 66% of hospitalized pulmonary patients said they would "welcome religious questions in medical history"; 16% of patients, however, said they would "not welcome religious questions." The healthcare professional needs to be sensitive to the patient's religious values in any interventions incorporating spirituality.<sup>32</sup> In most cases, healthcare professionals can provide spiritual support to people coping with mental disorders by devoting some time to exploring spiritual issues and asking questions to discover a patient's deeper meaning in life. Healthcare professionals can initiate support of a patient's spirituality-health connection through a spiritual assessment such as the FICA interview,<sup>33</sup> now taught at over two-thirds of medical schools, which includes four questions and can be administered in 3 to 5 minutes.

In 2003, Randal, Simpson, and Laidlaw conducted a study<sup>34</sup> to assess whether a recovery-focused, multimodal therapy can improve the symptoms and functioning of treatment-resistant psychotic patients. Their treatment included medication, supportive therapy, focus on recovery, spirituality, and cognitive-behavioral therapy, as well as psycho-education and affective regulation. Although the sample size was small (9 patients), they found a significant improvement in the overall positive and negative symptoms. Of special note is the spiritual focus of the treatment.

Spiritual support can include:

- Educating the patient about recovery as a spiritual journey with a potentially positive outcome;
- Encouraging the patient's involvement with a spiritual path or religious community that is consistent with their experiences and values;
- Encouraging the patient to seek support and guidance from credible and appropriate religious or spiritual leaders;
- Encouraging the patient to engage in religious and spiritual practices consistent with their beliefs (eg, prayer, meditation, reading spiritual books, acts of worship, ritual, forgiveness and service). At times, this might include engaging in a practice together with the patient such as meditation, silence, or prayer;
- Modeling one's own spirituality (when appropriate), including a sense of purpose and meaning, along with hope and faith in something transcendent.

## Conclusion

People recovering from mental disorders have rich opportunities for spiritual growth, along with challenges to its expression and development. They will find much-needed support for the task when they are clinically guided to explore their spiritual lives. Thus directed, they can begin to create a positive health-promoting outcome for their spiritual journey in recovery.

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**|** *The reward of patience is patience.*

—Saint Augustine

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