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Client Report of Spirituality in Recovery From Serious Mental Illness

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Concerns about the ability to understand and communicate about spiritual material have become a source of controversy regarding spiritually integrated care for individuals managing serious mental illnesses (Hathaway, 2011). In this study, 91 people receiving outpatient services for serious mental illnesses provided information on their symptoms, level of recovery, spiritual functioning, and preferences about spiritually integrated care, as well as their responses to an infrequency/inconsistency scale. Results indicated that (a) most participants were interested in spirituality and wanted to discuss this with mental health care providers, (b) as a group, most participants were able to provide reliable and valid responses to questions about spirituality.

Keywords: recovery, serious mental illness, spirituality

Converging forces are directing mental health providers' attention to religion and spirituality. These include the rapidly growing research base in the psychology of religion (Plante, 2007), the influence of positive psychology, and awareness of multicultural concerns in psychotherapy (Mizock, Miller, & Russinova, 2012). Another relevant force is the Recovery movement (Mizock et al., 2012), which is becoming the standard of care for treatment of those with serious mental illnesses (Whitley & Drake, 2010). The Recovery movement requires holistic attention to all areas of a client's life, including values and natural supports in the community. For a majority of those with serious mental illnesses, these values and supports include spirituality and religion (Fallot, 2008; de Mamani, Tuchman, & Duarte, 2010; Russinova & Blanch, 2007; Whitley & Drake, 2010; Wong-McDonald, 2007).

Although these forces have promoted the integration of spirituality into the assessment and treatment of mental health conditions, a few have voiced concerns that addressing spirituality with a seriously mentally ill population could have adverse consequences (e.g., Hathaway, 2011). Specifically, concerns have been raised about seriously mentally ill clients' capacity to adequately understand spiritual concerns, to consent to spiritually integrated interventions, and to interpret discussions of spiritual material without distortion from psychotic ideation (Hathaway, 2011).

To address concerns about this population's ability to report meaningfully on spirituality, this study will specifically examine the quality of data collected from an outpatient sample of people managing serious mental illnesses in terms of response consistency and credibility. For the purposes of this study, spirituality was defined as the individual's relationship with what they consider sacred. This definition subsumes involvement in organized religions, but also includes spiritual beliefs outside of organized religions (Zinnbauer et al., 2001).

Relationships Between Religion, Spirituality, and Recovery From Serious Mental Illness

As in other areas of mental health, the research on spirituality and recovery from serious mental illnesses demonstrates that neither mental health nor spirituality are unitary constructs, so the relationships are far more complex than one might initially expect (Mohr, Brandt, Borras, Gillieron, & Huguelet, 2006; Mohr et al., 2011). Some aspects of spiritual and religious functioning are

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associated with poorer mental health, whereas others are associated with more effective recovery (Mohr et al., 2006, 2011). These associations with mental health status have been found in studies sampling individuals with a wide variety of presenting concerns such as serious medical illnesses, trauma exposure, and heterogeneous clinical samples (Exline, Yali, & Sanderson, 2000; Harris et al., 2008; Pargament, Koenig, & Perez, 2000). Positive spiritual functioning includes feeling that a Higher Power, Universal Force, and/or community of faith is a source of support and help, that there is some positive meaning related to coping with the illness, and that there is hope for the future (Mohr et al., 2006). In contrast, negative spiritual functioning is characterized by perceptions of a Higher Power, Universal Force, and/or community of faith as punitive or judgmental, negative meanings related to the illness motivating anger or sadness, and despair about failed expectations for spiritual healing (Mohr et al., 2006).

The literature on spirituality and serious mental illness is similar. There is evidence that, like other populations, people who manage serious mental illnesses evidence both positive and negative aspects of spiritual functioning (Mohr et al., 2006, 2011). For example, research on individuals managing serious mental illnesses uniformly finds that most such clients describe religion and spirituality as important and want to discuss this as part of their recovery (Bellamy et al., 2007; Corrigan, McCorkle, Schell, & Kidder, 2003; Fallot, 2007). Furthermore, most people who manage serious mental illnesses report that their faith facilitates their recovery (Bellamy et al., 2007; Corrigan et al., 2003; Fallot, 2007). There is evidence that among people with serious mental illness, those who are more religious evidence lower levels of psychopathology (Röhricht et al., 2009), describe better quality of life in physical, psychological, and social domains (Shah et al., 2011a), and demonstrate more adaptive coping skills (Shah et al., 2011b). A number of studies of religious coping among people with serious mental illness identify positive outcomes associated with religious coping (Fallot, 2007, 2008; Lukoff, 2007; Miller & McCormack, 2006). Cross sectional studies of people managing serious mental illnesses have found that those using more positive spiritual functioning have fewer symptoms, fewer suicide attempts, less substance abuse, higher levels of hope, better adherence to treatment, and better social integration, whereas those who evidence more negative spiritual functioning report more symptoms, more social isolation, more suicide attempts, more substance abuse, and poorer adherence to treatment (Mohr et al., 2006). A three-year longitudinal study of spiritual functioning in this population demonstrated that positive spiritual functioning predicted better quality of life, better social functioning, better scores on a global score of clinical impression, and fewer negative symptoms, whereas negative spiritual functioning was not predictive of any measured outcomes (Mohr et al., 2010, 2011). These studies demonstrate that for many, spirituality is an important resource that facilitates coping with life stressors and the demands of living with a chronic health condition.

For most people managing serious mental illness, the importance of religion and spirituality in coping with adversity becomes especially salient when this support is lost (Bussema & Bussema, 2007). Individuals with a serious mental illness diagnosis who experience rejection by their community of faith when the illness becomes known have reported depression, suicidal ideation, and lower levels of social support and community integration (Bradley, 1995; Ellison & George, 1994).

Despite the significant role that religion and spirituality can play, many clinicians may be reluctant to discuss spirituality with these clients out of fear that such a discussion would strengthen religiously themed symptoms. There is evidence that religious delusions are associated with poor outcomes (Miller & McCormack, 2006; Mizock et al., 2012; Mohr & Huguelet, 2004). However, research suggests that only a minority of people with serious mental illnesses experience religious delusions (Miller & McCormack, 2006), and no contemporary research in this area finds that discussing spirituality exacerbates such symptoms in this population (Miller & McCormack, 2006).

There are only a few studies of spiritually integrated interventions designed for people with serious mental illnesses, but they suggest that addressing spirituality can be beneficial (Kehoe, 1999; Phillips, Lakin, & Pargament, 2002; Revheim, Greenberg, & Citrome, 2010; Wong-McDonald, 2007). In a study of the impact of spiritual assessment for clients with serious mental illnesses, those who received a spiritual assessment at intake responded positively and attended more of their subsequent mental health care appointments than those who did not (Huguelet et al., 2011). Similarly, long-term implementation of groups to discuss spiritual issues for this population have yielded no evidence of adverse effects; because of lack of experimental control, benefits from interventions in these studies are unclear (Kehoe, 1999; Phillips, Lakin, & Pargament, 2002). Studies of spiritually integrated interventions for this population are limited by self-selection into control versus experimental groups. For example, Revheim et al., (2010) found that those who attended a spiritual issues group described better spiritual adjustment and higher levels of hope than those who did not attend. Similarly, a controlled study that allowed participants to self-select into a spiritual intervention versus a control group found that those who participated in the spiritual intervention group were significant more likely to meet their rehabilitation goals (Wong-McDonald, 2007). Although conclusions from these types of studies are very preliminary, available evidence indicates that participants who self-select into spiritually oriented interventions (a) report higher levels of spiritual/religious commitment, (b) report more self-efficacy in symptom management, (c) report better social functioning, and (d) describe higher levels of hope (Revheim et al., 2010). Across all of these studies there were no adverse events, and subjective responses from participants were uniformly positive (Kehoe, 1999; Phillips et al., 2002; Revheim et al., 2010; Wong-McDonald, 2007). The results of these preliminary studies suggest that spirituality integrated interventions can be safely offered to people managing serious mental illnesses, are of interest to this population, and appear to promote the recovery process (Huguelet et al., 2011).

Evaluating the Research and Questions About Self-Report Data

Despite evidence that use of spirituality integrated interventions may be fruitful with this population, their use remains controversial. Specific concerns voiced by opponents include doubts about capacity to consent, capacity to understand spiritual material, and ability to benefit from psychotherapeutic interventions (Hathaway, 2011). Given the research evidence on the role of spirituality in recovery from mental illness, including several studies and literature reviews recommending attention to spiritual concerns in this population (Koenig, Larson, & Weaver, 1998; Longo & Peterson, 2002; Mizock et al., 2012; Mohr et al., 2010, 2011), initially it appears difficult to under-

stand current sources that discourage spiritually integrated interventions among people with serious mental illness (Hathaway, 2011). Concerns, however, may come from perceptions of poor reliability or validity in self-report data taken from participants managing serious mental illnesses (Crisanti, Laygo, & Junginger, 2003).

Although there are very few studies of reliability and validity of self-report data in outpatients managing serious mental illness, a recent review of the literature concluded that as a group, such individuals are able to provide a valid and reliable report of their personal history (Crisanti et al., 2003). It is likely that researchers and clinicians in psychology of religion and spirituality would prefer to see evidence that participants can provide reliable and valid responses to questions about spirituality before drawing firm conclusions in this field. This study aims to address this concern by assessing the reliability and validity with which clients managing a serious mental illness report on their spiritual and religious functioning. Hypotheses are as follows:

1. A clear majority (>80%) of participants will provide valid self-reports as determined by measures of inconsistent or infrequent responses.

2. The internal consistency (coefficient alphas) of subscales measuring spiritual and religious functioning (i.e., religious coping and religious comforts and strains) will not be significantly different from those obtained in other populations.

3. The internal structure (factors) of spirituality measures (the Brief RCOPE and Religious Comforts and Strains Scale) will be comparable with the structure found in other populations.

Method

Participants

Participants were adults living in the upper Midwest and participating in programs serving people managing serious mental illnesses (i.e., serving people with psychotic spectrum disorders, such as schizophrenia and bipolar disorder). These programs were based in communities and at a Veterans Affairs Health Care System (VA) facility. None of the participating programs were faith-based. Participants were approached by providers familiar with their psychiatric history and were invited to participate in an anonymous written survey on spirituality and mental health recovery. All were identified through their participation in a psychoeducational group, psychiatric rehabilitation program, or community support program serving people with serious mental illnesses. The survey included a passive consent letter and measures (see below) of spiritual functioning, mental health symptoms, mental health recovery, and an assessment of inconsistent and infrequent responses. The project was approved as exempt from review with the local institutional research board, because no identifying data were collected.

Instruments

Religious coping. The Brief RCOPE (Pargament et al., 1998, 2000) is a 14-item Likert measure of religious coping that yields two subscales: positive and negative religious coping. Positive coping predicts fewer psychological symptoms, whereas negative coping predicts more psychopathology (Pargament et al., 1998, 2000; Ano & Vasconcelles, 2005). Subscale alphas are .90 for positive religious coping and .81 for negative religious coping (Pargament et al., 1998, 2000). In our sample the subscale alphas were .91 and .84, respectively.

Religious comforts and strains. The Religious Comfort and Strain Scale [RCSS] is a 20-item Likert measure of sources of emotional support versus distress related to religion and spirituality (Exline et al., 2000). It includes one subscale for religious comfort, and three subscales of religious strains, including alienation from G-d, fear and guilt, and religious rifts. Higher scores on religious strain subscales are associated with depression and suicidal ideation (Exline et al., 2000). Subscale alpha's range from .67 to .87 (Exline et al., 2000). Subscale alphas in our sample ranged from .78 to .94.

Psychological distress. The Kessler-10 (Kessler et al., 2002) is a 10-item Likert scale measuring common psychopathological symptoms that has been well-validated among people managing serious mental illnesses (Andresen, Caputi, & Oades, 2010; Rampton, Waghorn, DeSouza, & Lloyd, 2010). Its alpha in our sample was .92.

Level of recovery. The Mental Health Recovery Measure (Young & Bullock, 2003) is a 30-item Likert scale designed cooperatively with people who manage serious mental illness to tap quality of life dimensions most indicative of effective recovery (Young & Bullock, 2003). The instrument can be interpreted using a single summary score, or 8 subscale scores. To reduce both Type I error and the potential for redundant variance, a version of the single summary score that did not include a subscale assessing spirituality was used. The instrument has a reported internal consistency of .93 (Bullock et al., 2005; Andresen et al., 2010).

Infrequency/inconsistency responding. Fourteen items were also used to check for inconsistent and noncredible responding, for example, *I cannot remember a single occasion when I have ridden on a bus*, and *I believe that most light bulbs are powered by electricity*. These items have effectively identified inconsistent and invalid response patterns in comparable samples (Dinzeo et al., 2008). Those giving two or more atypical responses were deemed to be invalid responders.

Results

Ninety-one participants returned surveys. Potentially identifying demographic information was not collected to protect participant anonymity and to meet IRB exempt status requirements. Based on the demographics of the programs from which the sample was drawn, it is likely that participants were predominantly Caucasian with small numbers of African American, Native American, and Asian ethnicities. Because more than 50% of the sample was drawn from VA programs, men were most likely overrepresented in this sample. Average age of participants was likely between 40 and 70 years of age. Participants were asked for their religious affiliations, and responses were 79% Christian, 1% Jewish, 1% Buddhist, 7% Agnostic, 2% Atheist, and 10% "Other." Religious affiliations described in the "Other" category included Baha'i, Native American, Neo-Pagan, and Shamanism. Means and standard deviations for the dependent measures are presented in Table 1. Intercorrelations are presented in Table 2. Sample levels of psychological distress, mental health recovery, and positive and negative spiritual functioning appear similar to those in previous research using outpatient samples

Table 1
Means and Standard Deviations of Major Variables

Variable	Mean	Standard deviation
Kessler-10	17.25	9.55
Mental Health Recovery Measure	105.09	23.43
Negative Religious Coping	6.56	5.19
Positive Religious Coping	13.97	5.6
Religious Comfort	32.39	13.85
Alienation from G-d	11.16	10.43
Religious Fear and Guilt	10.11	7.89
Religious Rifts	12.24	8.19

(Andresen et al., 2010; Exline et al., 2000; Harris et al., 2008). Directions of significant correlations between positive and negative religious functioning and mental health outcomes (MHRM scores and Kessler 10 scores) mirrored those found in previous literature (Ano & Vasconcelles, 2005; Exline et al., 2000; Harris et al., 2008; Mohr et al., 2006, 2010, 2011) in that indicators of negative religious functioning were significantly and positively correlated with measures of symptoms, and indicators of positive religious functioning were significantly and positively correlated with mental health recovery (see Table 2). For all statistical analyses, participants who did not provide complete data on variables in each analysis were eliminated from that analysis.

Importance of Spirituality

When asked to rate their interest in spirituality on a 1 to 10 scale, with 10 reflecting the highest level of interest, 46% of the sample rated their interest at "10," and 84% of the sample rated their interest in spirituality at "5" or higher (see Figure 1). When asked to rate the extent to which they wanted mental health providers to ask about their spirituality, 24% of the sample rated this item at "10," and 74% of the sample rated this at "5" or higher (see Figure 2).

Validity and Consistency of Self-Report Data

Nine participants provided atypical responses to the inconsistency/infrequency items, and were removed from the sample, leaving 82 cases (90% of the sample) available for further analysis. This finding supported hypothesis 1—most participants provided consistent and valid self-reports. All other analyses were conducted with data from these 82 participants.

Scale reliability was assessed to address hypothesis 2. Coefficient alphas obtained for the subscales of the RCOPE and the RCSS were as follows: Positive Religious Coping (.91), Negative Religious Coping (.84), Religious Comfort (.94), Alienation from G-d (.91), Religious Fear and Guilt (.78), and Religious Rifts (.78). To test hypothesis 2, Feldt tests (Feldt, 1969; Feldt & Kim, 2006) were used to compare these alphas to those obtained in a community sample (Harris et al., 2008) and a clinical sample drawn from an anxiety and depression clinic (Exline et al., 2000). No significant differences were found for the alphas for any of the subscales of either the RCOPE or the RCSS in comparison with either the community or clinical sample. Hypothesis 2 was supported.

Factor Structure of Spirituality Measures

For hypothesis 3, factor analyses using principal components extraction and oblique rotation (Promax) were used to determine whether responses to items on measures of religious functioning in this sample differ from those found in a nonclinical community sample (Harris et al., 2008). All items for the RCOPE were used in the first factor analysis, and all items for the RCSS were included in the second factor analysis. In each case the resulting analysis was compared with the responses to these items in a previously collected, community sample of trauma survivors (Harris et al., 2008) to determine whether the factor structure of responses to these instruments were congruent across the sampled populations.

For the analysis of the Brief RCOPE both samples yielded three factors with an eigenvalue of 1 or greater, which were retained and interpreted using promax rotation (see Table 2). The first factor appeared to mirror the Positive Religious Coping subscale, the second the Negative Religious Coping subscale, and the third appeared to be extraneous variance. Tucker's coefficients of congruence were .99 for Factor 1, .99 for Factor 2, and .71 for Factor 3.

For the analysis of the Religious Comforts and Strains Scale, both samples yielded four factors with an eigenvalue of 1 or greater, which were retained and interpreted using promax rotation (see Table 3). The first factor was consistent with the Religious Comfort subscale, the second with the Alienation from G-d subscale, the third with the Religious Fear and Guilt subscale, and the fourth with the Religious

Table 2
Intercorrelations

Variable	MHRM	Kessler	RCO+	RCO−	Comfort	Alienation	Fear/Guilt	Rifts
MHRM	—							
Kessler	−.419*	—						
RCO+	.501**	−.125	—					
RCO−	−.473**	.306*	.132	—				
Comfort	.554**	−.302*	.730**	−.201	—			
Alienation	−.495**	.317*	−.341*	.623**	−.637**	—		
Fear/Guilt	−.217	.326*	.106	.327*	.068	.310*	—	
Rifts	−.095	.387**	.047	.388*	−.047	.260	.341*	—

Note. MHRM = Total score for the Mental Health Recovery Measure, excluding the spirituality subscale; Kessler = Kessler-10 score; RCO+ = Positive Religious Coping; RCO− = Negative Religious Coping; Comfort = RCSS Religious Comfort; Alienation = RCSS Alienation from God; Fear/Guilt = RCSS Religious Fear and Guilt; Rifts = RCSS Religious Rifts.
* $p \leq .05$, ** $p \leq .01$.

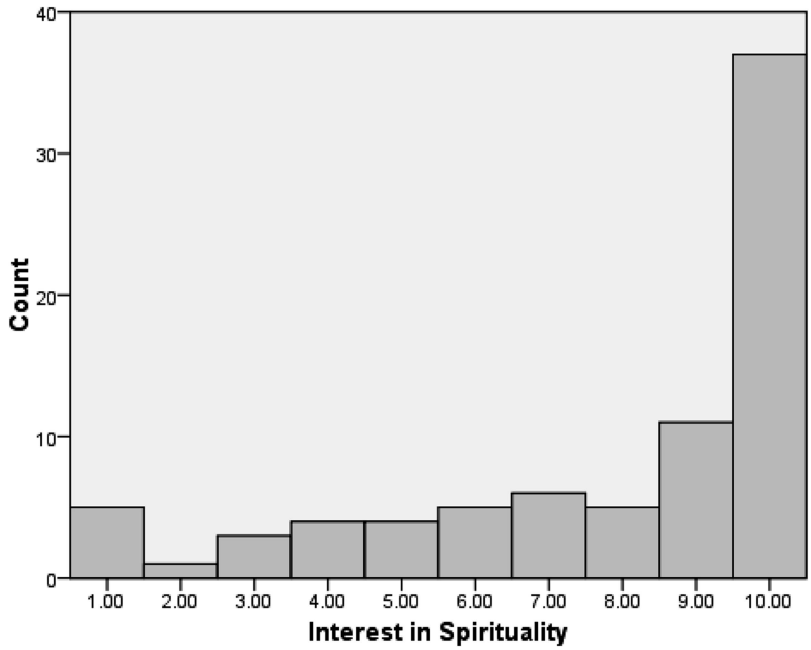

Figure 1. Responses to item asking about interest in spirituality. A response of "1" = *little or no interest*; a response of "10" = *very high interest*.

Rifts subscale. Tucker's coefficients of congruence were .97 for Factor 1, .98 for Factor 2, .95 for Factor 3, and .93 for Factor 4.

The internal factor structure for both instruments were very similar across samples, as evidenced by coefficients of congruence higher than .90 for all of the factors that corresponded to instrument subscales. Hypothesis 3 was supported.

Discussion

These findings add to the growing evidence that most people managing serious mental illnesses view spirituality as important in their recovery and want to be able to discuss spiritual concerns with their mental health providers (Bellamy et al.,

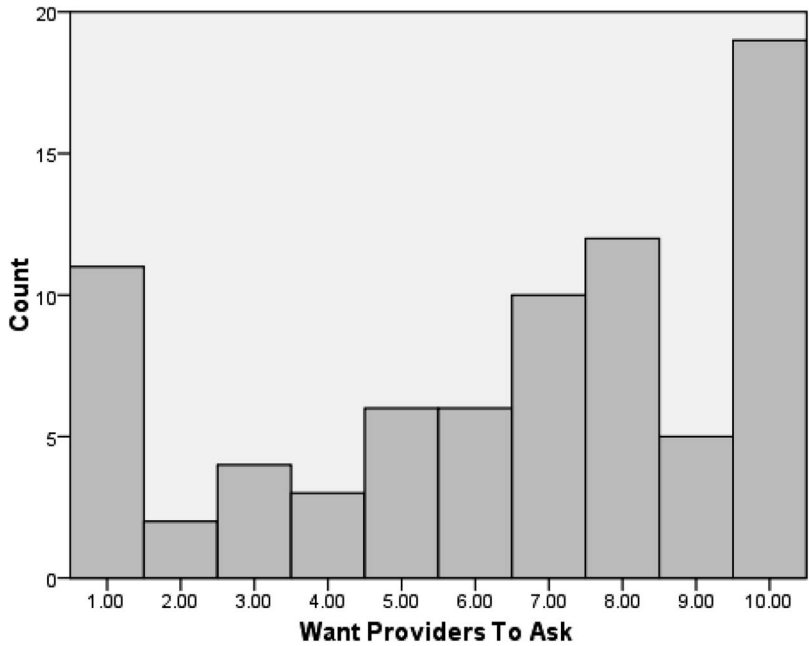

Figure 2. Responses to item asking whether participants want providers to ask about spirituality. A response of "1" = *do not want providers to ask*; a response of "10" = *very much want providers to ask*.

Table 3
Factor Analysis of the Brief RCOPE and the Religious Comforts and Strains Scale

	Brief RCOPE[a]						Religious Comforts and Strains Scale[b]							
	Current sample			Trauma survivors sample[a]			Current sample				Trauma survivors sample[c]			
Item	Factor 1	Factor 2	Factor 3	Factor 1	Factor 2	Factor 3	Factor 1	Factor 2	Factor 3	Factor 4	Factor 1	Factor 2	Factor 3	Factor 4
1	.872	.076	−.267	.824	.074	−.031	.884	−.602	−.058	−.097	.471	−.230	.013	.056
2	.892	.117	−.175	.825	.008	−.020	−.356	.260	.205	.840	−.165	.205	.180	.648
3	.831	.177	−.164	.757	.084	.169	.849	−.501	.032	.018	.705	−.415	−.100	−.004
4	.809	.109	.110	.771	−.033	.132	.894	−.610	−.076	−.167	.731	−.627	−.179	.042
5	.857	−.013	.079	.743	−.027	.262	−.202	.404	.080	.764	−.194	.284	−.153	.521
6	.753	.192	.198	.641	.127	.524	−.017	.386	.406	.700	−.102	.376	.395	.595
7	.725	.087	.038	.642	−.014	.391	−.063	.161	.838	.247	−.120	.205	.762	.205
8	.214	.746	.075	.013	.842	.070	.038	.158	.163	.728	−.082	.113	.331	.715
9	.144	.796	.321	.048	.740	.494	.133	.168	.730	.126	.078	.106	.688	.284
10	.013	.835	.434	.033	.852	.340	.887	−.557	.046	−.065	.694	−.599	.143	.014
11	.065	.845	.040	.031	.875	.110	−.478	.833	.168	.208	−.331	.796	.021	.160
12	.235	.635	−.270	.107	.657	.281	.799	−.279	.017	−.186	.585	−.197	−.169	−.268
13	.088	.284	.875	.115	.219	.822	−.445	.900	.228	.317	−.304	.719	.258	.268
14	−.114	.725	.350	−.051	.675	.049	.733	−.041	−.093	−.182	.563	−.002	−.176	−.469
15							.867	−.553	−.018	−.093	.783	−.503	−.021	−.188
16							−.451	.754	.500	.289	−.459	.771	.227	.202
17							−.318	.500	.712	.369	−.369	.439	.605	.152
18							.094	.222	.755	.055	−.080	.098	.774	.153
19							−.443	.881	.449	.323	−.513	.655	.343	.259
20							.296	.752	.222	.351	−.421	.660	.383	.178
Eign.	5.02	3.52	1.16	4.11	3.60	1.06	7.5	3.4	1.8	1.5	2.4	5.5	1.4	1.3
P.V.E.	35.9	25.2	8.3	29.4	25.7	7.6	37.5	16.9	9.1	7.3	12.2	27.6	7.1	6.4

Note. Eign. = Eigenvalue; P.V.E. = Percent Variance Explained.
[a] Tucker's Coefficients of Congruence: Factor 1 r = .99, Factor 2 r = .99, Factor 3 r = .71. [b] Tucker's Coefficients of Congruence: Factor 1 r = .97, Factor 2 r = .98, Factor 3 r = .95, Factor 4 r = .93. [c] Harris et al., 2008.

2007; Corrigan et al., 2003; Fallot, 2007). As in community samples (Harris et al., 2008; Ogden et al., 2011) and in other clinical samples (Mohr et al., 2006, 2010, 2011), positive spiritual functioning is correlated with positive mental health outcomes, and negative spiritual functioning is correlated with poorer mental health outcomes.

One participant wrote a note that they would have rated their interest in discussing spirituality with providers much higher if they did not fear being viewed as "sicker" when talking about spiritual material. Based on previous findings on provider perceptions of spirituality among clients with serious mental illnesses (Huguelet, Mohr, Borras, Gillieron, & Brandt, 2006), this participant's perception is likely accurate.

One of the purposes of this study was to address concerns about the likelihood of unreliable or invalid responding associated with thought disorder and/or delusional symptoms. To address this concern, inconsistent and infrequent response styles were assessed, reliabilities of spirituality measures were computed, and the factor structure of the constellation of spiritual measures administered were analyzed. Ninety percent of the sample scored within normal limits on the measure of infrequent or inconsistent responses, indicating that the majority of outpatients with a serious mental illness can reliably and credibly report on their spirituality. After participants giving grossly inconsistent responses were removed from the analysis, responses from this sample were as consistent as participants from other community and clinical samples. The factors that contributed to inconsistent and noncredible responding in 10% of the sample cannot be determined from this study but likely include symptom severity, cognitive confusion, and limited cooperation from the participant. These results suggest that the majority of outpatient clients managing serious mental illnesses will be able to describe their spiritual preferences to clinicians with as much consistency and accuracy as they can describe other aspects of their personal history.

The factor structure emerging from the spiritual measures was very similar to that found in studies of other samples (Harris et al., 2008). Furthermore, correlations between spiritual measures and both positive and negative mental health outcomes evidenced a very similar pattern as found in nonclinical samples (Harris et al., 2008). These two findings suggest that the manner in which clients managing serious mental illnesses conceptualize and experience their spirituality is consistent with that of the general population.

Limitations

One limitation of this study is its cross-sectional nature. Consequently, it is not possible to draw cause–effect conclusions based on this study. Nine participants were removed because of responses that appeared inconsistent or invalid. Note that these findings are from a sample of people participating in outpatient treatment; it is not clear that they would generalize to inpatient or untreated samples. Although based on sampling procedures, it is clear that participants all had psychotic spectrum disorders such as schizophrenia or bipolar disorder, specific diagnostic data were not collected, so the extent to which these data apply in populations with specific diagnoses are not clear. At the same time, the robust

alphas in our sample suggest that the item responses of such individuals group consistently in ways that are comparable with those observed in community and clinical samples. Follow-up with a longitudinal study, collecting a broader range of demographic variables, as well as data on potential confounding variables, is warranted.

Summary

Despite these limitations, the relationships between spirituality and mental health outcomes found in this study are very similar to those found in other studies of this population (Mohr et al., 2006, 2010, 2011), and the findings on inconsistent/infrequent responding and reliability of responses to measures on spirituality are new and inform our understanding of the quality of self-report data. These findings may be useful in resolving existing controversy about the use of spiritually oriented interventions among people managing serious mental illnesses. The results of this study suggest that the vast majority of such individuals (a) are able to communicate effectively and accurately about their spiritual concerns, and (b) highly value the role of spirituality/religion in their lives. These findings do not lend credence to concerns that individuals managing serious mental illness may have difficulty in giving truly informed consent, or may be harmed because of idiosyncratic interpretations of spiritual content. In contrast, the results of this study indicate that the way clients with a serious mental illness communicate about and experience spiritual concerns is very similar to individuals in other populations who may or may not come to clinical attention. Although further study in this area is clearly necessary, based on these results, most individuals managing a serious mental illness on an outpatient basis could give informed consent for spiritually integrated interventions with the same level of validity as consent to any other types of treatment. Previous studies of spiritually integrated interventions for this population (Kehoe, 1999; Phillips et al., 2002; Revheim et al., 2010; Wong-McDonald, 2007) have found no significant risks for harm with such interventions, and suggest that the possibility that such interventions may be helpful. Given available data, it seems appropriate to pursue further study of spiritually integrated interventions for this population, rather than ruling out this class of interventions based on diagnostic category.

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