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# Spiritual Strengths Assessment in Mental Health Practice

Vincent R. Starnino*, Sachiko Gomi, and Edward R. Canda

*Vincent R. Starnino, LICSW, Ph.D., is an Assistant Professor at Indiana University School of Social Work (IUPUI), where he teaches in the area of mental health. His main area of research focuses on the recovery process from severe mental illness. Vincent has several publications focusing on the role of spirituality in recovery and has presented internationally on the topic. Sachiko Gomi, MA, MSW is a Ph.D. student in the Social Welfare department of the University of Kansas. She has publications in the areas of cultural diversity, spirituality and the holistic approach to social work both in Japan and the USA. Edward R. Canda, MA, MSW, Ph.D., is Professor in the School of Social Welfare of the University of Kansas, USA, and coordinates the online Spiritual Diversity and Social Work Resource Center there (*www.socwel.ku.educanda*). He founded the Society for Spirituality in Social Work, currently co-edits the Council on Social Work Education's (USA)* Religion and Spirituality Clearinghouse*, and has more than 150 publications mostly related to connections between spirituality, cultural diversity, and health and mental health resilience.*

*Correspondence to Vincent R. Starnino, Indiana University, School of Social Work (IUPUI), 902 W. New York Street, Indianapolis, IN 46202, USA. E-mail: *vstarnin@iupui.edu*



## Abstract

Proponents of recovery and strengths-based approaches recognise spirituality as an important factor in mental health recovery. Minimal guidance is available, however, for how to assess spirituality with people diagnosed with severe mental illnesses. To address this gap, six focus group interviews were conducted with a total of forty-eight community mental health service providers and users who have been involved in spiritual strengths assessment. An additional panel of ten international leaders in the strengths case management approach gave feedback on focus group insights in order to expand recommendations congruent with the strengths model. Findings revealed that, while spirituality can be a recovery-related resource for people with severe mental illnesses, some service providers and users experience challenges related to spiritual strengths assessment such as a sense of discomfort about the topic, and uncertainty related to defining spirituality and setting relevant case management goals. This article addresses these and other challenges by offering guidelines for spiritual assessment within the context of the strengths model.

**Keywords:** Assessment, mental health, recovery, spirituality, strengths

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## Introduction

Throughout the past several years, mental health policy makers and service providers in a variety of countries such as Australia, Canada, Denmark, New Zealand (NZ), the UK and the USA have been advocating for mental health systems to become increasingly recovery-oriented (Bonney and Stickley, 2008; Department of Health, 2011; Le Boutillier *et al.*, 2011; President's New Freedom Commission, 2003; Ramon *et al.*, 2007; Tew *et al.*, 2011). Proponents of recovery emphasise that mental health service users, including those diagnosed with severe mental illnesses (SMI), such as major depression, schizophrenia and bipolar disorder, have the potential to live high-quality lives. A goal of recovery-oriented treatment is to help those with SMI to recognise, develop and utilise their strengths and resources through a holistic and empowering working partnership that inspires hope. Strengths may be individually oriented, such as positive character traits (e.g. he makes friends easily) or community-oriented, such as accessing environmental resources (e.g. she has a part-time job).

In particular, research has shown that spirituality can function as an important recovery-related resource for people with SMI (Corrigan *et al.*, 2003; Tepper *et al.*, 2001). In mental health fields, the concept of spirituality typically refers to a person's search for a sense of meaning and connectedness with self and others, including a relationship with aspects of reality viewed as sacred, transcendent or deeply profound (Canda and Furman, 2010; Fallot, 2007; Pargament, 2007). Spirituality is often expressed and experienced in religious communities, which involve shared beliefs, symbols, practices and moral standards that can support spiritual development, encourage healthy lifestyles, and provide support systems and ways of coping with adversity. Empirical studies have linked positive sense of spiritual meaning and religious participation to mental health-promoting qualities, such as engaging in a meaning-making process following an illness experience, developing a sense of hope, enhancing well-being and self-esteem, promoting self-growth and positive emotions (e.g. forgiveness, acceptance), motivating actions towards wellness, decreasing risk behaviours, providing social support (e.g. involvement in a religious community) and to decreased levels of anxiety, depression and substance abuse (Fallot, 2007; Koenig, 2005; Pargament, 2007; Sullivan, 2009).

The Strengths Model (SM) of mental health services for people with SMI has been in wide use for over two decades in the USA and recently has grown internationally, for example, in the UK, NZ, Japan and Hong Kong (Le Boutillier *et al.*, 2011; Rapp and Goscha, 2011). The SM shares themes with the contemporary recovery framework, including a focus on people's personal and environmental strengths and resources. The mental health worker is viewed as a companion or facilitator, who helps individuals to identify their goals, to gain awareness of their strengths and resources, to

develop new ones as needed, and to apply skills for utilising these to enhance recovery. The service user is viewed as the director of the helping process, which is important because people are more motivated when their interests and aspirations are respected. Research on the SM has shown consistent findings indicating symptom reduction and improved social functioning (Barry *et al.*, 2003; Marcias *et al.*, 1997; Rapp and Goscha, 2011; Stanard, 1999). While both the recovery paradigm and the SM recognise the importance of spirituality, mental health literature and surveys of social workers in the UK, USA, NZ and Norway show that many mental health providers remain sceptical and uninformed about its potential value for service users (Canda and Furman, 2010; Fallot, 2007). Further, there is very little guidance for providers about how to assess spirituality with people with SMI (Huguelet *et al.*, 2006).

This article addresses this gap by providing guidelines for spiritual assessment within the context of the SM, based upon the experiences of providers and service users within the mental health field. It identifies issues and barriers that providers and users of mental health services experience in regard to addressing spirituality and it offers recommendations to assist providers. Recommendations are based on findings from focus groups that explored how providers and service users engage spirituality in assessment and the recovery process, and follow-up consultations with leaders of the SM approach who have international experience in research and training. This ensures that the recommendations are rooted realistically in the direct experiences of people within community mental health settings and that they are congruent with SM and recovery principles.

Strengths Assessment (SA) is a tool used in the SM. It is designed to assist the worker and service user to explore collaboratively the variety of strengths and resources that individuals possess or can develop, including past (e.g. 'What have I used in the past to help me through difficult times?') and present (e.g. 'What are my current strengths, talents, community resources that help me reach my goals?'), as well as future desires (e.g. 'What do I want to achieve and how can I build on my strengths and resources to succeed?'). Conducting a SA supports recovery by helping to organise and highlight a person's positive resources, which can 'ultimately lead to the development of goals that are meaningful and important to the person' (Rapp and Goscha, 2011, p. 110).

Originally, SA consisted of six domains including: (i) Daily Living Situation, (ii) Financial/Insurance, (iii) Vocational/Educational, (iv) Social Supports, (v) Health, (vi) Leisure/Recreational (Rapp, 1998). The spirituality domain was added during the past fifteen years, in part due to requests by mental health service users (R. Goscha, personal communication, 12 November 2010; Rapp and Goscha, 2011). The domain was recently named Spirituality/Culture because SM practitioners found that many service users in various countries (such as NZ and Hong Kong (SAR of China)) viewed spirituality as integral to their culture. This paper focuses

specifically on spirituality in the Spirituality/Culture domain. Rapp and Goscha (2011) define spirituality as 'any set of beliefs and/or practices that give a person a sense of hope, comfort, meaning, purpose in their life, or a connection to a greater universe' (Rapp and Goscha, 2011, p. 276). They point out that people may or may not associate it with God, organised religion, individual relationship with a higher power or may not define it specifically. Therefore, SM spiritual strengths assessment (SSA) encompasses the wide variety of possible views of spirituality among individuals, whether they are religious or not, and whether or not they view spirituality as personal or as integral to their culture. For the remainder of this article, the term 'spirituality domain' will be used to represent the spirituality component of the Spirituality/Culture SA domain.

The idea for conducting this study stemmed from the authors' experiences of training mental health service providers on the topic of spiritual diversity during the past three years in the state in which the study was conducted. During these trainings, many practitioners discussed possible benefits of addressing spirituality with people with SMI, challenges they faced and advice for meeting the challenges. This study was conducted in order to gather more detailed information about practitioners' insights in a systematic manner. The perspective of service users was included to provide their insights on what worked or did not work well in SSA. At the time of the study, each participating agency incorporated SA in standard practice protocol. Insights from service providers and service users were then brought to consultations with a panel of SM leaders in order to expand recommendations and ensure fidelity with the SM.

## Methodology

Approval for the study was obtained from the authors' university's human subjects research institutional review board. Six focus groups, including forty-eight participants, were conducted at three community mental health centres in a mid-western state of the USA from April to December 2010. Morgan and Krueger's (1997) focus group research approach was used to guide the entire design. This pragmatic approach combines methods from a variety of qualitative research genres, including but not limited to components of grounded theory specific to focus group research. Pragmatic approaches flexibly integrate various methods to fit research questions and contexts to generate practicable insights (Patton, 2002).

### Interview process

A semi-structured interview guide approach was used (Morgan and Krueger, 1997). The wording of planned questions, probes and follow-up questions was

adapted flexibly in response to actual ensuing conversation. Each group interview lasted approximately two hours. The first and second authors moderated the groups. The main topics covered included: (i) participants' experiences utilising the spirituality domain of the SA, including positive experiences and challenges (e.g. What have been your experiences exploring the spirituality domain of the SA with your clients/service providers?); (ii) recommendations regarding effective strategies for addressing the spirituality domain (e.g. Please give suggestions about questions or strategies that providers can use to more effectively address the spirituality domain). Interviews were audio-recorded with the consent of the participants and later transcribed verbatim.

## Sampling

A purposeful sampling strategy (Morgan and Krueger, 1997) was used for selecting focus group participants. Criteria for participation in the professional focus groups included a mental health professional (aged eighteen and older) (i) employed at a community mental health centre in the north-eastern region of a mid-western state and (ii) who has used SA with people diagnosed with a SMI. Consumer focus group participation criteria included an adult (aged eighteen and older) (i) diagnosed with a SMI who currently uses services at a community mental health centre in the same region as above and (ii) who has used SA with their provider.

## Recruitment procedures and sample characteristics

Directors and supervisors at three regional community mental health centres that utilise the SM assisted in recruiting study participants by distributing a set of flyers, which included a description of the study and criteria for participation. One professional group and one consumer group were formed at each centre, ranging from five to twelve members, for a total of forty-eight participants, including twenty-three professionals (twenty-one case managers and two therapists) and twenty-five consumers. Professionals had an average age of forty-three and 13.8 years of practice experience. Eighteen were female. The most common race was white (twenty), followed by Asian (two) and African American (one). Eight professionals self-identified as Christian (six Protestant, two Catholic), eight as spiritual-but-not-religious and two as neither-spiritual-nor-religious. Five reported adhering to more than one spiritual orientation (e.g. Protestant and Buddhist).

Consumers' average age was forty-eight. Thirteen were female, twenty were white and five were African American. The most common primary diagnosis was bipolar disorder (nine), followed by schizophrenia (six),

schizoaffective disorder (four), major depressive disorder (four), post-traumatic stress disorder (one) and obsessive-compulsive disorder (one). Thirteen self-identified as Christian (nine Protestant, four Catholic), while the remainder identified as spiritual-but-not-religious (seven), Native American Spirituality (one) and Buddhist (one). Finally, two reported adhering to multiple spiritual orientations (e.g. Christian and Wiccan), while one did not specify any particular form of spirituality.

## Data analysis

The constant comparative method, including open and axial coding, were utilised to conduct data analysis. These analytic strategies stem from grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990), but have been adapted to other qualitative research genres, including focus group research (Boeije, 2002; Morgan and Krueger, 1997; Patton, 2002). For each group type (professional and consumer), initial analysis consisted of open coding, in which conceptual labels were created to represent the main ideas portrayed in the data. The first two authors reviewed all transcripts and conducted coding collaboratively in order to reach unanimity of coding. Themes were independently viewed for clarity and completeness by the third author. A final codebook was then used to code all interviews systematically. The next step consisted of a deeper level of analysis which included the formation of higher-level themes (i.e. axial coding). The final analytic step made comparisons among the professional and consumer focus groups to determine similarities and differences. To facilitate comparisons, themes were categorised into summary tables according to participant type (professional and consumer) and mental health agency. Analysis was conducted with assistance of the Atlas.ti computer software.

As Thomas (2003) points out, qualitative data analysis commonly 'is determined by both the research objectives (deductive) and multiple readings and interpretations of the raw data (inductive)' (Thomas, 2003, p. 3). This study emphasised an inductive approach to form codes and group codes into themes, meaning that themes emerged from raw data as discovered in the transcripts. However, the analysis was influenced by deductive thinking. An example is the theme 'goal setting'. Although this theme emerged through an inductive process (discovered in the raw data), the authors' goal to explore strengths-based SSA influenced their recognition of consumer-focused goal-setting as relevant to SM.

Upon completion of the focus group analysis, a summary of focus group insights was presented to a consultant panel of SM leaders (including ten internationally active scholars, researchers and lead trainers) from a university-affiliated SM centre (located at the University of Kansas, School of Social Welfare) that originated and publishes extensively on the SM, currently implements SM, trains practitioners, and studies fidelity

with and outcomes of SM. During two separate meetings of about one to one and one half hours each, consultants engaged in detailed reflection and discussion about the focus group participants' ideas in relation to the standards of the SM. Hand-written notes were taken at each meeting. The authors converged insights from focus groups and the consultant panel into a set of recommendations for SSA. The flowchart in Figure 1 illustrates the link between interviewing, focus group analysis, consultant panel feedback and practice recommendations.

## Findings

Findings are organised in two major sections. The first addresses focus groups' insights about the relevance of spirituality to SM practice and challenges related to SSA. The second presents recommendations for SSA based on the collective wisdom of professionals and consumers (i.e. focus groups) and the SM consultant panel. Subheadings reflect the major themes that emerged from analysis. Each distinct insight was included in findings regardless of the number of people who commented about each. More detail is given regarding themes that were mentioned by several participants across the focus groups.

### Focus group insights

#### *Relevance of spirituality*

Focus group participants described ways in which spirituality can serve as a strength. Consumer participants, for example, stated that they relied upon spirituality to help them grow, cope with daily life and major losses, increase self-esteem, deal with substance abuse issues, increase social support and become more motivated about life.

Professional participants added that some service users draw upon spirituality to experience positive emotions such as thankfulness and gratitude, to manage symptoms (e.g. praying or meditating to reduce anxiety) and to protect against suicidal ideation.

#### *Challenges related to spiritual strengths assessment*

Professionals were more apt than consumer participants to focus on challenges in assessing spirituality. Three types of challenges were discussed.

*General challenges in discussing spirituality*. Several professional participants expressed that service users are sometimes resistant to discussing spirituality, especially when initially entering into services. Reasons include

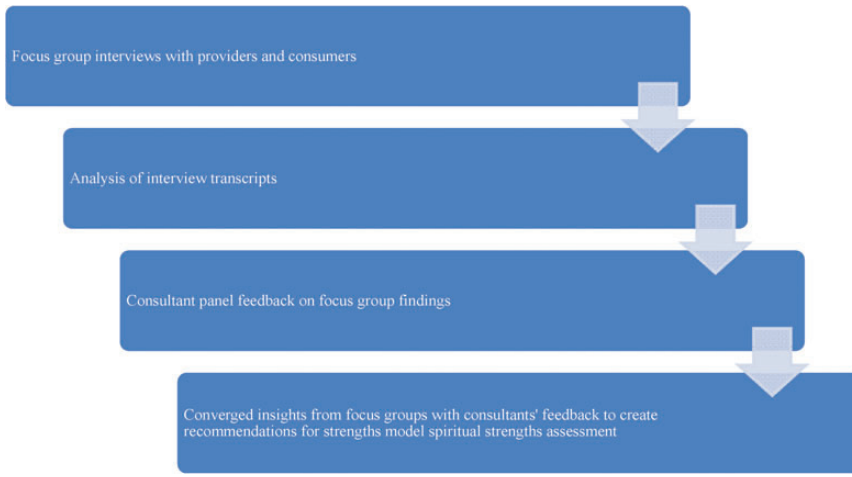


**Figure 1** Stages of Study

service users carrying guilt (e.g. related to not living up to expectations from religious upbringing), feeling disillusioned (e.g. interpreting mental illness as abandonment by God) and having received negative responses from past providers (e.g. told not to discuss spiritual beliefs). Professional participants also mentioned that some service users may perceive spirituality as 'too personal' to discuss with a provider, especially if a trusting therapeutic relationship is not significantly developed. Likewise, a few consumer participants said that some service users might view spirituality as 'a private matter', while some might carry guilt from their religious upbringing or have experienced stigma from a religious community.

Professional participants also spoke about general challenges that mental health providers might experience. Consumer participants did not comment about this. Professionals said that providers might experience a sense of inadequacy or discomfort with spirituality, which could impede their ability to address the topic effectively with service users. For example, several expressed uncertainty about how to ask people about their spirituality. Several mentioned feeling inadequate when encountering service users who hold beliefs that are vastly different from their own. As one said, 'the challenging part of it for me is when I'm talking to clients who have a different religious belief than I do, that I don't have any experience or knowledge about'. Professionals mentioned discomfort due to gaps in their professional training background. One professional stated 'In our education we've been taught to kind of steer away from that topic'. Some mentioned that spirituality feels too personal to discuss with service users; for example, 'I almost feel like it's unfair of me to be asking them these kinds of intrusive personal questions . . . when I'm not willing to disclose'.

Other challenges include a consumer participant who mentioned their spirituality and mental illness intersecting with one another (e.g. obsessive-compulsive disorder connecting with 'intrusive blasphemous thoughts') and a professional participant who expressed concern about an individual who felt obligated to tithe an amount of money higher than she could afford.

*Challenges defining spirituality.* Several professional participants mentioned that some service users may lack understanding about what the provider means by spirituality, because the term has different meanings to different people or is too abstract. For example, 'everything else [in the SA] is so concrete but that one [spirituality domain], you have so many different aspects you can talk about, and there is a confusion between spirituality and religion'. Several professionals mentioned struggling when service users' definition of spirituality was closely tied to a religious activity (e.g. church attendance), since they viewed this as too narrow.

Two consumer participants spoke about issues related to defining spirituality. One said that some service users might have difficulty knowing what the provider is asking of them due to spirituality being a 'vague' concept. Another, who had an emotionally painful past history with the religious tradition of her upbringing, spoke about the possibility of feeling limited through understanding spirituality strictly in terms of a religious tradition.

*Challenges with goal setting.* Several professional participants mentioned challenges assisting individuals in formulating goals around spirituality. Some suggested that service users might have greater difficulty formulating goals in the spirituality domain, as opposed to other life domains that address more concrete needs (e.g. daily living, finances, health and housing). One challenge had to do with providers' uncertainty about how to ask individuals about spiritually related goals. As one put it, 'What do you say? "Do you have any spiritual goals?" ... I said something similar to that and kind of hit a brick wall with the client'. Additional concerns include service users setting goals that the provider views as having a 'narrow' focus (e.g. 'the goal itself ends up being belonging to a church') or as being problematic (e.g. a service user wanted to paint a spiritual symbol on the floor of a rented apartment without the landlord's consent). Some professionals expressed confusion about their expected role in assisting individuals with their spiritually related goals (e.g. providing transportation for someone who wants to visit a religious service). Some expressed uncertainty about how to document work focused on spiritually related goals. Interestingly, a majority of professional participants who mentioned experiencing goal-related challenges were from one focus group at one agency, suggesting that the agency context might be affecting the experience of practitioners addressing spirituality.

Two consumer participants mentioned goal-related challenges. These connected to feeling pressured by providers to translate spirituality into concrete 'measurable goals' and that are 'billable'.

## Recommendations for spiritual strengths assessment

The following is a summary of practice recommendations developed from the focus group findings and consultant feedback. Recommendations reflect agreement between focus group participants and the consultant panel, with consultants expanding on participant insights in relation to fidelity with the SM approach. Descriptors are included below to help clarify participant and consultant input.

### *Utilise a person-centred approach*

Study participants and consultants agreed that providers should utilise a person-centred approach when assessing spirituality. This includes relating to service users that spirituality is 'a permissible subject'; 'letting the client lead' the discussion; being 'non-judgemental'; along with 'valuing' and 'engaging' with people around their spirituality.

### *Support person's strengths*

Participants and consultants uniformly stated that providers should be supportive of a person's strengths around spirituality. This includes tapping their spiritually related resources. For example, a consumer participant mentioned 'It was like a boost' when his provider consistently expressed interest in his involvement in Alcoholics Anonymous, including the spiritual aspects.

### *Engage in natural conversation*

Several participants mentioned that discussion of spirituality should take place in a natural flow of conversation at the service user's own pace as opposed to utilising a questionnaire-like approach. This was reinforced by consultants who explained that those for whom spirituality is important will often spontaneously mention it in the context of talking about their life and what helps them to recover. Consultants pointed out that themes related to spirituality (e.g. meaning, purpose, connectedness, the sacred, involvement in religious communities) can arise during conversation about any domain in the SA, even when words such as spirituality, religion or faith are not used.

### *Use a flexible and individualised approach*

Participants and consultants recommended that providers utilise a flexible and individualised approach for addressing spirituality. This is important

because service users have diverse characteristics and life situations, and come with a wide range of spiritual belief systems, including religious and non-religious. Also, individuals vary in their level of openness to discussing the topic. A consumer explained: 'There're inappropriate times for it [discussion of spirituality] and different times of recovery and different people with different viewpoints on it, so just understand the person.'

### *Consider person's priorities*

Participants and consultants mentioned that many people enter services with a variety of practical and psychological needs (e.g. housing, financial issues, safety, crisis) and therefore, for some, it may be necessary to address these needs adequately before jumping into in-depth discussion about spirituality. A consumer participant explains:

> A lot of times when we first come and get involved with [name of agency] here, we're under a lot of crisis . . . so spirituality's pretty much on the back burner . . . . There's a lot of things that have to be done in order just to get us into condition to where we can even attend groups with a little bit of focus . . . .

Consultants reminded that this is not always the case, however, as concrete and psychological needs may be fused with spirituality for some. For example, a person might rely on food pantry services provided by a religious congregation or might meditate to deal with anxiety symptoms. Such individuals might desire to explore spirituality in depth with a provider at the start of services.

### *Assess person's readiness*

Participants and consultants agreed that providers need to assess a person's readiness and type of interest in regard to the spirituality domain. For example, a consumer participant recounted sharing with a provider his interest in joining a church similar to one that he was part of in the past. He reports feeling 'pressured', however, when his provider repeatedly probed whether he had taken action. Consultants added that providers should also be cautious about the readiness of people experiencing extreme emotional states or mental illness-related challenges. For example, individuals might receive little benefit from engaging in a deep discussion about spirituality with a provider when experiencing intense psychotic symptoms. Finally, providers need to respect the wishes of those who have little or no interest in discussing spirituality.

### *Develop a trusting therapeutic relationship*

Participants and consultants emphasised that, for many service users, a prerequisite for engaging in discussion about spirituality is a trusting therapeutic relationship. A professional explained:

> I tend to find when it comes to the spirituality domain, that initially most clients are not honest and not open but as you view it and update it, they'll get a feel for the case manager more and they will share it with you.

Participants and consultants mentioned provider traits such as being 'warm', 'listening' and 'understanding' are conducive for gaining trust. Consumer participants discussed the importance of 'consistency' of the therapeutic relationship, mentioning high turnover among staff as a barrier to developing trust.

### *Explore past difficulties around spirituality*

Participants emphasised that providers can assist service users by exploring past difficulties related to spirituality, such as unwarranted guilt, stigma or disillusionment. This can be especially beneficial for those whose painful past experiences prevent them from reaching current life goals. A professional explained: 'I think people have been hurt so much in that they've shut down. And I end up doing a lot of validating.' Consultants added that providers could begin by learning about a person's spiritual history including upbringing, spiritual practices and transition points. Also, before engaging in an in-depth exploration of a person's negative past spiritual experiences, it is recommended that the therapeutic relationship be adequately developed and that a person is not in an excessively vulnerable state. Finally, it is important that service users themselves desire to engage in such a discussion with a clear understanding of its relevancy to the recovery process.

### *Strategies for dealing with defining spirituality*

Participants and consultants agreed that service users should take the lead in defining spirituality whenever possible. Consultants mentioned that the provider's role is primarily to seek understanding of the person's frame of reference rather than attempting to impose the provider's beliefs and terminology. Also, the provider's focus should be on the function and results of people's engaging with spirituality and religion as relevant to their beliefs and recovery goals, rather than making assumptions or personal judgements. For example, an individual who defines spirituality as 'going to church' might benefit by increasing his or her social network within a congregation. Additionally, a person who defines spirituality as a personal

endeavour that includes 'connecting to the universe' might obtain an increased sense of self-worth and comfort through meditation or spending time in nature.

Professional participants recommended the following approaches for use in situations in which a service user expresses uncertainty about what spirituality is and requests an explanation from the provider. First, providers could help draw connections between a person's spirituality and things they are already doing in their lives. A professional participant explains:

> Maybe it's artwork that they do that they [service users] lose themselves in. Maybe it is exercise. Maybe it's just going for a walk in nature . . . I think it just goes back to a basic education where we teach them 'This really *is* a spiritual part of your life'.

Second, to open the conversation, providers could share a definition if a service user would find it useful. A professional offered the following definition: 'It [spirituality] has to do with what has value and meaning to you, or what are the things that motivate you to be the best person you can. And to move toward a goal that is beyond yourself.' Consultants added that providers should use a tentative definition of spirituality that is consistent with professional ethical standards. For example, the SM definition of spirituality given by Rapp and Goscha (2011), explained earlier, could be offered. Or a more detailed definition could be adapted, such as that of Canda and Furman (2010), similar to that mentioned in the introduction, based on respect for self-determination and human diversity. The provider should convey that a tentative definition is meant to open conversation to discover and utilise the service user's own understanding of spirituality. The provider follows the service user's lead and terminology in ensuing conversations.

### *Goal-related practice principles*

The following practice principles were recommended by study participants and consultants for helping individuals identify and enact their spiritually related goals: (i) support person in formulating spiritually related goals, (ii) assist person in linking their spiritual resources to treatment goals and recovery efforts and (iii) facilitate person in their efforts to expand upon and pursue their spiritually related goals.

*Support formulating spiritually related goals*. Participants and consultants pointed out that service users should take on the primary role of formulating spiritually related goals (unless, of course, it involves immanent risk of harm to self or others). A professional participant gave an example of supporting the goal of a Mormon client who expressed a desire to go on a mission trip:

> I felt like once I got to a point where I understood how much meaning that had for him and the support he got from the church, it just seemed like the relationship grew from there because he was willing to talk to me about stuff.

Consultants commented that individuals are most motivated when they identify goals in which they are highly interested. Also, such an approach honours the ethical standard of client self-determination. The provider's role, therefore, is primarily to support people in both the exploration process (by being curious and asking questions) and in the pursuit of their goals.

Consultants added that some people will have difficulty identifying spiritually related goals despite receiving a provider's support, especially during early sessions. In this case, providers can revisit the topic at a later time to see whether anything has changed, as some individuals will develop a clearer picture of spiritually related goals as they become more comfortable with their provider. It is important that providers allow service users to come up with goals at their own pace and to change them when needed. For those who express no interest in spirituality, the spirituality domain can remain blank when conducting a SA.

*Assist linking spirituality to recovery*. Participants and consultants emphasised that spirituality can be identified as a resource for accomplishing a variety of recovery-related goals. A consumer participant explained how a provider helped make this link: 'She just asked me these questions about how I want to implement part of my spirituality in my recovery.' Several participants discussed service users who might wish to increase social supports by joining a spiritual community. In such situations, the provider could assist the person in linking interest in attending a weekly service or ceremony to increasing her or his social network. Another example would be an individual who expresses a desire to pray or meditate more because it is something that helps them manage symptoms or experience a sense of well-being.

*Facilitate efforts to expand upon and pursue spiritually related goals*. Participants and consultants mentioned that providers could explore ways in which service users can expand upon their spiritual interests. A consumer study participant, for example, reported it being helpful when his provider encouraged him to borrow spiritual books from a local library. Through continued reading, he was able to engage in a self-growth process which had a positive impact on his recovery. Key factors for success included the provider using the service user's existing spiritual framework as a starting point and having ongoing open communication about the topic.

In addition to assisting people in expanding their spiritual interests, providers can play a role helping individuals pursue their spiritually related goals. Some people might benefit from receiving encouragement, especially during the early phase in which they are beginning to take action. A consumer focus group participant who practises Wiccan spirituality explained:

> I have an online business where I sell oils and incense that I make myself for Wicca. And so I would work on my business while she [provider] would do some of her work. And she would keep me goal-oriented and motivated to work on my business.

## Discussion

Study participants revealed ways that spirituality can function as a recovery-related strength which are consistent with recent research reviewed in the introduction. It is also congruent with the increasing use of spiritually related mental health treatments, such as mindfulness training and spiritual support groups (Baer, 2006; Lindgren and Coursey, 1995; Wong-McDonald, 2007) as well as an international trend towards holistic and spiritually attuned social work practice (e.g. Canda and Furman, 2010; Crisp, 2010; Gardner, 2011; Lee, 2009).

Spiritually related struggles mentioned in this study are very similar to those mentioned by other scholars (e.g. guilt, stigma, disillusionment; Fallot, 2007; Koenig, 2005; Miller and Kelley, 2005; Pargament, 2007). This study contributes by offering suggestions for how practitioners could address spiritual struggles in the context of conducting SSA. This is especially important for service users whose recovery process remains stuck due to negative past experiences.

This study adds new information about challenges that providers experience around SSA including a sense of discomfort and inadequacy, and uncertainties related to defining spirituality and helping individuals set goals connected with the spiritual domain. The ten recommendations offer guidance for practitioners which can lead to a greater comfort and self-efficacy addressing the topic. In regard to definitional challenges, a key finding is that some professionals viewed service users' understanding of spirituality as lacking due to difficulty thinking abstractly or to defining spirituality strictly within a religious framework. Previous literature has noted the possibility of a disconnect between helping professionals and service users' views of spirituality and religion. One reason, depending on level of secularisation in various countries, may be due to a higher rate of professionals claiming to be spiritual-but-not-religious, while a majority of service users identify themselves as religious (Canda and Furman, 2010; Smith and Orlinsky, 2004; Wong and Vinsky, 2009). Another may be that professionals are more concerned about possible exacerbation of mental illness symptoms (Fallot, 2007). Definitional issues are important to address because confusion in this area risks creating a communication barrier. Consumer focus group participants were especially adamant that they are more likely to respond positively to providers whom they perceive as respectful, open and validating of their spiritual perspectives. SM consultants echoed this viewpoint, culminating in a recommendation that providers make strong efforts to emphasise service users' terms, definitions, priorities and life experiences related to spirituality. This approach is consistent with the recovery paradigm (Jacobson, 2004; Ramon *et al.*, 2007).

This study reveals that some practitioners experience challenges with goal setting specific to spirituality. This study offers insights into how

practitioners could assist individuals in formulating spiritually related goals, linking their spiritual goals to the recovery process, and taking action towards accomplishing spiritual goals.

There is high congruence between this study's recommendations for SSA and SM principles. Rapp and Goscha (2011), for example, recommend that practitioners conduct SA through engaging in natural conversation. They also recommend utilising an individualised approach. This includes recognising recovery as a journey in which people are at various stages of readiness for change. SM authors view the development of a trusting therapeutic relationship as necessary for utilising the SA tool effectively.

A high level of congruence was expected considering that the current study included participants and consultants who are immersed in the SM. It was important, however, to determine to what extent SM principles might apply to SSA because the spirituality domain is a relatively recent addition to the SA, and practitioners expressed uncertainty about how to address spirituality during trainings conducted by the authors on the topic.

## Limitations and areas for further research

This study was designed to generate insights and recommendations about conducting SSA in mental health settings. The opinions of focus group participants and SM consultants are not intended to be representative of the views of larger groups of practitioners or service users.

However, in order to support the criterion of transferability (i.e. theoretical and practical relevance beyond the study context) for qualitative research findings (Patton, 2002), insights from service users and providers with direct experience of SSA within SM were linked to consultation with internationally engaged leaders in the SM approach and to the larger body of international literature on spirituality in mental health. This process generated a set of recommendations with examples rooted realistically in mental health settings, so that practitioners can evaluate the usability of the recommendations and adapt them to their own settings. Future research could study the implementation and adaptation of these recommendations in a wide variety of communities so that more locality and culture-specific recommendations could be developed. This is consistent with guidelines for the SM, for recovery practice and for spiritually sensitive and culturally appropriate practice (e.g. Canda and Furman, 2010; Crisp, 2010; Gardner, 2011; Lee *et al.*, 2009; Rapp and Goscha, 2011).

A criterion for participation in this study was that participants had experience utilising the spirituality domain of the SA. Therefore, those who joined were likely motivated by a high interest in spirituality. Future research examining the relevance and impact of SSA for practitioners and service users who consider themselves non-spiritual or non-religious is needed.

An interesting finding included differences between professional and consumer focus group participants in describing their experience related to SSA. Consumer participants identified some challenges but were more apt to focus on spiritually related strengths. Professional participants, meanwhile, put a higher emphasis on challenges related to the SSA process. A possible explanation is that service users are more likely to be comfortable with where they are at or where they want to go in regard to their spirituality, whereas providers tend to focus on what needs to change, including possible symptoms of mental illness, in order for individuals to move forward. Another possibility is that some providers may tend to under-value people's spiritual resources, perhaps partly due to differences in how providers and service users conceptualise spirituality. Further research is needed in this area. Also, professional study participants at one agency gave disproportionately high mention of experiencing challenges conducting SSA, especially in the area of helping individuals with spiritually related goals. Consumer focus group participants at this agency, meanwhile, were similar to other agencies in emphasising strengths rather than challenges. Further research is needed to determine to what extent agency context (such as policies, procedures and training opportunities regarding spiritual diversity or lack thereof) serves as a barrier or facilitating factor for practitioners interested in conducting SSA.

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