CHAPTER 12

SPIRITUAL AND RELIGIOUS DIMENSIONS OF MENTAL ILLNESS RECOVERY NARRATIVES[1]

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Theorists in many fields of inquiry have examined the importance of narrative in structuring human experience. Philosophers of religion (Crites, 1971), theologians (Goldberg, 1982), personality theorists (McAdams, 1993), psychoanalysts (Spence, 1982; Schafer, 1983), and psychiatric rehabilitation specialists (Harris and others, 1997), among others, have demonstrated the many ways in which stories may provide coherence, meaning, and direction to self-understanding. McAdams (1993) claims that each of us "naturally constructs [a story] to bring together the different parts of ourselves and our lives into a purposeful and convincing whole" (p. 13). In the last decade, this line of thinking has come to include the stories people tell of their experiences with illness and suffering: their "illness narratives" (Kleinman, 1988; Frank, 1995). Focusing on the spiritual and religious dimensions of stories, this chapter explores a narrative approach to the experiences of people who have been diagnosed with severe mental illness and discusses the roles such stories may play in recovery.

The stories people tell about their lives call attention to the need to make sense of—to discover or construct meaning in response to—life events and circumstances. Personal narratives have the power not only to disclose the individual's core values and implicit philosophies but to shape ongoing life activities—to open up some possibilities and to constrict others. For instance, if a particular story, overtly or covertly, prioritizes constancy and minimizes change, the individual's motivation for maintaining stability may be paramount, and exploring alternatives may be correspondingly foreshortened.

Like all stories, personal narratives may be viewed through the lens of literary criticism. Theme, plot and subplot, characterization, activity, tone, movement, and voice are among the listener's descriptive and interpretive tools. Frank (1995), writing primarily about chronic physical illnesses, offers a typology of illness narratives. *Restitution* narratives, he claims, convey a central movement motif—from a state of health through one of illness to restored well-being. In distinct contrast, *chaos*

narratives lack clear, linear movement. They are more reactive to momentary stress than they are reflective; they hold little hope that life will get better. Finally, Frank notes, is the *quest* narrative—the type most commonly seen in published illness stories. Here the teller accepts the illness and holds to the belief that something may be gained through its experience. The illness becomes the occasion for discovering and enacting some purpose on the quest.

Led by consumers, the mental health field has come, in the last decade, to place increasing emphasis on the concept of recovery (Anthony, 1993; Spaniol, Koehler, & Hutchinson, 1994). In fact, many of the writings by consumers (Cooke, 1997; Deegan, 1988; Unzicker, 1989) spurring this new emphasis may be thought of *as recovery narratives*. By this I mean that writers often frame their personal stories of mental illness, its impact, and its aftermath in recovery terms; they acknowledge both the reality of mental illness and its effects, yet develop a sense of meaning and direction that supports their moving beyond the limitations imposed by the illness and by societal responses to it. Recovery, in this context, involves narrative themes of challenge and hope, of stigma and assertiveness, of limitations and new possibilities, of struggle and empowerment.

Published recovery narratives in mental illness have drawn primarily, then, on elements of Frank's quest narratives, whereas restitution and times of acknowledged chaos are secondary. The reality of most persistent and recurring mental illnesses is a cyclical one that "complicates enormously the problem of establishing new identities, new purposes, and new meanings" (Hatfield & Lefley, 1993, p. 186), as well as new personal narratives. When the very illness around which recovery is sought may function to disturb mood or to cloud cognitive clarity, the process of consistent meaning-making is itself at risk. So it becomes all the more important for many consumers to weave a self-story encompassing disruption, stability, and growth.

From this perspective, mental illness recovery narratives reflect a particular set of values and related motifs that place the individual in relationship to her or his immediate and larger contexts. They provide a general orienting system in which specific coping techniques may find particular salience. Because of this overarching function of recovery narratives, religious and spiritual themes may be of great importance for many individuals. Spiritual commitments may dispose people to make sense of their experience in ways consistent with their religious beliefs, to draw on religious resources for both more general and more specific coping (Pargament, 1997), and to construct further narrative development so that they take spiritual realities into consideration. So, although recovery narratives may serve as coping mechanisms for dealing with

the stressors related to mental illness, they do so primarily by offering a more comprehensive scheme for understanding, adapting to, and overcoming the challenges of severe mental disorders—a scheme that for many individuals includes religious and spiritual dimensions.

This is not to say, of course, that spirituality always plays a positive role in these narratives and in their associated coping styles. Religious and spiritual concerns may become part of the problem as well as part of the recovery. Some people have experienced organized religion, for example, as a source of pain or guilt or oppression. Rather than being a positive resource for recovery, religion in this sense may merely deepen and complicate the need for recovery. Alongside those who experience the faith community as welcoming and hospitable are those who find it stigmatizing and rejecting. Alongside those who feel uplifted by spiritual activities are those who feel burdened by them. And alongside those who find comfort and strength in religiousness are those who find disappointment and demoralization. Given the relative neglect of religious issues in the mental health field, however, and given a history of overemphasis on the difficulties associated with religion, it is important to see that for many people with severe mental illnesses, spirituality is a core element in the narrative context for recovery.

Key Religious and Spiritual Themes in Recovery Narratives

In spiritual discussion groups, psychotherapy sessions, consumer satisfaction interviews, trauma recovery groups, clinical interviews, and numerous consultations at Community Connections, individuals have shared parts of their personal recovery stories. Before turning to certain themes distilled from these interactions, it is important to indicate some of the characteristics of these consumers. Consumers at Community Connections have all been diagnosed with a severe mental illness at one time. They are predominantly African American and largely identify themselves as Christians, mostly Protestant. Significant histories of substance abuse, physical and sexual abuse, homelessness, and poverty are also prevalent in this inner-city population. Recovery in this setting is thus not focused only on the experience of mental illness but is a multidimensional process that responds to broadly based experiences of marginalization and victimization.

Theme One: Whole-Person Recovery Takes Whole-Person Involvement. For many people, recovery narratives may draw on a somewhat paradoxical image of spirituality: it is at once the most profound center of one's life and the most encompassing whole. In a survey at Commu-

nity Connections, nearly half of the participants agreed or strongly agreed with this statement: "My whole approach to life is based on religion" (Fallot & Azrin, 1995). This sort of affirmation—that spirituality lies at the heart of recovery and that it forms the basis for other dimensions of growth—is common. It may be rooted in the beliefs and rituals of organized religion, in twelve-step programs that emphasize the centrality of a higher power, or in a personal conviction that the self is most clearly defined by its spiritual expression. But whatever its foundation, *spirituality* as the core of identity stands as a sharp contrast and frequent antidote to *mental illness* as a core identity. People who incorporate in their recovery an understanding of themselves as children of God or as being an integral part of the larger world often adopt a more positive and hopeful tone about their place and roles in the community.

When consumers say, then, that "spirituality has been the most important part of my recovery," they are often referring to this whole-person orientation. Usually such comments are not intended to minimize the value of psychiatric medications nor of psychotherapeutic relationships nor of other rehabilitative supports. But they do claim a holism that points beyond the biopsychosocial dimensions to an ultimate source of meaning and identity.

Theme Two: True Recovery Is a Long-Term and Often Effortful Journey. Many religious traditions and spiritual movements offer avenues to healing. The image of spiritual growth as a journey or pilgrimage is a prominent one. Recovery narratives drawing on this theme differ significantly from those calling for a quick and all-encompassing solution to the problems attending mental illness. One spiritual discussion group, for instance, explored the distinctions between *magic* and *healing*. Some individuals held out hope for a "magic pill" or life-transforming moment that would relieve them of their struggles, whereas others talked about their own experiences with healing and recovery as a journey that requires considerable time and effort. The latter group strongly opposed the notion that some human or divine intervention would instantly change their lives. Rather, they emphasized their own responsibility and activity while simultaneously drawing on the sustenance of divine support. This stance, they claimed, led to greater fulfillment and less disappointment than passively waiting for miracles.

Theme Three: Hope Is an Essential Ingredient for Continuing Recovery. The recurrent nature of most severe mental disorders is often demoralizing for consumers, families, friends, and professionals. Given such cyclical problems, the maintenance of a hopeful position is diffi-

cult. Yet, according to many consumers, it is also essential to sustained recovery. Spirituality and religion are prime resources for hope. Some consumers build hopeful elements of their recovery narratives around beliefs in God and God's benevolence ("God's purposes are for the best" or "God will never give me more than I can handle" or "God wants the best for my life"). Christians reported drawing on scriptural stories of hope in the face of apparently overwhelming obstacles (the account of God's deliverance of the Hebrew people from Egypt, for example). The idea of a force in the universe that is allied with good and opposed to evil was voiced by some individuals who did not see themselves as connected to organized religion. Being in tune with this positive power then became a reason for hopefulness.

Many recovery narratives struggle with the difference between realistic hope and blind optimism. More realistically hopeful stories acknowledge the difficulties posed by mental illness and by societal responses to it but find hope in spite of these problems. Other narratives minimized or deny them, asserting that all will somehow work out for the best. Spiritual and religious dimensions of hope, then, place it in its ultimate context of divine or universal purposes. Personal narratives may draw on this ultimacy to sustain hope necessary for the journey.

Theme Four: Recovery Depends on the Experience of Loving Relationships. Many stories include the importance of divine love in strengthening and sustaining recovery. This experience of relationship with God, often nurtured in religious practice, may have affirming and valuing motifs—that God truly cares for each person as an individual and that God is deeply interested in each person's welfare. When a personal God-image is less prominent, a sacred quality of love may still be acknowledged. Some research has supported the idea that relationships with "divine others" may be related to psychological aspects of well-being (Pollner, 1989). In qualitative terms, stories that describe the self as strengthened by this relationship seem to involve greater confidence, capacity to tolerate stress, and willingness to take initiative. One woman talked about how her relationship with God had given her inner strength so that she could face more directly the pain of her trauma history and mental illness.

Some recovery narratives give a prominent place to reciprocal caring; one must give as well as receive love in order to feel whole. One man described his struggles, for example, with the idea of loving your enemies. This was hardly an abstract concern for him, as it directly affected how he chose to handle conflicts with roommates and other acquaintances. How tolerant or how confrontational should he be? Other

people recounted the vitalizing importance of caring for their children. Especially when such care had been disrupted by psychiatric or substance abuse problems, recovery of these connections focused not simply on renewed contact with their children but on re-establishing ongoing loving relationships. For many consumers, the love found in human relationships is a reflection of the sacred—a further expression of divine love. For others, it is a primary animating force, giving direction and purpose to daily life.

Theme Five: The "Serenity Prayer" Expresses a Key Process in Recovery. It is perhaps not surprising in a population with extensive substance abuse and twelve-step experience that Reinhold Niebuhr's ([1943] 1980) "Serenity Prayer" should have a prominent place in many recovery narratives: "God, give us grace to accept with serenity the things that cannot be changed, the courage to change the things which should be changed, and the wisdom to distinguish the one from the other" (p. 823). Yet the images involved in this prayer are by no means limited in applicability to those with addictive disorders. When applied to coping with the apparent vagaries of mental illness, disability, societal stigma, and discrimination, such wisdom is indeed highly valued. Many consumers have built some version of this sentiment into their spiritual understanding and practice. Each phrase has a unique part to play in recovery.

Simply deciding which goal to pursue or which problem to address is daunting for many individuals with mental disorders. Choosing to focus on those over which the individual has or can develop greater control is often portrayed as a key step in recovery. Having devoted too much effort to attempts to change other people or to meet unrealistic expectations or to conquer psychiatric symptoms by using will power, consumers here describe the tremendous relief, hopefulness, and confidence that may grow from identifying goals over which they can exert at least some significant control. Rather than feeling aimless in their recovery attempts, they feel an enhanced ability to channel energy toward arenas in which their efforts are likely to make a difference. So the "wisdom to know the difference" is often recognized as a turning point in recovery stories.

Second, many consumers recount their attempts to accept aspects of their lives that cannot be changed. Most commonly, the stories of their personal, sometimes painful, pasts pose special challenges in this regard. Some expressions capture specific, religiously framed variations of this process: "Letting go and letting God" or "I turned that over [to God]" or "I left that in God's hands." Others rely on twelve-step acknowledgments of powerlessness and reliance on a higher power than the self. There may be struggles around the apparent intractability of

the consumer's problems. In some recovery narratives, the ability to accept periodic symptoms without accepting the demoralizing idea of begin chronically and permanently disabled led to significantly greater motivation. Recognizing that the acknowledgment of their mental illness did not require them to renounce meaningful life goals was in fact energizing rather than depleting.

Finally, the "courage to change the things I can" takes on special significance in many recovery stories. The importance of developing assertiveness and the experience of empowerment can hardly be overstated in this context. Empowerment is both the central value and central goal of the recovery movement for many consumers. Developing or renewing a sense of power in solving personal problems and pursuing meaningful life goals is a corollary of this principle. Mental illness recovery stories often highlight learnings around symptom management, including the importance of medication, ways to minimize intrusive thoughts or hallucinations, and methods for coping with identified stressors. Developing and enhancing skills in interpersonal, educational, or vocational domains contribute to a sense of empowerment, as does the ability to define one's own needs and hopes and actively seek to fulfill them. Consumers report that having a more effective voice and becoming an active collaborator in their own service planning and evaluation is often one of the main shifts toward greater personal strength. Many understand this empowerment in terms that reflect spiritual or religious convictions in addition to any psychosocial ones. The divine or sacred can be a resounding source of personal power, which can be expressed as follows: being uplifted or given courage, feeling valued enough not to settle for less than one deserves, being freed to follow one's own life course, and cultivating the belief that God wants each person to live a life of abundant wholeness.

Yet empowerment to change what can be changed may include not only immediate personal and interpersonal spheres but public and political ones as well. Although for many consumers this is a secularly informed concern, for many others it has distinctly religious and spiritual meanings. Some consumers talk of their involvement in advocacy or in public policy (as well as in personal choices) as a *mission* or a *vocation*. Both of these terms may carry traditional religious implications. The consumer's story is being allied with a larger sacred story, and his or her purpose is being allied with larger, often divinely construed, purposes. This is precisely where some mental health professionals become skeptical about the use of religious language. For example, does talking about "doing God's will" necessarily point to some delusional process? Only a careful assessment of the meaning of such language—

both in that individual's overall functioning and in any relevant faith community context—can provide answers to this question. But for many people with severe mental illnesses, such a claim does not differ from that made in spiritual or religious contexts by innumerable believers. Their faith entails developing a sense of their unique role (a calling, perhaps) in bringing into reality certain core values.

It is certainly true that for some individuals the "Serenity Prayer" is useful primarily as a cognitive-behavioral framing; it serves to distinguish the controllable from the inevitable and to focus change efforts in the most potentially responsive arenas. For many others, however, the fact that it is offered as a prayer is essential to its power. Its petitionary form places the serenity, courage, and wisdom sought in the context of the individual's relationship with God (and often that of a faith community as well). For believers, this is especially relevant. Bringing such fundamental requests to God acknowledges in process what is stated in content: that these virtues may not be entirely at the individual's disposal and that they may be more properly experienced as gifts than as achievements.

Theme Six: Recovery Is a Journey Toward Genuineness and Authenticity. One of Frank's (1995) primary interpretive categories for illness narratives is the extent to which the teller's unique voice finds clear expression. In the accounts of people recovering from mental illness, this experience is also central and often enormously complex. Many metaphors reflect this process: discovering—or rediscovering—one's "true self"; feeling that one is "centered" or "grounded"; recognizing moments when action emerges from what is "really me" or truly "spontaneous"; becoming more regularly in consonance with "who I really am." Some frame this as a journey of return; its imagery involves "getting back to the person I was" (usually before the trauma or substance abuse or symptoms of mental illness) and thus draws on restitution themes. Some view it as a journey forward; the emerging self is being both discovered and created along the way, incorporating many struggles as well as achievements in its composition. Although consumers in either case often report the challenges of recognizing and consolidating a consistent sense of self in light of complicating psychiatric symptoms, there remains a fundamental motive to do so.

In some frameworks, the development of greater authenticity is inherently and implicitly a spiritual concern. Nothing is more fundamental to human existence than the achievement of genuine selfhood. In others, this connection to the spiritual or religious is explicit. Being "the self that one is meant to be" points to a sense of ultimacy, or under-

lying direction and coherence that transcends that self. Many religious people place this ultimacy in relationship to a personal God or to a faith community in which one's genuine identity is formed and finds fulfillment. Many recovery stories place authentic self-expression, then, in the context of spiritual and religious life. Here the "true self" emerges not only in dialogue with one's own history and one's own relational context but with the most basic questions of identity, meaning, and purpose.

Theme Seven: Recovery Is a Story of Action and Pragmatism as Well as Conviction. Many of the previous themes have emphasized the kinds of understandings and beliefs that characterize spirituality in recovery narratives of people with mental illness. But virtually all of these stories have concrete implications for daily living. Some examples will demonstrate the more immediate functions of these activities.

Faith communities. Religious groups can be a profound source of affirmation, comfort, and belonging in the lives of individuals who have often experienced stigma, rejection, and exclusion. One woman who had returned to church after many years of homelessness and isolation talked about her surprise and gratification that she could once again join others in worship, that she could be accepted—even welcomed—by such a community, and that she could begin to fit in with a group that represented key values in her life. Others describe the ways in which faith communities have extended themselves to meet some specific need—for transportation or food or emotional support. For people whose sense of themselves as marginal and unworthy is frequently reinforced by the larger society, religious groups may play a powerful role in reasserting their value and place in the wider community and in offering social, emotional, and tangible supports.

Prayer and meditation. Meditative time may deepen a sense of connection to self and, in prayer, to God. But mental illness recovery narratives often recount other, more tangible benefits as well. Some stories emphasize prayer or meditation as a very specific mode of self-soothing—a calming, relaxing, and reassuring response to external or internal stress, including hallucinations. Others focus more on its problem-solving functions: talking things over with God helps to sort through options and make better decisions; prayer reinforces motivation to abstinence from drugs and alcohol; meditating or praying puts things back in perspective and helps control emotional over-reaction. Still others describe how prayer improves mood. It may renew hope and expand the range of personal possibilities, or it may cultivate a sense of gratitude and draw attention to the positive aspects of some individuals'

lives, or it may clarify a sense of purpose. Whether one considers their more abstract or more concrete effects, prayer and meditation often play an active role in these recovery narratives.

Religious literature and music. Both devotional materials and scripture appear frequently in the stories of people recovering from mental illness. Over half of the Community Connections participants in a recent survey said that they read scripture at least once a month (Fallot & Azrin, 1995). In addition to the general deepening of spiritual life this literature offers, it may also be responsive to specific individual needs. For example, certain biblical passages (such as many of the Psalms) are deeply reassuring and comforting. They may be read repeatedly as a steady source of strength or may be drawn on in particular moments of stress. Other passages speak directly to God's concern for the sick and the marginalized and serve as distinct reminders of God's care. Consumers read still others as challenges to use all of their talents and strengths as fully as possible.

Listening to religious music has in some ways very similar functions in recovery stories: comforting, strengthening, reminding, and challenging. African American spirituals, for instance, have special significance for many believers. This music expresses a wide and deep emotional range, engaging listeners in both the painful reality of suffering and the comfort, hope, and joy available to the faithful. And actively participating in the singing and movement of religious music may offer social and emotional benefits beyond that of listening. A gospel music group at Community Connections has played an important role for people (re)discovering musical interests and abilities. It has encouraged many people who are usually withdrawn and isolated to join in making music and in sharing their talents publicly. Culturally as well as musically, singing has helped many group members re-establish active roles in an important community.

Ritual. For many people with severe mental illness, disorganization has characterized a great deal of their daily lives. It is not surprising, then, that rituals associated with religion or spirituality are highly valued by consumers who prize their structure, regularity, and predictability. Whether these are rituals built around personal practice (for example, prayer at regular times, devotional readings, listening to music, watching worship services on television) or they constitute participation in formally structured activities of a faith community (worship, community service, making music), many recovery narratives describe the important capacity of such rituals to organize experience, provide meaning, offer trustworthy and safe social engagement, and express core beliefs.

Conclusion

These themes are intended to be an illustrative rather than exhaustive compilation of the ways spirituality and religion may serve as resources in the stories people tell of their ongoing recovery from mental illness. Such stories present important opportunities for mental health professionals working with this group of people. First, service providers may serve as accepting and empathic hearers of these stories, including their religious and spiritual dimensions. Rather than ignoring or minimizing references to spirituality in recovery and rehabilitation, these domains should be explored seriously. And, if an assessment supports the value of religion in a particular consumer's recovery, clinicians should be prepared to support collaboratively the consumer's convictions and practices. Second, professionals may play a very important role in the further development and elaboration of recovery narratives. Recovery stories do not emerge in a vacuum. They are created out of the teller's relationships and conversations with important others and from available social and cultural resources. By actively engaging with the consumer's story, the clinician offers new perspectives, challenges limits, and affirms strengths. Being respectfully open to expression of spiritual beliefs and activities is one of the keys to facilitating the telling and living of many consumers' recovery stories.

Note

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Spirituality and Religion -For many on the course of recovery from mental illnesses such as psychotic disorders, spirituality and religion are positive significant aspect of their journey (Fallot, 2001;Corrigan, McCorkle, Schell, & Kidder, 2003;Lindgren & Coursey, 1995;Murphy, 2000).Â Spirituality as a dimension of quality of life and well-being has recently begun to be more valued within person-centred treatment approaches to mental health in the UK.Â A new diagnostic category entitled religious or spiritual problem has been included in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) under Other Conditions That May Be a Focus of Clinical Attention.