ABSTRACT

The Role of a Religious Psychoeducational Group in Recovery from Mental Illness: An Outcome Evaluation

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In light of recent attention to the overwhelming burden of care for those with mental illness, one proposed addition to the portfolio of services is a peer-led, religious psychoeducational support group called the Living Grace Group (LGG). These groups are based on an evidence base supporting each key component: psychoeducation for diverse mental health issues, religious integration in psychological services, and peers as leaders and facilitators of care. Nevertheless, the combination of psychoeducation and religious integration in a peer led support group, especially one designed to run in churches, has not previously been examined. In the present study, members of existing Living Grace Groups across the U.S. and internationally were surveyed before and after the course of the groups for the purpose of describing typical members of the groups and examining changes typical of group participants. Members of the National Alliance on Mental Illness' Peer-to-Peer Program were similarly surveyed and served as a comparison group for the LGG.

The characteristics of LGG participants in the current study were typical of a clinical sample with individuals reporting high religiousness and a desire for religious

integration in treatment. These individuals reported high levels of satisfaction with the group and significant changes in religious coping, spirituality, anxiety, depression, and recovery. When compared to the Peer to Peer group, LGG participants manifested significantly greater change in recovery over the duration of the group, and greater but non-significant changes on other measures. The LGG appears to be a feasible and helpful intervention that is culturally sensitive for religious individuals. Because leading requires minimal training and the groups are supported by church communities, these groups expand options for care while addressing significant barriers to service.

The Role of a Religious Psychoeducational Group in Recovery from Mental Illness: An Outcome Evaluation

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DEDICATION

To all those who have modeled for me an authentic and thoughtful integration of faith and science

CHAPTER ONE

Introduction

There have been several recent calls for psychology to re-evaluate current practice and training in order to address shortcomings in the current mental health delivery system. In his presidential address, James Bray (2010) identified a future path for psychologists to assume leadership roles in developing and implementing evidence based practices and programmatic changes in service delivery. Shifting from being primarily direct service providers, he calls clinicians to create, organize and direct new systems of mental health service. He also identified a need to be prepared to serve an increasingly diverse nation. Though he did not identify dimensions of diversity, religion is one aspect of our national diversity, and church communities are often hosts for gathering a great diversity of people. Bray also mentioned a need to address mounting financial barriers in accessing mental health services.

Similarly, Alan Kazdin and Stacey Blase (2011) noted a number of challenges and advocated a new approach to reducing the burden of mental illness. "Interventions are needed that can reach many more people, but also with particular attention to select subpopulations" (p.23). They pointed out that the majority of those with need do not get help, there are far too few clinicians to serve those in need, and clinicians are not geographically distributed well to meet need. They also identified a problem with trying to serve all those with need by individual therapy, or even direct contact with the clinician. In the view of the authors, this is not a search for a best intervention model, but creating a portfolio of approaches under which more people with need receive some

service. Among the proposed new directions they mentioned are working in special settings where those with need already are present. Though the authors do not specifically mention churches, they are one place where those with psychological issues already present with problems. The article identifies non-professionals as important players in the process of providing more service to all. The authors also specifically mention self-help programs and self-help groups led by group members as interventions likely to reduce barriers such as geographic and financial limitations. This is in line with a large amount of research on self-help groups and peer-led groups such as AA that serve many people without requiring the individual time of a mental health professional (Clay, Schell, Corrigan, & Ralph, 2005; Kelly & Yeterian, 2011; Pistrang, Barker, & Humphreys, 2008). A last point pertaining to the current project, the authors raise the possibility of collaborating with other disciplines in order to reduce the burden of mental illness.

Toward this end, clergy and religious congregations have long tended to the psyche, and now are increasingly recognized as important allies in serving those with mental illness. In their landmark 2001 work, *The Handbook of Religion and Health*, Koenig, McCullough and Larson specifically note a need for research examining the role of the church in meeting the needs of the chronically mentally ill. They add that "Innovative programs are needed to take advantage of the religious and spiritual resources of patients and of the manpower resources within religious communities to facilitate recovery and to provide the emotional support and understanding these people need." (p. 465)

Change is needed, and new delivery options for services seem to be a large part of the solution. The current project is an investigation of one response to this call for recovery-oriented support within a church context. This response combines several existing factors which each have significant support bases. The result is a peer-led, faith based, psychoeducational support group which meets in the context of church communities and uses the language of Christian faith. Led by peers or laypeople in the church community, the group does not require the involvement of a licensed professional, and operates without charge to the participants. Each meeting has an educational topic, covering information shown to be helpful in a variety of settings and for many disorders. The supportive, community building aspects of the group create interpersonal connections and foster emotional support among members, providing a healing experience of universality. What sets this group apart from other recovery-oriented psychoeducational groups is its distinctly religious nature. Forming through church communities, it offers a culturally sensitive approach to recovery for religious individuals, and may reach those with a tendency to prefer spiritual to psychological assistance. Led from a religious perspective and using the language of faith, groups discuss spiritual aspects of mental health issues and foster positive religious coping, addressing a need rarely met in mental health groups. The intention is to create a synergy between religious and psychological sources of support and healing, leading to a more holistic recovery that is easily accessible to a broad group.

CHAPTER TWO

Literature Review

Peer-Led Groups

Peer-led groups are one way of using fewer resources. Addressing mental health issues in such a group multiplies possible leaders, serves many people at once, and includes the many powerful benefits of group treatment, such as social support and universality. Peer-led groups come in several forms. Mutual help groups aim to provide social support by sharing struggles, and emphasize meeting topics chosen by those who attend, as opposed to a structured curriculum (Pistrang et al., 2008). In contrast, peer-run courses usually involve a structured, time-limited set of topics that are taught by someone who has experienced the course as a consumer (e.g. Van Gestel-Timmermans, Brouwers, Van Assen, & Van Nieuwenhuizen, 2012). Others are more supportive groups led by peers who provide a structure and sequence to the interactions of members. These groups provide a middle ground where leaders are clearly identified, but the structure of the groups are less formal. All three types of peer-led groups have evidence supporting their effectiveness.

Mutual help groups such as Alcoholics Anonymous have a long history in treatment of alcohol use disorders, and play a major role in addressing the burden of care in that area. Kelly and Yeterian (2011) reviewed evidence for the effectiveness of these groups, and found that mutual help groups generally performed as well or better than professional intervention but had significantly lower treatment cost per individual. Considering a broader spectrum of mental health issues, a recent review concluded that

initial evidence indicated that outcomes for mutual help groups were comparable to much more costly professional treatments (Pistrang et al., 2008). The authors also noted the importance of describing the group in enough detail to determine how it functioned, noting that "support group" and "self-help group" describe a wide range of groups.

Group interventions appear especially popular as part of the treatment of serious mental illnesses like schizophrenia and bipolar disorder. Several examples of widely-implemented peer-led programs have been documented. Building Recovery of Individual Dreams and Goals (BRIDGES; Pickett et al., 2010) "is an 8-week peer-led course designed to empower adults with psychiatric disabilities by providing them with basic education about the etiology and treatment of mental illness, self-help skills, and recovery principles" (p. 97). Social support and the real life recovery example of peer leaders are seen as central to fostering hope. A randomized controlled trial of this intervention showed significant improvements in recovery among participants (Cook, Steigman, et al., 2012).

Several programs combine some form of manualized self-help and a peer-led group setting. Wellness Recovery Action Planning (WRAP; Cook et al., 2010) is a peer-led self-management intervention intended to help individuals manage long-term illnesses whether or not they receive formal services. Delivered over eight sessions, leaders emphasize holistic health, wellness, strengths, and social support, often while sharing illustrations from their own lives. A number of studies have examined the effectiveness of WRAP, with all reporting increased markers of recovery as a result of participation (Cook et al., 2010; Cook, Copeland, et al., 2012; Fukui et al., 2011; Starnino et al., 2010). In Pathways to Recovery (Fukui, Davidson, Holter, & Rapp, 2010) peers

guide individuals through a specific workbook over 12 weeks to help them "develop a personalized recovery plan wherein they explore their lives and set goals across nine domains of life that include (1) home, (2) learning, (3) assets, (4) meaningful work, (5) leisure and recreation, (6) health and wellness, (7) intimacy and sexuality, (8) spirituality, and (9) social support" (p. 43). A similar 12 week group organized around the Recovery Workbook has also demonstrated significant improvement in recovery for participants (Barbic, Krupa, & Armstrong, 2009). The Peer-to-Peer program offered by the National Alliance on Mental Illness (NAMI) is a "structured, experiential, self-empowerment, relapse prevention and wellness program for people with mental illness" (Lucksted, McNulty, Brayboy, & Forbes, 2009). It is led by trained peer mentors who themselves have a mental illness, and groups consist of ten weekly two-hour meetings. Initial evaluation of the group indicated that participants reported increased knowledge about their illness, increased feelings of confidence and agency in dealing with the illness, and better connections with others.

There is strong evidence for the efficacy of peer involvement across the spectrum of mental health services, from case management to workshops to leading groups. In a recent editorial for *Psychiatric Rehabilitation Journal*, Judith Cook (2011) described several review articles and recent randomized controlled trials which demonstrated that peer-delivered services had at least equivalent effectiveness to non-peer delivered services, and in many cases were accompanied by additional benefits. She noted that the evidence is especially strong when peers deliver well defined services, and concluded that current evidence is strong enough that the question is not whether to fund peer-delivered services, but how. Clearly, there are many voices supporting the efficacy of

peer delivered services and their value in addressing the large burden of care for mental illness.

Religion and Mental Health

The terms religion and spirituality have been defined countless times, and popular meaning for the terms seems to be shifting over time, making differentiation between them particularly difficult (Zinnbauer et al., 1997; Zinnbauer, Pargament, & Scott, 1999). Recently spirituality has come to be seen as a more positive term embodying individual experience, while religion has been used more with a negative connotation for mere institutional affiliation or activity. Nevertheless, this polarization may be not be particularly helpful in accurately delineating the constructs (Hill et al., 2000). The authors propose that *spirituality* can be defined as "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. … The term "sacred" refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual" (Hill et al., 2000, p. 66). *Religion* is then defined as 1) spirituality and/or 2) a search for non-sacred goals in a context which has as its main goal the facilitation of spirituality, and 3) "the means and methods of the search that receive validation and support from within an identifiable group of people" (Hill et al., 2000, p. 66). Religion therefore is often spirituality lived in the context of a formally organized religious group, while spirituality without religion may be a more individual meaning making endeavor. Religion and spirituality are not entirely discrete or easily separable constructs. Consequently, many studies routinely speak of "religion and spirituality" as a way of acknowledging this difficulty. Following that tradition, this work uses religion/spirituality (R/S) as a broad and inclusive term, except where greater specificity

is warranted or when the research has been more intentionally specific. In those instances, the authors' terms are used in describing their research.

Despite the efforts and opinions of many leading psychological figures (Freud, Skinner, Ellis), religion and mental health are intimately connected. Long before psychologists existed, clergy counseled their flock, providing support and healing as part of their pastoral role. They still provide counsel to nearly a quarter of all people who seek help for a mental illness (Wang, Berglund, & Kessler, 2003). Part of the mission of church is to seek and tend to those who need help, to provide meaning, connection and support. Indeed, a large and growing literature is demonstrating usually positive connections between religion/spirituality and mental health.

General Links Between R/S and Mental Health

In contrast to many previous vocal assertions, religiousness has demonstrated robust and generally positive associations with well-being (Koenig, McCullough, & Larson, 2001). The authors reviewed 100 studies examining the relationship between religion and well-being. They found that 78 of the studies found a positive relationship and only one found a negative relationship. The remaining studies had mixed findings or found no significant relationship. In this research, religiousness was often measured with a single item asking about the importance of religion, the individual's religious affiliation or attendance. Considering the preponderance of positive results despite the generality and non-specificity of the measures of religiousness, this analysis provides strong evidence for a link between religion and well-being. Similarly, two thirds of studies found lower rates of depression or fewer symptoms in those who were more religious. In a follow-up to this review, Koenig (2009) noted that studies of subjects in different

settings, with different backgrounds, of different ages, and in different locations generally show that "religious involvement is related to better coping with stress and less depression, suicide, anxiety, and substance abuse" (p. 289).

However, religion does not have uniformly positive influences. Take for example the research on religious coping, which identifies both positive and negative forms. The construct of religious coping concerns "the use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Koenig, Pargament, & Nielsen, 1998, p. 513). Religious coping research attempts to illuminate how religion impacts mental health by influencing the coping strategies of an individual, and therefore looks at both positive and negative religious coping. The most commonly used measure of these constructs is the Brief RCOPE (Pargament, Smith, Koenig, & Perez, 1998). According to Ken Pargament, "The positive religious coping subscale (PRC) of the Brief RCOPE taps into a sense of connectedness with a transcendent force, a secure relationship with a caring God, and a belief that life has a greater benevolent meaning. The negative religious coping subscale (NRC) of the Brief RCOPE is characterized by signs of spiritual tension, conflict and struggle with God and others" (Pargament, Feuille, & Burdzy, 2011, p. 58).

A meta-analytic review of 49 studies (with 105 effect sizes) found distinct relationships between styles of religious coping and psychological adjustment (Ano & Vasconcelles, 2005). The authors calculated average Pearson product-moment correlations for each category studied using Fisher's z transformation. Positive religious coping (PRC) was moderately positively correlated with good psychological adjustment (avg. $Z_r = .33$, moderate effect), indicating that those who used PRC typically

experienced more stress-related growth, spiritual growth, positive affect, and had higher self-esteem. PRC was also moderately inversely correlated with negative psychological adjustment (avg. Z_r = -.12, small effect), meaning that individuals using PRC experienced less depression, anxiety and distress. Negative religious coping (NRC) was uncorrelated with positive psychological adjustment, possibly reflecting findings that while negative religious coping can be harmful, people sometimes still experience positive outcomes. For example, one woman suffering from schizophrenia stated "I think my illness is God's punishment for my sins; it gives meaning to what happened to me, so it is less unjust" (Mohr, Brandt, Borras, Gilliéron, & Huguelet, 2006, p. 1954). NRC was positively correlated with negative psychological adjustment (avg. Z_r = .22, modest effect), meaning that individuals using NRC experience more anxiety, depression and distress. Thus individuals whose religious coping could be characterized by connectedness, secure relationship with God and benevolent meaning tended toward positive psychological adjustment. Individuals whose religious coping is characterized by doubt, tension, conflict and struggle tend to have negative psychological adjustment.

Longitudinal studies confirm that the particular expression of religion matters: participants experience different outcomes depending on religious coping style, status of attachment to God and security in faith. A prospective study of PCUSA clergy and laypersons demonstrated that "a secure attachment to God at baseline is associated with a decrease in distress over time; (2) a secure attachment to God buffers against the deleterious effects of stressful life events on distress; and (3) an anxious attachment to God exacerbates the harmful effects of stress" (Ellison, Bradshaw, Kuyel, & Marcum, 2012, p. 493). Similarly, a study of religious coping in a sample of 48 young adults with

SMI over a one-year period found that positive religious coping was generally related to positive mental health, while negative religious coping was linked to increased distress and personal loss from mental illness (Phillips & Stein, 2007). When Dew and colleagues (2010) studied 145 adolescents at two outpatient clinics, they found that forgiveness, negative religious support, loss of faith, and negative religious coping all had significant relationships with BDI-II scores during a cross-sectional assessment. Moreover, loss of faith predicted less reduction in depression scores over six months, after accounting for depression scores at baseline. A longitudinal study of offspring of depressed parents found that increased religious service attendance and importance of religion were related to reduced risk of developing a depressive disorder (Kasen, Wickramaratne, Gameroff, & Weissman, 2012). A large catchment area study identified increased religious attendance as predicting fewer suicides, despite use of a categorical any vs. never measure of religious attendance (Rasic, Robinson, Bolton, Bienvenu, & Sareen, 2011).

These findings highlight an important caveat of research on religion, namely that religiousness can be either resource or burden. It does not uniformly foster positive coping, increase hope, or protect against stressors. Nevertheless, studies consistently find that the positive aspects of religion are more prevalent than the negative. This prevalence of positive effects or uses of religion may account for the generally positive correlation of general or global measures of religiousness with mental health. Across all studies in one review, PRC tends to be more frequently and more strongly endorsed than NRC (Pargament et al., 2011). In a study of 115 patients with psychosis (Mohr et al., 2006), religion provided hope, purpose and meaning for 71%, while increasing despair for 14%.

Religion increased symptoms for 10% and decreased them for 54%. Clearly, specific assessment of R/S is needed, and fostering healthy forms of religion and spirituality is important.

Religious Help-seeking

Given the power of religious coping, it is not surprising that a significant number of individuals struggling with mental illness turn for help to their religious communities (Farrell & Goebert, 2008; Stanford & Philpott, 2011; Wang et al., 2003). Churches and clergy have provided counsel, support and healing for millennia. Moreover, most Americans belong to a church, making religious support very accessible for most.

In a nationwide sample of over 8,000 individuals in the National Comorbidity Survey, nearly 24% of respondents with a mental disorder reported contacting clergy for help (Wang et al., 2003). This help seeking was not only for mild problems: one quarter of all those reporting that they sought help from clergy were classified as having a serious mental illness, and the odds of seeking help from a clergy member increased if the individual reported suicidal ideation. This data confirms earlier studies that reported those with SMI often seek out clergy (Koenig, Larson, & Weaver, 1998), and there is no difference in diagnoses between those who seek help from professionals or clergy (Larson, 1988).

Despite the prevalence of help-seeking in a religious context, churches and clergy are not usually equipped to handle mental health problems completely on their own. There is evidence that clergy sometimes struggle to recognize when individuals need treatment for a mental disorder. In a case vignette study, clergy recognized a need for professional care in only 66% of cases including religious aspects of psychopathology

(Noort, Braam, van Gool, & Beekman, 2012). When they do recognize that individuals have a mental disorder, clergy often feel they lack training or ability to handle them, especially those with serious mental illness (Farrell & Goebert, 2008; Leavey, Loewenthal, & King, 2007). For example, one research team surveying clergy in New York found that clergy felt more confident in dealing with grief, death and dying, anxiety, and marital problems, and less confident dealing with depression, alcohol/drugs, domestic violence, severe mental illness, HIV/AIDS, and suicide (Moran et al., 2005). Mannon and Crawford (1996) found that clergy feel a particular lack of ability to adequately respond to those with serious mental illness.

Nevertheless, many of those who present at churches do not get or seek help elsewhere. Even when they feel their training is inadequate, clergy often treat congregants with mental illness rather than refer them out (Farrell & Goebert, 2008). Only 10% of those who contacted clergy for help were referred to another professional (Lowe, 1986; Meylink & Gorsuch, 1988) and of all those who had contact with clergy, less than 40% had any contact with another health professional (Wang et al., 2003). At the same time, clergy met with those who sought help the fewest times of any provider type, with less than six meetings on average. These studies describe a kind of dead end, where individuals seek help at church, but are neither likely to get much counseling contact with a clergy member nor get a referral to a mental health professional. Part of this may have to do with clergy inability or unwillingness to refer, but much of it also may have to do with the characteristics and circumstances of the individuals themselves.

Problems in accessing professional help present one reason for church help seekers to stop there. Meeting with a pastor, church staff, or church group usually carries

no financial cost, in marked difference from meetings with a professional. In one example from the National Health Interview Survey, Ramin Mojtabai (2005) found that the cost of service prevented 20% of individuals from using mental health services, and 34% of individuals from using medication. Geographic restrictions can also inhibit ability to seek treatment. In many rural areas, the options for professional mental health treatment are rare or non-existent (Health Resources and Services Administration, 2012). Nevertheless, it is rare to find a community of any size without a church.

Another reason for this lack of professional care among those who seek help from clergy may be acceptability problems: negative perceptions of professional helpers or of seeking professional help. There is a long history of fear that psychologists and other mental health professionals will reduce religious and spiritual issues to psychological phenomena if they don't simply reject them outright (Fallot, 1998). Alternately, those with mental illness may believe they have a spiritual problem and believe that they should only rely on God or church for help (Koenig et al., 2001). One qualitative study examined the views of ten current or former therapy patients who defined themselves as having strong R/S beliefs (Mayers, Leavey, Vallianatou, & Barker, 2007). The authors found that clients had preconceptions that secular therapy would be antagonistic to their R/S beliefs. Some felt that seeking a secular therapist would demonstrate a lack of faith in God, while others believed their R/S views would be minimized or neglected in therapy. Some reported fears that the therapist would attempt to "convert" them or convince them of the error of their beliefs. Indeed there are those in the church community who believe that psychology essentially misleads people from the truth of the Bible and faith, preaching its own "false" faith (Adams, 1970; Powlison, 2000).

The picture described above paints churches as a kind of "front line" for those with mental illness. Religion and spirituality help many to deal with problems and support in religious contexts is often easily available. Moreover, many people may have hesitations, including those resulting from religious beliefs that dispose them against seeking help outside the church. Psychologists have long assumed that church leaders would simply refer those who need professional help, but this has not proved a reliably valid assumption (Meylink & Gorsuch, 1986, 1988; Moran et al., 2005; Wang et al., 2003). Partly, this may reflect clergy or congregational views of psychologists as non-religious or anti-religious, especially given the significantly lower prevalence of strong religious belief among psychologists (Bergin & Jensen, 1990; Jensen & Bergin, 1988). Indeed, clinical psychology does have a history of marginalizing religion in treatment. This has deprived clinicians of valuable tools in working with clients, and led to incomplete or distorted images of client worldviews. That picture is changing, however, with many professional voices calling for assessment and integration of R/S in mental health services.

Religion and Treatment

But why incorporate R/S in mental health services? Why not just emphasize better connections with churches and let the churches handle the R/S aspects of clients' lives? Roger Fallot (1998) gave several reasons: R/S relates positively to psychosocial well-being, it reflects consumer self-understanding, enhances cultural sensitivity of services and facilitates recovery.

Relates Positively to Psychosocial Well-Being

Mental health professionals are usually interested in any aspects of their client's lives that have the potential to aid healing and growth. As related above, a large body of work has established the generally positive links between R/S and mental health and adjustment. Many mechanisms have been proposed by which religion exerts positive effects on mental health. Previous research has suggested that religion may impact mental health via its effect on health promoting behaviors, the social support it provides, and the sense of coherence that it offers (George, Larson, Koenig, & McCullough, 2000). Fallot (2007) and Longo and Peterson (2002) list several themes that may account for the positive impact of R/S:

R/S may strengthen a sense of self and self esteem. Religion often is central to the identity of individuals. Seeing themselves as children of a loving God, as connected to a "higher power", as part of a world with a benevolent purpose, or as a "whole person" are some ways that people have expressed this sense of religious identity (Fallot, 2007). These very positive views help counter shame and stigma that attend mental illness, and connect individuals to a sense of meaning that transcends mental illness.

R/S may involve distinctive coping responses that mitigate distress. Extensive work has been done on religious coping and its relation to physical and mental health. Patterns of positive religious coping include a secure relationship with God, sense of connection with others, and conviction about meaning in life (Pargament et al., 1998). Religious beliefs may also provide individuals with a sense of meaning, control and identity (Pargament, Koenig, & Perez, 2000). Individuals may redefine their stressors in

light of these religious beliefs, or the beliefs themselves may provide a buffer against stressors. Though distinct patterns of negative religious coping also exist, positive coping is much more prevalent, and contributes to a range of positive health and mental health outcomes (Nooney & Woodrum, 2002; Pargament et al., 2000, 1998).

R/S may provide important sources of social support and community. Religious congregations are important sources of community for many individuals (Nooney & Woodrum, 2002; Richards & Bergin, 2005). Congregational support has also been found to mediate the effects of church attendance on mental health, suggesting that it is this increase in social support that is most effective (Cohen, Yoon, & Johnstone, 2009). Religious support is not merely one setting for general social support, however; there is also evidence that religious support provides benefits over and above regular social support (Fiala, Bjorck, & Gorsuch, 2002).

R/S is basic to a sense of hope. If spirituality is about the search for the sacred, it makes sense that it can be a source of hope. Most religions systems state that there is life after death, and that suffering has a meaning in the context of the sacred. These beliefs may offer comfort to those suffering with a mental illness and hope that life can be better and change is possible. Religion and spirituality also provide many people with answers to the meaning of their life and other ultimate questions. Having a sense of purpose in this context can lead people to live more positively (Fallot, 2007), and even to find value in their condition. These aspects (hope, meaning, purpose in life) have been identified as fundamental to recovery (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004).

Reflects Consumer Self-Understanding

A huge majority of those in the US (83%) report affiliation with a specific religious tradition (Pew Forum on Religion & Public Life, 2008). Gallup polling in 2012 reported that 69% of American adults are very or moderately religious, based on self-reports of the importance of religion in their daily lives and attendance at religious services. Religious views of those experiencing mental illness are often even more strongly positive than those of the general population. In one large sample of 1,824 individuals with serious mental illness, 90% reported that religion or spirituality is important for them (Corrigan, McCorkle, Schell, & Kidder, 2003). Many of those individuals reported that R/S is very helpful in coping with their illnesses. Another survey of 406 mental health patients revealed that 80% used religious coping to deal with their illness and a majority spent half or more of their coping time in religious coping (Tepper, Rogers, Coleman, & Malony, 2001). Indeed, this group of authors commented, "Religious forms of coping may be particularly relevant and compelling for persons with schizophrenia, recurrent major depression, and other forms of severe mental illness, because of the overall loss of hope, control and purpose that those illnesses engender" (pp. 660-1).

Despite the high salience and helpfulness of religion for these individuals, mental illness can also impair their ability to access religious supports (Pfeifer & Waelty, 1995; Scott, Garver, Richards, & Hathaway, 2003). Mental illness may curtail the ability to participate in many organized religious activities, cause the individual to doubt their faith or question the support of their faith community. One study sampled 115 outpatients with a psychotic disorder, asking about their religious coping (Mohr et al., 2006).

Religion was reported as important in the lives of 85% of the sample, with 45% stating it was the most important element of their life. Nevertheless, 56% of the sample stated they never participated in religious practices with others, and only 30% attended a religious service at least once a month. The authors concluded that religion had a high level of clinical significance in treatment for schizophrenia, and despite patients reporting higher importance of religion in daily life, they were less connected with community religious activities. Those with serious mental illnesses often pray more but attend church less during periods of serious impairment, which can lead to stress and value conflicts (Koenig, Larson, et al., 1998). At the very time that they most need the supports of church attendance and community, they often get the least. For many, this negative impact of mental illness on their ability to practice their religion could be considered clinically significant distress (Hathaway, 2003). Given the importance of religion in the lives of many and its value in coping with mental illness, ignoring religion and spirituality in mental illness would be clinically irresponsible.

Enhances Cultural Sensitivity of Services

The APA has recognized this state of affairs by including religion and spirituality in their list of aspects of diversity that must be respected for ethical conduct in therapy (American Psychological Association, 2002). They also published the *Handbook of Psychotherapy and Religious Diversity* (Richards & Bergin, 2000), with chapters on ways to work with clients from various religious traditions in order to help clinicians to respect and utilize the religious beliefs of their clients. Indeed, there is little question that many individuals want treatment that respects and incorporates their faith beliefs (Knox, Catlin, Casper, & Schlosser, 2005; Martinez, Smith, & Barlow, 2007; Rose, Westefeld, &

Ansley, 2001; Walker, Worthington, Gartner, Gorsuch, & Hanshew, 2011), even if they are not sure whether it is appropriate to deal with such issues with a mental health provider.

A survey of clients at a religiously-affiliated university counseling center found that participants generally perceived religious interventions in therapy as helpful (Martinez et al., 2007). These highly religious clients rated out of session interventions as more appropriate, but in-session interventions as more helpful. Notably, they included comments on interventions that were both effective and ineffective. The authors noted that this study underscores the increased insight and reframed understandings induced by religious interventions, as well as yielding relational and emotional benefits. All the same, the pattern of responses indicates that religious interventions which do not match client values, readiness and reason for seeking therapy are at risk for being ineffective.

Another survey of clients, this one conducted at several clinical sites, assessed psychotherapy clients beliefs about the appropriateness of discussing religious and spiritual concerns in counseling (Rose et al., 2001). They found that clients believed it was appropriate and they had a preference for discussing both religious and spiritual variables in therapy. Many wanted to discuss these topics because they viewed them as essential for healing and growth. As one participant reported: "I had been in therapy for several years and could only heal to a certain level. It wasn't until my present counselor approached me about spirituality that I could receive healing at a deeper level." Preference for discussing R/S was not significantly related to their expectations about counselors or the presence of a religious or spiritual problem. Indeed, the clients in this study appeared on average to be less religious than the general population.

In a sample of therapy clients about to begin counseling with a Christian counselor, results also showed that most clients wanted to discuss R/S issues in therapy, even though they generally did not believe that R/S issues were part of the problem they sought therapy for (Walker et al., 2011). Indeed many religious clients voiced a desire to discuss scripture or pray during psychotherapy. Religious commitment as well as beliefs, attitudes and values in this case did predict the preference of clients for addressing R/S issues in therapy.

Of a sample of 100 psychiatric outpatients (Huguelet, Mohr, Borras, Gillieron, & Brandt, 2006), only 10% believed there was any conflict between religion and therapy, while almost 80% felt at ease in bringing up religion with their clinician. Nevertheless, only 40% had done so. Consequently, and in roughly half of cases, the clinician's perception of the client's religious group involvement was inaccurate. Clinicians were able to describe individual religious practices, or the patient's views on the meaning of their illness in the context of religion in only a third of cases. In another study, schizophrenic outpatients were assigned to traditional treatment or to receive a religious assessment (Huguelet et al., 2011). Those in the religious assessment group missed significantly fewer appointments during follow up, though overall outcomes at three months did not differ. Despite reporting clinical uses for the assessment information for 67% of patients, the psychiatrists reported only moderate interest in continued religious assessment.

These studies indicate that many clients want R/S issues to be addressed in therapy, and many even want explicit incorporation of religious material such as scripture or prayer. Many clinicians do not share their enthusiasm. Though some therapists might

balk at combining religion and therapy so directly, there exist populations of clients for whom this is a preferred situation. Moreover, ignoring or avoiding religion in therapy may mean that clinicians fail to understand important aspects of client worldview, coping with illness, and attitude toward treatment.

Facilitates Recovery

In the context of serious mental illness, the term recovery is prominent. The Substance Abuse and Mental Health Services Administration (SAMHSA;(2012) has proposed a working definition of recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Recovery is different from "cure" and emphasizes a journey of improvement. The SAMHSA definition includes several principles with application to R/S: (1) Hope is fundamental to recovery, and it is a process that can be fostered by support from and the example of others. (2) Recovery occurs via many pathways, including faith-based approaches and peer support. (3) Recovery is holistic, encompassing the whole person, mind, body, spirit, and community. (4) Recovery is supported by peers, grows with social networks and is culturally based and influenced. A recovery model allows for hope and improvement regardless of whether symptoms completely cease. One definition describes it as "the process of learning how to live with and manage or compensate for an ongoing condition, while being engaged in the process of living one's life as fully as possible within or beyond the limitations imposed by that condition" (Davidson et al., 2005, p. 180). Recovery as conceptualized here is more person-centric and less disease-focused, leading to treatment that values the experience of the individual over a count of symptoms or severity.

A large nationwide sample of those with a serious mental illness reported that categorical indices of religion and spirituality were significantly positively related to recovery, hope and personal empowerment (Corrigan et al., 2003). Similarly, Yangarber-Hicks (2004) reported that religious coping styles including God in decision making predicted more involvement in recovery enhancing activities than those that excluded divine agency. Providing a more nuanced view, Webb, Charbonneau, McCann and Gayle (2011) reported that recovery was positively related to enduring with God, but negatively related to struggling with God. However, religious support mediated the relationship between struggling with God and recovery. In addition to indicating the power of positive religious coping to aid recovery, this also means that religious support may especially help those most likely to experience negative effects of religious belief. When mental illness is an open topic at church, the faith community can be a powerful source of support for those with mental illness (Shifrin, 1998).

Indeed, interviews with consumers indicate that religiousness may provide a powerful means of coping for many with SMI (Hugen, 2007). The analysis of their statements indicated that their religious orientation helped them cope in several different ways. It helped them accept themselves as having value despite their condition, and they reported that life has purpose and a part in God's work in the world. It provides a sense of strength and courage, for example: "There were some times that I didn't think I would make it, but then God shows me, you know, ways that He can help…me through it" (p. 411). A religious orientation also provided a sense of hope along with the impetus to stay connected with others and build new relationships. Last, participant's statements

indicated that religious belief gave them a sense of comfort and consolation, lifting their spirits when they felt most helpless or lonely.

Weisman de Mamani, Tuchman and Duarte (2010) described a family focused and culturally informed way of working with schizophrenic patients. They included a Spiritual Coping module in the treatment and described positive outcomes that participants experienced as a result of the inclusion of spirituality in their treatment. Other evidence from schizophrenic patients indicates that positive religious coping is frequently used, and positively linked with recovery (Huguelet, Mohr, & Borras, 2009). In a 3 year prospective design, the higher salience of religion in coping with symptoms was associated with better scores on the evaluation of clinical status, while using religion to make meaning of life was associated with better quality of life (Mohr et al., 2011). These findings were true for those who tended to use positive religious coping, and were not found with those who used negative coping. Indeed the authors have elsewhere stated the need for assessment of R/S not only for its potential to help heal, but also to identify those who are at increased risk due to negative religiosity. Addressing R/S values and concerns may not only bolster positive expressions, but help temper or correct negative expressions, facilitating recovery in both cases.

Response of the Profession

In light of this voluminous research, a multitude of voices have called for religion/spirituality to be routinely assessed and addressed in clinical work (Frazier & Hansen, 2009; Hathaway, Scott, & Garver, 2004; Huguelet et al., 2009; Koenig et al., 2001; Richards, Bartz, & O'Grady, 2009). Consideration of R/S has moved into the mainstream in professional psychology: Since 1996, the American Psychological

Association has published more than a dozen books on religion or spirituality in clinical work (e.g. (Aten & Leach, 2009; Aten, McMinn, & Worthington, 2011; Pargament, 2013; Plante, 2009; Richards & Bergin, 2000, 2005; Shafranske, 1996; Sperry, 2012). The 2002 Code of Ethics recognized religion as an important aspect of diversity that psychologists must be aware of, respect and consider in their professional work (American Psychological Association, 2002). In a recent policy statement on religious discrimination the APA concluded by encouraging psychologists to work with religious communities: "Therefore be it further resolved that the American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles" (American Psychological Association, 2007). It is clear that religion and spirituality are not only constructs of interests to psychologists who study religion, but are of vital importance in the lives of many clients, and therefore need to be attended to in all clinical work.

Professional creativity has not stopped at merely assessing R/S factors in clients and addressing R/S issues if they arise in therapy. Many researchers have designed treatments that incorporate R/S elements intentionally in primary therapeutic interventions. One recent example is provided by a trial of a single session behavioral activation of religious behaviors (BARB; Armento, McNulty, & Hopko, 2012). The authors worked with 50 mild or moderately depressed college students to increase religious behaviors, attitudes and coping skills in a single session. Compared to a supportive therapy group, the BARB group had significantly greater decreases in

depression and anxiety and increased quality of life. These gains were maintained over a month follow-up. It was also reported that religious behaviors and attitudes mediated the relationship between treatment condition and a decrease in depression. This is merely one of many examples of the ways that religion has been integrated with standard psychological care.

The growing literature examining outcomes of these therapies has been the subject of several recent meta-analyses. Hook et al. (2010) identified 24 randomized clinical trials of R/S therapies for psychological issues. They found that two treatments (Christian accommodative cognitive therapy for depression and 12-step facilitation for alcoholism) met current stringent criteria (Chambless & Hollon, 1998) to be deemed efficacious. Two other therapies met criteria to be considered effective in conjunction with medication (Muslim psychotherapy for depression and anxiety), while several others were considered possibly efficacious. The authors note that the evidence is generally positive, but note several limitations with the current body of research. One limitation concerned the inability of these studies to determine specificity, or whether the religious adaptation to a proven secular psychotherapy added value in terms of outcome. The most recent meta-analysis (Worthington, Hook, Davis, & McDaniel, 2011) examined the outcomes of 46 studies of religious accommodative therapies and nonreligious spirituality therapies. R/S therapies produced better outcomes than secular therapies on both psychological ($d = .26$) and spiritual ($d = .41$) measures. A smaller, but more stringent, sample of dismantling studies demonstrated that R/S therapies were superior to secular therapies on spiritual ($d = .33$) but not psychological outcomes. The authors conclude that psychological treatments that incorporate religious/spiritual elements produce

psychological outcomes at least equivalent to secular treatments, while producing positive changes in religion/spirituality that exceed secular treatments. Given the extensive literature on the benefits of positive R/S, this improvement in R/S alone would be sufficient reason to select such a treatment for a religious client.

Religion and Mental Health Groups

Group treatments are a subset of R/S therapies, and comprise some of the therapies analyzed above. But are they equally effective? When group treatments that make religious adaptations have been studied they have generally demonstrated effectiveness and equivalent or better outcomes than similar secular treatments (Smith, Bartz, & Richards, 2007). In this review of religiously accommodated psychotherapy, 22 out of 31 treatments studied used a group format. The 22 group treatments had an average standardized mean difference of $d = 0.58$, a moderate effect. When religiously accommodated treatments were compared to equivalent secular treatments, the effect size remained considerable at $d = 0.51$. There appears to be considerable potential for R/S group treatments to be uniquely effective with religious clients.

One limitation of this meta-analysis is the population for many of the studies. They often involved normal community participants, or addressed issues such as stress management or forgiveness. Though they have not been meta-analytically aggregated, a number of studies exist which do use R/S group treatments for clinical mental health issues. Sharon Bowland, Tonya Edmond, and Roger Fallot (2012) demonstrated that an 11 session spiritual group intervention was effective in reducing depression, anxiety and physical symptoms in older female survivors of trauma. Another group found that CBT with religious content and pastoral counseling were both superior to standard CBT group

treatment over a 3 month course of treatment for clinical depression (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). Scores for all treatments were comparable at 3 month and two year follow ups. A study of women on an inpatient unit for eating disorders found that participants in a spiritual support group tended to score significantly lower on psychological disturbance and eating disorder symptoms at the conclusion of treatment compared to patients in cognitive or emotional support groups (Richards, Berrett, Hardman, & Eggett, 2006). The spiritual group participants also experienced better spiritual well-being. These studies give evidence that spiritual groups or religiously-integrated group treatments are effective in treatment for psychological disorders, and group members benefit from the spiritual dimension of the group.

Further specifying our criteria, we find very few studies of R/S group therapy have targeted or included individuals with severe mental illness. Nancy Kehoe (1999, 2007) has described a long-running spiritual issues group in an outpatient day program. She noted that the group fosters tolerance, awareness and therapeutic exploration of value systems. Contrary to staff fears, the group did not foster delusional ideation, but provided a supportive place to address important issues otherwise neglected in treatment. Unfortunately, no empirical assessment of the group has been attempted. Similarly, Phillips, Lakin and Pargament (2002) described a seven week semistructured psychoeducational group intervention during which seriously mentally ill participants discussed religious and spiritual topics. Several clinical vignettes were presented to illustrate the benefits of participation in the group, but again, no quantitative data was reported.

Lindgren and Coursey (1995) described a four week, highly structured psychoeducational group intended to help clients utilize their spiritual beliefs to foster healthy self esteem. They conducted outcome assessments of both psychological and spiritual constructs (e.g. Beck Depression Inventory and Spiritual Support Scale) and used a wait-list control group. However, small sample sizes (treatment, n = 13; control, n = 15) yielded a very low power to detect group differences. Consequently, no significant differences were found on measures of hopelessness, depression, self-esteem or purpose in life. Even so, they found a significant difference on the Spiritual Support Scale scores, demonstrating the power of a very brief group to make changes in a construct potentially valuable in recovery.

Ana Wong-McDonald (2007) described an optional adjunct spiritual issues group that took place in the context of an outpatient psychosocial rehabilitation program. The group chose topics for discussion based on the interests and spiritual styles of its members, and included referring to spiritual writings, encouraging spiritual and emotional support, and helping to see their self-worth from a divine perspective. They were also encouraged to be active in their faith communities and seek support from clergy and the faith community. All twenty participants in the spiritual group for at least three months completed all of their self-defined goals, compared to 57% of the 28 participants not in the spiritual group who achieved their goals. Clinical vignettes were provided to illustrate some of the ways that integration of spirituality enhanced recovery.

Revheim and Greenberg (2007) described a spirituality group run on a state hospital inpatient unit for persons in clinical trials for refractory symptoms associated with schizophrenia. Their Spirituality Matters Group had leaders from psychology,

pastoral care and rehabilitation fields and focused on "exploring nondenominational religious and spiritual themes designed to facilitate comfort and hope, while addressing prominent therapeutic concerns" (p. 308). This highly structured group included activities such as reading Psalms, reading and writing prayers and sharing stories from a variety of faith perspectives, all within an emotion-focused coping model. A later report (Revheim, Greenberg, & Citrome, 2010) provided a cross-sectional comparison of 20 group attenders and 20 non-attenders. They found that attenders of the group had higher scores on a measure of spirituality and a measure of hope. Also, the higher group members scored on a spirituality measure, the more they perceived themselves as capable of dealing with psychiatric symptoms. This supports the idea that consumers who choose to attend R/S groups are likely to be able to make use of them to bolster positive religious coping.

Though all of these initial descriptions are positive, there is much that is yet to be examined in the realm of R/S groups for those with serious mental illness. Specifically, the groups reported to date have lacked detailed quantitative data in a treatment outcome design. Indeed, several authors have identified this lack and pointed to the need for more research. Huguelet, Mohr and Borras (2009) indicated that future study needed to assess group impact in terms of recovery, quality of life, and symptoms. Revheim, Greenberg and Citrome (2010) similarly indicated that longitudinal outcome analyses of recovery outcomes were needed to improve on the research to date. Marcia Webb and colleagues (2011) cited a need for research not only on efficacy of R/S interventions for those with SMI, but also psychoeducational interventions in the context of church communities. They also cited several existing ministries in the context of church communities

dedicated specifically to serving those with SMI, while noting that none had as yet been empirically investigated. Though several professional-led R/S therapy groups for specific disorders have been examined, I am aware of no empirical examination of any peer-led R/S recovery or support group including those with serious mental illness.

There is a huge literature on the benefits of R/S in the lives of clients, and a growing evidence base for R/S integrated professional interventions. Secular peer-led pyschoeducational groups are increasingly being utilized and evaluated with positive results. Several authors have pointed to the need for information on the efficacy of similar groups operating from a faith basis. This investigation of the Living Grace Groups is one response to those identified needs.

Description of the Living Grace Groups

> Grace Groups are designed to provide an ongoing support structure to help those living with mental illness hold one another up and give each person practical skills and tools necessary for them to regain their lives and rebuild their families. All of this is done in a Christ-centered environment with a clear focus on the necessity of God's grace for life transformation.
>
> Grace Groups focus on the positive with each meeting hopefully ending with those involved having greater understanding and vision concerning their mental illness. While the Grace Group does allow some time to share pressing difficulties, the emphasis is on learning how to filter difficulties through God's grace and implementing the many practical skills and tools presented during the meetings. (LGG Leaders Manual: Padilla & Stanford, 2011)

Living Grace Groups are peer-led, faith-based, psychoeducational support groups for those living with any diagnosed mental illness. They are not therapy groups, instead focusing on a recovery model and emphasizing learning practical tools and providing support. The evidence for each of these aspects of the group has been presented above, and the following will serve to describe how they are integrated in a LGG.

Peer-led. Leaders of groups are identified from within a faith community that sponsors the LGG, and it is primarily the church that ensures the individual is capable of group leadership. No formal mental health training is required, but personal experience with mental illness is highly valuable. The leader should be someone who has recovered from a mental illness, has a loved one with a mental illness and has successfully navigated the stages of grieving, or is involved in other mental health advocacy work. Training to lead the group is provided in written form through a leaders guide, and via a brief video conference seminar with one of the creators of the curriculum.

Faith-based: The groups are run in specific church communities, and material is written in the language of faith. The work of the groups takes place in a distinctly religious atmosphere, where faith is the worldview through which all difficulties are seen. Each group involves prayer and scripture reading, and members are encouraged to share stories of God's grace working in their lives in positive ways. At the same time, dogma specific to any particular denomination is minimized, and a diversity of ways of relating to God and understanding his work in the world are welcomed. Use of prayer and specific religious examples models the positive use of religion to cope with mental illness, and promotes a more vibrant personal and communal spirituality.

Psychoeducational: Each group meeting has an educational topic as its focus. This aspect of each meeting attempts to convey facts and practical skills that will help members in their recovery. These topics are based in well-researched psychological principles. For example, topics include dealing with stigma associated with mental illness, understanding the role of medication in recovery, examining and challenging negative thinking, and learning coping skills to prevent or ameliorate relapses.

Support group: Facilitating connection between group members is a primary goal of the group. Discussion-style meetings promote connection and sharing positive experiences, increasing hope as members listen to each other grow and realize they are not alone on their own journey. Leaders are encouraged to make space for participants to socialize and connect before and after each group meeting. The last meeting of the group is also dedicated to discussion of ways to connect with more support in the community.

Inclusion Criteria

This group does not focus on any specific mental illness, but addresses the common factors that are found in most mental illnesses. As such there are no disorder specific criteria for inclusion or exclusion, the only condition being that members have a diagnosed mental illness. Members consequently have a spectrum of mental disorders, with many members reporting severe mental illnesses such as chronic severe depression, bipolar disorders or schizophrenia. Participation in this group does not require full stability, but members must be stable enough to attend meetings without damaging comments and behaviors toward other members. If prescribed medication, members are asked to be consistent in taking it.

Group Topics

The topics and principles of LGGs (e.g. psychoeducation, relapse prevention, medication adherence, coping skills training, social support, peer mentorship) are consistent with those used in widely implemented and often studied peer-led groups reviewed above (e.g. (Cook, Copeland, et al., 2012; Cook, Steigman, et al., 2012; Fukui et al., 2010). They also correspond highly with the content of the best evidence-based interventions designed for professional delivery. Like the majority of studies of group

psychosocial interventions for serious mental illnesses (Segredou et al., 2012), the LGG uses cognitive and behavioral principles and healthy doses of psychoeducation.

For example, the Illness Management and Recovery Program (Mueser et al., 2006) was developed based on research on self-management strategies for clients with severe mental illness. It incorporates five evidence based strategies, including psychoeducation, cognitive behavioral approaches to medication adherence, developing a relapse prevention plan, social skills training, and coping skills training. Its purpose is to help those individuals manage their illness better in the context of their own personal goals. To accomplish this, 9 main topics are addressed over roughly 9 months of treatment in either group or individual therapy with a mental health professional. Though addressed in the language of faith, and taught by peers rather than professionals, psychoeducation on mental illness, discussion of the role of medication, coping skills training, and building social support are all important aspects that LGGs share with IMR and other recovery groups for those with serious mental illness.

Structure of Each Meeting

Each LGG meeting has a similar structure. Participants are given time at the beginning of the meetings to connect with each other, talk together and catch up. This helps form the social bonds of the group. The leader then welcomes the group and introduces the topic for the night. Group members then have an opportunity to share times since the last meeting where they have experienced improvement, insight, or seen how God is working in their lives. This helps provide hope and encouragement. After an opening prayer, the main topic is explored. A scripture is read to provide a faith connection and context for the topic, and then the educational information is covered.

Discussion of this material is invited, and some topics have worksheets that participants complete or use as part of discussion. This is followed by time to process ways of changing for the future, or integrating the material into life. The group closes in prayer, which is often in dyads. Afterwards there is time reserved for members to talk, connect and continue informal discussions sparked by the group.

Summary

It appears that religious communities are a frontier in psychological service: those seeking help often present there, and religious support and positive religious coping are associated with reduced incidence and improved recovery from mental illness (Bjorck & Thurman, 2007; Fiala, Bjorck, & Gorsuch, 2002; Pargament, Smith, Koenig, & Perez, 1998; Webb, Charbonneau, McCann, & Gayle, 2011). Simple church participation is not a substitute for mental health care, yet many individuals with mental health needs never seek or are unable to access professional care outside their church. Religious communities are geared to support their members; when churches actively assist those struggling with mental illness the power of congregational support and religious resilience factors are unleashed in the service of recovery. There is a growing body of evidence demonstrating that religious individuals not only want R/S incorporated into mental health interventions, but also experience added benefit when R/S are intentionally addressed. For these individuals, a R/S integrated approach may be more culturally appropriate. Basic helpful interventions such as psychoeducation, coping skills and increased interpersonal connection are ideal for implementation in a religious community setting, and are well suited to a group format. Peer-led groups have been shown to be

effective at delivering these types of interventions, and have the added benefits of minimal cost and maximum accessibility.

Living Grace Groups are one response to these needs. They follow a successful tradition in using a psychoeducational manual as a guide for group sessions and discussion led by peers. They are consistent with a growing literature expounding the benefits of incorporating R/S in treatment. By forming in church communities and using the language of faith for discussion, they serve as a culturally sensitive option and reduce the barriers to treatment frequently found in a religious population. They actively foster healthy spirituality and positive incorporation of religious beliefs in the recovery process. They provide an opportunity for connection and support from others with a similar worldview who are struggling with similar problems. They address the "whole person" of religious individuals, honoring the power and meaning fostered by faith and directing it in service of recovery.

Aims

The current study proposes to assess the feasibility and effectiveness of the Living Grace Groups in order to further understanding of the role such a group might play in the portfolio of mental health interventions.

Describing the feasibility of Living Grace Groups as a support for religious individuals with a mental illness is the first aim of this study. LGG's are designed to promote recovery for individuals with any mental illness, with a particular emphasis on accessing religious resilience and increasing cultural congruence for religious individuals. They are feasible to the extent they attract members with identified mental health problems who are religious and want R/S addressed in the context of mental health.

Evidence that participants are satisfied with the group, believe they benefitted from attending and are willing to refer others additionally supports feasibility.

If the group is feasible, it remains to be seen if it is actually helpful. Thus, the second aim is to investigate the psychological, religious and spiritual changes reported by Living Grace Group participants during the course of the group. The group is designed to provide education that helps individuals better understand and manage their illness and the common symptoms associated with it. An effective educational component should be accompanied by reductions in indicators of depression, anxiety and stress. The group further promotes recovery through supportive group contact in a religious context. This includes facilitating awareness of religious principles and examples that may aid participants in understanding and coping with illness. As religious content is integrated towards addressing mental health, positive religious coping may be modeled, while the explicit discussion of religion in a supportive community may combat negative religious coping. By experiencing increased support, sharing struggles with others, and integrating religious and psychological education on healing, members should move forward in recovery and towards a healthier spirituality. To the extent that the group is indeed helpful, individuals should report increases in recovery, positive religious coping, and spirituality and decreases in symptoms and negative religious coping.

As discussed earlier, there are other peer-led groups that have demonstrated effectiveness. For Living Grace Groups to add value to current options, they should demonstrate at least equivalent recovery outcomes while providing content and a culture that is preferable to religious individuals. Thus the third aim of this study is to compare the Living Grace Groups with a similar, but established and secular program. The Peer-

to-Peer (P2P) program will serve as a secular analog for comparison with the LGG. Since the format, leadership, time frame and psychoeducational content are similar, but P2P classes do not emphasize religion or spirituality, the two groups should be similar on psychological outcomes, but differ on religious and spiritual outcomes.

Hypotheses

In service of the first aim, the following hypotheses will be tested:

1) LGG will attract members typical of a clinical sample, as shown by reporting a broad spectrum of diagnosed mental disorders and reporting significant levels of distress.

2) LGG will attract members who are highly religious, as demonstrated by reporting religious affiliation, high attendance and high religious commitment.

3) LGG participants will express a desire for religion/spirituality to be incorporated in their treatment.

4) LGG participants will be subjectively satisfied with the groups, and willing to refer others to future groups.

5) LGG participants will describe religious components of the LGG as helpful in the healing/recovery process from mental health issues.

The following hypotheses will be tested to support the second aim:

6) LGG participants will report statistically significantly reduced psychological distress.

7) LGG participants will report statistically significantly improved recovery.

8) LGG participants will report statistically significant improvement in personal spiritual attitudes.

9) LGG participants will report using statistically significantly more positive religious coping and less negative religious coping.

The following hypotheses address the third aim of this study:

10) Positive psychological changes reported by LGG participants will not be less than those reported by P2P participants.

11) Religious/spiritual changes reported by LGG participants will be statistically significantly greater than those experienced by P2P participants.

CHAPTER THREE

Methods

Participants and Recruitment

Two primary groups were recruited for this study: individuals in the intervention group were recruited from Living Grace Groups, and individuals in the comparison condition were recruited from NAMI Peer-to-Peer classes. The Peer-to-Peer program was selected as a comparison because of its similarity to the LGGs on several levels: they meet for similar periods of time, are sponsored by community organizations and led by peers. Any individual who voluntarily attended any Living Grace Group (LGG) or selected Peer-to-Peer courses after the beginning of the study was a potential participant.

The researcher was introduced to group leaders for the Living Grace Groups by an email from one of the creators of the curriculum. Each group leader was then personally contacted and engaged in discussion of their willingness to participate in the research. They were given information about the purposes and procedures of the study, and whatever questions they had were answered. The researcher discussed their role in providing information about the project to group members, including the voluntary nature of the research. Group leaders were responsible for inviting group members to participate, informing them about risks and confidentiality, administering surveys, collecting responses in sealed envelopes, and returning them to the researcher. LGG groups in the following cities participated: Batemans Bay, Australia; Conneautville, PA; Dallas, TX; Hagatna, Guam; Heber Springs, AR; San Antonio, TX; San Diego, CA; Waco, TX.

Leaders at NAMI San Antonio, NAMI Houston and NAMI San Diego have offered the study to members of Peer-to-Peer groups that began during summer and fall of 2013 and spring of 2014. Those who voluntarily completed the study measures are the comparison group. In the NAMI structure, the researcher made contact with a leader within the local affiliate for approval, and subsequently contacted the peer mentors via phone to complete their preparation for the survey process. In the same manner as LGG leaders, the peer mentors were responsible for inviting class members to participate, informing them about risks and confidentiality, administering surveys, collecting responses in sealed envelopes, and returning them to the researcher.

Participation in the research study was not required to participate in any group. Participants were invited to participate in the study at the beginning of their first group meeting. They were verbally informed of the voluntary nature of participation and the requirements and benefits of participation.

Measures

Depression Anxiety Stress Scales-21 (DASS-21)

The Depression Anxiety Stress Scales (DASS; P. F. Lovibond & Lovibond, 1995; S. H. Lovibond & Lovibond, 1995) are a 42-item measure of past week symptoms of depression and anxiety. The scales were developed in an effort to more clearly differentiate between depression and physiological markers of anxiety, with the third scale (labeled "stress") containing items related to generalized anxiety or psychological tension that are common in both depression and anxiety diagnoses. The items on the depression scale represent low mood, low self-esteem and poor outlook for the future, e.g. "I couldn't seem to experience any positive feeling at all." The anxiety scale items

represent fear response and physiological arousal ("I experienced trembling [eg, in the hands]"), while the stress subscale represents persistent arousal, irritability and psychological tension ("I found myself getting agitated"). Participants were asked to rate how much each item applied to them in the past week, using a four point likert scale with anchors *not at all*; *to some degree, or some of the time*; *to a considerable degree, or a good part of the time*; and *very much, or most of the time*.

The three factor structure has been repeatedly replicated and the instrument has excellent internal consistency, with $\alpha > .88$ for all scales and the total score in both clinical and population samples (Antony, Bieling, Cox, Enns, & Swinson, 1998; Brown, Chorpita, Korotitsch, & Barlow, 1997; Crawford & Henry, 2003; Page, Hooke, & Morrison, 2007). The scales demonstrated expected patterns of correlation with the Beck Depression Inventory and Beck Anxiety Inventory – the Depression and Anxiety scales correlate most highly with their corresponding Beck scales and least highly with the opposite scales. The Stress scale had intermediate and roughly equivalent correlations with both Beck scales.

The DASS-21 consists of three 7-item self-report scales taken from the full version of the DASS, and scores on the 21-item measure may simply be doubled for comparison with the original DASS. In a clinical sample, the DASS-21 has demonstrated adequate internal consistency (α's >.87), a cleaner latent structure than the full DASS, and score equivalence with the full DASS (Antony et al., 1998). Several population-based studies confirmed these findings and established population norms for the DASS-21 (Crawford, Cayley, Lovibond, Wilson, & Hartley, 2011; Henry & Crawford, 2005).

The DASS-21 has also been supported for use as a routine clinical outcome measure (Ng et al., 2007).

Recovery Assessment Scale (RAS)

The RAS (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999) is a 41-item instrument developed to measure the concept of recovery in persons with serious mental illness, and specifically to evaluate outcomes of programs promoting recovery. Participants are asked to rate their agreement with each item on a five point Likert scale with anchors *strongly disagree*, *disagree*, *not sure*, *agree* and *strongly agree*. The overall scale is reported to have high reliability (α =.93) in a sample of individuals with severe mental illness (Corrigan et al., 1999). Factor analysis of the scale yielded five factors utilizing 24 items; these factors have internal consistencies ranging from .74 to .87 (Corrigan et al., 2004). The factors (with sample items) are named Personal Confidence and Hope ("I am hopeful about my future"), Willingness to Ask for Help ("I ask for help when I need it"), Goal and Success Orientation ("I believe I can meet my current personal goals"), Reliance on Others ("I have people I can count on"), and No Domination by Symptoms ("My symptoms interfere less and less with my life"). Analysis of the five factors revealed convergent validity with several aspects of recovery, including empowerment, quality of life, meaning of life, and number of psychological symptoms. Hope was the highest correlate of each factor, suggesting that it is important to all aspects of recovery.

The RAS has the most extensive use among existing measures of recovery, with 22 separate investigations reporting on its psychometric properties or sensitivity to change, compared to five for the next most investigated measure (Sklar, Groessl,

O'Connell, Davidson, & Aarons, 2013). It is often used as a standard measure to establish the validity of newer measures being tested. A recent systematic review stated that "Based on psychometric properties alone, the RAS appears to be the strongest instrument for measuring the mental health recovery of service users at the present time" (Sklar et al., 2013, p. 1092).

Brief Measure of Religious Coping (Brief RCOPE)

The Brief RCOPE (Pargament et al., 1998) is a 14-item measure of positive and negative religious coping methods that is the most commonly used measure of religious coping. It was designed to provide an alternative to general or dispositional measures of religiousness, instead allowing for assessment of type and intensity of religious coping, giving a more specific look at how religious beliefs affect individual response to stressors. According to the scale author,

> The positive religious coping subscale (PRC) of the Brief RCOPE taps into a sense of connectedness with a transcendent force, a secure relationship with a caring God, and a belief that life has a greater benevolent meaning. The negative religious coping subscale (NRC) of the Brief RCOPE is characterized by signs of spiritual tension, conflict and struggle with God and others, as manifested by negative reappraisals of God's powers (e.g., feeling abandoned or punished by God), demonic reappraisals (*i.e.*, feeling the devil is involved in the stressor), spiritual questioning and doubting, and interpersonal religious discontent. (Pargament et al., 2011, p. 58)

A sample PRC item is "looked for a stronger connection with God", while "wondered what I did for God to punish me" is a NRC item. Participants are asked to rate how much or how frequently they did what the item describes using the anchors *not at all*, *somewhat*, *quite a bit* and *a great deal*. The positive religious coping (PRC) and negative religious coping (NRC) subscales each consist of 7 items scored on a four point Likert scale, resulting in a minimum scale score of 7 and maximum of 28.

In a review of 30 published studies, median α for the PRC was .92 and median α for the NRC was .81 (Pargament et al., 2011). The majority of studies found the PRC and NRC to be uncorrelated, though a few found small positive correlations. This same review found significant evidence of concurrent and incremental validity. Though designed for cross-sectional research to describe the typical pattern of coping used by an individual, this review found promising support for the sensitivity of the measure to change, citing two studies that used the Brief RCOPE in a longitudinal fashion and which noted significant changes (Bay, Beckman, Trippi, Gunderman, & Terry, 2008; Piderman, Schneekloth, Pankratz, Maloney, & Altchuler, 2007).

Theistic Spiritual Outcome Survey (TSOS)

The TSOS (Richards et al., 2005) is a 17-item measure developed specifically to assess the spiritual outcomes of counseling. In response to a lack of valid means of measuring the spiritual outcomes of mental health treatment, the TSOS was designed to assess core components of spirituality in general harmony with the main tenets and practices of the major theistic world religions. The TSOS consists of three factors. "Love of God" (LG) assesses feelings of love and connectedness with God; "I felt God's love" is a typical item. "Love of Others" (LO) includes items with content related to ideal humanitarianism, referencing feelings and actions toward others; "I wanted to make the world a better place" is one example. "Love of Self" (LS) is characterized by items denoting self-acceptance and feelings of moral worthiness; "I felt worthy" is one such item. Each item is rated on a five point Likert scale with anchors *never*, *rarely*, *sometimes*, *frequently*, and *almost always*. The Love of God factor showed higher correlations with spiritual well-being, while the Love of Self factor is more highly

correlated with measures of mental health. The TSOS was found to have adequate reliability, validity, and usefulness among a sample of college students (each factor α's ≥ .80), a sample of inpatient women with eating disorders, and two samples from inpatient psychological clinics in Germany (α =.90) (Richards et al, 2005).

Religious Commitment Inventory -10 (RCI-10)

The RCI-10 (Worthington et al., 2003) is a measure of religious commitment, or "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (p. 85). It was developed to provide a better brief indicator of religious commitment for use in research and counseling, giving a more detailed information than single item measures of attendance, but measuring more concisely than existing lengthy scales. Factor analyses have revealed that the RCI-10 is composed of two subscales which are highly correlated: (a) Intrapersonal Religious Commitment and (b) Interpersonal Religious Commitment. An example of an Intrapersonal item is "My religious beliefs lie behind my whole approach to life" while an Interpersonal item is "I enjoy working in the activities of my religious organization." Each item is rated on a five point likert scale with anchors *not at all*, *somewhat*, *moderately*, *mostly*, or *totally* true of me.

A series of six studies revealed high internal consistency reliabilities (ranging from .87 to .96) for the RCI-10's total scale and subscales (Worthington et al., 2003). Despite expected patterns of convergent validity with each subscale, because correlations between the two subscales were high (r = .72), the total score is recommended for interpretation. The test-retest reliability for the full scale score was .86 over three weeks and .84 over five months. The RCI-10 is highly correlated with self-rated religious

commitment, religious attendance and spirituality as participation in the transcendent. Correlation between the RCI-10 and morality or spirituality as exemplary humanism was very low or nonsignificant. The authors have provided considerable evidence supporting the validity and usefulness of the RCI-10 with both Christian and non-Christian, client and non-client samples.

Other Survey Questions

In addition to demographic questions and validated scales, several additional items were included at the beginning of each of the LGG survey packets (Appendix A contains a full reproduction of these items). Because they were related to the R/S integration in the group, these were not included in the Peer-to-Peer survey packets. Four of them specifically asked about preference for various forms of inclusion of R/S in counseling. Three of these items ("How important is it to you that Scripture is used in your counseling?", "How important is it to you that your counselor is a Christian?" and "How important is it to you to pray with members of the Living Grace Group?") were adapted from similar questions used by Walker et. al. (2011). The last was written in a similar style for the purposes of this project: "How important is it to you that counseling explicitly incorporates religious principles?" Each of these four items was rated on a five point likert scale with 1- "Not at all important", 3 – "Somewhat important" and 5 – "Very important."

Another set of questions asked LGG participants to rank the top three of a possible five motivations to attend the groups. Participants were also queried about insurance coverage, financial strain, diagnoses and treatment history. These questions are all reproduced in Appendix A. On the final surveys, these questions and the

demographics were replaced with six questions regarding satisfaction and helpfulness of various aspects of their particular program. Appendix B contains the six satisfaction questions included on the final surveys for both LGG and Peer-to-Peer participants. The only exception is the question "How helpful were the religious components of the group to your recovery?" which was omitted from the Peer-to-Peer survey because it was not assumed that there were religious components of that program.

Procedures

The researcher communicated with group leaders to train them in appropriate survey procedures, to deliver survey packets and collect results, but had no contact with group members. Group leaders informed group members of the voluntary nature of participation, read an explanation of the research, and distributed the survey materials. Members of Living Grace Groups who opted into the research completed a packet of brief measures, including demographic measures and individual questions of interest (Appendix A), before beginning their first group meeting. These paper measures were filled out by hand. When finished, group members sealed anonymous completed packets in unmarked envelopes. Group leaders collected these sealed envelopes and returned them to the researchers in a prepaid envelope.

Once participants consented to the study, their responses were linked only to a self-generated ID code. The code consists of the last letters of first and last name, last two digits of a phone number and a two digit code for their birth month. In this way, researchers never had access to client identities. All of the completed surveys are kept in a locked cabinet in a locked office, with only members of the research team having access.

The post intervention survey occurred at the end of the last group meeting, when participants completed a similar packet of measures. This round omits the demographic questions and adds satisfaction questions (Appendix B) in addition to the outcome scales. Participants who missed the last group meeting did not complete the final questionnaire. There was no report of any participant who completed the initial survey refusing the final survey. The same procedure was used with a comparison sample from the several NAMI Peer-to-Peer classes.

Data Analysis

Demographic data and individual questions from all individuals surveyed (including those who had previously attended a group or who failed to complete post-group surveys) were used to describe members of the Living Grace Groups, their attitudes towards religion and its integration in the groups, and their satisfaction with the groups. Correlations between RCI score and the five-point outcome rating scales were calculated to assess the impact of religious commitment on satisfaction with the group. Consistent with the exploratory nature of the first aim, descriptive statistics (item averages and percentiles) were the basis for evaluating the following hypotheses:

1) LGGs will attract members typical of a clinical sample, as shown by reporting a broad spectrum of diagnosed mental disorders and reporting significant levels of distress.

2) LGGs will attract members who are highly religious, as demonstrated by reporting religious affiliation, high attendance and high religious commitment.

3) LGGs participants will express a desire for religion/spirituality to be incorporated in their treatment.

4) LGG participants will be subjectively satisfied with the groups, and willing to refer others to future groups.

5) LGG participants will describe religious components of the LGG as helpful in the healing/recovery process from mental health issues.

In the process of preparing survey responses for analysis, missing items on the dependent scales were replaced by imputing the mean score for all valid responses on that item across the appropriate sample. Downey and King (1998) noted that this method produced minimal distortion of scale reliability, mean or standard deviation when less than 20% of cases were missing less than 20% of data. In this study, missing scale items were replaced if 10% or less of the items were missing on a scale, or one item was missing on a scale less than 10 items. For scales with a higher number of items missing, the scale was omitted from analyses in pairwise fashion (all other data from the respondent was utilized).

Several analyses were utilized to test for homogeneity in the LGG sample. Analysis of variance was used to determine if participants differed significantly between sites. Post hoc Tukey tests were used to identify which groups differed when the overall ANOVA was significant. Only participants who completed the survey at their first LGG meeting and completed the second survey after the group concluded were included in outcome analyses. Chi-square or t-tests were used to test for differences between those who completed the LGGs and those who completed initial surveys but failed to complete the group. To accomplish the second aim, each of the following analyses used a dependent samples t-test to evaluate within-group changes over time. Cohen's d was calculated as a measure of effect size.

6) LGG participants will report statistically significantly reduced psychological distress as measured by the DASS-21.

7) LGG participants will report statistically significantly improved recovery as measured by the RAS.

8) LGG participants will report statistically significant improvement in personal spiritual attitudes as measured by the TSOS.

9) LGG participants will report using statistically significantly more positive religious coping and less negative religious coping as measured by the Brief RCOPE.

Characteristics of the intervention group (LGG participants) and the comparison group (NAMI participants) were compared with chi-square or t-tests. Both LGG and P2P participant responses at pre- and post-intervention were analyzed with a repeated measures ANOVA. The interaction term was used to evaluate between groups differences in changes over time. Partial eta squared was used as a measure of the size of the effect.

10) Improvement in psychological symptoms and recovery attitudes reported by LGG Participants will not be less than those experienced by P2P participants. The DASS-21 and RAS changes over time will not be significantly lower for LGG participants than P2P participants.

11) Religious/spiritual changes reported by LGG participants will be statistically significantly greater than those experienced by P2P participants. TSOS and Brief RCOPE improvements over time will be significantly higher for LGG participants than P2P participants.

CHAPTER FOUR

Results

Participation

During the course of the study LGGs in seven U.S. and two international locations were active and invited to participate. All accepted participation initially, but two were eventually excluded from the study. One international site was excluded because it ran as part of a residential substance use treatment program, meaning that participation in the LGG was not entirely voluntary and many members had no diagnosable mental illness aside from substance use. Another U.S. site attempted participation, but participants were mostly incapable of filling out the survey due to lack of education, traumatic brain injury or developmental disabilities. The leader reported that her group was characterized by these more limiting characteristics, and no data were returned from this site. At the seven sites which participated, 15 groups were surveyed. 116 individuals were invited to participate, and 101 (87%) agreed and completed the initial round of surveys (Time 1). Forty-seven of those 101 (47%) also completed the second round of surveys (Time 2), while an additional six individuals who were not present at the initial group meeting completed surveys at Time 2. Of the individuals who completed surveys at both time points, nine were excluded from pre-post analysis because they had previously attended a Living Grace Group, while three were excluded because they completed the initial survey sometime after the second group meeting. This left 35 individuals who completed some part of the survey at both time points, henceforth called “Completers”. Figure 1 presents this data in the LGG participant flowchart.

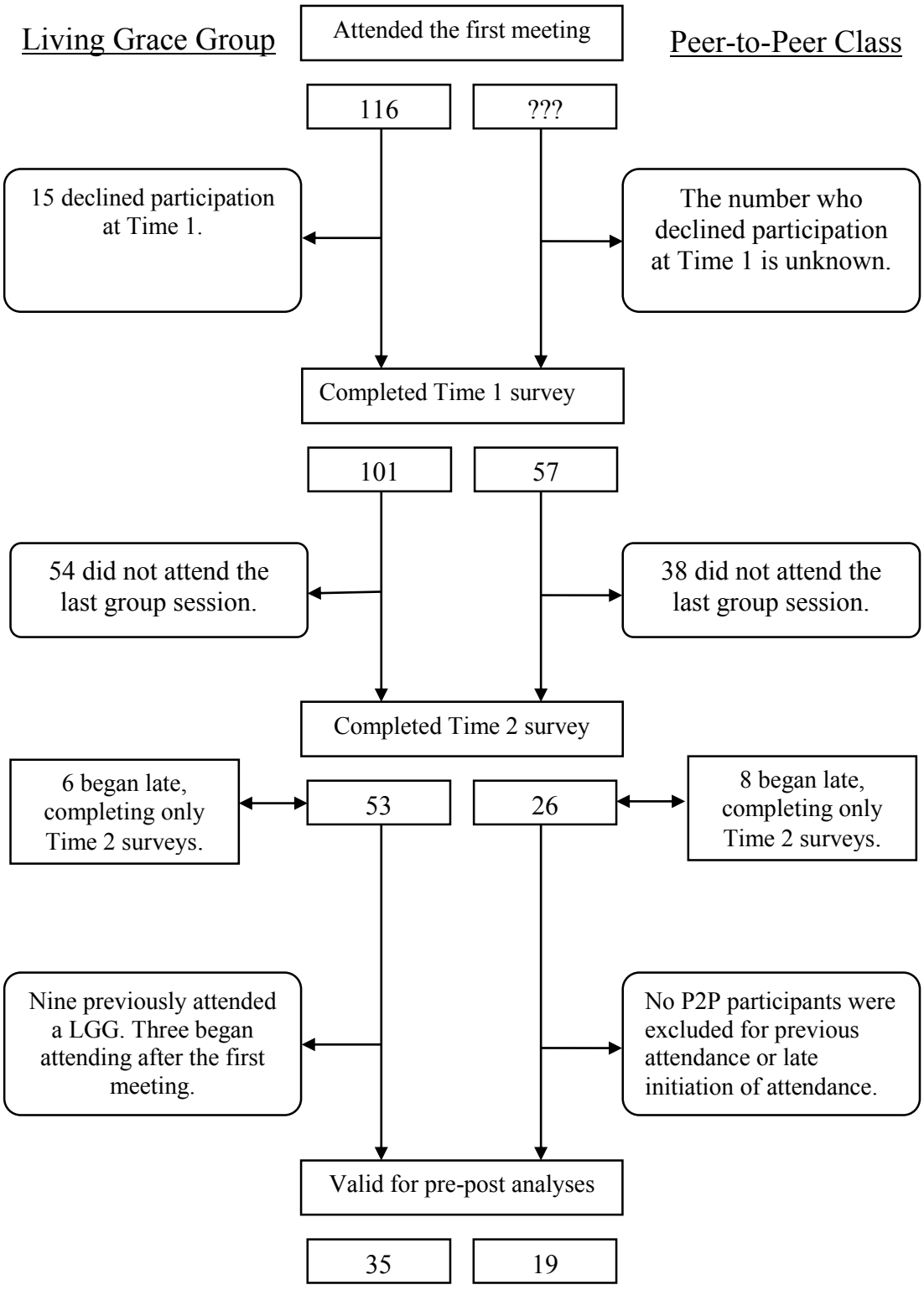

Figure 4.1. Flowchart of Study Participation

Any of the 101 initial surveys which contained any demographic data were used to describe LGG participants in terms of demographics, diagnoses and desires in counseling. For the sake of clarity, these participants will be called the Initial LGG participants. In order to minimize bias from experience, descriptive statistics for the dependent measures used only the subsample of Initial LGG participants that was attending a LGG for the first time and completed the survey sometime before the second meeting of the group (First-Time LGG participants). Because LGG Completers are a subset of only the First Time participants, First Time respondents are also the appropriate group for comparison with the Completers.

This study included NAMI Peer-to-Peer classes at three locations in the United States. Six classes were surveyed at the three sites. The number of individuals invited to participate is unknown because those numbers were not reported by a majority of the class leaders. 57 individuals agreed to participate, completing some part of the initial survey. 19 of those 57 also completed some part of the outcome survey at the completion of the P2P class. An additional 8 completed only the outcome surveys.

Participant Characteristics

The LGG Sample

Individuals in the Initial LGG sample at Time 1 tended to be Caucasian (75%) and female (79%) with an average age of nearly 45 years. The large majority (81%) had at least some college education, and over half were either employed or retired (54%). Nearly half reported being currently married (44%). Full demographic descriptive statistics are presented in Table 4.1.

Table 4.1

Descriptive Statistics for the Initial LGG and P2P Samples at Time 1

		LGG		P2P			
Category	Response	n	%	n	%	χ^2	Phi
Age	Mean (SD)	44.8	(15.56)	42.0	(14.18)	t(146) = 1.08	
Gender						6.50*	0.210
	Female	79	79.0	33	57.9		
	Male	17	17.0	19	33.3		
	No Response	4	4.0	5	8.8		
Racial/Ethnic Identity						21.28***	0.372
	Caucasian	75	75.0	28	49.1		
	Hispanic	14	14.0	8	14.0		
	Black	2	2.0	13	22.8		
	Multi-Racial	4	4.0	3	5.3		
	Other	3	3.0	4	7.0		
	No Response	2	2.0	1	1.8		
Marital Status						15.16**	0.312
	Single, Never Married	35	35.0	16	28.1		
	Married	44	44.0	12	23.1		
	Divorced/Separated	18	18.0	24	46.2		
	Widowed	3	3.0	2	3.8		
	No Response	0	0.0	1	1.9		
Living Arrangements						5.82	NA
	Alone	23	23.0	16	28.1		
	With Spouse/S.O.	43	43.0	18	31.6		
	With Children	10	10.0	4	7.0		
	With Other Family	17	17.0	8	14.0		
	Inpatient/Homeless	1	1.0	7	12.3		
	Other	5	5.0	2	3.5		
	No Response	1	1.0	2	3.5		
Employment Status						13.11**	0.290
	Employed	43	43.0	13	22.8		
	Unemployed	20	20.0	16	28.1		
	Retired	11	11.0	3	5.3		
	On Disability	17	17.0	21	36.8		
	Student	9	9.0	3	5.3		
Level of Education						1.07	NA
	HS Graduate or Less	19	19.0	12	21.1		
	Some College	40	40.0	18	31.6		
	College Degree	22	22.0	15	26;3		
	Any Graduate Work	19	19.0	10	17.5		
	No Response	0	0.0	2	3.5		

* significant at $p < .05$ **significant at $p < .01$ *** significant at $p < .001$.

The descriptive statistics for each of the scales completed by First Time LGG participants at Time 1 are listed in Table 4.2. ANOVA was used to test for heterogeneity of LGG members in different locations on each of these primary dependent measures. These analyses revealed no significant differences between locations on any of the five scales used in outcome analyses. Therefore, members of all LGGs were treated as a single group in subsequent statistical analyses.

Table 4.2

Initial Values of Dependent Measures and Between Groups Comparisons

	Living Grace Group			Peer-to-Peer Classes				
Scale	n	Mean	SD	n	Mean	SD	t	p
RCI-10	74	34.32	9.40	54	24.80	12.15	4.81	.000
PRC	77	22.09	4.64	55	18.42	8.09	3.03	.003
NRC	77	13.92	6.02	55	11.47	5.75	2.35	.020
RAS	74	144.47	20.83	51	157.02	23.94	-3.12	.002
DASS-21	76	29.01	15.26	51	26.45	16.69	0.89	.373
TSOS	75	55.33	13.11	49	56.84	14.54	-0.60	.551

RCI-10 – Religious Commitment Inventory-10, PRC – Positive Religious Coping subscale of the Brief RCOPE, NRC – Negative Religious Coping subscale of the Brief RCOPE, RAS – Recovery Assessment Scale, DASS-21 – Depression Anxiety Stress Scales-21, TSOS – Theistic Spiritual Outcome Survey.

The Peer-to-Peer Sample

Individuals in the P2P sample at Time 1 also were likely to be Caucasian (49%) and female (58%) with an average age of 42 years. The large majority (75%) had at least some college education, but less than a third (28%) were either employed or retired, while 37% reported receiving disability benefits. Twice as many P2P participants reported being divorced or separated (46%) as currently married (23%). Full demographic descriptive statistics are presented in Table 4.1.

The descriptive statistics for each of the scales completed by P2P participants at Time 1 are listed in Table 4.2. ANOVA was used to test for heterogeneity of P2P participants in different locations on each of these primary dependent measures. These analyses revealed no significant differences between locations on any of the five scales at Time 1. Therefore, members of all P2P classes were treated as a single group in subsequent statistical analyses.

Contrasts Between Samples

The LGG and P2P samples at Time 1 were compared on demographic dimensions using chi-squared tests of independence. For demographic categories with cell expected values less than five, response options were collapsed into more broad categories for analysis. For example education was collapsed from six into four categories: high school or less, any college, college degree, and any graduate work. The two groups differed on indicators of gender, race/ethnicity, marital status and employment status. Compared to LGG participants, P2P participants were more likely to be male, represented more racial diversity, were more likely to be divorced or separated, and more likely to be on disability.

Two-tailed independent samples t-tests were also performed to compare means on the dependent scales between the First Time LGG and P2P samples. Results are presented in Table 4.2. The LGG sample reported much higher religious commitment, and reported utilizing significantly more positive and negative religious coping than the P2P sample. The two groups had similar and not significantly different reports of psychological distress and spirituality. The P2P participants had significantly higher

report of recovery attitudes, indicating they held a better view of their own recovery than did the LGG participants at Time 1.

Feasibility Analyses

Hypothesis One: LGG members will be typical of a clinical sample, as shown by reporting a broad spectrum of diagnosed mental disorders and reporting significant levels of distress.

The clinical characteristics of the sample were illuminated by questions about diagnosis and treatment. Participants were asked to indicate their current primary diagnosis and any other diagnoses they had ever received from a mental health professional. Due to the large number of respondents who did not validly indicate a single primary diagnosis, results describe participant report of any diagnosis given by a professional over their lifetime. Most individuals reported multiple diagnoses and a wide range of diagnostic categories were indicated (Table 4.3).

The most commonly reported diagnoses were depressive disorders (66%) and anxiety disorders (58%), but a significant percentage also indicated they had been diagnosed with schizophrenia (9%), a bipolar disorder (40%) or PTSD (19%). Participants' report of therapeutic services they received at any time in the last year is also displayed in Table 4.3. Both the mean (January 2000) and median (July 2000) date of first diagnosis was at least 12 years ago. The mean (August 1999) date of onset of the current problem was in a similar range, while the median (Feb 2005) was more recent, reflecting that some individuals described a consistent problem that predated diagnosis, while for others the current problem may be different than previous mental health difficulties. These responses indicate that most of these individuals have been dealing

Table 4.3

Diagnoses and Other Mental Health Services Reported by LGG Subsamples

	Total Sample		First Time*		Completers	
Item Text	n	%	n	%	n	%
Diagnoses						
Schizophrenia	9	9.0	3	6.8	4	11.4
Bipolar Disorder	40	40.0	20	45.5	13	37.1
Depressive Disorder	66	66.0	27	61.4	22	62.9
Anxiety Disorder	58	58.0	25	56.8	22	62.9
PTSD	19	19.0	8	18.2	5	14.3
Substance Use Disorder	2	2.0	1	2.3	0	0.0
Personality Disorder	5	5.0	3	6.8	1	2.9
No Diagnosis	2	2.0	1	2.3	1	2.9
Other diagnosis	11	11.0	8	18.2	2	5.7
Mental Health Services (In Last Year)						
Case Management	7	7.0	4	9.1	3	8.6
Spiritual Guidance	20	20.0	5	11.4	9	25.7
Individual Therapy	60	60.0	26	59.1	24	68.6
Group Therapy	26	26.0	12	27.3	5	14.3
Prescription Medication	61	61.0	29	65.9	18	51.4
Employment Assistance	4	4.0	0	0.0	2	5.7
Residential Treatment	5	5.0	2	4.5	0	0
Substance Abuse Treatment	2	2.0	1	2.3	0	0
No Services Indicated	13	13.0	8	18.2	5	14.3

* All participants who completed the initial survey at the beginning of the first Living Grace Group ever attended, and did not complete the final survey.

with chronic or recurrent mental illness, and many have been struggling with their current problem for many years.

In a further indication of the severity of mental health issues in the sample, 44% reported that they had received inpatient treatment for their mental health issue at some point. 81% of the sample reported that they are currently taking medication for their mental health problem, while 54% were currently receiving psychotherapy. Only 13% of

the sample reported receiving no assistance other than the LGG with their mental health issues over the last year.

The DASS-21 also provides a measure of the severity of anxiety and depression symptoms common in clinical samples. DASS-21 raw scores are simply doubled for comparison with the reported statistics for the DASS and DASS-21. The mean total score for the LGG sample (58.02) falls in a range that is typical of clinical clients with diagnosed anxiety and depressive disorders (Antony et al., 1998). As seen in Table 4.4, the subscale scores are generally higher than for individuals diagnosed with an anxiety disorder but slightly lower than for those diagnosed with a Major Depressive Disorder or those assessed on admission to hospital treatment (Page et al., 2007). Overall, the LGG

Table 4.4

Mean DASS subscale values for LGG and clinical populations

DASS Scale	LGG	PD[a]	OCD[a]	MDD[a]	Hosp.[b]
Depression	21.34	12.75	13.30	29.96	24.15
Anxiety	16.03	18.72	9.26	14.04	17.85
Stress	20.66	20.00	17.59	24.30	23.07

[a] From Antony et al., 1998. [b] From Page et al. 2007
LGG – Living Grace Group, PD – Panic Disorder, OCD – Obsessive Compulsive Disorder, MDD – Major Depressive Disorder, Hosp. – Hospital admission for depression.

sample is clearly experiencing significant psychological difficulty and distress consistent with clinical samples, and many individuals have a chronic history of mental health issues.

Hypothesis Two: LGG participants will report high religious commitment.

Several indicators of religiousness and religious commitment were also requested. As expected, LGG participants reported large differences and significantly higher rates of religious affiliation and attendance than P2P participants (See Table 4.5). LGG participants' average score on the RCI-10 was 34.93 with a median score of 36. These values are consistent with samples of clients at explicitly Christian clinics and fall nearly a full standard deviation above the mean score of individuals in secular settings (Worthington et al., 2003). This value was also significantly higher than P2P participants rating (M = 24.80) and would be described as a large difference (Hedges' g = 0.95). In addition, religious affiliation and attendance are the two demographic dimensions on which LGG and P2P groups differed most markedly (as evidenced by the largest chi-squared values), and RCI-10 scores had the largest between group differences of the six

Table 4.5

Religious Affiliation and Attendance

	LGG		P2P			
Item Text	n	%	n	%	χ^2	Phi
Religious Affiliation					78.81***	0.711
Protestant Christian	92	92.0	15	26.3		
Catholic	7	7.0	9	15.8		
Jewish	1	1.0	0	0.0		
Other	0	0.0	19	33.3		
None	0	0.0	13	22.8		
Religious Attendance					28.99***	0.440
A few times a year or less	15	15.0	29	50.9		
One a month	13	13.0	3	5.8		
One a week	46	46.0	10	17.3		
2-3 times a week or more	25	25.0	9	17.3		
No Response	1	1.0	6	10.5		

*** significant at $p < .001$

dependent scales at Time 1. Clearly, the Living Grace Groups are attracting a highly religious set of members.

Hypothesis Three: LGG participants will express a desire for religion/spirituality to be incorporated in their treatment.

LGG members gave high ratings (four or above on a five point scale) to several questions of religious preferences in counseling (Table 4.6). On average, the presence of each of these religious factors was more than "somewhat important" to LGG members. When given the chance to rank five factors that attracted them to participation in a LGG, "Incorporates faith and a Christian perspective" was clearly the most important factor. It was named as a reason for choosing the group by the largest percentage of the sample (88% vs. 58% for the next highest response) and was most frequently indicated as the primary reason for choosing the group (49%). Rankings of preferences in counseling and the importance of a Christian perspective in drawing members to the group both support the third hypothesis.

Table 4.6

LGG Participants' Religious Preferences in Counseling

Item Text	Mean	(SD)
How important is it to you that Scripture is used in your counseling?	4.05	1.12
How important is it to you that your counselor is a Christian?	4.14	1.20
How important is it to you that counseling explicitly incorporates religious principles?	3.88	1.24
How important is it to you to pray with members of the Grace Group?	4.00	1.15

All questions were rated on a 5-point Likert scale with 1 - "Not at all important", 3 – "Somewhat Important" and 5 - "Very important"

Cost may also have been important to members of the LGGs. 33% of participants reported either that they did not have insurance (12%) or that their insurance did not adequately cover mental health treatment (21%). 24% stated that financial strain factored in their decision to attend a LGG. Since there is no financial cost to attending a LGG, these groups are likely more accessible, especially for those with financial strain.

Pilot Study of LGG Outcomes

Demographic information for LGG completers was compared to information for all other First Time LGG participants with chi-squared tests of independence. As before, demographic categories with cell expected values less than five had response options collapsed into more broad categories for analysis. The Completer group and other First Time participants were not statistically different in any categories except for gender. Though women were the large majority throughout the groups, men who completed initial surveys were more than twice as likely as women to complete surveys at Time 2. 77% of men who completed Time 1 surveys also completed at Time 2, compared to only 37% of women who completed both $\chi^2(1) = 8.07$, phi = .330.

In addition, the Completers were compared to other First Time responses with regard to reported diagnoses and treatment services received. No significant differences between the groups were found. The Completer group was further compared to the First Time attenders on the six dependent measures. The two groups showed no significant differences on any of the scales. Of all the comparisons between Completers and other First Time participants, gender was the only variable that significantly differed between the two groups.

Hypothesis Four: Participants will be subjectively satisfied with the groups, and willing to refer others to future groups.

Six individual items were used to assess self-report of satisfaction with the group and perception of the helpfulness of religious and psychological aspects of the material (Table 4.7). These items were rated on a five point likert scale by all participants (n=55) who completed the surveys at Time 2. The anchors for each scale were slightly different, and all scale anchors can be found in Appendix B. Five of the six items had mean scores well above four, indicating a very high level of agreement. Most participants responded that they were *very likely* to recommend the group to a friend, and were *very satisfied* with their experience in the group. The lone scale with an average below four differed in a few ways from the other questions. First, it asked participants to rate actual change in faith that had occurred, as opposed to satisfaction or helpfulness. Second, the anchors for this question differed from the others in that the midpoint value of 3 corresponded to *unchanged*, allowing participants to indicate stronger faith with a higher rating or weakened faith with a lower rating. Overall, participants who attended the last group

Table 4.7

Descriptive Statistics for LGG Satisfaction Items

Item text	Mean	SD
How likely are you to recommend the group to a friend who needed help?*	4.75	.682
How satisfied are you with your experience in the Living Grace Group?	4.69	.547
How helpful were the religious components of the group to your recovery?	4.51	.758
How helpful were the psychological/educational components of the group to your recovery?*	4.63	.595
How has your faith changed as a result of participating in the group?	3.92	.627
Overall, how helpful was the Living Grace Group to your recovery process?	4.29	.729

n = 51. * n = 52 All items rated on a five-point likert scale.

meeting indicated that they were highly satisfied with the group and very likely to recommend the group to others.

To determine if satisfaction ratings were related to level of religious commitment, RCI-10 total scores from the Time 1 survey were correlated with each of the six satisfaction questions for all individuals who completed surveys at both time points (n=47). A statistically significant correlation was observed only between RCI-10 score and helpfulness of the religious components of the group ($r = .391$, $p = .009$). The only other correlation to approach significance occurred between RCI-10 score and the overall helpfulness of the LGG for recovery ($r = .286$, $p = .060$).

Hypothesis Five: LGG participants will describe religious components of the LGG as helpful in the healing/recovery process from mental health issues.

In response to the question "How helpful were the religious components of the group to your recovery?" most LGG participants chose "very helpful" (the most positive option), yielding an average score of 4.51 on a five-point likert scale (see Table 4.7). LGG Participants were also asked to list three things they found "most beneficial" about the group, and three things they "would change". Analysis of these responses indicated that 15 of the 44 participants (34%) mentioned religious aspects of the group among the most beneficial factors. Only one participant mentioned wanting less religious content as something they would change, while three individuals mentioned a desire for more religious content. Through both numerical rating and free response, religious components of the LGG were described by members as helpful.

Hypotheses Six through Nine: LGG participants will report statistically significant improvement on scales measuring psychological distress, recovery, spirituality and religious coping.

In addition to asking about satisfaction, we also examined changes reported by the participants on the dependent scales. Dependent samples t-tests were used for each scale and its component subscales to examine the difference between responses at Time 2 vs. Time 1. Results are displayed in Table 4.8. The PRC scale did not show a significant change, but every other scale did, with all the changes in the direction of clinical improvement. The NRC scale showed a small but significant reduction, indicating that less negative religious coping was reported at the end of the LGG. A medium size

Table 4.8

Dependent Samples t-tests of LGG Outcome Measures and Subscales (Time2 – Time1)

Scale	Mean Difference	SD	SE	95% CI Lower	95% CI Upper	t-value	Cohen's d
PRC†	-0.68	5.68	0.97	-2.66	1.30	-0.69	0.12
NRC‡	-2.34	4.95	0.84	-4.04	-0.64	-2.80**	0.47
RAS Total	15.42	13.11	2.28	10.77	20.07	6.76***	1.18
PCH	3.45	3.56	0.62	2.19	4.72	5.57***	0.97
HEL	1.21	1.95	0.34	0.52	1.90	3.57**	0.62
GSO	1.45	2.78	0.48	0.47	2.44	3.00**	0.52
ROO	1.27	1.99	0.35	0.57	1.98	3.68**	0.64
NDS	2.03	2.20	0.38	1.25	2.81	5.30***	0.92
DASS Total	-7.45	10.65	1.85	-11.23	-3.68	-4.02***	0.70
Depression	-4.33	5.75	1.00	-6.37	-2.30	-4.33***	0.75
Anxiety	-1.76	4.26	0.74	-3.27	-0.25	-2.37*	0.41
Stress	-1.36	3.26	0.57	-2.52	-0.21	-2.40*	0.42
TSOS Total	7.70	9.58	1.67	4.30	11.10	4.61***	0.80
Love of God	3.36	4.37	0.76	1.81	4.91	4.42***	0.77
Love of Others	1.97	3.60	0.63	0.69	3.25	3.14**	0.55
Love of Self	2.36	3.22	0.56	1.22	3.51	4.22***	0.73

* significant at $p < .05$ **significant at $p < .01$ *** significant at $p < .001$. † n = 34. ‡ n =35 n = 33. PCH – Personal Confidence and Hope, HEL – Willingness to Ask for Help, GSO – Goal and Success Orientation, ROO – Reliance on Others, NDS – No Domination by Symptoms

reduction was noted on the DASS-21, while a large increase was reported on the TSOS. The RAS showed the largest effect of any scale, indicating that participants were rating their recovery much more positively at the end of the group compared to the beginning. On the DASS-21, the Depression subscale showed the largest decrease, while the Personal Confidence and Hope subscale of the RAS and the Love of God subscale of the TSOS had the largest increases relative to other subscales.

Peer-to-Peer Outcomes and Group by Time Interaction Effects

Demographic information for P2P completers was compared to information for all other Time 1 P2P participants with chi-squared tests of independence. As before, demographic categories with cell expected values less than five had response options collapsed into more broad categories for analysis. The P2P completers and other Time 1 participants were not statistically different in any categories. In addition, the P2P completers were compared to other Time 1 responses with regard to reported diagnoses and treatment services received. No significant differences between the groups were found on these factors.

Last, those who completed the P2P group were compared to other Time 1 P2P participants on the six dependent measures. Those who completed both surveys rated themselves significantly higher on the RAS (Table 4.9). The differences between groups also approached significance for the NRC and TSOS. In all cases the completers Time 1 mean score indicated healthier adjustment than the Time 1 score of those who failed to complete Time 2 surveys (study dropouts).

Like the LGG sample several indicators pointed to the clinical nature of the P2P sample. 75% of P2P participants reported that they had received inpatient treatment for

Table 4.9

Initial Values of Dependent Measures by P2P Participant Sub-Groups

	Non-Completers			Completed both surveys				
Scale	n	Mean	SD	n	Mean	SD	t	p
RCI-10	35	24.60	11.96	19	25.16	12.82	0.16	.874
PRC	36	18.50	8.15	19	18.26	8.21	-0.10	.919
NRC	36	12.39	6.16	19	9.74	4.52	-1.82	.076
RAS	33	151.21	25.19	18	167.67	17.48	2.46	.017
DASS-21	33	28.12	17.24	18	23.39	15.62	-0.97	.338
TSOS	32	54.22	15.31	17	61.76	11.84	1.768	.084

their mental health issue at some point. 81% of the sample reported that they are currently taking medication for their mental health problem, while 65% were currently receiving psychotherapy. Only 11% of the sample reported receiving no assistance other than P2P with their mental health issues over the last year.

For the purposes of comparison with LGG scores, dependent-samples t-tests of P2P completers were completed for each outcome measure. The results are presented in Table 4.10. The only significant change was a reduction on the NRC, though the RAS,

Table 4.10

Dependent Samples t-tests of P2P Outcome Measures and Subscales (Time2 – Time1)

Scale	n	Mean Difference	SD	95% CI Lower	95% CI Upper	t-value	p	Cohen's d
PRC†	19	-1.95	5.61	-4.65	0.76	1.512	.148	0.35
NRC‡	19	-1.37	1.86	-2.27	-0.47	3.203	.005	0.73
RAS Total	17	5.18	12.33	-1.16	11.51	-1.732	.103	0.42
DASS Total	17	-6.35	13.54	-13.31	0.61	1.935	.071	0.47
TSOS Total	16	4.06	8.28	-0.35	8.48	-1.962	.069	0.49

TSOS and DASS showed a trend toward significance with small to medium effect sizes. Small sample size appears to be precluding statistical significance in these cases.

In total, 35 eligible LGG participants and 19 P2P participants completed some overlapping scales on both the initial and final surveys. These responses comprised the set of outcome data available to test hypotheses about relative improvements between the groups over time.

Hypothesis Ten: Improvement in psychological symptoms and recovery attitudes reported by LGG participants will not be less than those experienced by P2P participants.

After demonstrating positive changes for LGG members on the RAS and DASS-21, these changes were compared to changes reported by P2P participants. Results for the Group by Time interaction effect in a repeated measures ANOVA are presented in Table 4.11. For the DASS-21, no significant interaction was found, and indeed the mean scores of each group are very similar at both time points. For the RAS, a significant

Table 4.11

Group by Time Interaction Results of a Repeated Measures ANOVA

	Living Grace Group			Peer-to-Peer					
Scale	Mean	SD	n	Mean	SD	n	F	p	η^2
PRC (Time 1)	21.88	4.45	34	18.26	8.21	19	0.616	0.436	0.012
(Time 2)	21.21	4.35		16.32	8.13				
NRC (Time 1)	13.23	5.97	35	9.74	4.52	19	0.680	0.413	0.013
(Time 2)	10.89	4.14		8.37	3.34				
RAS (Time 1)	145.94	17.09	33	167.65	18.01	17	7.130	0.010	0.129
(Time 2)	161.36	13.59		172.82	21.43				
DASS-21 (Time 1)	26.21	14.06	33	24.24	15.68	17	0.100	0.754	0.002
(Time 2)	18.76	9.99		17.88	13.14				
TSOS (Time 1)	54.70	11.09	33	62.38	11.95	16	1.690	0.200	0.035
(Time 2)	62.39	9.12		66.44	12.56		0.616	0.436	0.012

interaction was found, indicating that the amount of improvement over time differed between the two groups. Examination of group means shows that the LGG members RAS score increased nearly three times as much as P2P participants. Since neither DASS-21 nor RAS improvements were significantly less for LGG than P2P participants, this hypothesis is supported.

Hypothesis Eleven: Religious/spiritual changes reported by LGG participants will be statistically significantly greater than those reported by P2P participants.

Contrary to the hypothesis, none of the group by time interactions were significant for the PRC, NRC or TSOS (see Table 4.11). In each case, the magnitude of change in scores was greater for the LGG group, but the differences were not large (the effect size was small). Combined with a relatively small sample size this produced results that were not statistically significant.

CHAPTER FIVE

Discussion

The results just presented indicate that the Living Grace Groups are fulfilling many of their goals. They attract highly religious individuals who want R/S integrated into their counseling and care. These individuals reported high levels of distress, a broad range of diagnoses, high comorbidity and high rates of utilization of mental health resources, all of which indicate a level of severity typical of a clinical sample. LGG participants reported that they were highly satisfied with the groups, found both psychoeducational and R/S aspects to be helpful, and indicated a willingness to refer others. It appears that the integration of R/S in these groups increases the cultural fit of the intervention with the population that they attract.

In addition, LGG participants report significant change during the course of the group. Though no significant change was observed on positive religious coping, participant responses indicated significant increases in recovery and spirituality, and significant decreases in negative religious coping and symptoms of depression and anxiety. These changes compared favorably with an established secular group (NAMI Peer-to-Peer). While the magnitude of change scores was larger for LGG participants, the difference between change scores was not significant for four of the five variables. On the last variable, recovery, the LGG group had a statistically larger change over time than did the P2P group. These results support the effectiveness of the LGG in that the highly religious individuals attracted to the Living Grace Groups report equivalent or

greater gains on a number of key variables compared to participants in an established secular program.

Feasibility of the Living Grace Groups

Primarily, the takeaway from the initial stage of the study is that clinical samples can indeed be reached and served by a religious group formed through a church. Indeed, church appears to be an acceptable venue for recovery-oriented efforts to serve those with mental illness. Results of this study confirm that individuals with mental illness are present in church, and those individuals want help from their church community (Rogers, Stanford, & Garland, 2012). Others have found that many with mental illness turn to the church or clergy for help (Farrell & Goebert, 2008; Meylink & Gorsuch, 1986, 1988; Wang et al., 2003). The intensity and chronicity of mental health issues reported in this sample further demonstrates that programs run in church may be ideally placed to intervene with mentally ill individuals.

High average religious commitment and religious attendance of participants indicates that LGGs do not primarily serve as merely another community group that happens to run in the church, but particularly appeal to and attract religious individuals. Even so, no relationship is evident between religious commitment or attendance and satisfaction with the group, and individuals of all levels of religiousness are just as likely to recommend it to a friend. This indicates that while the LGG has particular appeal to highly religious individuals, it does so without becoming distasteful to those with lower religious commitment. Indeed, lower religious commitment scores may in part reflect growing distance from the faith community potentially due to mental illness (Hathaway,

2003; Pfeifer & Waelty, 1995). These individuals may be prime targets for a R/S integrated intervention that helps them reconnect with religious community support.

Participation of individuals with all levels of religiousness in the LGGs indicates that these individuals may see the church as not merely a place to receive religious direction and spiritual support, but also an option for receiving culturally consistent care for mental illness in a psychoeducational manner. This is a key difference from a solely religious support group – the LGG has brought psychoeducation to church in an integrated format acceptable to both churches and religious individuals. Living Grace Groups indeed are an "innovative program" as called for by Koenig, McCullough and Larson (2001) that mobilizes the internal religious resources of the participant and the community resources of the church to facilitate recovery in a supportive and caring environment.

It is also very clear that R/S integration is key to successful implementation of the LGG. First off, R/S integration helps to attract members for the LGG. In addition to reporting significant chronic mental health issues, the sample of LGG participants is both highly religious and indicates that they desire R/S integration in their recovery process. This finding is consistent with literature reporting that many individuals want religion addressed in psychological counseling (Cornish & Wade, 2010; Post, Wade, & Cornish, 2014; Rose et al., 2001). Multiple other treatment, group and support options are available for those who do not desire R/S integration; therefore it is the single aspect that most distinguishes the LGG from similar programs. Indeed, the LGG sample indicated that the most significant reason they chose to attend the Living Grace Group was that "it incorporates faith and a Christian perspective." There is evidence that some church

members may be suspicious of secular treatment (Fallot, 1998; Mayers et al., 2007; Powlison, 2000), and for those an integrated approach may be more acceptable.

R/S integration also allows the group to utilize the resources and organization of the church. The association of each group with a church community is the reason why most groups were successful in forming and running with only a modicum of professional assistance and no financial support. Several authors have noted the largely untapped potential of church communities (Koenig et al., 2001; Webb et al., 2011), and LGGs would not have been possible without this collaboration. It is highly unlikely that the groups would have been so quickly or readily adopted if they did not integrate R/S. Nearly universally, churches who asked permission to use the LGG materials found the group and selected it precisely because it was written from within a Christian worldview and explicitly incorporated R/S.

R/S integration further contributes to the success of the LGGs by enhancing the cultural sensitivity of psychoeducational intervention. Regardless of whether the group was chosen explicitly for its religious content, the integration of R/S fits with the highly religious sample that was attracted. They largely indicated that they wanted faith-inclusive counseling, and rated religious aspects of the group as helpful. Beyond these individual preferences, being sponsored by a church and explicitly discussing R/S principles may help promote a feeling of community and shared worldview.

Effectiveness of the Living Grace Groups

Within-Group Change

Of all the outcome scales, the PRC scale was the single scale with a non-significant change. Aside from concluding that the group simply was not effective in

increasing positive religious coping, there are several factors that could partially explain this finding. First, characteristics of the measure itself may have interfered. The instructions do not include a specific time-span for responses (such as the past week) and do use past tense to ask how individuals "have coped" with their problem. This may bias respondents to indicate more habitual or past styles, reducing sensitivity to change. The literature support for sensitivity to change is based on a very few studies with individuals who began with lower levels of PRC than the LGG. The ability of the scale to measure change also may be partially determined by the baseline levels of coping reported in the sample, with less sensitivity to change for those already reporting high PRC or low NRC.

Indeed, the LGG sample mean at Time 1 for both PRC and NRC was at the very high end of the range of all samples reported in Pargament, et. al's 2011 literature review. The mean PRC response was greater than a three on the four point likert scale used to measure responses, indicating the respondent used each positive religious coping method "quite a bit." This indicates that the LGG sample were on the whole already actively using high levels of positive religious coping. In contrast, while the average response on the NRC scale corresponded to only "somewhat" using that coping method, this represented more negative religious coping than other samples. Hence, one explanation for the significance of change in NRC and not PRC may simply be that it is easier to bring an extreme mean closer to the population average (in this case NRC) than it is to make an outlying score more extreme (PRC). Reducing maladaptively high NRC may be easier than increasing already adaptively high PRC.

Stated another way, the LGG's may be most effective at activating a positive religious coping style for those who use it very little rather than maximizing positive

coping potential for those who already actively use religion in positive ways. Participation in the LGG may be more likely to activate positive coping for low scorers and deactivate negative coping for high scorers than it would to incrementally increase or decrease scores for every individual. The reason for a difference in significance between PRC and NRC in this study then might simply be a function of the characteristics of the sample – only the extreme score for which a regression to the mean represented an adaptive response was found to change.

Aside from the PRC, LGG members reported significant changes in the direction of growth and recovery on every scale. Members reported less negative religious coping, meaning that they experience less spiritual tension, conflict with God and interpersonal religious discontent. LGG participants also reported increases in spirituality, specifically love of God, love of others, and moral self-acceptance. Given that spirituality, relationships with others, hope and a sense of meaning in life are aspects of recovery, it is not surprising that participants reported large gains in self-rated recovery, particularly on a scale with items assessing hope and personal confidence. Finally, even reported symptoms of depression and both physiological and psychological markers of anxiety decreased. Taken together, during their time in the Living Grace Groups, participants described reductions in spiritual tension and conflict, improvements in their view of relationships with others, increased feelings of self-worth and self-acceptance, more hope and confidence in their ability to handle symptoms, all in addition to reporting fewer anxious/depressive symptoms.

This is good news for individuals who prefer R/S integration in their mental health care. It indicates that not only is the approach acceptable, even preferable, to a

highly religious population, but it is described as helpful by participants on well-validated standardized outcome measures. Present results further corroborate previous studies indicating that integrating R/S with established psychological principles of change is an effective strategy with appropriate populations (Hook et al., 2010; Smith et al., 2007; Worthington et al., 2011). As a quantitative outcome design, this study provides evidence regarding services that have rarely been empirically tested, and serves to begin to extend the positive findings regarding R/S integrated, professionally delivered treatments to peer-led, psychoeducational support groups.

The literature support for peer-led groups for mental illness is rapidly expanding (Cook, 2011; Repper & Carter, 2011). Most previous work on peer-led groups takes place within the mental health system, as community mental health centers train peers and sponsor courses (Cook, Copeland, et al., 2012; Cook, Steigman, et al., 2012; Fukui et al., 2011; van Gestel-Timmermans et al., 2012) or consumer-run organizations provide leadership (Cook et al., 2010; Fukui et al., 2010). The Living Grace Groups are different – designed to be more independent and portable by relying on church communities for support. This study also adds to the peer-run literature by examining a group that is R/S integrated and runs in church.

Change Between LGG and P2P Groups

In terms of pilot outcomes, the LGG within-group analysis provided significant optimism. The results of comparisons with the P2P groups on recovery and symptom scales solidified this judgment. As expected, there were no significant differences noted between the groups change on symptoms of depression or anxiety, but the LGG participants reported a significantly larger improvement in self-described recovery.

While not predicted to be significantly larger, there are several potential reasons this could have occurred. A smaller percentage of P2P participants completed the group than LGG participants, meaning that dropout effects would be magnified for P2P. Compounding this, those who completed the P2P class had significantly higher initial scores on the RAS than P2P non-completers, indicating that those who might have benefitted most failed to complete the study. Stating it in reverse, those with initially high recovery scores were less likely to drop out, and more likely to be included in outcome analysis, likely leading to less measured change in the P2P participants.

One potential interpretation of this is that some aspect of the LGG groups fostered better retention, especially for members with lower initial scores on recovery. Other authors have suggested that professionals who understand and value the worldview of their religious clients may have greater credibility and establish a stronger working alliance (Richards & Bergin, 2005; Young, Dowdle, & Flowers, 2009). This may extend to the group setting where R/S integration in the LGG may promote group bonding and member retention. The integration of R/S into the group may also have potentially helped in retaining individuals with lower recovery and spirituality scores, if they felt that spiritual struggles and doubts were a hindrance to recovery that was directly addressed in the LGG.

A related possibility is that the integration of R/S in this particular group potentiated the recovery-related impact of the group. Many R/S factors have been identified as either influencing recovery or an aspect of recovery itself, including relationship with God, spiritual struggle, interpersonal religious discomfort, hope, sense of meaning and self-acceptance (Corrigan et al., 2003; Fallot, 2007; Pargament et al.,

2000, 1998). There is also evidence that R/S integrated services have an impact on several spiritual aspects of recovery (Richards et al., 2005, 2006). Given that current results showed significant changes on scales measuring all of these constructs for LGG participants, the cumulative impact of all these aspects on recovery may have been much larger than the change in any one individual variable. This may partially explain why a significant difference was noted between the LGG and P2P groups on recovery, but not measures of religious coping or spirituality.

Indeed, though Brief RCOPE and TSOS mean changes were greater for LGG participants than P2P participants, contrary to hypothesis the difference was not statistically significant. For the PRC, there was no within-group effect, and so no interaction effect would necessarily be expected. For the other scales, the main contributor to lack of significance may have been the small sample size of the comparisons. The NRC comparison had a total sample size of 54, while the TSOS was just 49. Using G*Power, in order to detect a small effect such as observed with the NRC, 222 participants would be needed for power of .80 (as opposed to the 56 for an effect of the medium size demonstrated by the RAS).

Another potential contribution is more theoretical. Previous research has shown that anxiety, depression and distress are positively related to NRC (Ano & Vasconcelles, 2005), and the TSOS measures relationships with others and moral self-acceptance. P2P classes were expected to provide effective psychoeducation, thereby reducing self-stigma, increasing hope, and reducing symptoms. Some of these improvements are very similar to aspects of spirituality measured by the TSOS (i.e. moral self-acceptance), and a reduction in symptoms may well influence the use of negative religious coping. If any

notable positive change occurred on these scales in the P2P group, corresponding changes in the LGG group would have to be very large to manifest a significant interaction effect with this sample size. In other words, the interaction effect between two groups, one with a large within-group effect and the other with a medium within-group effect, may easily be small, and therefore need a much larger sample size to detect. Failing to account for the likelihood of some positive change in religious coping and spirituality in the comparison group likely led to this study being underpowered.

Nevertheless, results of the comparison of LGG and P2P samples have several important meanings. On the most obvious level, the present pilot data indicate that the LGG is at least as effective on the outcomes studied as an established community peer-led program (Lucksted et al., 2009). This not only increases confidence in the use of LGGs as a recovery-oriented psychoeducational program for mental illness, but more broadly supports the effectiveness of R/S integrated psychoeducational groups.

A number of authors have pointed out the importance of R/S to individuals struggling toward recovery from mental illness (Corrigan et al., 2003; Fallot, 2007; Tepper et al., 2001). In this evaluation, the R/S integrated group did produce significantly greater positive changes in self-reported recovery than a secular class. Though others have described benefits of R/S psychoeducational groups before (Kehoe, 1999; Phillips et al., 2002), this study is one of few that lend empirical support to the idea that incorporating religion and spirituality in care for religious individuals may have a uniquely beneficial effect on recovery.

Limitations

The implications of this study are primarily limited by aspects of its design. Because participants at existing groups were surveyed with the assistance of the group leader without the direct personal presence of any researcher, the groups were more loosely controlled than if they had been overseen more directly. This was necessary both to protect the confidentiality of the participants and to make it possible to include widely geographically distributed groups. It did however, result in some irregularities with respect to participation. For example, one group's leader was sick on the last day of group, and though the group was run by a substitute, most of the group members did not attend. A leader running a different group that contained mostly members repeating the curriculum decided not to offer participation to the few new individuals. Another group had a week break immediately before the last group to accommodate a religious holiday, and significantly fewer individuals attended the last meeting then the penultimate meeting. These instances contributed to a lower survey completion rate, and the omission of those individuals increases potential error.

Similarly, there were some difficulties in partnering with NAMI to offer participation at Peer-to-Peer groups. The process of gaining administrative clearance to work with the program led to delays in beginning the survey process and resulted in several leaders deciding not to offer participation, while simultaneously restricting the number of groups who could be contacted for participation. Because of the multiple administrative layers at some affiliates, information about the number of participants who declined participation or dropped out was not reported by two of the three sites. A

smaller sample size and unknown participation rate affect the confidence that can be placed in these results.

The study was designed as a pilot test of the Living Grace Groups, and as such had a relatively small sample size, especially for making comparisons between the LGG and P2P groups. The larger size of the sample of initial LGG surveys is adequate to describe typical LGG participants, and the number of LGG outcome pairs provides appropriate power for the dependent samples t-tests. In contrast, the total sample of outcome pairs including the P2P participants is underpowered for the more complex interaction analyses.

The largest limitation for drawing implications about the effectiveness of the LGGs, however, is the quasi-experimental nature of the design. Since participants were recruited at existing groups and not randomly assigned, causality is not determined and factors outside of the LGG (such as concurrent psychotherapy or medication) may have contributed to the treatment effects demonstrated. The comparison with P2P provides some evidence that not all of the effect should be attributed to outside factors, as the P2P group had generally higher rates of outside help-seeking, yet LGG gains were equal or greater to P2P. In addition, a quasi-experimental design allowed for description of LGG members and their evaluation of the groups as they function in actual practice, increasing the ecological validity of the results. Nevertheless, this treatment design cannot completely rule out other factors as causes of the changes evidenced by LGG members.

Implications

As an option for religious individuals, LGGs appear feasible, effective and comparable to an established peer-run program. On the most basic level, this further

demonstrates the benefit of peer-delivered services and provides a new option for community care for those with mental illness. Beyond that, the religious nature of these groups is a potential game-changer. Psychoeducation need not be limited to mental health organizations like community mental health centers or NAMI affiliates. Because the groups integrate a Christian religious worldview, they are ideally placed to be adopted in most church communities, increasing access to care in a number of ways. There are geographic areas where the mental health care structure is nearly non-existent, but even the smallest communities usually have a church.

Indeed, in many ways the Living Grace Groups meet those in need where they already are. Many individuals with mental health needs seek help at church (Farrell & Goebert, 2008; Stanford & Philpott, 2011; Wang et al., 2003), and a LGG could be an immediate resource for them, and introduction to more intensive care when needed. By forming within the existing and established community organizations that churches are, LGGs benefit from the enormous resources present there as suggested by Koenig, McCullogh and Larson (2001). Because they further the mission of the church to serve, heal and support its members, resources such as leaders, meeting spaces, publicity, basic supplies, and administrative support are provided. Moreover, the group forms where those with mental illness already are present (Rogers et al., 2012), and the church itself often helps identify those within its community that may benefit from the group.

LGGs also meet their participants where they are in terms of worldview and beliefs. Self-identified Christians make up an large majority of the U.S. population (Pew Forum on Religion & Public Life, 2008), and many clients, especially religious ones, express a preference for R/S integration in their care (Knox et al., 2005; Martinez et al.,

2007; Rose et al., 2001; Walker et al., 2011). Thus, the LGG meets these individuals where they are by providing a culturally consonant and attractive option for education and support. Furthermore, by explicitly incorporating R/S and treating religious coping as a potential strength, the group strengthens and mobilizes existing resilience factors in the service of recovery. The incorporation of R/S in this group may help reduce the negative impact of mental illness on religious practice (Pfeifer & Waelty, 1995; Scott et al., 2003), reducing distress and increasing access to important relationships, coping strategies and support.

As a powerful new option for the portfolio of mental health services suggested by Kazdin and Blase (2011), this group indeed reduces many barriers to care. A Living Grace Group provides a more culturally sensitive and attractive option for a large group, physically meets in the communities where need exists, is self-sustaining and supported by existing community organizations, and requires a minimum time investment from professionals. Cost is no barrier, as the group is free of charge.

Turning to the community to offer care and support represents a shift in approach within mental health. Rather than having to seek and enter the mental health system for care, individuals in their faith communities are empowered to offer support, education and guidance. Care arises from within the community that includes the individual, rather than being delivered from an outside individual or organization. This approach is more integrated, potentially helping participants form or repair connections within their existing community as one aspect of the support received in the group. There is less of a separation between the care the individual receives and their usual daily environment, including others invested in their wellbeing.

On an even broader level, the existence of empirically examined R/S integrated groups such as the LGG increases the opportunities for rapprochement between psychology and faith. These groups provide a relatively easy way for a church to offer care to those with mental illness, and one that brings together R/S and psychological methods, rather than forcing individuals to pick one. Starting a LGG may be the beginning of a broader conversation about mental illness in that church, and clients who participate in LGGs may be more likely to bring up faith and religion with their professional helpers. This in turn may reduce the hesitation of mental health providers to make a place for R/S in the therapy they provide, or increase their willingness to partner with faith communities.

Future Directions

Looking to the future for research on the Living Grace Groups, there are several open questions and possibilities. The current results indicate that the integration of R/S was appreciated and helpful, but it remains to be determined what aspects of the groups produce beneficial effects. Is it specific content related to religious and spiritual practices, supportive discussions in a community of believers, positive modeling of positive religious coping, all of these, or some other factor? In a similar vein, a more precise measurement of a variety of R/S outcomes could better specify the particular R/S benefits of the group. One particular construct of interest for further investigation is religious social support, which may be strengthened by a church-based group such as the LGG. Further work along this line could also examine whether R/S inclusion is helpful mainly by increasing cultural comfort with the groups, or whether R/S components are also directly contributing to improvements in recovery.

Future study would also benefit from some methodological changes. An experimental investigation with random assignment would more definitively establish the efficacy of the LGG intervention, while extended post-group follow up would allow for examination of the duration of the observed effects. In this study, LGG participants were a relatively homogenous group, especially on racial and gender dimensions. It remains to be seen how a more diverse set of members would respond to this particular group and content.

The Potential for LGGs

Results of this study indicate that LGGs are beneficial and compare favorably to existing programs. This means that they are a legitimate candidate for inclusion in a broad portfolio of mental health efforts as suggested by Kazdin and Blase (2011). In terms of reducing the burden of care for those with mental illness, they have numerous advantages. They reduce financial barriers for help, are self-sufficient at a local level, and require very few professional psychological resources. LGGs are designed to be helpful for individuals with a wide spectrum of diagnoses. They can be a powerful vehicle for psychoeducation while fostering social support through a group experience. By virtue of R/S integration, Living Grace Groups appeal to a large section of the population, and are able to increase the cultural sensitivity of the support offered to those individuals. They foster healthy spirituality and religious coping while providing effective psychoeducation, thereby enhancing recovery and reducing the impact of symptoms. For some individuals, the groups may complement existing treatment (therapy, medication) by addressing R/S or providing a supportive environment. For

others, the groups may be a first experience, in the "safety" of a church environment that introduces them to the potential for further help.

Whatever the most salient reason for their adoption in a particular place, evidence from this study provides optimism about the helpfulness of the Living Grace Groups. Those considering offering the groups should have confidence that they are an effective program that is responsive to the desires of those who wish to have R/S integrated with psychoeducation in a supportive group environment.

APPENDICES

APPENDIX A

Initial Survey Questions

Demographic Form

Describe yourself by circling the appropriate answers.

Today's Date: __ __/__ __/__ __ __ __

1. Gender: 1 = Male 2 = Female

2. Age (in years): _____

3. What racial and ethnic group do you consider yourself?

1 = Caucasian	4 = Asian or Pacific Islander
2 = Hispanic or Latino	5 = Native American
3 = Black	6 = Other race/ethnicity: _____

4. Is English your first language? (1=Yes, 2=No)

5. Marital Status:

1 = Single, Never Married	5 = Legally Separated
2 = Unmarried, Living with Partner	6 = Divorced
3 = Married, Living with Spouse	7 = Widowed
4 = Married, Not Living with Spouse	

7. Usual (most frequent) living arrangements during the last 90 days:

01 = Alone	06 = Incarcerated/Jail/Prison
02 = With Spouse / Significant Other	07 = Homeless
03 = With Spouse and Children	08 = Psychiatric Unit
04 = With Children	09 = Inpatient Alcohol/Drug Tx
05 = With Other Family	10 = Other

8. Usual employment status during the last 90 days:

1 = Full-Time Employment	4 = On Disability
2 = Part-Time Employment	5 = Unemployed
3 = Retired	6 = Full/Part Time Student

10. Education:

1=Less than High School	4 = College degree
2 = High School Diploma or GED	5 = Some Graduate work
3 = Some college	6 = Graduate degree

12. What is your religious affiliation?

1 = Christian	3 = Jewish
2 = Catholic	4 = Other

13. How often do you attend religious services?

1 = One a year or less	4 = One a week
2 = A few times a year	5 = 2-3 times a week
3 = One a month	6 = 4 or more times a week

Circle any of the following services (aside from the Grace Group) that you received for your mental health issues in the last year:

1 = Case Management	5 = Prescription Medication
2 = Spiritual Guidance	6 = Employment Assistance
3 = Individual Therapy	7 = Residential Treatment
4 = Group Therapy	8 = Substance Abuse Treatment

Have you participated in a course of Grace Groups before? (1=Yes, 2=No)

Which diagnosis best fits your primary diagnosis (choose one):

1 = Schizophrenia	6 = Substance Use Disorder
2 = Bipolar Disorder	7 = Personality Disorder
3 = Depressive Disorder	0 = No Diagnosis
4 = Anxiety Disorder	9 = Other Diagnosis (specify):
5 = Post-Traumatic Stress Disorder	_____

Circle any other diagnoses you have received from a professional:

1 = Schizophrenia	6 = Substance Use Disorder
2 = Bipolar Disorder	7 = Personality Disorder
3 = Depressive Disorder	0 = No Diagnosis
4 = Anxiety Disorder	9 = Other Diagnosis (specify):
5 = Post-Traumatic Stress Disorder	_____

When were you first diagnosed with any mental health issue? (MM/YYYY) __ __/__ __ __ __

Have you ever taken medication for a psychiatric problem? (1=Yes, 2=No)

Have you ever received inpatient psychiatric treatment? (1=Yes, 2=No)

When did the problem you are currently seeking help with begin? __ __/__ __ __ __

Are you currently receiving psychotherapy for this issue? (1=Yes, 2=No)

Are you currently taking medication for this issue? (1=Yes, 2=No)

Does your insurance adequately cover mental health treatment? (1=Yes, 2=No, 3=No Insurance)

Did financial strain factor in your decision to participate in the Grace Group? (1=Yes, 2=No)

Using 1, 2 and 3, rank the top three factors which attracted you to participation in a Grace Group:

_____ It incorporates faith and a Christian perspective
_____ It addresses proven psychological principles of change
_____ There is no charge for the group
_____ I personally knew and trusted the group leader
_____ I was referred to it by someone I trust

How important is it to you that Scripture is used in your counseling?

1	2	3	4	5
Not at all important		Somewhat Important		Very Important

How important is it to you that your counselor is a Christian?

1	2	3	4	5
Not at all important		Somewhat Important		Very Important

How important is it to you that counseling explicitly incorporates religious principles?

1	2	3	4	5
Not at all important		Somewhat Important		Very Important

How important is it to you to pray with members of the Grace Group?

1	2	3	4	5
Not at all important		Somewhat Important		Very Important

APPENDIX B

Final Survey Questions

Today's Date: __ __/__ __/__ __ __ __

How many of the 10 Living Grace Group sessions did you attend? _____

1. How likely are you to recommend the group to a friend who needed help?

1	2	3	4	5
Wouldn't Recommend		Might Recommend		Definitely Recommend

2. How satisfied are you with your experience in the Living Grace Group?

1	2	3	4	5
Not at all Satisfied		Somewhat Satisfied		Very Satisfied

3. How helpful were the religious components of the group to your recovery?

1	2	3	4	5
Not at all Helpful		Somewhat Helpful		Very Helpful

4. How helpful were the psychological/educational components of the group to your recovery?

1	2	3	4	5
Not at all Helpful		Somewhat Helpful		Very Helpful

5. How has your faith changed as a result of participating in the group?

1	2	3	4	5
Much weaker faith	Weaker	Unchanged	Stronger	Much stronger faith

6. Overall, how helpful was the Living Grace Group to your recovery process?

1	2	3	4	5
Not at all Helpful		Somewhat Helpful		Very Helpful

List three things you found most beneficial about the group:

1. _____

2. _____

3. _____

List three things you would change about the group:

1. _____

2. _____

3. _____

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