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Over the past several decades, psychological literature has illuminated many positive correlates of religion and spirituality (Koenig, King, & Carson, 2012, for review). There is, however, a darker side of religion and spirituality. Spirituality can serve as a source of problems; the phenomenon of *spiritual struggles* refers to questions, tensions, and conflict about religious and spiritual issues that arise around the supernatural, interpersonal relationships, and within oneself (Pargament, Murray-Swank, Magyar, & Ano, 2005). In recent years, researchers have documented links between markers of negative physical and psychological health and spiritual struggles (Ano & Vasconcellas, 2005; Exline, 2013; McConnell, Pargament, Ellison, & Flannelly, 2006). However, the field has only begun to explore how to help people address and resolve spiritual struggle within the context of psychotherapy.

Religion and spirituality may offer particularly valuable resources to those struggling with severe or chronic mental illness. The literature is clear that adults with mental illness often make sense of their illness in religious or spiritual terms, and strive for a connection with a transcendent force to lend coherence to their experience (Huguelet, Gilliéron, Brandt, & Borras, 2010). Furthermore, people with mental illness may be particularly vulnerable to the negative effects of spiritual struggle, particularly when such struggles are not appropriately addressed in an effective and time-sensitive manner (Currier, Smith, & Kuhlman, 2017; Mohr, Brandt, Borras, Gilliéron, & Huguelet, 2006; Phillips & Stein, 2007). Questions remain, however, as to how these struggles should be addressed in the context of psychological treatment. The current study is the first attempt to evaluate a systematic approach to addressing spiritual struggles among people with mental illness by using an intervention entitled *Winding Road*. This intervention was previously evaluated within a sample of college students and yielded promising results (Dworsky et al., 2013). We next turn to defining the construct of *spiritual struggle*, and then offer a rationale for an intervention for addressing spiritual struggle in adults with mental illness.

DEFINING SPIRITUAL STRUGGLES

Spirituality has been defined as “a search for the sacred” (Pargament, 1999, p. 12). Pargament (2007) explains that “for many people the sacred is the focus point of their striving, the object of significance that lends order and coherence to all other goals” (p. 55). A person’s spiritual framework is often resilient even in times of significant life transitions and traumatic events. Nevertheless, there are times when people find themselves struggling not only in terms of their physical, psychological, or social well-being, but their spiritual well-being as well (Pargament, 1997).

Spiritual struggles represent an effort to “conserve or transform a spirituality that has been threatened or harmed” (Pargament, Murray-Swank, Magyar, & Ano, 2005, p. 247). They emerge as a result of an interaction between stressful life experiences and a person’s spiritual orienting system. They surface when people encounter situations that call into question their most basic spiritual beliefs, practices, and strivings (Pargament et al., 2005). Three different types of struggles have been delineated: interpersonal, intrapsychic, and supernatural (see Exline, 2013, for review). Interpersonal spiritual struggles consist of conflicts with family members, congregation members, and friends that center on religious or spiritual matters. Intrapsychic spiritual struggles occur when people experience doubt and uncertainty about their religious beliefs and practices or spirituality. Lastly, supernatural spiritual struggles reflect tension between the individual and the Divine (e.g., anger at God, feeling abandoned or punished by the Sacred, belief that the devil caused a negative event). It is important to note that these types of spiritual struggles are not mutually exclusive and often co-occur (Pargament, 2007).

MENTAL AND PHYSICAL HEALTH CORRELATES OF SPIRITUAL STRUGGLE

The literature is clear that spiritual struggles are a common occurrence. For example, 63% of adults from a probability sample in the United States indicated at least sometimes experiencing anger toward God (Nielson, 1998). In a study of more than 5,000 university students, 44% of the sample endorsed current distress related to religious or spiritual concerns (Johnson & Hayes, 2003). Forty-six percent of a college student sample (*n*=3,493) reported frequently or occasionally experiencing anger toward God (Bryant & Astin, 2008). However, several studies show that people may be reluctant to admit their personal experience of spiritual struggle due to fearing judgment from others or beliefs that these struggles, particularly negative emotions toward God, are morally wrong (Exline & Grubbs, 2011; Exline, Kaplan, & Grubbs, 2012). Given the stigma connected to spiritual struggle and the reluctance to report struggles, it is likely that these prevalence figures underestimate actual percentages of people encountering these types of struggles.

There is now an extensive literature linking spiritual struggles to poorer health, including indicators of both mental and physical health. Regarding mental health, struggles have been correlated with increased depression (Ano & Vasconcellas, 2005), anxiety and other emotional disorders (Bryant & Astin, 2008; McConnell et al., 2006), and even suicidal ideation (Exline, Yali, & Sanderson, 2000; Rosmarin, Bigda-Peyton, Ongur, Pargament, & Bjorgvinsson, 2013). Studies such as these have examined spiritual struggle in a global sense; other studies have examined correlates of specific *types* of spiritual struggle (e.g., interpersonal, intrapsychic, supernatural). Several studies have indicated that depression may be particularly linked to *supernatural* spiritual struggles. For instance, with a sample of 238 medical patients, Fitchett et al. (2004) found significant correlations between depression and feeling punished or abandoned by God, or questioning God’s love or power. Similarly, in a study of 268 medically ill, elderly inpatients, Pargament, Koenig, Tarakeshwar, and Hahn (2004) found that depression and declines in spiritual outcomes were tied to feeling punished by God. In a sample of 230 Pentecostals, Trice and Bjork (2006) found that many participants attributed depression to demonic oppression or possession (a form of divine spiritual struggle). Working with a representative national sample of American adults, Abu-Raiya, Pargament, Krause, and Ironson (2015) reported that five types of spiritual struggle, including struggles with the divine, were associated with more symptoms of depression and generalized anxiety. Finally, Exline, Yali, and Sanderson (2000) studied correlates of spiritual struggle in a nonclinical sample of 200 college students and a clinical sample of 54 people seeking outpatient psychotherapy. Results indicated that, in participants of both samples, depression was linked to feelings of alienation from God. Additionally, they found that depression was related to interpersonal spiritual struggle among the student participants. Taking the above findings together, the literature clearly suggests that depression is linked to spiritual struggle, particularly supernatural spiritual struggle. Because spiritual struggle can lead to self-isolation, self-loathing, self-pity, suicidal ideation and behavior, and an apathetic attitude toward life (Pargament, 2007), addressing spiritual struggle is of particular concern when working with depressed individuals.

In terms of physical health, spiritual struggles have been tied to poorer health status, disease process, and biomarkers of illness (Exline, 2013, for review). For example, in a longitudinal study of 94 myeloma patients undergoing stem cell transplants, Sherman et al. (2009) found that patients who engaged in more negative religious coping (used interchangeably with the phrase *spiritual struggles* in this paper) reported lower functional and physical well-being after their transplants. Similarly, Trevino et al. (2010) found that negative religious coping in a sample of HIV/AIDS patients predicted worsening symptoms 12 to 18 months later. Furthermore, Ai and colleagues (2009, 2010) studied patients facing cardiac surgery, and found spiritual struggles to be linked to higher levels of interleukin-1, an inflammatory cytokine.

This body of outcomes literature highlights the clinical relevance of spiritual struggle with regards to both mental and physical health. There is some empirical evidence that, with proper support, however, spiritual struggles can be integrated into one’s life and can spur growth (see Pargament, Desai, & McConnell, 2006, for review). Whether spiritual struggles lead to spiritual growth or decline may depend upon the degree to which the individual has a well-integrated spirituality (Pargament, 2006). As such, there is a need for treatment programs to help people achieve growth – as opposed to decline – through their spiritual struggles.

SPIRITUAL STRUGGLES AMONG ADULTS WITH MENTAL ILLNESS

Recent empirical evidence suggests that spirituality and religiosity may be particularly salient components of the lives of those suffering with severe and persistent mental illness (Mohr et al., 2010). Religious/ spiritual coping, however, can either aid or impede recovery; the difference is the nature of the religious coping employed – positive versus negative.

Negative religious coping or spiritual struggles have been found to exacerbate the symptoms associated with mental illness (Mohr et al., 2006). While benevolent religious appraisals of mental illness are predictive of psychological well-being, interpreting mental illness as a punishment from God or as the consequence of an ineffective God is predictive of increased distress and feelings of personal loss (Phillips & Stein, 2007). In a longitudinal study of 115 individuals diagnosed with schizophrenia or schizoaffective disorder, 20% of participants reported that religion served as a resource for mitigating troublesome symptoms (Mohr et al., 2010). On the other hand, 17% experienced negative outcomes as a result of chronic spiritual struggle. These participants relied less on religion as a resource for recovery and reported negative experiences of religion. Additionally, spiritual struggles have consistently been associated with negative mental health consequences including suicidality and PTSD (Ano & Vasconcelles, 2005; Currier, Smith, & Kuhlman, 2017; Wortmann, Park, & Edmondson et al., 2011).

Positive religious coping, on the other hand, has been found to support recovery for individuals living with mental illness. In this vein, in a study of over 400 people with serious mental illness, more than 80% reported using some form of religious belief or practice to cope with their symptoms (Tepper et al., 2001). Moreover, Loewenthal (2010) found that nearly 70% of individuals with mental illness engage in one or more spiritual practices, and tend to do so prior to seeking professional mental health treatment. In a study of patients with psychosis, Huguelet, Gilliéron, Brandt, and Borras (2010) found that most (62%) participants explained their illness in spiritual terms, suggesting that those with severe mental illness understand their condition – at least at some level – in spiritual terms. These findings are not altogether surprising; faced with the reality of their human limitations and inadequacies, people with mental illness may be especially likely to pursue a connection with a transcendent force (Pargament, 2007).

A significant subset of the sample in the Huguelet at al. (2010) study reported that their spiritual explanatory models of their illness changed over time. More specifically, over the span of three years, only 31% of participants maintained an *unchanging* spiritual view of their illness, while another 31% of participants experienced their spiritual views as evolving and ephemeral. Having a spiritual view of psychosis in this study was equally distributed across religious denominations (i.e., esotericism, spiritism, Christian Science, and Scientology). Additionally, having a spiritual view of their mental illness was linked to the subjective importance of religion in day-to-day life, attributing meaning to life and the illness itself, coping with the illness, gaining control, and gaining comfort. Huguelet et al recommended that clinicians caring for patients with psychosis individually tailor their interventions to their patients by asking them about their particular explanatory models for their illness and then weaving spiritual coping into treatment.

Spiritual struggles may have far-reaching consequences for those battling severe mental illness. Furthermore, the negative impacts of spiritual struggle may be accentuated when people become stuck in their struggles. Although correlates of these chronic spiritual struggle have not been specifically studied in clinical samples to date, two longitudinal studies have identified negative correlates of chronic struggle in medical samples. In a two-year study of elderly, medically ill individuals, Pargament et al. (2004) studied spiritual struggles in four distinct groups: nonstrugglers, transitory strugglers (struggle at baseline only), acute strugglers (struggle at follow-up only), and chronic strugglers (struggle at both time points). Chronic strugglers were the only group who showed declines in physical and mental health outcomes over the two year period. Similarly, in a one-year longitudinal study with cancer patients, Exline and colleagues (2011, Study 5), found that patients who reported anger at God at both time points showed the worst physical and mental health outcomes.

Unfortunately, in spite of the significant implications of spiritual struggles for health and well-being, individuals with severe mental illness may receive little help for their struggles. To the contrary, they may experience alienation or exile from spiritual communities as a result of stigma associated with their illness or associated spiritual struggle. Further, there is a lack of empirically-validated spiritually-sensitive psychological interventions to help this population address their spiritual struggles and prevent them from becoming chronic. Research attention on spiritually integrated approaches to psychotherapy has increased over the past twenty years, and by-and-large, such approaches have yielded promising results (Captari, et al., 2018). Evaluations of spiritually integrated interventions have shown positive psychological and/ or spiritual effects in various samples, including veterans (Decker, 2007; Harris et al., 2011), survivors of sexual abuse (Murray-Swank & Pargament, 2005; Murray-Swank & Pargament, 2008), women reporting postabortion grief (Dyer Layer, Roberts, Wild, & Walters, 2004), church members reporting spiritual struggles in the moral realm (Ano, Pargament, Wong, & Pomerleau, 2017), and cancer patients (Cole, 2005). However, as yet, spiritual struggles among adults with mental illness have not been targeted for psychological intervention.

An intervention designed to help people with severe and persistent mental illness address spiritual struggle is called for as spirituality may offer resources that are unique to the problems of mental illness. Through spirituality, individuals are able to connect with what they perceive as the divine and take on a new perspective in which they view themselves and their mental illness through a “spiritual lens.” This spiritual view, in turn, can pave the way for a new sense of hope and empowerment. Spirituality may also enable them to engage in a more positive appraisal of mental illness, and provide distinctive coping and problem-solving resources (Dein, 2006; Pargament, 1997). Additionally, as previously stated, spiritual struggle can lead to growth when skillfully integrated into the larger spiritual landscape of one’s life (Pargament, Desai, & McConnell, 2006). The question, then, is how to help individuals with mental illness manage and make sense of their spiritual struggles in a way that allows for growth rather than decline.

*Winding Road* - a 9-session, spiritually integrated, group-based intervention grounded in Pargament’s (2007) model of spirituality – is an attempt to create a space for wholeness and growth by addressing the spiritual struggles of those suffering with severe mental illness. The intervention is not affiliated with a specific religion and does not provide participants with theological information. Rather, its goals are to: (a) encourage acceptance of spiritual questions, conflicts, and doubts; (b) enhance willingness to articulate and explore spiritual struggles; (c) decrease stigma associated with spiritual struggle; (d) broaden and deepen understandings of the divine; (e) facilitate greater integration of spirituality into daily life; and (f) increase emotional, behavioral, and spiritual flexibility in the presence of spiritual struggles.

Dworsky et al. (2013) piloted *Winding Road* with a sample of 12 undergraduates at a medium-sized state university in Northwest Ohio. Despite the small sample size, results were robust indicating statistically significant improvements in participants’ reports of spiritual struggle, conceptualizations of God, behavior-values congruence, struggle-related stigmatization, affect, emotion regulation, and general psychological distress. Dworsky et al. (2013) provide a detailed discussion of the development of the intervention.

CURRENT STUDY

Spiritual struggles among people with mental illness are commonly reported and have negative implications for health and well-being. The need for effective treatment programs to address spiritual struggle in this population is clear. Although there is increasing attention to the integration of the spiritual dimension in psychological treatment, minimal attention has been given to spiritual struggles that clients bring into treatment.

The goal of the current study is to provide an initial evaluation of one promising program, *Winding Road*, with a sample of adults with mental illness who are experiencing spiritual struggles. People with mental illness may be particularly vulnerable to the negative effects of spiritual struggle, especially when such struggles are not appropriately addressed in a timely manner. Moreover, religion and spirituality may offer especially valuable resources to those struggling with mental illness. We hypothesized that in comparison to a treatment as usual group, participants in *Winding Road* would report greater improvements on both spiritual and psychological outcome measures.

METHOD

*Participants*

Adults enrolled in a partial psychiatric hospitalization program were recruited at a private psychiatric hospital in south central Pennsylvania through announcements and flyers hung in group therapy rooms. The study was advertised as a group designed to “give those with spiritual struggles a safe place to explore and work through their struggles, while learning and practicing healthy coping strategies.” Inclusion criteria were: age 18 or older; current enrollment in the hospital’s partial hospitalization program; commitment to attend all sessions; expression of current engagement in spiritual struggle (via self-report in initial screening session); openness to exploring spiritual struggles with fellow clients from other religious orientations; and no expressed desire to proselytize other group members.

The primary treatment modality of the partial hospitalization program was group therapy. Depending on various factors (i.e., level of symptom severity, insurance coverage), clients attended the program between three and five days per week. Treatment days consisted of 3.5 to 6.0 hours of group therapy, depending on the number of hours recommended by the attending psychiatrist and authorized by clients’ insurance coverage. Additionally, clients met with a psychotherapist individually on average one time (45-60 minute session) per week and were seen by the program psychiatrist every 5 treatment days for medication management. Therapy groups offered by the program were primarily psycho-educational in nature; they covered a broad range of topics, including coping with depression and anxiety, recovery, and building resiliency. One group per day was process-oriented, designed to address clients’ interpersonal effectiveness skills and provide them the opportunity to personally share about their psychosocial stressors and receive feedback and social support. Participants who were randomly assigned to the spiritual struggles intervention group attended the *Winding Road* sessions at a time when the other participants (and all other partial hospital clients) were attending a psycho-education group.

See Fig. 1 for a CONSORT flowchart of participant enrollment and attrition. Forty adults volunteered to participate during the recruitment period. All volunteers met with the group leader for a brief screening session to determine that they met inclusion criteria, and to review and sign informed consent forms. No volunteers who expressed interest in participating in the study were excluded; all met inclusion criteria and were deemed appropriate for enrollment in the study. Participants were randomly assigned to one of two treatment conditions; 22 participants were assigned to receive partial hospitalization treatment *plus* the spiritual struggles intervention (referred to as “the SSI group” hereafter), while 18 participants were assigned to receive continued partial hospitalization treatment as usual (referred to as “the TAU group” hereafter). Random assignment occurred in the order that participants enrolled in the study; for example, the first participant to enroll was assigned to the SSI group, the second participant to the TAU group, the third participant to the SSI group, and so on. Eighteen participants in the SSI groups completed the pre-treatment assessment; 9 of these participants attended at least 7 out of 9 *Winding Road* sessions and completed the post-treatment assessment. Fifteen participants in the TAU groups completed the pre-treatment assessment, and 9 participants completed the post-treatment assessment. The high attrition rate was due to the patients’ short stays in the partial hospitalization program in which the study was housed; some patients were treated for as briefly as one to two weeks before being discharged to a different level of mental health care. When patients were discharged from the program, they were automatically withdrawn from the study.

Data from a total of 18 participants were included in analyses – 9 participants in the SSI group and 9 in the TAU group. The majority of these participants were female (*n*=16) and Caucasian (*n*=17); one participant identified as “Other” in terms of ethnicity. Mean age across all participants was 42.8 years; mean age for the WR group was 44.6 years, while mean age for TAU group was 40.9 years. Participants represented diverse religious affiliations including Protestant (*n*=6), Non-denominational Christian (*n*=3), “Other” (*n*=3), None (*n*=3), Catholic (*n*=1), Wiccan (*n*=1), or No response (*n*=1). The primary psychiatric diagnosis for nearly all of them was a depressive disorder (i.e., Major Depressive Disorder, Unspecified Depressive Disorder; *n*=14). The remaining participants had the following diagnoses: Unspecified Mood Disorder (*n*=1), Bipolar I (*n*=1), Bipolar II (*n*=1), and Unknown (*n*=1).

*Group Leader*

One post-doctoral resident in clinical psychology served as the *Winding Road* group leader (first author). She had prior training in spiritually integrated psychotherapy, and was a member of the research team that developed the intervention. Furthermore, she served as a group facilitator during the initial piloting of the intervention (Dworsky et al., 2013). Due to her post-doctoral status at the hospital, her facilitation of the intervention was under supervision of a licensed clinical psychologist.

*Procedure*

Clients interested in participating in the study were scheduled for an individual screening interview with the first author to establish eligibility with respect to inclusion criteria.

The duration of the study was 5 weeks. Intervention sessions were held twice weekly, and were each 90 minutes in length. Because *Winding Road* was initially developed to address the spiritual struggles of college students, small adjustments were made to several intervention exercises to make them more relevant to this population. Sessions were audio-taped for the purposes of upholding treatment integrity and to provide the opportunity to glean anecdotal data from participants. Participants completed a survey within one week of beginning the intervention (pretreatment) and within one week of completing the intervention (posttreatment). Both the pretreatment and posttreatment surveys included the full complement of measures described below and were selected to assess changes specifically linked to the intervention’s goals. Exit interviews were conducted by a neutral clinician (not the group leader) to gather anecdotal information about the intervention’s helpfulness.

*Measures*

*Demographic Information*

Participants reported their age, race, gender, personal religious affiliation, religious affiliation of parents, level of participation in religious and spiritual practices (e.g., church attendance, prayer, meditation), and self-rated religiousness and self-rated spirituality. Various measures designed to assess both spiritual and psychological outcome were included and are described below.

*Spiritual Outcome Measures*

*Spiritual struggles*

A 23-item modified version of the Negative Religious Coping subscale (NRCOPE) was used to measure the three different types of spiritual struggles: Intrapsychic (5 items; e.g., “Wondering if God really exists”), Interpersonal (5 items; “Experiencing tension in my relationships with my friends and family because of differences in religious opinions”), and Divine (13 items; e.g., “Wondering whether God has abandoned me”) (Pargament, Smith, Koenig, & Perez, 1998). Respondents rated the degree to which they experience items using a 1 (*not at all*) to 4 (*a great deal*) scale. In this study, Cronbach’s 𝝰 for the Intrapsychic, Interpersonal, and Divine subscales at pre-treatment were .80, .73, and .92 respectively. Higher scores indicate greater use of negative religious coping, or higher levels of that particular type of spiritual struggle.

*Positive religious coping*

Positive religious coping (POS-RCOPE) was measured by seven items taken from the Brief Religious Coping Inventory (RCOPE; Pargament et al., 1998). The items assess religious coping behaviors that have been linked to positive physical and psychological health outcomes. Participants rated how much they use each strategy as a means to “cope with difficult situations or events” on a scale from 1 (*not at all*) to 4 (*a great deal*). Examples of items include “Sought God’s love and care” and “Looked for a stronger connection with God.” In this study, Cronbach’s 𝝰 at pre-treatment was .86. Higher scores indicate greater use of positive religious coping.

*God image*

Two of the six subscales of the God Image Inventory (GII) were included to assess participants’ affective (vs. cognitive) experiences of God (Lawrence, 1991, as cited by Hall & Sorenson, 1999). The Acceptance subscale measured their experience of feeling worthy of God’s love, while the Presence subscale measured the degree to which they perceived God as accessible for support in difficult times. Items are rated 1 (*strongly disagree*) to 4 (*strongly agree*). Illustrative items include, “I know I’m not perfect, but God loves me anyway” (Acceptance) and “God is always there for me” (Presence). In this study, Cronbach’s 𝝰 for the Acceptance and Presence subscales at pre-treatment were .88 and .96, respectively.

*Forgiveness*

Forgiveness was assessed using the Forgiveness subscale of the Brief Multidimensional Measure of Religiousness/Spirituality developed by the Fetzer Institute (Idler et al., 2003). Participants respond to the subscale’s 3 items with regard to the regularity with which they experience forgiveness because of their religious or spiritual beliefs. Each of the items asks about a different dimension of forgiveness: forgiving others, forgiving oneself, and knowing God forgives. Item response options range from 1 (*never*) to 4 (*always or almost always*). In this study, Cronbach’s 𝝰 for this three-item scale at pre-treatment was .59. A forgiveness score represents an average across the three items, with higher scores indicative of more forgiving experiences.

*Behavior-values congruence*

Two items that were created for the initial piloting of *Winding Road* (Dworsky et al., 2013) were included to assess the extent to which participants perceived that their behavior was consistent with their (a) spiritual values and (b) religious values. The two items take the following format: “To what extent are you living in a manner that is consistent with your [spiritual/religious] values?” and are rated on a 10-point scale ranging from 1 (*not at all*) to 10 (*completely*).

*Psychological Outcome Measures*

*Struggle-related self-stigma*

The Negative Self-Image subscale of the HIV Stigma Scale (Berger, Ferrans, & Lashley, 2001) was adapted to measure self-stigmatizing attitudes related to spiritual struggles. The term “spiritual struggles” replaced “HIV” for each item. Example items include, “Having spiritual struggles makes me feel that I’m a bad person” and “I work hard to keep my spiritual struggles a secret.” The nine items of the Spiritual Struggles Self-Stigma Scale are rated on a 4-point scale reflecting one’s degree of agreement from 1 (*strongly disagree*) to 4 (*strongly agree*), with higher scores indicating more struggle-related self-stigma. In this study, Cronbach’s 𝝰 for this scale at pre-treatment was .91.

*Struggle-related positive and negative affect*

A modified version of the Positive Affect/Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988) assessed positive and negative affect related to spiritual struggle. The PANAS consists of two 10-item subscales, one measuring positive affect (PANAS-Pos) and the other measuring negative affect (PANAS-Neg). For this study, the scale’s instructions were modified to introduce the list of words such as “feelings and emotions that may be related to your experience of spiritual struggle.” The word list itself was unaltered. Participants indicated the degree to which they experienced each emotion during the prior week using a scale from 1 (*very slightly or not at all*) to 5 (*extremely*). In this study, Cronbach’s 𝝰 for the PANAS-Pos and PANAS-Neg subscales at pre-treatment were .92 and .84, respectively.

*Struggle-related difficulties with emotion regulation*

Seventeen selected items from the Difficulties with Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) were included to assess emotion regulation difficulties specific to spiritual struggle-related distress. The preface to the original DERS, “When I’m upset…,” was modified to read, “When I’m upset about my spiritual struggle…” Response options range from 1 (*almost never*) to 5 (*almost always*). Illustrative items include, “When I’m upset about my spiritual struggle, I lose control over my behaviors;” “When I’m upset about my spiritual struggle, I have difficulty getting work done;” and “When I’m upset about my spiritual struggle, my emotions feel overwhelming.” In the present study, Cronbach’s 𝝰 at pre-treatment was .93. Scores reflect average item response with higher scores indicative of greater difficulties with emotion regulation.

*Addictive behaviors*

A 22-item measure that was created for the initial piloting of *Winding Road* was included to assess addictive behaviors. These items were adapted from various measures ([Christo, et al., 2003;](https://www.sciencedirect.com/science/article/abs/pii/S0306460301002313#!) Salguero & Moran, 2002; Thatcher & Goolam, 2005), and are scored on a 5-point rating scale, from 1 (*Not like me*) to 5 (*Like me*). Seven distinct addictive behavior patterns were assessed, including addiction to Alcohol (e.g., “I often drink significantly more alcohol than I intend to”), Exercise (e.g., “I always try to exercise several times a day”), Food Binging (e.g., “Others have expressed repeated serious concern about my excessive eating”), Food Starving (e.g., “I often avoid meal times by claiming that I have already eaten when it is not true”), Internet (e.g., “I feel distressed when I cannot connect to the Internet”), Shopping (e.g., “I particularly enjoy shopping bargains so that I often finish up with more than I need”), Video Games (e.g., “When I can’t play video games, I get restless or irritable.”), and Work (e.g., “Once I start work in any day I find it difficult to get `out of the swing of it' and relax”). In the present study, Cronbach’s 𝝰 at pre-treatment was .82. Scores reflect average item response across the seven subscales with higher scores indicative of greater addictive behaviors.

RESULTS

A series of repeated measures analyses of variance (ANOVA) was conducted with spiritual and psychological outcomes variables to test for differences between the SSI and TAU groups over time. See Table 1 for outcomes means and standard deviations for both treatment conditions across time.

*Treatment Effects*

*Spiritual outcomes*

As compared to TAU participants, SSI participants reported significantly less Divine Spiritual Struggle from pre- to post-treatment (*F*(1,16)=7.18, *p*=.02). However, results did not yield significant time by group interactions for Intrapsychic Spiritual Struggle (*F*(1,16)=1.56, *p*=.23) or Interpersonal Spiritual Struggle (*F*(1,16)=1.59, *p*=.23). Illustrative of decline in divine spiritual struggle, one *Winding Road* participant shared that, “God became more personal to me. Before He was just, you know, up there and not very accessible but…the struggles are easier now.” In the words of another participant, “I feel that I became closer to God [as a result of *Winding Road*] because I was able to talk to Him instead of worrying about Him being mad and not listening to me.”

As compared to TAU participants, participants in the SSI group reported significantly greater forgiveness of self, others, and God over time (*F*(1,16)=8.25, *p*=.01). A significant time by group interaction did not emerge for greater perceived acceptance (*F*(1,16)=3.24, *p*=.09) or presence (*F*(1,16)=.09, *p*=.78) from God, Behavior-Values Congruence (*F*(1,16)=4.28, *p*=*.*06), nor Positive Religious Coping (*F*(1,15)=.13, *p*=.72*).*

*Psychological outcomes*

As compared to TAU participants, SSI participants reported significantly lower levels of overall addictive behaviors from pre- to post-treatment (*F*(1,16)=12.16, *p*=.003).

*Winding Road* participants reported significantly greater positive emotions as related to spiritual struggle over the course of the intervention (*F*(1,16)=6.96, *p*=.02), as compared to TAU participants. However, the groups did not differ in the degree to which they reported changes in negative affect related to their spiritual struggle (*F*(1,16)=.47, *p*=.50).

As compared to TAU participants, participants in the SSI group reported significantly lower levels of spiritual struggle-specific stigma over time (*F*(1,16)=11.05, *p=*.004). Illustrative of declines in struggle-related stigma, one *Winding Road* participant shared that,

It was good to be with people that at least went through some of the same stuff and had some of the same questions and dealt with some of the same things, and know that you’re not alone… I thought they [other group members] were great. They became more like a …family.

In the words of another participant,

It [*Winding Road*] got me talking more, opening up about spiritual things…Things weren’t as bad when I did talk about it as I thought. Because it is a spiritual group, you can talk about spiritual stuff without fear, no judgment or criticism. I didn’t feel any…I was relieved.

A significant time x group interaction (*F*(1,16)=5.58, *p*=.03) also emerged, such that *Winding Road* participants reported a more drastic decline in difficulties regulating struggle-related emotion as compared to TAU participants. Consistent with this quantitative finding, one participant described her experience this way:

I’m not as angry as I used to be. I still get fits of anger of memories and thoughts when my head goes down a certain path, but being able to talk and open up kind of made me think a little more of maybe I do want to get back spiritually to where I had been.

A total of 13 repeated measures ANOVA’s were run, with six Time x Group interactions reaching statistical significance. Using the general rule that statistical power of greater than or equal to .80 is indicative of a study having a large enough sample to minimize Type II error, only two of thirteen outcome variables yielded adequate power; the addictive behaviors scale and the spiritual struggle-specific stigma scale yielded powers of .91 and .88, respectively. Both of these outcomes variables reached statistical significance for the Time x Group interaction. The remaining four outcomes variables that were statistically significant had powers less than .80 (.60, .70, .71, and .77).

DISCUSSION

Religion and spirituality may offer particularly valuable resources to those suffering with mental illness. Empirical research has demonstrated that adults with mental illness often make sense of their illness in religious or spiritual terms, and strive for a connection with a transcendent force to lend coherence to their struggle. Moreover, people with mental illness may be particularly vulnerable to the negative effects of spiritual struggle, especially when such struggles are not effectively addressed in a timely fashion. These findings point to the potential value of psychological interventions aimed at supporting adults with mental illness who are facing spiritual struggle.

This study reports on the first systematic effort to evaluate a manualized, spiritually integrated intervention, *Winding Road*, to address spiritual struggle in adults with mental illness. This study involved an effectiveness trial in a naturalistic treatment environment in which participants were randomly assigned to receive TAU at a partial psychiatric day hospitalization program they were already enrolled in, or TAU plus *Winding Road*. As compared to participants receiving treatment as usual, participants in *Winding Road* demonstrated significantly greater positive spiritual and psychological changes.

*Spiritual Impact*

*Winding Road* impacted the spiritual lives of adults with mental illness who were encountering spiritual struggles. Specifically, as compared to TAU participants, *Winding Road* participants reported significantly less divine spiritual struggle, greater forgiveness (of self and others, and perceived forgiveness from God), and greater perceived acceptance from God. The changes in spirituality that resulted from the program are significant in and of themselves given the importance people with serious mental illness assign to spiritual issues. Consider, for example, the illness of depression as conceptualized in spiritual terms:

As one reflects upon the nature of depression it becomes clear that it is a profoundly spiritual experience that cannot be understood and dealt with through drugs and therapy alone. Its central features of profound hopelessness, loss of meaning in life, perceived loss of relationship with God or higher power, low self-esteem and general sense of purposelessness, all indicate a level of spiritual distress…There is thus seen to be a sense of spiritual crisis inherent within depression. (Swinton, 2001, pp. 95-96)

Furthermore, given the degree to which spiritual struggles are linked to poorer mental health, it is possible that changes in spirituality may facilitate further changes in treatment effectiveness and mental health outcomes.

*Psychological Impact*

*Winding Road* impacted not only the spiritual lives of adults with mental illness, but also their psychological well-being. Data reveal that, as compared to participants in the TAU group, *Winding Road* participants reported significantly less stigma related to their spiritual struggle, increased positive affect and more effective emotion regulation as related to their spiritual struggles, and a decrease in addictive behaviors.

The latter finding is consistent with previous research that has drawn a connection between spiritual struggles and increased addictive behaviors. Faigin, Pargament, and Abu-Raiya (2014) examined spiritual struggles as a predictor in the development of addictive behaviors among 90 freshman college students. Results indicated that higher levels of spiritual struggles were linked to higher levels of 11 out of 14 domains of addiction, including prescription drugs, recreational drugs, sex, caffeine, exercise, food starving, gambling, shopping, work, and tobacco. These findings were consistent with their theory that spiritual tensions and conflicts produce an internal void that people strive to fill with a substitute for healthier significant strivings - addiction. It follows that, as spiritual struggles decline, there may be less need for addictive behaviors to fill that internal void.

Taken as a whole, the findings involving spiritual and psychological outcomes are consistent with other studies showing ties between spirituality and growth among people experiencing stressful life events (Ai, Tice, Lemieux, & Huang, 2011; Gall, Charbonneau, & Florack, 2011; Pargament, Smith, Koenig, & Perez, 1998; Winter, et al., 2009). Although we cannot establish formal causal pathways, the findings would fit with a model in which the positive spiritual changes among spiritually struggling patients engendered through *Winding Road* led to indicators of growth, including increased positive emotions and better emotion regulation as related to spiritual struggle, and less struggle-related stigma. Further studies would be needed to put this model to test systematically.

*Limitations and Future Directions*

Despite the promising results of this initial evaluation of *Winding Road*, there is still much to be investigated with regard to spiritually integrated interventions for adults with mental illness, and their applicability and effectiveness.

The initial evaluation of *Winding Road* among patients with serious mental illness yielded promising results; the intervention appeared to have a robust effect on both spiritual and psychological outcomes. These results are especially noteworthy given the small number of psychiatric patients in the study. Clearly, the findings need to be extended to a larger number of patients. The high attrition rate in both treatment conditions limited the sample size. Participant retention was a challenge due to the patients’ short stays in the partial hospitalization program (as short as 1-2 weeks). Upon discharge to their next level of mental health care, participants automatically became drop-outs in the study.

A larger sample size is necessary to minimize the chance for Type II error. A total of 13 repeated measures ANOVA’s, with six Time x Group interactions reaching statistical significance. Using the general rule that statistical power of greater than or equal to .80 is indicative of a study having a large enough sample to minimize Type II error, only two of these six outcome variables yielded adequate power; the addictive behaviors scale and the spiritual struggle-specific stigma scale yielded powers of .91 and .88, respectively. Both of these outcomes variables reached statistical significance for the Time x Group interaction, which lends good confidence that these interactions were truly significant. The remaining four outcomes variables that were statistically significant had powers less than 0.80 (.60, .70, .71, and .77), suggesting that these interactions had too few data points which introduces the possibility of Type II error. Further study with a larger sample is warranted to clarify the impact of the intervention on these outcomes.

Because there was only one group leader for the SSI treatment condition, it is difficult to distinguish whether the positive effects of *Winding Road* reflect the intervention itself or the skills of that particular therapist. Future research should examine the effectiveness of *Winding Road* with multiple facilitators.

It would also be important to explore whether *Winding Road* is more or less effective when applied to adherents of different religious groups (i.e., Christian vs. Muslim vs. Hindi vs. religious unaffiliated or mixed) or if the intervention is found to be more or less effective when applied to those who adhere to a monotheistic religion vs. polytheistic religion. Theoretically, *Winding Road* was designed to be useful to a wide range of individuals from any number of different backgrounds, and yet evaluations of the comparative effectiveness of this program across diverse groups have yet to be made.

Further research could consider the effects of potentially important moderating variables on the effectiveness of *Winding Road*. For example, in light of literature that highlights the link between God image and mental health (Jonker, Eurelings-Bontekoe, Zock, & Jonker, 2008), researchers could evaluate whether the effects of *Winding Road* vary as a function of the quality of psychiatric patients’ God image.

Additionally, longer-term follow-up data have yet to be collected among patients participating in *Winding Road*. It would be important to determine whether the immediate beneficial effects of the program are sustained six-months or 12-months after treatment.

*Winding Road* addressed spiritual struggles as a whole. However, as noted earlier, more specific sub-types of spiritual struggle have also been identified. More recently, Exline, Pargament, Grubbs, and Yali (2014) identified six types of spiritual struggles; divine, demonic, doubt-related, moral, ultimate meaning, and interpersonal. Tailoring interventions such as *Winding Road* to respond to patients dealing with any of these more specific struggles could prove to be a valuable direction for further research and practice.

Finally, this study is limited by a self-report bias; all of the outcomes measures were surveys completed by the participants themselves. Inclusion of behavioral ratings or clinician ratings could be valuable additions to the examination of the impact of this intervention.

In sum, this study suggests that the *Winding Road* program holds promise as a method for addressing the spiritual struggles of patients with severe mental illness. We hope these findings will encourage further evaluations of this and other spiritually integrated programs that respond to the often neglected spiritual challenges and needs of mental health patients.

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Figure 1. CONSORT flowchart of participant recruitment and attrition.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Table 1  *Changes in Psychological and Spiritual Outcome Variables by Treatment Condition from Time 1 to Time 2* | | | | |
|  | SSI (*n*=9) | | TAU (*n*=9) | |
| Variable | Time 1  *M* (*SD*) | Time 2  *M* (*SD*) | Time 1  *M* (*SD*) | Time 2  *M* (*SD*) |
| Spiritual Outcomes | | | | |
| NRCOPE – Intra | 2.09 (.84) | 1.76 (.72) | 2.07 (.93) | 2.20 (.89) |
| NRCOPE – Inter | 1.62 (.68) | 1.36 (.37) | 2.08 (.76) | 1.55 (.48) |
| NRCOPE – Divine | 2.50 (.65) | 1.90 (.69) | 1.97 (.88) | 1.87 (.86) |
| RCOPE | 1.86 (.52) | 2.02 (.38) | 2.32 (1.11) | 2.24 (.99) |
| God Image – Accept | 2.76 (.59) | 3.18 (.37) | 2.55 (.76) | 2.65 (.84) |
| God Image – Present | 2.78 (.54) | 3.04 (.47) | 2.26 (1.02) | 2.44 (1.02) |
| Forgiveness | 2.96 (.51) | 3.33 (.58) | 2.26 (.89) | 2.11 (1.03) |
| Behavior-values congruence | 5.33 (1.95) | 6.72 (1.48) | 6.28 (2.24) | 5.94 (2.35) |
| Psychological Outcomes | | | | |
| Self-stigma | 2.80 (.91) | 2.28 (.81) | 2.55 (.58) | 2.58 (.66) |
| PANAS – Positive | 2.02 (.75) | 2.68 (.72) | 2.64 (1.02) | 2.27 (.73) |
| PANAS – Negative | 2.73 (.86) | 2.16 (1.04) | 3.31 (.91) | 2.98 (1.12) |
| DERS | 3.07 (.93) | 2.27 (.76) | 2.83 (.89) | 2.73 (.79) |
| Addictive behaviors | 2.32 (.75) | 2.06 (.63) | 2.23 (.50) | 2.38 (.47) |

*Note.* SSI = Spiritual Struggles Intervention; TAU = Treatment as Usual; NRCOPE-Intra = Intrapsychic spiritual struggle; NRCOPE-Inter = Interpersonal spiritual struggle; NRCOPE-Divine = Divine spiritual struggle; RCOPE = Positive religious coping; PANAS-Positive = Positive affect (as related to spiritual struggle); PANAS-Negative = Negative affect (as related to spiritual struggle); DERS = Difficulties with emotion regulation (as related to spiritual struggle).