Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

Joanna M. Jungerman April 25, 2013

Qualitative Perspectives on Spirituality and Mental Well-Being

By

Joanna M. Jungerman

MPH

Behavioral Sciences and Health Education

Nancy Thompson

Committee Chair

Wendy Farley

Committee Member

Michael Windle

Department Chair

Qualitative Perspectives on Spirituality and Mental Well-Being

By

Joanna M. Jungerman

B.A.
Emory University
2013

Thesis Committee Chair: Nancy Thompson, PhD

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Behavioral Sciences and Health Education
2013

Abstract

Qualitative Perspectives on Spirituality and Mental Well-Being

By Joanna M. Jungerman

While the worldwide burden of mental illness increases, many disorders, particularly anxiety and depression, go untreated or are treated unsuccessfully. The possible incorporation of spiritual or faith-based practices into mental health promotion models warrants further investigation. While over a thousand studies have reported a relationship between spirituality and mental health, there is a need for greater in-depth exploration of the mechanisms and processes through which spirituality enhances mental, emotional and psychological wellbeing. There is also a paucity of research on this topic outside of the Judeao-Christian realm. We organized five semi-structured focus group discussions with members of five diverse faith organizations across metro Atlanta. The purpose of the discussions was to elicit information on participants' personal spiritual practices and beliefs and the perceived associations between these practices and mental or emotional health. Data was transcribed, coded and analyzed using modified grounded theory. Analysis highlighted the importance of community and social interconnectedness to mental wellbeing. Participants also described increases in peaceful emotions and decreases in negative thought processes through prayer and meditative practice. Public health and mental health professionals should consider the potential benefits of spiritually-based therapies, social interconnectedness and mindfulness practices when devising mental health promotion programs and interventions.

Qualitative Perspectives on Spirituality and Mental Well-Being

By
Joanna M. Jungerman

B.A.
Emory University
2013

Thesis Committee Chair: Nancy Thompson, PhD

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Behavioral Sciences and Health Education
2013

ACKNOWLEDGMENTS

I would like to thank my thesis committee, Dr. Nancy J. Thompson and Dr. Wendy Farley, for their support of this original research in the face of daunting recruitment challenges.

I am deeply indebted to all members of my focus groups for participating in this research in lieu of any compensation. Particularly, I am thankful to Dr. Deborah Weisshaar and Jonathan Blase for hosting two of the focus groups and for their determination in collecting participants.

Additionally, I would like to thank Eric Strunz, Dr. Dawn Comeau and Dr. Carla Berg for their sage advice during the planning and recruitment stages of this research; also Meredith Dark and Rafiqur Rahman for helping pilot test the focus group instrument.

Finally, thank you to my friends and colleagues at the Rollins School of Public Health for continuing encouragement and for attending my thesis defense.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

Problem Statement

The burden of mental illness, particularly depression and anxiety, is increasing worldwide. The World Health Organization currently ranks depression as the fourth leading contributor to the global burden of disease and projects that it will move to second place in the coming decade (Berry, 2011; WHO, 2010). In the United States, the mental illness burden is particularly significant. Between 2001 and 2003, the lifetime prevalence for all age groups was 46.4%, and 55% of U.S. adults aged 30-44 had been diagnosed with any mental disorder in their lifetime (Kessler et al, 2005). In the same period, only 40.5 percent of respondents with a serious mental disorder received treatment (Kessler et al, 2005). These statistics show that mental disorders, although highly prevalent, often go untreated or are not treated successfully.

Thus, the prevention of mental disorders and the promotion of mental and psychological health are becoming increasingly critical. What will future treatment programs look like, and how can they be made more effective? This study seeks to address to these questions by investigating the promising relationship between spiritual practices, spiritual beliefs, and mental health.

Research shows that the possible incorporation of spiritual or faith-based practices into mental health promotion models warrants further investigation. Over a thousand studies have reported a relationship between spirituality and health, both physical and mental (Hadzic, 2011). The studies focusing on mental health found that spirituality is preventive against mental or emotional disorders, particularly anxiety and depression (Koenig, 2009; Flannelly et al. 2006). Despite these findings, there remains little consensus in the field concerning the particular mechanisms by which spirituality contributes to positive mental

health (Hill & Pargament, 2008). The present study attempts to fill this gap by employing qualitative research methods to explore these mechanisms from the perspective of research participants from diverse spiritual orientations.

Problem Justification

Literature on spirituality and health is dominated by research within the context of religious observance (Baetz & Towes, 2009). However, spiritual practices such as personal prayer, contemplation, and meditation can occur outside of religious institutions. Additionally, research suggests that spiritual practices have a greater positive impact on mental health than purely religious practices do. Various studies have shown that better mental health is linked positively to internalized, intrinsically motivated forms of religion and linked negatively to a religion that is extrinsically motivated or imposed (Pargament, 1997; Breitbart 2002; Ahmed et al., 2011). For example, Breitbart (2002) found that those with intrinsic religious motivation are at a lowered risk for depression, while private religious activity and particular religious beliefs have no correlation to depression.

For these reasons, additional research in the field of spirituality and public health is needed, especially research that explores the mechanisms by which spirituality may exert its effect. This will become more and more important in the upcoming decades, as rates of church attendance decrease (Baetz & Towes, 2009). Spirituality, with its emphasis on the central role of meaning and purpose in life, has begun to emerge as a significant factor in well-being and quality of life, especially for patients dealing with cancer and other life-threatening illnesses (Carmody, 2008). Spiritual or faith-based programs are not always culturally appropriate because they do not apply across diverse faith groups, or because they are not accepted by secular populations.

The present research attempted to reconcile these challenges through the use of qualitative research methods. The goal was to investigate the mental health benefits of spirituality across a diversity of faith groups, focusing on spiritual beliefs and practices that can be applied outside of a religious context. Qualitative methodology was appropriate for investigating this topic because it allowed the researcher to ask open-ended, exploratory questions; questions aimed at understanding *how* and *why* spiritual practices and beliefs can improve mental health and well-being. Emphasis was placed on participants' experiences, perceptions, and opinions, rather than on preconceived assumptions from existing theory or literature. Participants took center stage in this research, which allowed them to explain, in their own words, what aspects of their spirituality they deemed to be most significant and meaningful.

Theoretical Framework

Grounded Theory

Qualitative research is often guided by the concept of grounded theory, a model for analysis and meaning-making developed by sociologists Barney Glaser and Anselm Strauss, in the 1960's (Hennink et al., 2011). Grounded theory built upon methods that qualitative researchers were already using, but made the process more transparent, credible and scientifically rigorous. The grounded theory method involves a series of tasks that are continuously repeated through data analysis. These analytic processes, however, are flexible rather than formulaic, and follow general principles and heuristic devices rather than rules (Charmaz, 2006).

As Clifford Geertz (1975) famously noted in *The Interpretation of Cultures,* in-depth, qualitative analysis is both a science and an art: "Believing… that man is an animal

suspended in webs of significance that he himself has spun, I take culture to be those webs, and the analysis therefore not an experimental science in search of law but an interpretive one in search of meaning" (p. 5). In this sense, qualitative research flexible yet deeply rooted in the data. In *The Discovery of Grounded Theory,* Glaser and Strauss (1967) explained that grounded theory is not a modification of existing theory, but something entirely new, "derived from data and illustrated with characteristic examples of data" (p. 2). In this way, they argue, grounded theory is more successful than theories coming from *a priori* assumptions, assumptions that can introduce bias. Grounded theory is also long-lasting, because it is intimately tied to the data.

Although its beginnings lie in sociology, grounded theory is now regularly used in other fields, including public health, education, nursing and business management. It is considered an influential and widely accepted mode for carrying out qualitative research (Strauss & Corbin, 1997).

Purpose

As described, previous studies have found strong associations between religion, spirituality and health, yet there is little consensus in the field about which particular aspects of religiosity contribute most to positive mental and physical health (Hill & Pargament, 2008). These findings beg the question: What is it about religious and spiritual pursuits that contributes to positive mental health? How and why is spirituality so powerful? The goal of this study was to investigate the perceived relationship between spirituality and mental or psychological well-being across a diversity of faith groups, using in-depth, qualitative methods. Due to the nature of qualitative research, this project was exploratory rather than hypothesis-driven, in hopes of limiting the number of assumptions made by researchers. In

addition, it examined similarities and differences across faith groups, in order to create more faith-conscious interventions or treatment options.

The three specific aims of the study were to:

1. Explore the perceptions and experiences of a diverse group of regarding the connection between spirituality and mental health/ emotional well-being;
2. Analyze the similarities and differences in these perceptions across faith groups; and
3. Generate recommendations for future mental illness treatment and mental health promotion programs.

CHAPTER TWO: LITERATURE REVIEW

Definitions

Before embarking on a full review of the literature on this topic, it is first necessary to define what we mean by spirituality, religion and mental health. While the concepts of religion and spirituality often overlap, religion has typically been considered an organized, social phenomenon that is practiced within a community with specific traditions (Hadzic, 2011; Idler et al., 2009; Koenig, 2009). Spirituality, by contrast, connotes a more subjective experience of religion and a personal relationship to the divine. Because of this subjectivity, spirituality is conceptually more difficult to define than religion.

In a recent study of more than 200 individuals from various nationalities, several common themes emerged from the phenomenological analysis of participants' definitions of spirituality and religion. Spirituality was seen as an "integral part of one's identity," a personal experience of the divine and as "unity with the greater world or mystery" (Gall et al., 2011: 158). In contrast, the group viewed religion is an external tool through which to access a spiritual state.

The International Center for the Integration of Health and Spirituality combined the most common notions underlying spirituality in research to create the following definition:

> [Spirituality is defined as] the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term "search" refers to attempts to identify, articulate, maintain, or transform. The term "sacred" refers to a divine being, Ultimate Reality or Ultimate Truth as perceived by the individual (Sawatzky et al., 2005: 157).

This definition poses some difficulty. Koenig argued in a 2009 review that, "this degree of inclusiveness, while admirable in the clinic, makes it impossible to conduct research on spirituality and relate it to mental health, as there is no unique, distinct, agreed-on definition" (Koenig, 2009: 284). However, qualitative research circumvents this problem, because a large degree of inclusivity is needed in order to capture subjective ideas of spirituality as participants themselves understand them. According to Koenig (2009), spirituality is highly personal, something that individuals define for themselves. In fact, a growing number of people interpret spirituality in secular terms, and deny any connection to religion. With this in mind, the definition provided by the International Center for the Integration of Health and Spirituality will be adequate for explaining the parameters of this research project.

The concept of mental well-being is broader than mental health in that it is defined not by the absence of mental disorders, but by the frequency of positive emotions, including feelings of peace, calm and joy (Hadzic, 2011). In this sense, mental well-being also encompasses emotional and psychological well-being.

Literature Review

Qualitative research on the topic of spirituality and mental health is scant. Additionally, none of the studies identified were conducted across faith groups (Holt & McClure, 2006). Quantitative studies and meta-analyses provide evidence for strong links between spirituality, religion and mental health, but it is difficult to determine why or how these connections occur without in-depth qualitative research. A number of proposed mediators are described below.

Ellison (1991) suggested four main ways in which religiosity may enhance various aspects of well-being: 1) through social participation and support; 2) through establishing a

close personal relationship to God or a divine other; 3) by providing systems of meaning to explain existence; and 4) through the promotion of healthy lifestyle choices. Flannelly et al. (2006) stressed three explanations for the inverse relationship between religious belief and depression: 1) religion provides a framework for understanding the world; 2) religion provides meaning in life; 3) and belief in life after death may help to put one's experiences in perspective.

The following literature review presents evidence from quantitative studies showing that spiritual practice can provide meaning, a sense of control, mindfulness, reduced anxiety, and a positive outlook on life. These mechanisms are discussed in greater detail below.

Meaning and Control

Breitbart (2002) defines meaning in life as "the conviction that one is fulfilling a unique role and purpose in a life that is a gift; a life that comes with a responsibility to live up to one's full potential as a human being and, in so doing, being able to achieve a sense of peace, contentment, or even transcendence through connectedness with something greater than one's self" (Breitbart, 2002: 275). Meaningfulness is also associated with the idea that events in life occur for a reason. In a review of cognitive-behavioral mechanisms that may explain the association between religion and spirituality and mental health, James and Wells (2008) propose that religious and spiritual beliefs provide a sense of meaning, control and predictability in stressful times.

Studies have also found that spirituality plays an integral role in increasing sense of coherence and meaning in life, and in decreasing of negative emotions among addicts (Carroll, 1993; Chen, 2006). In this sense, addicts must admit that they are powerless over drug addiction, and this admission represents a critical step in the recovery process, leading

to a change in the addict's self-image and identity (Chen, 2010). This can also be described as a process of surrender, of surrendering one's life to God.

Breitbart (2002) argues that spirituality is composed of two concepts: Faith and meaning. The "faith" component is more often associated with religion, while the "meaning" is more universal and can be found in both religiously and non-religiously identified people. This is important because this study aimed to understand spiritual ideas, beliefs, and practices among individuals who identify with a particular religious group and those who do not.

Mindfulness

Spiritual practices that reduce self-focus (such as contemplative prayer, mindfulness meditation, and rituals) produce a calming effect and are positively associated with mental health (Baetz & Towes, 2009). Mindfulness practices are rooted in Buddhism but are quickly becoming absorbed and accepted in Western nonreligious contexts, including Western psychology (Appel & Kim-Appel, 2009). The goal of mindfulness is to cultivate attention to the present moment in a non-judgmental way. It is theorized that mindfulness-based stress reduction (MBSR) programs, as well as other meditative practices contribute to well-being by reducing mental preoccupation with daily stressors (Carmody et al., 2008).

Research has shown that mindfulness-based therapies are effective treatments for a variety of mood disorders. A cross-national meta-analysis of experimental and quasi-experimental studies found that mindfulness-based interventions reduced depressive symptoms in adults with mental disorders (Klainin-Yobas et al., 2011). Hofmann et al. (2010) conducted an effect size analysis of mindfulness-based interventions and found that such therapies were moderately effective in improving mood and anxiety. Mindfulness-based

therapies have also shown promise in preventing substance use and addiction relapse (Appel & Kim-Appel, 2009).

Prayer

A number of studies reveal that prayer can significantly reduce depression and anxiety (Boelens et al., 2009; Anastasi & Newberg, 2008; O'Laoire, 1997). Boelens et al conducted a cross-over clinical to investigate the effect of person-to-person prayer on perceived depression and anxiety. After randomization to a prayer (intervention) or control group, participants completed Hamilton Rating Scales for Depression and Anxiety. The intervention group received six hour-long prayer sessions weekly while those in the control group received none. Rating scales were repeated after the six weeks and a month later. At completion, participants receiving the intervention showed significant improvement of depression, anxiety and optimism compared to controls ($p < 0.01$ in all cases) and maintained these improvements ($p < 0.01$) for at least 1 month after the final prayer session.

Anastasi and Newberg (2008) studied the impact of religious ritual prayer (reciting the Rosary) on thirty Catholic college students. The intervention group participated in a one-time recitation of the Rosary in a campus chapel, while the control group watched a video with religious content. Pre-test and post-test questionnaires were administered for both state and trait anxiety. Results showed a significant improvement in state anxiety (27%; $p= 0.004$) within the Rosary intervention group between pre-and post-test means. A significant reduction was also found in the post-test state anxiety scores for the Rosary intervention group compared to the control group ($p = 0.035$). The ritualized, repetitive nature of the Rosary, not provided by the religious-content video, may give participants a greater sense of calm.

Positive Outlook

Faith, in general, may promote virtues such as compassion, hope and forgiveness, resulting in better physical and mental health (Hadzic, 2011; Hill & Pargament, 2003). Both belief in a loving God (or higher power) along with a positive worldview, are associated with improved health status, consistent with psychoneuroimmunological models of health (Campbell & Yoon, 2010).

Summary

A plethora of studies have shown that religion and/ or spirituality can have a positive impact on mental health or well-being, as well as on physical health. This effect may occur through a number of proposed mechanisms, informed by quantitative research. For example, spiritual beliefs may imbue life with a sense of meaning and purpose; mindfulness, prayer and meditation can provide a calming effect; and spiritual virtues such as compassion, hope and forgiveness can promote a more positive worldview. However, these proposed mechanisms are by no means comprehensive and barely scratch the surface of a topic as thoroughly complex and varied as spirituality. A qualitative approach is useful in this regard, for it allows an in-depth exploration of perceptions, beliefs and opinions from an indigenous perspective. The goal of this study is to investigate the perceived relationship between spirituality and mental or psychological well-being across a diversity of faith groups, using in-depth qualitative methods. In addition, this study will examine similarities and differences across faith groups in order to create more faith-conscious mental health interventions or treatment options.

CHAPTER THREE: METHODS

This research is a qualitative study utilizing focus group discussions. In total, participants were recruited for five focus groups across the metro-Atlanta area. Support was obtained verbally or by email from the following faith-based or spiritual organizations, through which participants were recruited: The Emory Catholic Center, the Shambhala Center, the Emory Collaborative for Contemplative Studies, Drepung Loseling Monastery and the Marcus Jewish Community Center. This study received exempt approval from the Emory Institutional Review Board.

Participants

The sample consisted of five groups of residents of the metro Atlanta area (Fulton and Dekalb counties) who were between the ages of 18 and 90 and who were members of a faith-based or spiritual organization and selected by the principal investigator. These included Jews, Catholics, Buddhists and members of the Emory-Tibetan partnership, as well as members of a non-religiously- affiliated yet spiritual community, such as the Atlanta Mindfulness Institute and the Decatur Interfaith Contemplative group. The groups were chosen based on diversity of spiritual practice, willingness to participate, ease of access for the investigator, and the organization's scheduling flexibility. Within each group, participants will be selected on a first-come, first-served basis. The first ten people who responded to the recruitment flyer or announcement were invited to participate.

The Investigator collaborated with the The Emory Catholic Center, The Emory Collaborative for Contemplative Studies and the Faith Alliance of Metro Atlanta as well as with members of her thesis committee to identify relevant faith communities and to recruit participants. The investigator contacted the heads of the above organizations through email

and asked if they would be willing to participate. The PI also used snowball recruitment techniques to identify interested organizations as well as participants. Preliminary meetings with each representative were held to discuss additional recruitment procedures, and occasionally, announcements at regular group meetings were made. Recruitment of participants occurred through email and in-person at group member meetings. The focus groups discussions were scheduled using an online poll through which interested members could choose the dates and times they would be available. The PI chose the final dates and times for each discussion based on the options receiving the most voters in the online poll. The focus groups were conducted over a three-month period

Eligible participants: 1) were 18 years of age or older, 2) were fluent in spoken English, 3) identified themselves as members of any of the above-mentioned faith organizations, and 4) gave verbal consent.

Measures

The semi-structured focus group discussion guide was developed by the principal investigator and reviewed by the thesis chair (Appendix A). In general, focus group participants were asked to describe their spiritual beliefs and practices and explain any connection they perceived between these and their self-reported mental health or well-being. Questions included: "What part of your spiritual practice or belief system is most important to you?" and "What do you derive the most value from?" Questions were informed by literature on the core themes of spirituality and encompassed the three domains of spirituality identified by Rovers and Kocum (2010): Faith (religious or theistic attributes), hope (meaning-making attributes), and love (community or relational attributes).

Procedure

The investigator conducted five focus groups, one for each faith organization. Each focus group was comprised of between 4 and 7 individuals, for a total of 27 participants. The proposed number of subjects was based on the need to strike a balance between generalizability and feasibility. The focus groups were conducted at the Rollins School of Public Health, the Canon Chapel at Emory and at Drepung Loseling Monastery.

The principal investigator was responsible for conducting all interviews. Before the start of the focus group discussions, all participants provided oral informed consent, after viewing an information sheet about the study (Appendix B). The moderator and the participants interacted in a group discussion format; participants were encouraged to respond to each other's comments, as well as to those of the interviewer. Questions were open-ended and the interview style was conversationally flexible, allowing the interviewer to provide unscripted feedback in order to clarify the meaning of questions and answers as necessary and to probe more effectively (Schober & Conrad, 1997). An informal, conversational interviewing style for focus group discussions also helps create a non-threatening environment wherein participants feel at ease (Hennink et al, 2011).

The total respondent burden was, at most, two hours, including time for discussion and travel. The discussions were also audio-recorded, upon consent of participants.

Confidentiality

No Protected Health Information (PHI) was collected in this study. The researcher disguised the names or other possible identifying information related to the participants and their families. In some instances, pseudonyms were used in the final manuscript. To further protect the confidentiality of the research participants, the principal investigator stored the

collected data in a 128-bit, password-encrypted computer file on a personal computer. Research subjects were informed of these measures through the verbal consent sheet.

Analysis

The audio recordings of the focus group interviews were transcribed verbatim, summarized, and stored along with notes taken in a password-protected folder on the investigator's personal computer. The data were then coded independently by the PI and a fellow graduate student to ensure inter-rater reliability. Codification was a circular process, relying on repeated reading of interview transcripts and interplay between literature-based ideas and inductive themes. Analysis began with open coding, after which these codes were grouped into core themes (axial coding). Conflicting codes were discussed until consensus was reached and a codebook was created to ensure standardization of coding procedures. MAXQDA qualitative software was used to organize the data by code and to determine major themes. Data analysis led to the construction of grounded theory—the conceptualization and identification of a new typology distinguishable from existing theoretical concepts.

CHAPTER FOUR: RESULTS

RESULTS

Study Population

In total, 27 individuals participated in one of five focus group discussions, ranging in size from 4-7 participants each. The focus groups will be heretofore referred to as follows: A Buddhist group composed of members of the Drepung Loseling Monastery in Atlanta; A Catholic group composed of attendees of the Emory Canon Chapel; a Jewish group composed of members of the Marcus Jewish Community Center in Doraville; an interfaith group associated with the Faith Alliance of Metro Atlanta; and a "Meditation/ Contemplative" group associated with the Shambhala Meditation Center in Decatur and The Emory Collaborative for Contemplative Studies. There were 7 participants in the Buddhist group, 6 each in the Catholic and Jewish groups, and 4 each in the Interfaith and Meditation groups. An additional participant responded via email, for confidentiality reasons. Participants varied widely in their level of spiritual inclination; some participants described being quite religious and others identified themselves as secular, while maintaining certain spiritual practices. Participants also varied in age; the youngest members were in their early- to mid- twenties while the oldest member was approximately 80 years old. Fifteen participants were male and twelve were female. A majority of participants were Caucasian. Table 1 summarizes several demographic characteristics of the focus group participants.

Table 1

		Catholic	Interfaith	Meditation	Buddhist	Jewish	Total

Number Partici-pants		6 (22%)	4 (15%)	4 (15%)	7 (26%)	6 (22%)	27 (100%)
Gender	Male N (%)	2 (33%)	2 (50%)	2 (50%)	6 (86%)	3 (50%)	15 (56%)
	Female	4 (67%)	2 (50%)	2 (50%)	1 (14%)	3 (50%)	12 (44%)
Age Group	20-30 N (%)	5 (83%)		2 (50%)	2 (28%)		9 (33%)
	31-40			1 (25%)	2 (28%)	2 (33%)	5 (19%)
	41-60	1 (17%)	3 (75%)	1 (25%)	3 (43%)	3 (50%)	11 (41%)
	61-90		1 (25%)			1 (17%)	2 (7%)

Aim 1: Explore the perceptions and experiences regarding the connection between spirituality and mental health/emotional well-being

The first aim of this research was to explore how participants from diverse faith groups understood the relationship between spirituality and mental health, either personally or in a general sense. Analysis of the conversations showed that participants clearly felt that spirituality was related to positive mental health, in any religious environment except extremism. To put this in context, I will begin by describing the types of spiritual practices in which participants engaged. Types of practices included prayer, meditation, compassion meditation, introspection, attending religious holidays, engaging in ritualized activities, community service and participation in church and temple services. Participants also mentioned attending retreats and spending solitary time in contemplation. These practices comprised codes and sub-codes in the analysis.

For the majority of participants, involvement in spiritual practices was seen as a way to navigate mental and emotional battles. that forming a relationship with, or being connected to, a community, the universe, or a higher power was integral to the participants'

mental health. They also discussed the idea of surrendering to God or to a higher power, and that this giving up of control was extraordinarily beneficial to mental health. Finally, participants commented on their personal struggles with anxiety, depression substance abuse and eating disorders and they spoke of relying on meditation and prayer to overcome those issues. These three concepts or categories of spiritual pursuit (relationships, surrender, and prayer and meditation) emerged as the major themes in this analysis.

> …We're built in relation to one another, always...I acknowledge it and live with it, in my prayer life, by way of my service, by way of my surrender to the power greater than myself… In other words, it does come together for me, that, that's important to me (Interfaith participant).

This quote encapsulates the connections among relationship, surrender, and prayer/meditation. I will cover each in more detail in the following sections.

RELATIONSHIPS

The most persistent theme was the importance of relationships to mental wellbeing. In a way, this theme encompasses each of the other themes, as indicated by the quote above. Social support is a well-known benefit of religious participation, but, in this case, well-being was also related to communion with a higher power, with all beings, and with the universe in its entirety. Following are descriptions of each of these three manifestations of relationships.

Community. The first manifestation of relationship is Community. When participants spoke of mental health, they often mentioned the desire to feel supported and welcomed by others, whether in a congregation, *Sangha* (Buddhist community), or through a cultural affiliation. Community served as both a venue for emotional support and a way to

learn from other people's struggles. Participants in the Jewish focus group spoke of the importance of social support to mental health in the Jewish community:

> I would say, I think, among the strongest things that Jews have going for them in terms of psychological health is their community. Social support is such an important part of being healthy emotionally and stuff, and so if you can be part of a community, I think that's huge.

The need for community influenced some participants and their relatives to either become more religious or adopt a new religion: "And I will say, my brother did get really orthodox and we were not very connected to a community when we were younger." One member of the meditation group, after leaving her childhood home and faith, realized she missed the community support of her old church. Her therapist encouraged her to join a group of fellow meditators in Atlanta.

Similarly, Buddhist participants reported feeling emotionally supported by their *Sangha*, a community of Buddhists who practice together. Within the *Sangha*, participants felt comfortable sharing their challenges, their triumphs, and acknowledging a common ground: "But it's through so many experiences, being with my Sangha and hearing their struggles and how we all have this commonality, we all seek happiness and peace and that's been itself a great lesson." An Interfaith participant expressed a similar point of view: "And that's the other thing, being with other people, whether it's in groups or in Church, you know, and having them say, 'Sigh, yeah, I struggle with that too' [laughs]. Relationships again! [laughter]. It's all relationships."

Jewish participants emphasized the role of culture in maintaining a community in the context of the Jewish diaspora. Members of the focus group expressed pride in Jewish

culture and believed that cultural underpinnings differentiated Judaism from other religious faiths:

> So the thing I like the most is, it's a culture more to me than a religion. Not the rituals that go with it, but the -- just the feeling of it. It's a totally different aspect of a religious belief. I don't think Catholics feel that way.

Members of the Jewish group also spoke of the importance of home and family to Jewish life. Many important Jewish holidays are celebrated in one's home, so the household also becomes a focal point for religious or spiritual practice. Participants found this aspect of the Jewish faith comforting and inclusive. One participant converted to Judaism from the Episcopal Church after marrying a Jewish man from Israel. Her conversion was influenced by the strong sense of community she found in her husband's family: "So I just found -- just very welcoming and I loved that. I also love the history and the food and the culture." Participants associated supportive communities with mental and psychological well-being.

Relationship with God. The second important manifestation relationship was relationship with God**.** A Catholic participant, whom I will refer to as Casey, wrote a particularly moving email response recounting how her realization of God's love helped her overcome an eating disorder, which she referred to as Ed:

> I was dating someone for 5 years and we broke up and I think that triggered me to focus more on my relationship with God. I began turning to God for love and acceptance rather than Ed [eating disordered thinking] and through my relationship with God, I was able to rid myself of Ed. I had to realize and truly believe that I was loved by God and make that love a priority--not the love and acceptance of other people. It look me years to believe that God could love me but when I did--I was able

> to get rid of Ed… My entire mindset changed when I began to focus on God and not myself. When I allowed Jesus to love me. When I entered into a personal relationship with God.

Acknowledgment and acceptance of God's love represented a crucial turning point in Casey's recovery from anorexia. Other participants in the Catholic and interfaith groups also commented on the importance of developing a relationship with God for spiritual and emotional wellbeing.

Interconnectedness or Universalism. The third manifestation of the relationships theme was interconnectedness or universalism, a feeling of being connected to something much larger. The Buddhist members of the group described this as the "illusion of self," the idea that we are not truly separate people:

> But, there's a lot of emphasis, I mean, in Buddhist philosophy, in how my reactions affect you and your reactions affect me, we're not by ourselves, it's like, we're all systems. It's all one big system, that all affect each other.

The concept of being connected to and being an integral part of something larger was inseparable from the relationship theme, as expressed by members of the interfaith group:

> And I'm very much a Universalist in that sense, I'm very, very conscious of our being a part of the universe, that our little globe in this little solar system, but it's very significant, because it may be the only thing in the solar—in the whole universe, that is like us, we don't know! So I get into that sense of the immensity and yet I'm a part of that, and you're a part of that, Joanna, and each one of us is a part of it and our relationships… and that's the final thing I would get into—is very

> much into relationships and how important that is, because, as Americans, we are secular people, we are individualists with a vengeance.

The idea of universalism made participants feel more significant on a universal scale. Alone, we may be small and powerless creatures, but our relationships with others remind us that we are part of something much greater.

SURRENDER

The concept of surrender was a strong thread running through the focus groups. When I asked participants to define optimal mental health, one said, "I think of it being about you can balance everything… Part of being able to do that is giving up that you control it. Then you're surrendering to kind of a higher power (Catholic group). Participants found that when they gave up the idea that they could exert complete control over events in their lives, their mental health increased. They thought of this as surrendering to a higher power.

John, an interfaith participant, related the concept of surrender directly to his experience with addiction recovery:

> …The thing that's been popping up for me lately, comes out of the experience of Alcoholics Anonymous is the notion of surrender. And, uh, it runs through Islam, it runs through… it seems like it runs through all of the faiths. And it's been important to me, in terms of the topic mental health. It's giving up and not feeling like I'm in charge and I can make everything work and everything come together and solve all the world's problems and make peace in Palestine and you know, all the complicated things.

The act of metaphorically giving these problems to God and relinquishing control relieved his stress and worry over issues that were ultimately beyond his control. While John is still politically active, he no longer feels so burdened by responsibility.

Surrendering to a higher power necessitates a large degree of trust and faith. The importance of faith and hope for mental wellness was a concept permeating all focus groups, but predominated in the Catholic group, where faith often formed the basis for perception and understanding. As one participant said, "My faith forms the lens through which I look at the world." Participants in the Catholic group also expressed finding deep solace in their faith in God. They believed that God would carry them through tough times and that everything would turn out well in the end. These beliefs allowed participants to both accept and work through difficult situations. For example, one participant, who grew up in Rwanda during the Genocide, spoke of the role his faith played during this traumatic experience:

> I've learned to accept what I have control over and what I don't. I think it's something that with faith… it doesn't have to be faith, but, generally I think with faith when you go through the trials and tribulations and you overcome them and you are growing faith, it gives you that real sense of hope and that helps a lot as well. (Catholic).

Trust in God also moderated emotions. One participant noted: "I am slow to become frustrated or stressed, or upset about certain things because I have this faith that God has a plan for me." Overall, the notion of surrendering to God helped participants cope with stressful situations, emotions and worries.

Participants in the meditation/ contemplation group spoke of faith in a different sense. Rather than faith in God, they spoke of faith in the unknown, the belief that ultimate truth is unknowable:

> Scientists and religious people, I think, they run around in groups and they try to figure out what is the truth. And that's debated. So, for me, the spirituality is this kind of holding of the unknown and respecting it. So there is a kind of faith, I guess, that goes along with it. That there's a positive outcome in recognizing and exploring that aspect of reality.

Surrender, for members of this focus group, meant acknowledging the fact that one can never fully understand the world or universe. It was important, in a mental health sense, to become comfortable with this truth, as indicated in these quotes :

> Um, my, I guess my two cents I'll throw out is that somehow there… I feel like I need to accept that there would be no way that my human brain could actually comprehend the world in its totality. (Buddhist)

> But in Zen, you would contemplate, you just sit in this sort of not knowing, this koan, riddle, right? You've heard of this. So, you sit for hours just not knowing something, asking a question that sometimes—So that's trying to get comfortable with this. The fact is that we cannot, we really cannot, you know, we're [laughs], we just can't know at all. (Meditation)

While these groups stressed the need to accept lack of knowledge, Jewish participants tended toward skepticism and rejected the notion that adverse events should be accepted on faith:

> As a Jew, I accept the fact that you find comfort in that, but I, as a Jew, doubt it as much as you believe in it because of the Holocaust, because of cystic fibrosis, because of -- you know, bad things happen to good people…but I respect and accept, and encourage you because that gets you through the day, that gets you through tough times. But a lot of times, people who are in that position don't accept my position of questioning and doubting, and not knowing for sure.

PRAYER and MEDITATION

Prayer and meditation were described as similar processes with different aims. Each necessitates being quiet, listening, and paying close attention to feelings or emotions, and both prayer and meditation prompted calm and peaceful sensations. One Interfaith participant described prayer as talking to God and meditation as "listening for God." However, members of the meditation and Buddhist groups did not associate their meditation practice with any kind of higher power. Despite these differences, both practices were integral to spiritual life across the focus groups.

Prayer**.** Catholic and Interfaith participants used prayer as a means to make important life decisions or otherwise understand God's plans for them. This was process was called discernment:

> …You're discerning and you hear God speaking, in a way, because you feel that sense of peace, you feel that comfort, like, yes, that's what I'm supposed to be doing, or that discomfort, like no, that's not what I'm supposed to be doing, but I never really thought of, like, like I don't know. I was skeptical of hearing God actually saying words to you or doing something, things like that, a more concrete sign (Catholic).

These remarks indicate that God was understood to communicate through feelings and emotions rather than words. It proved necessary, then, to be mindful of one's emotions in order to hear God. In meditative practice, participants similarly emphasized the importance of awareness and acceptance of emotions, sensations and thoughts.

Participants in the Interfaith, Catholic and Jewish groups primarily associated prayer with feelings of calm and peace:

> I was praying the rosary, I still remember this, I was praying the rosary on my bed, in my room, back home and my mom was praying with me and like I had this little statue of Mary and all of a sudden I just felt this, I had this immense peace wash over me, and just felt like in a totally, like hyper-religious state, like I was very calm and peaceful and just felt really connected… with God. And it was so strong, like, as an eight year old, I still remember it today and my mom still remembers it, like being with me and those are the two, like big experiences I've had. (Catholic)

In the Interfaith and Catholic groups, prayer was viewed as essential for maintaining relationships, both with God and with other people:

> Well, let me put it this way. [Prayer] is as crucial, in general, to my spiritual life, as my relationship with my wife. In other words, our marriage is as successful as we are in communion, as we are communicating, as we are in active relationship, including being quiet with one another. And so, I expand that, then, to my relationship with God and then my relationship with other people (Interfaith).

This participant currently prays for 1,500 different people every single day. He keeps a list of these names and works through them every morning. Doing this reminds him of how grateful and blessed he is to have these people in his life. Another participant emphasized

the connecting power of prayer: "But that, that's something that you were talking about, prayer, sometimes your prayer just gives you the grace to get through it and knowing, knowing that you're not alone" (Catholic).

It was evident that interfaith and Catholic participants approached prayer as a way to connect with and communicate with God, providing a source of support and solace. Jewish participants mentioned prayer in the context of ritual rather than as a medium for communication with God. In all groups, prayer contributed to emotional awareness and calm, peaceful feelings.

Meditation**.** When participants spoke of meditation, they referred primarily to mindfulness meditation, the so-called "heart of Buddhist meditation," during which practitioners cultivate pointed focus and moment-to-moment awareness (Miller et al., 1995). Although associated with Buddhism, mindfulness meditation applies easily to a secular context.

While participants used similar language to describe the processes of both prayer and meditation, members of the Buddhist and meditation groups agreed that meditation was, ultimately, a training exercise for the mind. The meditation process helped practitioners handle stressful or upsetting situations:

> You're habituating your mind to get to a point where you're experiencing certain things so when bad things do happen, it doesn't mean they're not bad and they're not sad, it means this is how you handle them and react to them, so, that's the difference between Buddhism, in my own opinion, and, say, some of the Judaeo-Christian religions (Buddhist).

Various mental health benefits were attributed to this ability to control thoughts. One participant described how meditation helped her overcome debilitating worries:

> And meditation have [*sic*] helped me live far away from my son and stay calm because before I was a worrier and I saw demons all over the place: Oh, no I'm in the car, oh no he's riding the bicycle, oh, now he's… you know. And now I cannot control, but I can control my mind… What type of life is worries? Most of the worries never come. So I do believe in meditation. It's like a medicine—it's better than a medicine (Buddhist).

Similarly, a member of the meditation group described how meditation helped her control unhealthy thought patterns and achieve more balance and peace in life:

> It makes me feel more anchored and I can keep my balance in life better, and it helps my catch thoughts and feelings before they get carried away in terrible directions, and it makes me more sensitive to my physical reactions…

Lastly, participants believed that their meditation practice helped them improve interpersonal relationships. By controlling their thoughts about stressful events, they were better able to communicate with people whom they perceived as stressful or aggravating. In a larger sense, meditation promoted a feeling of connectedness, in that it illuminated what participants in the Buddhist and meditation groups described as "the illusion of self":

> The illusion of the self is the big one. And I think meditation is the way to get, to try to cut through it. We somehow grow to believe that we are this separate, single person, and the religions that believe in the soul, which includes various Buddhist religions, has made us—and we want to believe, for various reasons, it's like an

> evolutionary, genetic thing, that we are this one—you know, it's clear that I'm [Bill]. But in fact, who's [Bill]? (Meditation group).

Overall, both prayer and meditation contributed to mental well-being by promoting emotional awareness and emotional regulation, strengthening positive feelings (peacefulness and calm) and decreasing negative feelings (anxiety, sadness and loneliness). Additionally, prayer and meditation were seen as important for relationship building.

Aim 2: Analyze the similarities and differences in the perceptions identified in Aim 1 across faith groups.

Participants in each focus group expressed the importance of forming and maintaining relationships in the context of mental well-being. Community, whether in the form of a *Sangha*, family life or cultural affiliation, provided spiritual, mental and emotional support across all the focus groups. The groups also employed similar spiritual practices, albeit in different forms. For example, meditation and prayer were expressed as two sides of the same coin; both involved being quiet and being attentive to thoughts and emotions. Additionally, both practices increased feelings of calm and peace. Members of all groups practiced some form of meditation or prayer.

While the groups' responses were more alike than they were different, several differences did emerge. For example, only Jewish participants noted the importance of Jewish culture as an aspect of relationships. Jewish participants did not, however, speak to the theme of surrender. The surrender concept was common among the other groups, but expressed in a variety of ways. While Catholic and Christian participants in the interfaith group specifically expressed surrendering to God, others surrendered to a higher power, or even to the unknown. The Catholic and interfaith groups also described the act of surrender

as a giving up the urge to control things in life, and recognizing that the future is not always in your hands. In contrast, the meditation and Buddhist groups described this as giving up the need to *know* rather than the need to control.

It is important to recognize that faith was not static; participants were continually searching for meaning and direction in their spiritual lives. Participants varied greatly in terms of religious background, current practices and level of religious commitment. The question of how participants understood God came up a number of times. The Catholic and interfaith participants believed strongly that God took an active role in their lives. Participants in the other groups were more ambivalent about God's role or spoke instead of the presence of a connecting force in the universe.

Many participants reported searching for a spiritual outlet different from the one they had been raised with. In fact, every member of both the Buddhist and Meditation groups had originally been raised in Christian or Jewish households. They searched for something that would fill a spiritual void and found an answer through meditation and Buddhist beliefs. In contrast, all members of the Catholic group I spoke with were born and raised Catholic. Two members of the Jewish group were raised in Christian denominations and one had since converted to Judaism. Members of the non-Christian groups appeared to be far more skeptical than those in the Christian groups. They valued intellectualism, philosophy and pragmatism very highly. Many had also left the Christian faith because of traumatizing or highly off-putting experiences. Despite such diverse backgrounds and experiences, the three themes of relationships, surrender, and prayer/meditation captured the essence of the role of spirituality in mental well-being for these participants.

Aim 3: Generate recommendations for future mental illness treatment and mental health promotion

programs.

This aim is more appropriate to the recommendations section of the next chapter. For that reason, it is presented in that section.

CHAPTER FIVE: DISCUSSION

Theoretical Model

In the tradition of Grounded Theory, a model of the association between spirituality and mental wellbeing was inductively derived from these results. This theory is depicted in Figure 1.

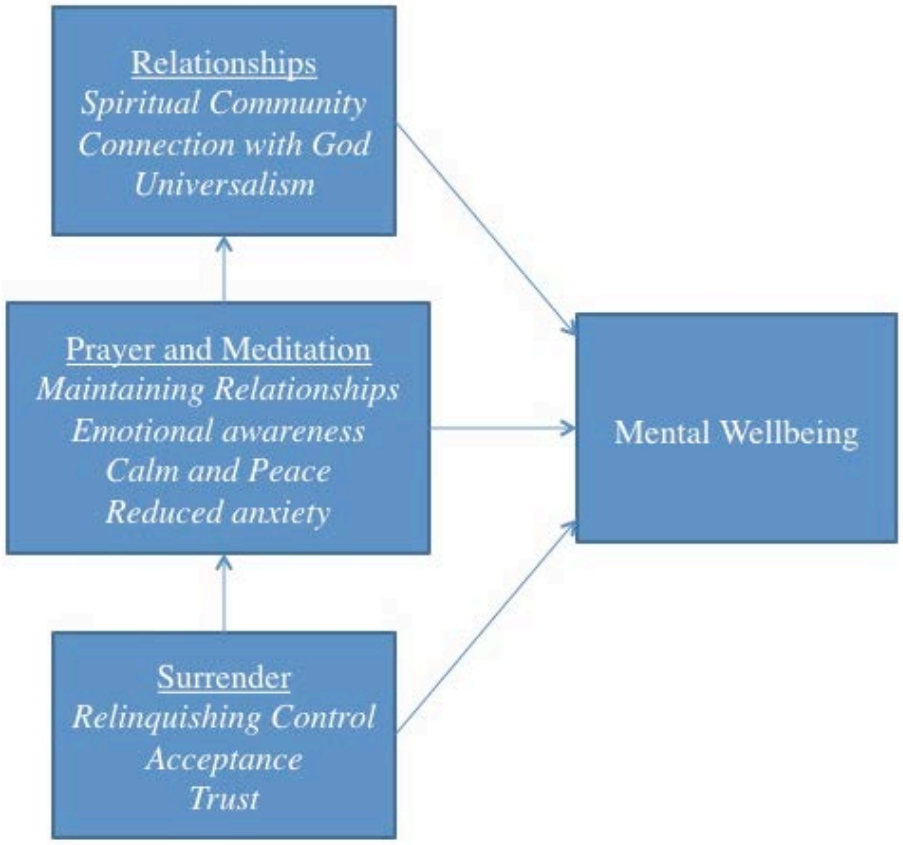

Figure 1: A model of the association between mental wellbeing and spiritual experience.

In this model, relational attributes, specific spiritual practices and the surrender concept relate directly to improved mental wellbeing. Additionally, these spiritual concepts built on each other.

Summary of Findings

This study corroborates the findings of earlier quantitative studies, which have clearly shown that spiritual practices and beliefs play a role in positive mental health and emotional well-

being. However, there is little consensus in the field concerning the particular *mechanisms* by which spirituality contributes to mental health (Hill & Pargament, 2008). For example, spirituality may provide: 1) social support through a religious community; 2) a personal relationship with God; 3) a sense of meaning in life; 4) perceived control over life circumstances; and 5) and feelings of peace and calm through meditation, mindfulness and prayer. This study's aim was to investigate these possibilities in a deeper fashion, through the use of exploratory qualitative research methods. Findings are summarized below.

Perceptions and experiences regarding the connection between spirituality and mental health. Participants associated three aspects of spirituality with mental and emotional wellbeing: Relationship formation, surrender through faith, and meditation/prayer. However, all themes ultimately underscored the importance of relationships and connectedness to mental wellbeing.

Relationships were shaped through community, culture, family and God. Additionally, participants mentioned feeling connected to the universe as a whole. These connections provided emotional support, love, compassion, and decreased loneliness. It appears that connectedness increases emotional support and decreases negative emotions such as loneliness, depression, and anxiety, thus contributing to mental wellbeing.

In addition, many participants felt that their spiritual tradition allowed them to surrender their worries to God, a higher power, or just to surrender, by recognizing and accepting the parts of life they could not control. Surrendering control to a higher power gave participants hope and an enduring sense that things would turn out for the best, while simply surrendering reduced distress.

Both prayer and meditation also contributed to mental well-being by enhancing emotional awareness and emotional regulation, strengthening positive feelings (peacefulness

and calm) and decreasing negative feelings such as anxiety, sadness and loneliness. But the overarching power of relationships was also evident in participants' experiences of meditation and prayer. For example, prayer was viewed as a form of communication with God. Participants also used prayer as a way to express compassion and care for people in their lives. Meditation elicited a sense of connectedness with the universe and was also used to improve challenges in personal relationships. Ideas about faith, control and surrender, and relationship that were expressed in the focus groups are reminiscent of twelve-step program philosophies. Twelve step programs such as Alcoholics Anonymous envision the process of recovery from addictive disorders through the lens of surrender and connection. The first step in the 12-step process is acknowledging the addiction and accepting that one needs *help* to overcome it (12Step.org, 2013; Chen 2010). The implication is that alone, one is powerless but, with the help of others, it is possible to embark on the journey toward recovery. Step two involves "finding common ground, unconditional love, and a magical sense of connectedness that will leave you as high as any drug, drink or new dress" (12Step.org, 2013). Again, the emphasis on relationships is clear. The third step is making the "decision to turn our will and our lives over to the care of God," in whatever way God is understood. In other words, "let go and let God" (12Step.org, 2013). To be clear, this does not mean giving up; it means acknowledging one's limitations and accepting help.

Overall, this study has shown that spiritual practices and beliefs can provide a sense that we are part of something greater than ourselves; that we are not isolated beings but integral parts of a greater universe. The spiritual traditions examined in this study provided practitioners with various routes for reaching this conclusion.

Cross-Group Comparisons. The main themes were present across all the groups, with relationships emerging as the most important theme overall. Community, whether in the form of a *Sangha*, family life or cultural affiliation, provided spiritual, mental and emotional support across all the focus groups. Members of all groups practiced some form of meditation or prayer. There were also differences. For example, Jewish participants noted the importance of Jewish culture as an aspect of relationships while other participants did not. Likewise, surrender was a common theme, but there was variation in in the nature and context of surrender. While Catholics described surrendering to God, others spoke of giving up control over external events and accepting the limits of human knowledge. Despite these differences, the three themes of relationships, surrender, and prayer/meditation captured the role of spirituality in mental well-being across participants from these diverse spiritual orientations.

Recommendations for future mental illness treatment and mental health promotion

Information from this project can be used in planning and implementing future mental health treatment or intervention programs, as well as to provide recommendations for counselors in regards to effective treatment strategies. Such intervention strategies will, ideally, be applicable across all faith groups as well as in a secular context. Results of this study reveal that this goal is both conceivable and feasible. Focus group participants generally agreed that one does not have to be religious in order to be spiritual, or to receive the benefits of spiritual practice. Many participants did not, in fact, describe themselves as religious. Meditation, for example, was described as a secular yet spiritual practice, as was relationship formation. The following recommendations build on faith-based practices but are easily translatable to secular contexts.

Recommendations for Mental Health Promotions Programs. First, mental health promotion programs must incorporate some aspect of community support, judging from the importance of relationships expressed across all focus groups. This might take the form of a support group or group therapy, but participants should also be encouraged to join larger community organizations. In general, mental health promotion programs or interventions should focus on helping individuals form connections with others, as well as incorporate the idea that people are not isolated entities, but part of a larger whole; a network or a system of connections. This idea was expressed across all focus groups.

Mindfulness is, in the words of the writer and Theravada monk Nyanaponika Thera (1962), "the unfailing master key for knowing the mind, and is thus the starting point; the perfect tool for shaping the mind, and is thus the focal point; the lofty manifestation of the achieved freedom of the mind, and is thus the culminating point" (p.??). This passage can be interpreted in a variety of ways. In this context, however, it is meant to suggest that mindfulness is a useful tool for developing a sound mind. In light of this, the following meditation and mindfulness practices will also be helpful.

Mindfulness-Based Stress Reduction. Mindfulness-Based Stress Reduction therapy, or MBSR, incorporates many elements of meditation practice that focus group participants found helpful for relieving mental and emotional symptoms. MBSR, originally referred to as the Stress Reduction and Relaxation Clinic, was developed by Jon Kabat-Zinn in 1979 (Kabat-Zinn, 2011). The program has Buddhist roots but is predominantly used in secular contexts. Mindfulness is a meditation therapy that encourages attentiveness to the present moment (Raab, 2009; Raes et al., 2013). Practitioners are instructed to become aware of thoughts and feelings, and to accept them without judgment. MBSR has proved effective against both depression and anxiety by allowing one to recognize and stop a succession of

negative thoughts; when we confront uncomfortable emotions and thoughts with kindness, compassion, and without judgment, we become less affected by them (Hofmann et al., 2011).

Results of this study support the use of MBSR as an effective mental health promotion program, as well as a treatment plan. Participants from each of the five focus groups used techniques to improve awareness of thoughts and feelings, whether through prayer or meditation. Public health practitioners should consider incorporating mindfulness-based stress reduction into future program plans.

Meditation on Emptiness. The British psychoanalyst Marion Milner (1936) wrote extensively about the notion of emptiness in *An Experiment in Leisure*. She believed that embracing the reality of emptiness actually increased psychological health (Mayo 1995; Sayers, 2002). Meditation on emptiness is a Buddhist analytical meditation tradition based upon the belief that suffering is a result of mental and perceptual distortions. Therefore, phenomena do not exist outside of our interpretations of them, and this is what causes us distress. The non-existence of phenomena in this sense is referred to as emptiness. Similar to Milner, Buddhist focus group participants spoke of meditation on emptiness as beneficial practice; one in which emptiness itself was not an end goal, but rather a starting point for exploring the validity of one's perceptions and assumptions.

Compassion Meditation. This type of meditation entails focusing on the alleviation of suffering for all sentient beings (including oneself and one's community as well as one's enemies) (Hofmann et al, 2011). The practice is based on *lojong*, a one-thousand year old Tibetan Buddhist mind-training practice. The purpose of *lojong* is to develop altruistic

emotions and behaviors towards others through challenging a person's unexamined thoughts and feelings toward other people (Emory Research Report, 2010).

The CALM study at Emory University is currently investigating the differential effects of compassion meditation and mindfulness training on stress responses in adults. Results from an earlier study with Emory college students found that those who regularly practiced compassion meditation exhibited significantly reduced stress as well as physical responses to stress (Baker, 2010).

Loving-kindness Meditation (LKM) is a form of compassion meditation in which the goal is to encourage empathic and loving feelings. Both loving-kindness and compassion are inseparable from the Buddhist belief that all living beings are inextricably linked. Salzberg (1995) has described that, through LKM, we come to recognize and appreciate our oneness with others and we "become deeply aware of the suffering caused by separation and of the happiness of knowing our connection with all beings" (p. 6).

Recommendations for Clinicians**.** Psychotherapist Dr. Kelley Raab Mayo (2009) writes that, "The goal of psychotherapy is to promote insight and growth, as well as to help patients assert better control in their lives" (p. 92). Spiritually-based therapies have the advantage of helping patients come to accept what they can control and what they cannot. This directly relates to participant experiences of "surrendering." Similarly, therapists can encourage patients to let go.

Clinicians can also help patients strengthen and deepen their meaningful personal relationships as well as improve social skills. While relationship building is not, in and of itself, a "spiritual" practice, relations are highly important in many faith contexts. For example, in the Christian faith tradition, compassion and service to others are highly

regarded virtues. Compassion entails, in a way, entering into the experience of someone else's suffering in order to empathize with them.

With this research in mind, clinicians can be encouraged to guide clients toward participation in spiritual activities or toward increasing their own practice if they are already engaged in one (Hackney & Sanders, 2003). Koenig and Pritchett (1998) list six types of spiritual interventions for use in psychotherapy. Included in the list are praying or meditating with patients and using the patient's religious or spiritual worldview to promote healthy behaviors. I recommend these approaches so long as the patient is comfortable with it.

Therapists can also utilize Cognitive Behavioral Theory (CBT) and MBSR to enhance promote positive feelings and thoughts. During CBT, clients participate in relaxation methods and are taught alternative ways to perceive stimuli that are less anxiety-provoking. Clinicians can help patients maximize the benefits of mindfulness by providing the encouragement and guidance necessary to establish a lasting meditation practice (Marchand, 2013).

Importance of the Therapeutic Alliance. This discussion would be woefully incomplete without acknowledging the role of the therapeutic alliance. The relationship between patient and therapist is an excellent predictor of treatment success (Chessick, 1993; Horvath & Symonds, 1991; Messer, 1988). In a meta-analysis of twenty-four research studies on the therapeutic alliance, Horvath and Symonds (1991) found that clients' perceptions of their relationship quality was the best predictor of success in treatment. This association was also independent of the type of therapy received, again indicating the significance of positive relationship formation to mental health.

Implications for the Public Health Field

The field of public health would benefit from greater acceptance of religious and spiritual ideas and practices, and should attempt to work with, instead of against, these ideas. The process has already begun; mindfulness is now a widely used and accepted tool for promoting mental health in children, adolescent and adult populations (Appel & Kim-Appel, 2009). It is possible that spiritual health will, in time, be seen as a component of overall health and mental health.

Limitations and Directions for Future Research

Ideally, a great diversity of faith groups would be represented in this study. Future studies should seek participation from members of Muslim and Baha'i organizations as well as other Christian denominations. This study would also benefit from more interviewees, a longer time period for data collection and funding to reimburse participants.

One possibly important limitation is that some focus groups had more participants than others. For example, the Catholic and Buddhist groups each had 7 members while the interfaith group had four. This was due to the difficult nature of scheduling focus groups. Recruitment was less problematic as finding a time and date that would fit the majority of participants' schedules. Future researchers might consider individual interviews as an alternative to focus groups. This might also help elicit personal stories that participants might have been reluctant to share with a group. Focus groups were used in this study because greater richness of data can be collected in a group setting, where participants are able to brainstorm and build of off each other's thoughts. Participants seemed to enjoy the focus groups and came away with new knowledge and understanding. Consistent with the relationship theme, participants appeared to benefit more from the group setting than they

may have during individuals, mostly because this gave them the opportunity to learn from each other.

Another limitation of this study is that I did not ask participants directly about their personal sources of distress, not wanting to make them feel overly vulnerable or exposed in a group setting. This is a limitation because conclusions cannot be linked to specific sources of mental or emotional distress, except in the cases that participants explicitly shared. This is another reason future research would benefit from replicating this study by conducting individual interviews rather than focus group discussions, or at least by supplementing focus group discussions with in-depth interviews. Such research could promote a deeper understanding of the nature of mental health and mental disorders.

Finally, this research project does not explicitly address diagnosed mental and behavioral disorders, although some participants noted that they had received a mental disorder diagnosis. The intersection of spirituality and diagnosed mental illness is another area for future research. In general, investigation into the relationship between spirituality and mental health must continue in order to develop broadly applicable mental health interventions that capitalize on the benefits of spirituality.

Conclusion

The present study investigated the impact of spiritual practices on mental well-being, in hopes of informing more effective mental health promotion programs. It was found that relationships, surrender, and prayer/meditation are important aspects of the way in which spirituality affects mental well-being among diverse spiritual practitioners. While prior research has indicated the potential value of social participation and support through religious communities, the present study suggests that relationship-building is more

important to mental health than previously thought. Spiritual practices and beliefs enhance and encourage positive, supportive and meaningful relationships, both inside and outside of the religious community, and across faith groups. Future mental health promotion programs, as well as clinical treatment strategies, can benefit from incorporating spiritually-based practices, viewpoints and philosophies. It can be hoped that improving spiritual wellness in the general population will decrease psychological distress and increase happiness, compassion, meaningful living, and overall well-being.

> *There can be no knowledge without emotion. We may be aware of a truth, yet until we have felt its force, it is not ours. To the cognition of the brain must be added the experience of the soul.*

-Arnold Bennett

REFERENCES

Chapter One

Baetz, M., and Towes, J. (2009). Clinical Implications of Research on Religion, Spirituality, and Mental Health. *Canadian Journal of Psychiatry, 54*(5): 292–301.

Berry, D. M., & York, K. (2011). Depression and religiosity and/or spirituality in college: A longitudinal survey of students in the USA. *Nursing & Health Sciences*, *13*(1), 76-83.

Carmody, J., Reed, G., Kristeller, J., Merriam, P. (2008). Mindfulness, spirituality, and health-related symptoms. *Journal of Psychosomatic Research, 64*: 393–403.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: Sage Publications.

Cohen, A. B., and Koenig, H. G. (2004). Religion and mental health. In C. Spielberger (Ed.), *Encyclopedia of applied psychology* (Vol. 3, pp. 255–258). Oxford, UK: Elsevier Academic Press.

Flannelly, K.J., Koenig, H. G., Ellison, C. G., Galek, K., & Krause, N. (2006). Belief in Life after Death and Mental Health: Findings from a National Survey. *Journal of Nervous and Mental Disease, 194*(7), 524–529.

Geertz, C. (1975). "Thick description: toward an interpretive theory of culture." In C. Geertz (ed.), *The Interpretation of Cultures.* London: Hutchinson.

Glaser, B. and Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research.* New Jersey: Transaction Publishers.

Hackney, C.H., and Sanders, G.S. (2003). Religiosity and Mental Health: A Meta-Analysis of Recent Studies. *Journal for the Scientific Study of Religion, 42*(1), 43-55

Hadzic, M. (2011). Spirituality and Mental Health: Current Research and Future Directions. *Journal of Spirituality in Mental Health, 13*(4): 223-235.

Hennink, M., Hutter, I., Bailey, A. (2011). *Qualitative Research Methods.* London: Sage Publications Ltd.

Hill, P.C., and Pargament, K.I. (2008). Advances in the Conceptualization and Measurement of Religion and Spirituality: Implications for Physical and Mental Health Research. *Psychology of Religion and Spirituality, S*(1), 3-17.

Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6): 593-602.

Kessler R.C., Demler, O., Frank, R.G., Olfson, M., Pincus, H.A., Walters, E.E., Wang, P., Wells, K.B., Zaslavsky, A.M. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine,* 352: 2515–2523.

Koenig, H.G. (2009). Research on Religion, Spirituality, and Mental Health: A Review. *The Canadian Journal of Psychiatry, 54*(5), 283–291.

Pargament, K.I. (1997). *The psychology of religion and coping: theory, research, practice.* New York: Guilford Press.

Strauss, A. and Corbin, J. (eds.) (1997). *Grounded Theory in Practice.* Thousand Oaks, CA: Sage Publications.

World Health Organization (WHO). (2010). Depression. Retrieved from http://www.who.int/mental_health/management/depression/definition/en/.

Chapter Two

Anastasi, MW, and Newberg, AB. (2008). A Preliminary Study of the Acute Effects of Religious Ritual on Anxiety. *The Journal of Alternative and Complementary Medicine, 14*(2): 163–165.

Boelens, PA, Reeves, RR, Replogle WH, Koenig, HG. (2009). A randomized trial of the effect of prayer on depression and anxiety. *International Journal of Psychiatry in Medicine, 39*(4): 377-392.

Breitbart, W. (2002). Spirituality and meaning in supportive care: spirituality- and meaning-centered group psychotherapy interventions in advanced cancer. *Supportive Care in Cancer, 10*(4): 272-80.

Campbell, JD, Yoon, DP, Johnstone, B. (2010). Determining Relationships Between Physical Health and Spiritual Experience, Religious Practices, and Congregational Support in a Heterogeneous Medical Sample. *Journal of Religion in Health, 49*(3): 3-17.

Ellison, C.G. (1991). Religious Involvement and Subjective Well-Being. *Journal of Health and Social Behavior, 32(*March), 80-99.

Gall, TL, Malette, J., Guirguis-Younger, M. (2011). Spirituality and Religiousness: A Diversity of Definitions. *Journal of Spirituality in Mental Health, 13(*3): 158-181.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of consulting and clinical psychology*, *78*(2), 169.

Holt, C.L. and McClure, S.M. (2006). Perceptions of the Religion-Health Connection Among African American Church Members. *Qualitative Health Research, 16:* 268-281.

James, A., and Wells, A. (2003). Religion and mental health: towards a cognitive-behavioural framework. *British Journal of Health Psychology, 8*: 359–376.

Klainin-Yobas, P., Cho, M.A.A., & Creedy, D. (2012). Efficacy of mindfulness-based interventions on depressive symptoms among people with mental disorders: A meta-analysis. *International Journal of Nursing Studies*, *49*(1), 109-121.

Miller, J.J., Fletcher, K., Kabat-Zinn, J. (1995). Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. *General Hospital Psychiatry, 17*(3): 192-200.

Rovers, M., Kocum, L. (2010). Development of a Holistic Model of Spirituality. *Journal of Spirituality in Mental Health, 12*(1).

Sawatzky, R., Ratner, PA, Chiu, L. (2005). A Meta-Analysis of the Relationship Between Spirituality and Quality of Life. *Social Indicators Research, 72*: 153–188.

Chapter Three

Hennink, M., Hutter, I., Bailey, A. (2011). *Qualitative Research Methods.* London: Sage Publications Ltd.

Schober, M.F., and Conrad, F.G. (1997) Does conversational interviewing reduce survey measurement error? *Public Opinion Quarterly, 61*: 576-602.

Chapter Five

12step.org. (2013). The 12 steps for freedom from addictive behaviors. Retrieved from http://www.12step.org./

Appel, J., Kim-Appel, D. (2009). Mindfulness: Implications for Substance Abuse and Addiction. *International Journal of Mental Health Addiction,* 7: 506–512.

Arch, JJ, Ayers, CR, Baker, A., Almklov, E., Dean, DJ., Craske, MG. (2013). Randomized clinical trial of adapted mindfulness-based stress reduction versus group cognitive behavioral therapy for heterogeneous anxiety disorders. *Behavior Research and Therapy, 51*(4-5):185-96.

Baker, K. (2010). Study will see if calm mind can mean healthy body. Emory University research report. Retrieved from http://www.emory.edu/EMORY_REPORT/stories/2010/10/11/visit_meditation_study.html.

Chessick, R. (1993). A dictionary for psychotherapists: *Dynamic concepts in psychotherapy*. Jason Aronson, Inc. Northvale: New Jersey.

Hofmann, SG, Grossman, P., Hinton, DE. (2011). Loving-Kindness and Compassion Meditation: Potential for Psychological Interventions. *Clinical Psychology Review, 31*(7): 1126-1016.

Horvath, A. O. & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A metaanalysis. *Journal of Counseling Psychology, 38* (2), 139–149.

Kabat-Zinn, Jon (2011). Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism, 1*(12), 281-306

Koenig, H. and Pritchett, J. (1998). Religion and psychotherapy. In H. Koenig (Ed.), Handbook of Religion and mental health (pp. 323-36). San Diego and London: Academic Press.

Marchand, W. R. (2013). Mindfulness meditation practices as adjunctive treatments for psychiatric disorders. *The Psychiatric clinics of North America*, *36*(1), 141-152.

Mayo, K.R. (2009). *Creativity, Spirituality and Mental Health: Exploring Connections.* Surrey, England and Burlington, VT: Ashgate Publishing.

Messer, S. B. (1988). Psychoanalytic Perspectives on the therapist-client relationship. *Journal of Integrative and Eclectic Psychotherapy, 7*(3), 268–277.

Milner, M. B. (1936/ 2011). *An Experiment in Leisure*. Taylor & Francis.

Nyanaponika, T. 1962. *The Heart of Buddhist Meditation.* 24. San Francisco: Weiser.

Raes, F., Griffith, J. W., Van der Gucht, K., & Williams, J. M. G. (2013). School-Based Prevention and Reduction of Depression in Adolescents: a Cluster-Randomized Controlled Trial of a Mindfulness Group Program. *Mindfulness*, 1-10.

Salzberg, S. (1995). *Loving-Kindness.* Boston, MA: Shambhala.

Sayers, J. (2002) Marion Milner, Mysticism and Psychoanalysis. *International Journal of Psychoanalysis, 83*(1): 105-120.

APPENDIX

Appendix A: Focus Group Script

1. Religious background: In what religion were you raised, if any?
Probe: Describe how your spiritual ideas formed, if you can.

2. Can you describe your current spiritual practices?

3. What is spirituality? What does spirituality mean to you?

4. Have you ever been aware of or influenced by a presence or power (whether or not you call it God) that is beyond from your everyday self? Describe this experience if you feel comfortable doing so.

Probe: Have you ever called on a spiritual presence? for help or guidance? Another reason?

5. Do you think that non-religious people can be spiritual or are the two mutually exclusive? Do you have to believe in God to be "spiritual?"

6. What part of your spiritual practice or belief system is most important to you? What do you derive the most value from?

7. What is it about your faith that makes you feel this way?

Probes: Community/ congregational support? Personal relationship to a divinity? Sense of purpose or security? The idea of love, compassion or forgiveness?

8. What does mental health or wellbeing mean to you? Can you describe a time in your life when you think your mental health was particularly good?

9. Describe the connection between your faith/ spiritual study and your mental or emotional well-being.

Probes: peace, happiness, calm, meaning, purpose?

Is there anything else you want to tell me before we end?

APPENDIX B: Consent Form

Emory University
About the Study

Title: Qualitative Perspectives on Spirituality and Mental Wellness

Principal Investigator: Joanna Jungerman, MPH candidate, Emory University Rollins School of Public Health

Co-Investigator: Nancy Thompson, PhD

Introduction
You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.**

Before making your decision:

Please carefully read this form or have it read to you

Please ask questions about anything that is not clear

You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form you will not give up any legal rights.

Study Overview
The purpose of this study is to investigate the potential benefits of spiritual practice and spiritual beliefs for mental well-being among various faith groups.

Procedures
This study will be conducted in a focus group interview setting, for one time only.

Risks and Discomforts
The only potential risks of this study are emotional due to the highly personal and potentially sensitive nature of the topic. If you are a student, your grades will not be affected by your choice to take part in this study. With focus groups, there is the risk of a breach in confidentiality if you choose to share something sensitive and it is repeated outside of the focus group. The P.I. and study team have taken precautions to minimize this in the conduct of the focus group and to protect your data after the session.

Compensation

You will not be offered payment for being in this study.

Risks and Benefits

This study is not designed to benefit you directly. This study is designed to learn more about your beliefs. The study results may be used to help others in the future.

There are no anticipated risks for participation in this study. Monetary compensation will not be provided for participation in this study. However, refreshments and snacks will be available during each focus group session.

Confidentiality

The researchers will not ask for any identifiable study information, such as full names, birth dates or medical records. A study number rather than your name will be used on study records wherever necessary. Your name and other facts that might point to you will not appear when we present this study or publish its results. All data will be kept private. To protect the confidentiality of those who take part, the research will store the collected data in a 128-bit, password encrypted computer file on the Principle Investigator's personal computer. Only the research personnel will have access to this file, with no identifiers. Research personnel include the Principal Investigator, the co-investigator (advisor) and another public health graduate student to take notes and assist with coding. All original data and audio recordings will be destroyed as soon as possible after the completion of data analysis. Research subjects will be informed of these measures through oral consent.

Voluntary Participation and Withdrawal from the Study

You have the right to leave a study at any time without penalty. You do not have to answer any questions that you do not wish to answer. If you withdraw from the study, you may request that your research information not be used.

Contact Information

Contact Joanna Jungerman at jmjunge@emory.edu or (510) 508-7281

if you have any questions about this study or your part in it,

if you feel you have had a research-related injury, or

if you have questions, concerns or complaints about the research

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

if you have questions about your rights as a research participant.

if you have questions, concerns or complaints about the research.

You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

Script

May I answer any questions for you concerning this research?

You are now asked to indicate verbally whether or not, you will be in this study. This is completely voluntary and will not affect any of your legal rights. You will be given a copy of this form to keep.