EXPLORING THE MENTAL HEALTH AND SPIRITUAL RECOVERY OF AN EXPERT-BY-EXPERIENCE: A DISCUSSION OF THE UNIQUE CONTRIBUTION SOCIAL WORKERS CAN MAKE TO SUPPORT THIS JOURNEY

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ABSTRACT

Increasingly, experts-by-experience want to explore their spiritual and religious needs as part of their mental health recovery; the contribution of social workers to the journey of spiritual recovery is under-developed. A first-person narrative about spiritual recovery experienced by the first author, an expert-by-experience and an academic, is presented to illuminate understanding of the elements supporting this journey. The

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method builds on evidence that acknowledges the significance of understanding direct expertise-by-experience alongside a tradition of using creative writing to facilitate professional reflection. Both authors use iterative processes to analyse the narrative and propose a tentative model of spiritual recovery. It is then argued that social work, with its foundation in the bio-psycho-social model and its specific practice methods is well placed to support the spiritual recovery of people who experience mental distress. Moreover social workers have an ethical duty to promote respect for cultural diversity and to demonstrate cultural competency. We discuss how professionals can work effectively with service users to support their mental health and spiritual recovery. Ensuring that social work education is based on anti-discriminatory practice, and that social workers have access to training to develop knowledge about spirituality, will enhance their abilities to meet the spiritual needs of experts-by-experience in their recovery.

INTRODUCTION

The importance of understanding spirituality in mental health is now widely accepted by professionals (Swinton, 2001; Smith, 2014); and furthermore attention to their religious and faith beliefs is expressly required by experts-by-experience[3] to support their recovery (Mental Health Foundation, 2002). Despite this, in the recent past, mental health professionals often diagnosed the religious and spiritual beliefs and practices held by users of mental health services as having a pathological content, as reported by Hall, Curlin and Koenig (2003). Research (Cornah, 2006) strongly suggests that for many experts-by-experience religion and spirituality are resources that help them to manage their mental ill-health symptoms and to build resilience (Mental Health Foundation, 2002) and can enable people to make sense of mental distress they experience (Swinton, 2001). This article explores how professionals, particularly social workers, can address the spiritual needs of users of mental health care through reflection on a narrative which describes the first authors' own experiences of spiritual and mental health recovery. Narrative story-telling (Riessman and Quinney, 2005) is adopted as the methodological framework for our work because it enables rich reflection on the individual experience of the first author and is commensurate with social work values which highlight the primacy of service user experience (Fox, 2016).

We draw on research by Winter, Buck and Sobiechowska (1999) who note how reflective story-telling can illuminate issues met in practice by enabling the professional to explore the emotional content of personal accounts and to develop practice accordingly. The first author is an English registered and qualified social

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[3] An expert-by-experience is a person who experiences mental distress. S/he is an expert in managing their own mental distress experiences and is often able to use this expertise to promote recovery in their peers.

worker, university academic at Anglia Ruskin University and writes from the perspective of using English mental health services with awareness of English policy. The second author is a Slovene social work academic from the University of Ljubljana, who worked for 5 years in a mental health non-governmental organisation[4]. The narrative, reflecting the experiential knowledge expressed by the first author, and analysed by both authors, leads us to consider firstly the elements that can lead to spiritual and mental health recovery for users of mental health care, explored through the experiences of the first author; and, secondly, enables us to highlight more widely the unique contribution that social workers can make, to support service users on this recovery journey. Furthermore our local contexts, from England and Slovenia, contribute to an understanding of this topic from our respective national environments.

LITERATURE REVIEW

Understanding spiritual and religious beliefs in mental health social work

Spirituality is a universal experience that extends across cultures (Swinton, 2001), although, simultaneously, it is uniquely experienced by each person (Cornah, 2006). It is understood as being a way in which people fulfil what they hold to be the purpose of their lives, a search for the meaning of life and a feeling that endows a sense of connectedness to the universe and to the world (Swinton, 2001). Many mental health service users believe that spirituality contributes to their sense of well-being and recovery; it is therefore important that social workers address the spiritual and religious dimension of people's lives because practice can only be effective if it responds to the expressed needs of service users. Moreover, despite recognition that social workers need to acknowledge the spiritual experiences in service users' lives, it is important to acknowledge that social work has only begun to address such issues in the last 40 years (Gilligan, 2003; Oxhandler and Pargament, 2014), firstly in the United States (Furman et al., 2004), and then almost 10 years later, in Europe. Thus, analysis of how social workers can deliver spiritually-affirming practice is lacking, and furthermore, the contribution that experiential knowledge can make to defining what makes such practice effective is under-developed. This article seeks to address this gap and illuminate how experiential knowledge can support the development of effective spiritually-affirming social work practice.

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[4]   We extend our thanks to Professor Shula Ramon for her insight into both the narrative of experience and our analysis.

There are three main considerations that are explored in social work academic research, education and practice about the significance of spirituality and religion on the lives of people using services. Firstly, it is recognised that principles of social work play a huge role in influencing and defining practice and the foundational documents address issues of anti-oppressive practice (British Association of Social Work, 2012), but fail to consider the impact of spirituality and faith beliefs on the lives of people using services; secondly, research identifies that social workers need to develop a working knowledge of the religious and faith beliefs that service users hold and to develop an insight into the impact that their own beliefs have on practice (Gilligan, 2003); thirdly, research notes that social work education does not adequately equip social workers with the skills to address the significance of spirituality and religion in the lives of people using services (Oxhandler and Pargament, 2014), and this is an area that needs consideration. Each of these topics are considered.

Firstly although social work has a commitment to anti-oppressive and anti-discriminatory practice with a focus on human rights and social justice (International Federation of Social Workers, 2014), it has little focus on the need to address the spiritual and religious beliefs of people using services. The international definition of social work states: »*Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work*« (International Federation of Social Workers, 2014). However the need to specifically address issues of religion and spirituality in social work practice is not specifically considered in UK and Slovene codes of practice. The UK codes of conduct underline a commitment to promoting dignity, upholding social justice and demonstrating anti-oppressive and anti-discriminatory practice (British Association of Social Work, 2012; Beckett, Maynard and Jordan, 2017); and in Slovenia, social workers adhere to the national codes of ethical principles in social protection (1995, 2002) and are mandated to recognise the needs of people from diverse backgrounds and to commit to upholding anti-discriminatory practice (Codes of Ethics for Social Workers, 2006). In contrast, the US National Association of Social Workers (2015:4) »Standards and indicators for cultural competence in social work practice« requires social workers to be »*culturally sensitive and deliver culturally competent interventions that address the importance of religion and spirituality in the lives of clients*«. However, although social workers in the UK and Slovenia may adhere to cultural competency and anti-oppressive practice, this does not presume a working knowledge and understanding of religious and spiritual beliefs. On the contrary, as we show, learning about faith beliefs in the context of cultural competency is key to professional practice. It is important that social workers avoid adopting a religious and spiritually blind approach to working with users of services.

Secondly, it is important to reflect on the wider models that influence the evidence base of mental health practitioners, and specifically of social workers, and to consider how this impacts on their understanding of the spiritual and religious needs of service users. Each professional group in a multi-disciplinary team has developed its own evidence base to support its beliefs regarding effective ways to treat and support users of mental health services (Golightley, 2011). The assumptions made by professionals about the effectiveness of different approaches to care are underpinned by the models used to explain the development of mental distress. McCulloch (2006, cited in Gilbert, 2014) has proposed four models of mental health, which are, similarly, widely reported in the literature (Tew, 2011; Golightley, 2011), namely: biological model; social/psychological model; intuitive/spiritual explanations; and existential beliefs. The first two models are well known whilst, the third, intuitive or spiritual explanations, describes the mind as a battleground for conflicting forces, and the last, existential beliefs, view mental distress as another valid form of human existence. Unlike medicine, with its focus on the biological model of mental health, social work has a foundation in the social/psychological model; although more so now, social workers adopt the bio-psycho-social model (Tew, 2011) that recognises the impact of biological, psychological and environmental impacts on mental health.

The evidence base that informs social workers, predisposes them to understand the social and psychological impacts of religion on people's lives (Gilbert, 2014). Moreover they are mandated by their professional codes to practise anti-oppressively. However, in order to deliver spiritually-affirming services, practitioners need to acknowledge the significance of the model which they both adopt in understanding mental health, and also in relating to what is adopted by the service user to understand and explain their own mental health condition (Gilbert, 2014). This includes a pre-requisite to understanding and being aware of the major faith and spiritual belief systems; which the social worker may lack because this topic may have been insufficiently explored in their qualifying education (Oxhandler and Pargament, 2014).

Thirdly, although research on religion, spirituality and mental health is of growing interest, researchers (Canda and Furman, 2010; Oxhandler and Pargament, 2014) reported that many social workers recounted not receiving education on how to integrate religion and spirituality into practice; Oxhandler and Pargament (2014) stated this subject was only included in social work education after the 1980s. Social work programmes at both Anglia Ruskin University and the Faculty of Social work, University of Ljubljana seek to increase the capacity of students to deliver effective spiritually-affirming care through the provision of education about religious and faith beliefs and the utilisation of ethical thinking. Indeed, investing time in enabling

social workers to acquire basic knowledge about different spiritual, faith and belief systems will increase their capabilities to meet service users' diverse needs.

Understanding the spiritual and religious experiences of experts-by-experience

This article seeks to clarify elements that make up spiritually-affirming social work practice in the context of reflections from user experience; which are now explored in this next section. Mental Health Foundation (2002:10) reports that experts-by-experience saw spirituality as a »quest for meaning that included many ups and downs, periods of anguish, confusion and doubts as well as profound insights and opportunities for transformation«. Furthermore some participants in a study undertaken by Swinton (2001) aiming to explore the connection between spirituality and mental health, described depression as not merely an expression of low mood, but rather as an experience of a deeply spiritual journey that was accompanied by a search for meaning, hope and identity. Some participants described their illness as resembling that of the 'crucible', a process of metal being refined by fire, which led them to believe that they were being purified for some higher purpose through their experience of suffering. This belief promoted a sense of healing from mental health suffering which gave meaning to their experiences as it led to feelings of completeness.

Spirituality can contribute to the building of identity and of belonging as people undertake activities that give meaning and value to their lives (Mental Health Foundation, 2002; Cornah, 2006). On the one hand, spirituality is seen as pertaining to one's search for meaning in life; whereas, on the other hand, religion refers more specifically to the major organised belief systems involving a higher power and associated practices and dogma (Gilbert, 2014); in this way religion can be understood as institutionalised spirituality (Leavey and King, 2007). Indeed, the word religion derives from a Latin word, *religio*, which means 'binding obligation', which demonstrates its connection with community and social cohesion (Gilbert, 2014).

Service users report that the social aspects of religion and spirituality support the development of good mental health itself: by improving their coping styles, helping them to develop a locus of control, promoting social support and social mechanisms through belonging to a peer group, enabling them to develop physiological mechanisms to promote well-being, and providing places to meet and relax through the built environment (Cornah, 2006). Moreover, religious-based communities can promote »*social capital ideals of reciprocity, integration, socialisation,*

activism and voluntarism, which are thought to solidify the community and benefit the individual« (Leavey and King, 2007:97). Despite their often positive impact, religions can also become institutions of oppression and service users may find certain belief systems repressive and their followers judgemental (Mental Health Foundation, 2017). Gilbert (2014) states that religion can sometimes be over-controlling of its members, paternalistic, repressive and homophobic, revealing the potential darker influences of religion and spirituality.

As we have established, many service users reflect on the importance of spirituality and religious belief to their recovery (Mental Health Foundation, 2002), and acknowledge the role that these elements play in supporting their mental well-being (Cornah, 2006). Given this significance, both experts-by-experience (Mental Health Foundation, 2017) and professionals (Royal College of Psychiatrists , 2013) recognise the need to integrate spiritually-affirming support into mental health care, but this is often linked to a wider question of how this can be achieved; and more specifically the unique contribution that social workers can make to recovery.

The next section presents a narrative about the spiritual recovery of the first author; there is a lack of literature on the subject that derives from first person narrative. This leads to an analysis of the elements that contributed to the first author's spiritual recovery and wider discussion about how social workers can provide spiritually-affirming mental health care. We believe that this first-hand experience, analysed from our perspectives as social workers, can co-produce knowledge that helps social workers to manage issues of religion and spirituality in everyday practice.

METHODOLOGY

Both authors have experience of working in or using mental health services; as such, we have found in both of our national contexts that opportunities for users of mental health services to express their religious and spiritual beliefs are limited. This area, as described above, is neglected in practice and under-developed in research and education (Canda and Furman, 2010; Oxhandler and Pargament, 2014). In order to explore this topic, we drew on the process of narrative story telling as the methodological framework for our work. Narrative frameworks, (Riessman and Quinney, 2005) enable us to evidence how, as a profession, we can demonstrate respect for people by spending time with them and listening to their story, elements which are central to social work ethics and values. Additionally Gauci (2011) emphasises the importance of reflection and narrative in the journey of spiritual healing. She stresses that it is helpful for the user of services to be able to tell their life story, a process which can lead to their healing.

The experiential narrative that forms the evidence base for this article is significant because knowledge of marginalised groups and the subjective elements of human experience (Humphries, 2009) contribute to the building of social work theory. Moreover Ramon (2003:16) acknowledges the significant role that experiential knowledge plays in underpinning the social work evidence base, stating that "knowledge itself is powerful in providing a way to make sense, give meaning and predict reality … it provides a new way of looking at what has been taken for granted"; it is not solely professional knowledge that is valued but also what is generated by experts-by-experience. This form of writing draws on the work developed by Winter, Buck and Sobiechowska (1999), who demonstrate how presenting professional perspectives in the format of fiction or creative forms of reflective writing can provide new insights for both the practitioners themselves and their wider professional group. Winter, Buck and Sobiechowska (1999:2) underline this by stating that this process »*introduces formats for representing professional understanding which enable practitioners to draw on the full range of their cultural resources and the full range of their capacities (including imaginative empathy), rather than requiring them always to present their understandings within the restricted but normally dominant modes of description and analysis*«.This process recognises the value of story-telling from experiential expertise and underlines the importance of cooperative learning between both authors.

The aim of the research was to explore the processes of mental health and spiritual recovery through storytelling, and more widely reflect on its significance for social work practice. The first author wrote her story and afterwards we worked together to deconstruct this narrative and reconstruct it in a way to build understanding about the meaning of mental health and spiritual recovery. The second author has insider status being both a social worker and advocate for people with mental health needs, and drew on her practice wisdom to develop this work. This enabled her to gain insight into the themes implicit in the narrative. We used thematic analysis (Braun and Clarke, 2006) in an iterative process to highlight the themes and allow us to reflect on the importance of these issues both for the first author and wider social work practice. Upon comparison of our ideas, the first author was surprised at the codes that were drawn out as she did not identify all these categories in the discussion; but she found herself to be in agreement with them. This method enabled us firstly to explore the realm of the first author's experience and to analyse its subjective meaning to her; and secondly to make sense of spirituality in a wider context of social work practice and hence to understand its potential contribution to the recovery journey. This reflection led us to directly explore the first research question and then allowed us to consider the second question addressing the wider implications for social work practice:

- How can spirituality be understood in the context of experiences of mental ill-health?
- How can social workers provide spiritually-affirming mental health care for people who experience mental distress?

We did not require ethical approval for this research in either Slovenia or the UK. In order to ensure respect for the integrity of the data collected in the research process, the first author could withdraw her data at any time and had control over the included material. Furthermore, in order to protect the mental wellbeing of the first author, she was able to address any distress or concerns with the second author with whom she was in frequent contact during the writing of this article. However, being accustomed to reflecting on her own personal experience of mental ill-health (Fox, 2016), the first author did not experience any negative effects from participating in the research and writing process. Moreover, in accordance with both the ethical concerns identified above, the first author led the reflection process, and with support from the second author, co-created the model of spiritual recovery.

MY JOURNEY OF SPIRITUAL RECOVERY

My experiences of mental distress are highly spiritual in nature: the feeling of other-worldliness when hearing voices; the belief in extra-ordinary powers; the sense of uniqueness in the world; and the extreme emotions derived from suffering. During my first episode of psychosis, I believed that my head was transparent and that people could see through it and understand each single individual thought as it traced its way through my mind. I believed I had immense power to change the world for the better; and yet I was overwhelmed by terror as I had never experienced such extreme emotion. During this period, I drew on comfort from a God who I didn't understand, but I had an innate instinct to turn to something for comfort. These experiences were so other-worldly, so beyond explanation in the physical world that I believed God was punishing me – but I did not know why, when it would stop, or what I had done to suffer this. I thought I was being given special powers to enable me to change the world, and that this power was accompanied by suffering. I needed to try to make sense of these experiences.

My recovery journey required me to reconcile and understand these experiences in relation to my beliefs as a Christian. How could God destroy my thinking, my identity and my future? My experiences of psychosis influenced how thought processes could automatically flow, making them abrupt and disjointed; making it impossible for me to concentrate and work successfully as a student. This whole

experience destroyed my lively and sharp mind as the trauma affected my thought processes and stopped their creative and imaginative capacity. Moreover, medication dulled my thoughts, as the sedation not only suppressed the symptoms, but also my whole ability to think as I struggled at university.

I was searching for a purpose to my life and a reason that led to this catastrophic experience occurring. In order to reconcile my experiences, I needed to believe that this suffering had a purpose. I began to explore my Christian faith and reflected on the process of the crucible, when the metal is heated and refined in fire to remove impurities. I came to believe that this process of suffering was refining me, as I became a wounded healer (Nouwen, 1979), using personal experiences to provide support and solace to other people who also experienced mental ill-health. This allowed the experiences to be utilised effectively and to help others. For me, the process of refining as I learned to help other people through using my experiences positively could be understood within a spiritual context. They linked to a purpose and answered my questions as I searched for meaning and reconciled my experiences to my spiritual beliefs.

Over many years of reflection, I have reached an understanding about the nature of these experiences and have found a need to rationalise them which allows me to manage them. I am able to understand this suffering by separating my mental ill-health from my religious belief. I acknowledge that God comforts me and upholds me in my times of mental distress, but I need to believe that he does not have any influence over the development of my illness and I need to believe he did not cause it to happen. Through this reflection, I have come to believe this illness is something that I can use to improve the lives of other people as I advocate on their behalf or help professionals and family carers to understand the nature of mental ill-health more clearly (Fox, Ramon and Morant, 2015). This is the purpose that links to the process of refinement.

However, I understand my illness itself, not as a spiritual issue but as a physical issue related to the medical model; this reduces its power by making it belong to the material world. If I named and identified it as other-worldly, it would become incomprehensible. The way in which I understand my symptoms helps me to progress my recovery as, when I experience mental distress, I believe that this is a process of refinement which connects me to a higher purpose. This allows me to 'hang on' to some sense of purpose in suffering if I am unwell and allows me to make connections with my religious beliefs.

However, the way that I understand my illness experience may be different to that of other people. From speaking with other people who use services, it has become clear to me that recognising and valuing the spiritual nature of mental ill-

health can be very helpful. It can acknowledge and validate experience and assist in understanding these complex thoughts. For me, if I were to denote psychosis as a spiritual manifestation, then this would mean it could not be understood in our everyday world. In conversation with other service users, on the contrary, some people answer that naming mental health symptoms as spiritual is liberating for them, it enables them, conversely, to my experiences, to understand them beyond the medical model of deficits and disease. Indeed, the experiences of the supernatural can help some service users to make sense of their world whilst the medical model may reduce this existential experience to the material substance of chemical imbalance in the brain. How can we help people to make sense of their symptoms and support them in their spiritual struggle that may have a significant impact on their wellbeing?

DISCUSSION

In this section, firstly we explore the different frameworks in which the mental and spiritual distress of the first author can be rationalised; secondly we examine the potential contribution that social workers can make with their unique theoretical base and practice methods in supporting the service user's spiritual recovery; thirdly we explore the implications of this discussion for our local contexts.

Understanding the journey of spiritual recovery

Spirituality is increasingly seen as a fundamental experience in the journey of recovery (Mental Health Foundation, 2002; 2017). We therefore propose a model of spiritual recovery, illustrated in Figure 1, based on an analysis by both authors of the narrative of experience presented above. Figure 1 parallels elements of the recovery model posited by Spaniol et al. (2002) that notes recovery as being a cyclical and progressive journey to well-being, yet simultaneously we acknowledge that each spiritual journey is unique and not all people will manage to fully reconcile and rationalise their spiritual beliefs on their journey of recovery.
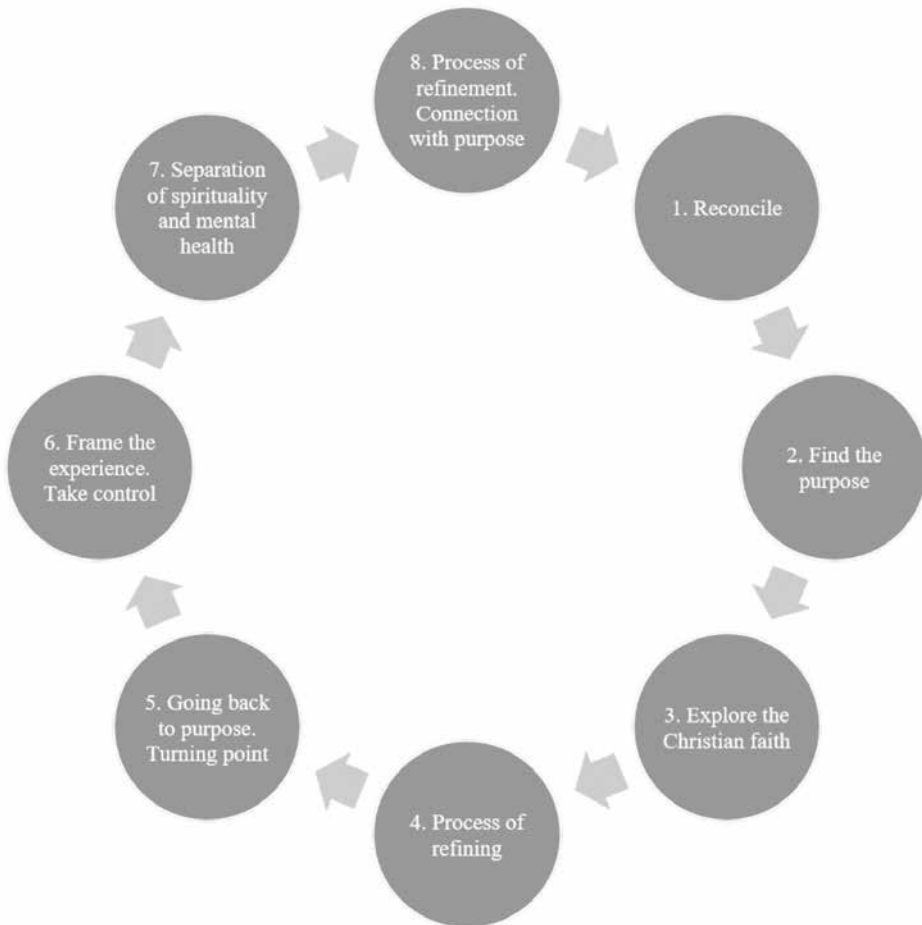
Figure 1. A model of spiritual recovery

The cycle of spiritual recovery has two phases; each phase has four stages. Phase 1 is composed of stages 1-4; and phase 2 comprises stages 5-8. The first phase is made up of the process of reflecting on the initial mental health crisis and trying to make sense of the suffering. The second phase starts with a turning point in which the first author tries to take control of this experience and frame it so that she can reconnect with her purpose for living. This relates to experiences that take place during the later steps of the recovery journey. Some of the stages in phase 2 replicate the initial reflection in phase 1; this however emphasises the cyclical nature of this journey of spiritual recovery.

In the first phase, as the first author reflected on the elements that comprised her initial mental health crisis, she expresses the need to

- reconcile her experience,
- find a purpose,
- explore the Christian faith, and
- experience a process of refining.

At the onset of illness, as she considered the content of her spiritual experience, she reflected that her encounters with other-worldly elements during this time involved two components: on one side, spirituality and religious beliefs were seen as helpful; on the other, supernatural occurrences caused her oppression and suffering. This paradox led to her experiencing confusion in her spiritual journey which needed time for her to reconcile. The next step she emphasised in this recovery was the need to find a purpose in her life. This stage links with how she explored the Christian faith that she adhered to. This is followed by a process of refining. She encounters the crucible, metal being refined by fire, as she reflects on how her suffering can institute healing in other people, and learns to use these painful experiences to improve the lives of other people. The latter two stages in phase 1 are combined with how she saw herself as becoming a wounded healer (Nouwen, 1979).

After she learnt to make sense of her suffering in the first phase, she entered the second phase of the model. This phase comprises reflections which occur as she enters a period where her recovery is more established and she has learnt to manage her mental health more effectively. This second phase encompasses:

- go back to purpose and experience a turning point
- frame the experience and take control
- separate the experiences of spirituality and mental health
- experience a process of refinement by reconnecting with purpose.

At this point the first author tried to find a reason for her suffering which allowed her to experience a turning point. She relates how she took control and reframed the experience enabling her to understand this incident by separating her mental distress from her spiritual life, viewing mental ill health as only a physical experience. This separation of the physical and spiritual experiences allows her to revisit the previous stage to take control of this experience and reconcile her beliefs. She then experienced a process of refinement by reconnecting with her spiritual beliefs and she seeks to utilise these experiences to make a positive contribution to society. This experience enables the first author to realise that she is no longer the wounded healer, but has become an expert-by-experience who can use this knowledge to directly enrich her own life and indirectly enhance her teaching and practice (Fox, 2016).

On a journey of spiritual recovery, a person may need to revisit some of the stages, as recovery is not always linear (Spaniol et al., 2002) and likewise a person's

spiritual recovery is unique and may have more or fewer steps than those indicated by the first author's narrative, and as represented in Figure 1.

How can social workers deliver spiritually-affirming support in mental health?

The social work profession occupies a unique position in the multi-disciplinary team with its focus on the bio-psycho-social model (Tew, 2011) and it has a theoretical base which is different from medicine and psychiatric nursing (McCulloch, 2006 cited in Gilbert, 2014); this enables the social worker to make a valuable contribution to the spiritual needs of people who use mental health services. In the next section, the model of spiritual recovery proposed in Figure 1 is used to help us to consider how we can deliver spiritually-affirming care in mental health and to explore the second research question: How can social workers provide spiritually-affirming mental health care for people who experience mental distress?

Spiritually-affirming care can only be effectively delivered by creating a space that allows users of services the opportunity to talk about and explore their spirituality. This reflects the second element identified in our literature review. Mental Health Foundation (2017) notes that a mental health service that responds to spiritual needs should offer the following in order to achieve the best possible outcomes: acknowledging the spirituality in people's lives; giving service users and staff opportunities to talk about spirituality; encouraging service users to tell staff their needs; helping service users to express their spirituality and using person centred planning that incorporates spiritual needs. In order to achieve this, the professional needs to become accepting of a person's own illness experience and how they develop their own explanatory narrative of their experiences. In order to aid discussion, a number of standardised practice tools have been developed to support spiritual assessment in mental health, such as Neely and Minford's (2009) »Faith scale« and Anandarajah and Hight's (2001) »Hope scale«. Such templates can help the practitioner to understand the support that the person who uses services may receive from their spiritual beliefs. However, practitioners should always take a spiritual history (Culliford, 2007) in order to enable them to differentiate between the service user's spiritual experiences and their symptoms of psychosis because psychiatric symptoms can sometimes have a religious content. Maintaining a balance between the understanding of the pathological aspect of religiosity and of helpful forms of belief is central to ensuring that both appropriate spiritual care is mobilised to support recovery and that service users are protected from harmful influences (Royal College of Psychiatrists , 2013).

Figure 1 helps us to understand this how of delivering effective spiritual care in mental health. Our model identifies that the social worker needs to help the service user frame their experience and explore their spiritual beliefs. In recognition of the need to define the HOW of support, whilst Saleeby (2009) notes that social workers may be trained to develop a holistic understanding of the needs of experts-by-experience, Oxhandler and Pargament (2014) indicate that understanding their diverse experiences is not the same as knowing how to apply and integrate such knowledge into practice. It is therefore important to go beyond merely understanding and acknowledging the experiences of service users, to understand how to support them effectively. Furness and Gilligan (2010) outline reflective models that support professionals to develop relevant skills and awareness in general terms and an assessment model that enables them to evaluate and understand service user's strengths, needs and circumstances. Gilbert's (2014) assertion reinforces this as he states that social workers need to be reflective in facilitating dialogue with service users about spirituality by considering their own identity. They need to ask: How important is spirituality to me? What words and language do I use when discussing spiritual and religious topics? Where am I coming from? This process of reflection helps social workers to create safe spaces to talk about concerns, experiences and future visions as to how spirituality can facilitate recovery. Moreover, social workers uniquely work from a strengths perspective in order to assist a service user to identify their own potential on their recovery journey (Fukui et al., 2012); thus helping the person to find their purpose. Furthermore, we need to help service users to frame the experience to take control, regardless of their religious or faith belief. This is indeed central to social work practice as we engage with people from faith backgrounds and recognise the importance of working in an anti-discriminatory and anti-oppressive way (Humljan Urh, 2013).

Our local national contexts

In the final section we reflect on our own national contexts and locate the issues within our own respective local environments which were briefly touched upon in the literature review; but we do not attempt to provide a definitive European perspective. As both the UK and Slovenia environments are becoming more multi-cultural and people live their lives across a number of different cultures; social workers need to be able to respond to the spiritual needs of all service users and to provide culturally sensitive services for experts-by-experience (Humljan Urh, 2013). In an apparently secular age, social workers need to consider their role in promoting spiritually-affirming practice in the context of the profession's commitment to

anti-oppressive practice (Gilligan, 2003). This leads to the question of how we can engage with people who hold different spiritual beliefs to the mainstream.

If we turn to the UK context, providing spiritual care to people from BAME (Black, Asian and Minority Ethnic) service users in the UK can be complex as they may be more likely to experience institutional discrimination than their counterparts in the majority population (Care Quality Commission & National Mental Health Development Unit, 2010). Service users in the UK from a BAME background are more likely to be assessed and compulsorily detained in hospital under the Mental Health Act (1983, 2007), more likely to receive a diagnosis of schizophrenia, and experience physical restraint more often (Care Quality Commission & National Mental Health Development Unit, 2010).

Likewise, similar issues of social exclusion and institutional discrimination are also faced by Roma people in Slovenia (Urek and Ramon 2008; Videmšek, 2012). Videmšek (2012) has indicated that the mental health of members of the Roma community is worse than that of the majority of the Slovene population, furthermore, they may receive less good care and support than the majority population. One example of this, is that Roma women in Ljubljana receive less support for their mental distress and are more likely to experience medical intervention; and have less access to counselling, often being unable to utilise community services as users of non-governmental organisations may need to possess Slovene citizenship to access such resources.

Consequently, social workers need to understand their role in working with people from diverse belief systems and faith traditions (Humljan Urh, 2013) and show discernment and sensitivity as they work with people who may have experienced oppression and discrimination (Hall, Curlin and Koenig, 2003); this is detailed in our respective national occupational and professional standards, as described in the literature review. Social workers need to go beyond evidencing cultural competency, and become aware of the spiritual and faith beliefs of people using services and how to respond to their needs – as identified in the literature review.

Guidance in the UK (Royal College of Psychiatrists, 2013) underlines the need to work in partnership with pastoral care workers and religious leaders to support service users to access appropriate spiritual and religious resources. This links with the importance in Figure 1 of enabling a user to frame their experience and explore their faith. However, for some service users, religious and spiritual beliefs may impact negatively on their mental health and well-being through experiences of oppression from other faith believers (Hall, Curlin and Koenig, 2003). This can have a destructive role in their life. Social workers may occupy a dominant position in society through their participation in patriarchy, and their experiences of ethno-centrism, euro-centrism and heteronormativity (Dominelli, 2002); unconscious bias may

lead them to maintain the interest of dominant groups, including, in some contexts, that of people from majority religious and faith beliefs. This may exclude those who occupy minority beliefs from accessing and receiving the same social benefits as the majority culture. Additionally some spiritual groups may promote dangerous ideologies which exploit the incapacity of service users and it may be inappropriate for professionals to liaise with such groups (Leavy and King, 2007). Social workers may need to intervene to combat the oppressive and negative influences of some spiritual and faith belief systems.

On the contrary, although many professionals acknowledge the importance of respect for minority beliefs, some people of majority faiths, both, who use services and who deliver services, do not feel as if they are accorded such respect. Sometimes, in the UK, Christians may feel devalued by the secular community which may hold stereotypes about their behaviour, values, and ethics; they may experience discrimination and stereotyping as they are suspected of proselytising non-Christians or disrespecting the beliefs of the minority. Sometimes discriminatory behaviour against those from majority beliefs, may be judged acceptable because believers adhere to a religious belief that is established in the legal system. However it is important to accord people of all religious and faith beliefs equal treatment and respect; although it is necessary to remain aware of the potentially dangerous ideologies that can impact on people's lives (Leavey and King, 2007). This underpins the need to not only be culturally competent but also to understand the impact of spiritual and religious beliefs on the lives of people using services.

Gilligan (2003) suggests that if social workers lack the required competencies to act in a spiritually-sensitive way, then this may be related to social work education failing to address these needs. Training and education in both religious and ethical practice are therefore required to provide social workers with the tools to manage professional decision-making in spiritual and religious practice, and enable them to develop spiritually-affirming mental health care. It is fundamental that, central to university education is an emphasis on anti-oppressive and anti-discriminatory practice, with understanding of human rights to ensure that social workers promote social justice, with due attention placed on increasing awareness of how to deliver spiritually-affirming mental health care.

CONCLUSION

Spirituality is increasingly seen as a fundamental experience on the journey of recovery (Mental Health Foundation, 2002, 2017); religion, an institutional form of organised spirituality (Cornah, 2006), and can provide support for those who

experience mental distress, as well as being an obstacle to their recovery. This article utilises the method of story-telling in professional practice (Winter, Buck and Sobiechowska, 1999). We presented a reflection of spiritual recovery, written from the first-hand experience of the first author to illuminate discussion about this very personal topic of mental health and spirituality and developed a model representing this journey.

Acknowledgement of the importance of spirituality in recovery requires mental health services to recognise the importance of spirituality in service users' lives and provide appropriate and effective care to support their recovery (Royal College of Psychiatrists, 2013). By considering the model of spiritual recovery we explored the unique contribution that the social work profession can make to supporting spiritually-affirming care by using both its practice methods and skills and its theoretical constructs. Moreover we concluded that practitioners need to create space to conduct spiritually-affirming practice (Neely and Minford, 2009), and the social worker is well-placed to begin to do this with their focus on the bio-psycho-social model (Tew, 2011).

Social work is both a theoretical and practical profession that seeks to support and respond to the needs of experts-by-experience, working to co-create solutions to support recovery. Social workers work within a diverse, multi-faith society in which religious and other beliefs play a role in shaping the worldview of many people; it is imperative that social workers are equipped to do this (Gilligan, 2003). In order to deliver the how of ensuring effective spiritually-affirming support, social workers need: to be reflective of the models that people use to explain their mental ill-health (Gilbert, 2014), to recognise the importance of spirituality in people's lives (Swinton, 2001), to be non-judgemental (British Association of Social Work, 2012), to support recovery (Gilbert, 2014) and to work in partnership with both service users and faith leaders to promote spiritual recovery (Leavey and King, 2007). Moreover spirituality is inevitably a topic that will become of more significance as we respond to users' requirements for care. Furthermore if social workers ignore this demand they will fail to support the effective recovery of people they purport to support. Social workers need to develop their capacity to deliver spiritually-affirming mental health care and effective care needs to be systematically implemented across services. However, currently, this often remains a potential of service provision rather than the actuality.

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ISTRAŽIVANJE MENTALNOG ZDRAVLJA I DUHOVNOG OPORAVKA STRUČNJAKA PO ISKUSTVU: RASPRAVA O JEDINSTVENOM DOPRINOSU SOCIJALNIH RADNIKA U PODRŠCI NA TOM PUTU

SAŽETAK

»Stručnjaci po iskustvu« sve više žele istraživati svoje duhovne i vjerske potrebe u procesu oporavka mentalnog zdravlja, no doprinos socijalnih radnika na putu duhovnog oporavka ne prati njihove potrebe. Predstavljena je priča u »prvom licu« o duhovnom oporavku prve auto-rice, ujedno »stručnjakinje po iskustvu« i sveučilišne profesorice, u svrhu boljeg razumijevanja elemenata koji sačinjavaju taj put. Metoda se temelji na pokazateljima koji podupiru važnost razumijevanja izravnih stručnih znanja iz iskustva uz tradicionalnu primjenu kreativnog pisanja kako bi se olakšala profesionalna refleksija. Obje autorice analiziraju priču pomoću iterativ-nih procesa i predlažu okvirni model duhovnog oporavka. Zatim se navodi da socijalni rad, zahvaljujući svojim temeljima u biopsihosocijalnom modelu i svojim specifičnim praktičnim metodama, može odgovoriti na potrebe duhovnog oporavka osoba koje dožive duševnu bol. Osim toga, socijalni radnici imaju etičku dužnost promicati uvažavanje kulturne raznolikosti i pokazati kulturnu kompetentnost. U radu se razmatra kako stručnjaci mogu učinkovito raditi s korisnicima usluga kako bi potpomogli njihov duhovni oporavak i oporavak njihova mentalnog zdravlja. Konačno, ako se obrazovanje socijalnih radnika temelji na antidiskriminacijskoj praksi i ako socijalni radnici imaju pristup osposobljavanju za razvoj znanja o duhovnosti, moći će pružiti kompetentniji odgovor na duhovne potrebe »stručnjaka po iskustvu« tijekom njihova oporavka.

Ključne riječi: mentalno zdravlje, duhovnost, priča u »prvom licu«, oporavak, socijalna skrb.