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A church-based peer-led group intervention for mental illness

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Religion and spirituality (R/S) can be powerful supports and provide important coping resources for individuals in recovery. Faith communities seem to offer many advantages for recovery-oriented support, but have rarely been the setting for empirically examined psychosocial rehabilitation efforts. This study describes the outcomes for individuals in Living Grace Groups (LGGs), a peer-led group intervention for mental illness that is based in churches and integrates R/S. Persons at all active LGGs were surveyed before and after participation using well-validated scales for recovery, psychiatric symptoms, and spirituality. LGGs attracted individuals with a broad range of persistent psychiatric difficulties, who described religion as important to them and rated the groups as very helpful. Participants reported improvements in recovery and spirituality as well as reductions in psychiatric symptoms. R/S-integrated support groups may improve care by increasing cultural match, as well as providing more access to recovery-oriented care by tapping the resources of faith communities.

Keywords: support group; religious support; church; peer leadership

It appears that religious communities are a frontier in psychological service: those seeking help are often present there, and religious support and positive religious coping are associated with reduced incidence and improved recovery from mental illness (Fiala, Bjorck, & Gorsuch, 2002; Pargament, Smith, Koenig, & Perez, 1998; Webb, Charbonneau, McCann, & Gayle, 2011). Simple church participation is not a substitute for mental health care, yet many individuals with mental health needs never seek or are unable to access professional care outside their church (Koenig, McCullough, & Larson, 2001; Wang, Berglund, & Kessler, 2003). Religious communities are geared to support their members; when churches actively assist those struggling with mental illness the power of congregational support and religious resilience factors are unleashed in the service of recovery. In their landmark work, *The Handbook of Religion and Health*, Koenig et al. (2001) specifically note that "Innovative programs are needed to take advantage of the religious and spiritual resources of patients and of the manpower resources within religious communities to facilitate recovery and to provide the emotional support and understanding these

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people need" (p. 465). Nevertheless, investigations of psychological supports offered through faith communities have been few.

There is a growing body of evidence demonstrating that religious individuals not only want religion and spirituality (R/S) incorporated into mental health interventions, but also experience added benefit when R/S are intentionally addressed (Huguelet et al., 2011; Huguelet, Mohr, Borras, Gillieron, & Brandt, 2006; Weisman de Mamani, Tuchman, & Duarte, 2010). This evidence has been collected in both treatment (Huguelet et al., 2011; Weisman de Mamani et al., 2010) and recovery-oriented programmes (Wong-McDonald, 2007), from individuals across the spectrum of illness intensity. For those who use R/S to cope and who identify as religious, an R/S-integrated approach may be more culturally appropriate, and support offered through faith communities may be particularly effective.

Basic helpful interventions such as psychoeducation, coping skills, and increased interpersonal connection are ideal for implementation in a religious community setting, and are well suited to a group format. Peer-led groups have been shown to be effective at delivering these types of interventions, and have the added benefits of minimal cost and maximum accessibility. Several examples of brief, psychoeducational, peer-led programmes have shown effectiveness in assisting individuals with persistent psychiatric disabilities on the journey of recovery. Wellness Recovery Action Planning (Cook et al., 2010), Pathways to Recovery (Fukui, Davidson, Holter, & Rapp, 2010), and groups organised around the Recovery Workbook (Barbic, Krupa, & Armstrong, 2009) are all 8 or 12 week programmes which combine some form of manualised self-help and a peer-led group setting. Similarly, Building Recovery of Individual Dreams and Goals (Pickett et al., 2010) "is an 8-week peer-led course designed to empower adults with psychiatric disabilities by providing them with basic education about the etiology and treatment of mental illness, self-help skills, and recovery principles" (p. 97). There is ample evidence that each of these programmes is effective in promoting recovery (Cook, Copeland, et al., 2012; Fukui et al., 2011; Starnino et al., 2010).

It appears there is both need and opportunity for peer-led support groups that can serve those with mental illness through local faith communities. Living Grace Groups (LGGs) are one response to these needs. They follow a successful tradition in using a psychoeducational manual as a guide for group sessions and discussion led by peers. They are consistent with a growing literature expounding the benefits of incorporating R/S in treatment. By forming in church communities and using the language of faith for discussion, they serve as a culturally sensitive option and reduce the barriers to treatment that may be found in a religious population. LGGs actively foster healthy spirituality and positive incorporation of religious beliefs in the recovery process. They provide an opportunity for connection and support from others with a common worldview and similar problems. They address the "whole person" of religious individuals, honouring the power and meaning fostered by faith and directing it in service of recovery.

Living Grace Groups

LGGs are peer-led, faith-based, psychoeducational support groups for those living with any diagnosed psychiatric disorder. They are not therapy groups, instead they focus on a recovery model which emphasises empowering participants, teaching practical tools, and providing support.

Leaders of groups are identified from within a faith community that sponsors the LGG. The leader is someone who has recovered from a mental illness, has a loved one with a mental illness, or is involved in other mental health advocacy work. Training to lead the group is provided in written form through a leaders guide, and via a brief video conference seminar with one of the creators of the curriculum.

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

Each group meeting has an educational topic as its focus. This aspect of each meeting attempts to convey facts and practical skills that will help members in their recovery. These topics are based on well-researched psychological principles.

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

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

The topics and principles of LGGs (e.g., psychoeducation, relapse prevention, medication adherence, coping skills training, social support, and peer mentorship) are consistent with those used in widely implemented and often studied peer-led groups reviewed above (e.g., Cook, Copeland, et al., 2012; Cook, Steigman, et al., 2012; Fukui et al., 2010).

While several spirituality groups or programmes run in existing psychiatric or community mental health settings have been described in the literature (Kehoe, 1999; Revheim & Greenberg, 2007; Revheim, Greenberg, & Citrome, 2010; Wong-McDonald, 2007), detailed outcome evaluations have been scarce. In addition to introducing a church-based recovery-oriented, religiously integrated option, the current project aims to add to the literature on R/S groups for individuals with mental illness by providing pilot outcome data from the LGGs using psychometrically sound measures of psychological and religious functioning.

Methods

Participants and recruitment

All individuals who voluntarily attended a LGG after the beginning of the study were potential participants. Each group leader was personally contacted and offered the opportunity to assist in data collection by presenting the survey to their group. Those willing to assist were informed about the study broadly and trained in procedures of survey administration specifically. Group leaders were responsible for inviting group members to participate, ensuring informed consent, collecting responses in sealed envelopes, and returning them to the researcher. The procedure was identical across sites.

Since this study aimed to sample existing groups, participation in the research was not a requirement for membership in any group. Participants were invited to participate in the study by the group leader at the beginning of the first group meeting. The leaders read a script which informed group members of the voluntary nature of participation and provided an explanation of the research, including requirements, benefits, and potential risks of participation. After soliciting and addressing any questions, they distributed the survey materials. To avoid the need for public declaration on participation, all present were given the materials and instructed to complete them only if they desired and consented to participation. Consenting participants were identified by an ID code self-generated during the survey process for the sole purpose of linking individual responses across time. When finished completing the measures, participants sealed anonymous completed packets in unmarked envelopes. The leaders collected these sealed envelopes and returned them to the research team. The same measures were offered post-intervention at the end of the last group. There was no report of any participant who completed the initial survey refusing participation in the final survey.

During the course of the study LGGs in six US and one international location (Australia) were active and agreed to participate. Fifteen groups were surveyed, 116 individuals were invited to participate, and 101 (87%) agreed. Twenty-three of these were excluded from the study because they had participated in a LGG previously. Seventy-eight individuals completed the initial pre-group survey. Thirty-five (45%) of those participants also were present at the last group meeting and completed the post-group survey.

LGG curriculum

The LGG curriculum is a 10-week cognitive behavioural-based group recovery intervention for mental illness to be facilitated by peers (Stanford & Padilla, 2011). The curriculum focuses (Table 1) on three main areas related to mental health recovery: psychoeducation (40%), relationship and support building (30%), and cognitive skills development (30%). Each week's material is laid out in a simple-to-follow common format: FAITH, a biblical story that highlights the week's topic; FACTS, specific facts related to the week's topic to be used for discussion; and FUTURE, practical suggestions and tips that participants can immediately apply in their daily lives. Each session is expected to last 1.5–2 hours.

Outcome measures

All study participants were asked to complete the following self-report outcome measures before the first LGG session and again after the last session.

Depression Anxiety Stress Scales-21

The Depression Anxiety Stress Scale-21 (DASS-21) consists of three 7-item self-report scales (symptoms of depression (DEP), physiological markers of anxiety (ANX), and worry or psychological tension that is common to both anxious and depressive diagnoses (STR)) taken from the full version of the DASS (P. F. Lovibond & Lovibond, 1995; S. H. Lovibond & Lovibond, 1995). Scores on the 21-item measure may simply be doubled for comparison with the original DASS. In a clinical sample, the DASS-21 has demonstrated adequate internal consistency (α's > .87), a cleaner latent structure than the full DASS, and score equivalence with the full DASS (Antony, Bieling, Cox, Enns, & Swinson, 1998). The DASS-21 has also been supported for use as a routine clinical outcome measure (Ng et al., 2007).

Table 1. LGG curriculum overview.

Week 1: *Identity* – Who you are really? You are not defined by your disorder or the events and circumstances that surround you. Your true identity is defined by God, who created you and loves you deeply.
Week 2: *Stigma* – Stigma is always born out of fear and misinformation. The purpose of stigma is to minimise, disgrace, or dehumanise someone so that inaction and a lack of compassion can be justified. Stigma can only be overcome by truth and education.
Week 3: *Medication* – Mental illnesses are brain disorders that require medication and therapy for treatment, not merely stronger faith to overcome. Medication is not the cure or fix all, but part of a process towards stability and recovery.
Week 4: *Being Holistic* – In order to have a truly balanced view of mental disorders, it is necessary for us to see ourselves holistically as God made us. Is your current treatment plan holistic? In other words, are your physical, mental, spiritual, and relational needs being met?
Week 5: *Healthy Thinking* – Our emotions are the result of what we think or believe about other people, the world, and ourselves. The more a person's thinking is characterised by distortions, the more likely they are to experience negative emotions and engage in maladaptive behaviours.
Week 6: *Rest, Relaxation, and Joy* – The physical symptoms of stress and anxiety (e.g., heart racing) can be overwhelming. Relaxation techniques, such as paced breathing, can not only be helpful during episodes of panic, but can also help when done on a daily basis to bring down your general level of stress.
Week 7: *Coping Skills and Strategies* – Everyone has natural ways of coping with problems. Some coping strategies are positive and healing, while others are negative and adversely affect the person trying to recover. When an individual takes direct positive action to cope with their problems, they put themselves in a position of power.
Week 8: *Cycles and Triggers* – We all have good days and bad days, and it is no different for individuals living with mental illness. Educate yourself about the predictable cycles related to your disorder. During times of stability, prepare for difficulties to come.
Week 9: *Community* – An active and supportive community of believers cultivates life while isolation brings frustration and fatigue. The same spirit that connects us to God also connects us to one another. Sharing the burden lightens the load for everyone.
Week 10: *It's not Your Fault* – Individuals struggling with mental illness often feel as though they have failed themselves, others, or God. Truth removes guilt and condemnation, and helps the afflicted know "it is not their fault".

Recovery Assessment Scale

The Recovery Assessment Scale (RAS) (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999) is a 41-item instrument developed to measure the concept of recovery in persons with serious mental illness, and specifically to evaluate the outcomes of programmes promoting recovery. The RAS includes five subscales, personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination by symptoms, which are summed to give a total score. The total score is reported to have high reliability ($\alpha = .93$) in a sample of individuals with severe mental illness (Corrigan et al., 1999). The RAS has the most extensive use among existing measures of recovery, with 22 separate investigations reporting on its psychometric properties or sensitivity to change, compared to five for the next most investigated measure (Sklar, Groessl, O'Connell, Davidson, & Aarons, 2013).

Theistic Spiritual Outcome Survey

The Theistic Spiritual Outcome Survey (TSOS) (Richards et al., 2005) is a 17-item measure developed specifically to assess the spiritual outcomes of counselling. In response to a lack of valid means of measuring the spiritual outcomes of mental health treatment, the TSOS was designed to assess core components of spirituality in general harmony with the main tenets and practices of the major theistic world religions. The TSOS consists of three factors. Love of

God (LG) assesses feelings of love and connectedness with God; "I felt God's love" is a typical item. Love of Others (LO) includes items with content related to ideal humanitarianism, referencing feelings, and actions towards others; "I wanted to make the world a better place" is one example. Love of Self (LS) is characterised by items denoting self-acceptance and feelings of moral worthiness; "I felt worthy" is one such item. The TSOS was found to have adequate reliability, validity, and usefulness among a sample of college students (each factor α's $\geq .80$), a sample of inpatient women with eating disorders, and two samples from inpatient psychological clinics in Germany ($\alpha = .90$) (Richards et al., 2005).

R/S survey questions

In addition to demographic questions and the above mentioned self-report outcome measures, several additional items were included at the beginning of each of the LGG survey packets. Four of them specifically asked about preference for various forms of inclusion of R/S in counseling. Three of these items ("How important is it to you that Scripture is used in your counseling?", "How important is it to you that your counselor is a Christian?", and "How important is it to you that counseling explicitly incorporates religious principles?") were adapted from similar questions used by Walker, Worthington, Gartner, Gorsuch, and Hanshew (2011). The item "How important is it to you to pray with members of the Grace Group?" was written in a similar style for the purposes of this project. Each of these four items was rated on a 5-point Likert scale with anchors 1 – "Not at all important", 3 – "Somewhat important", and 5 – "Very important."

Data analysis

Outcome analyses utilised only responses from participants who completed surveys at both time points. For scales with a high number of items missing (>30%), the scale was omitted from analyses in pairwise fashion (all other data from the respondent were utilised). These choices incur a loss of power, but also acknowledge that missing data are not necessarily at random when entire scales are omitted or survey completion was discontinued. When less than 10% of items were missing on a scale, the items were replaced by imputing the mean score for all valid responses on that item across the appropriate sample. Downey and King (1998) noted that this method produced negligible distortion of scale reliability, mean, or standard deviation when less than 4% of the total responses for any scale were missing. In this study, no scale had more than 1% of total responses missing.

Chi-square or *t*-tests were used to test for differences between completers and dropouts, as well as between pre- and post-LGG. Because measurement occurred at only two time points, main effects of time for each group were tested with a dependent samples *t*-test.

Results

Participant characteristics

Participants in the study at Time 1 tended to be Caucasian (73%) and female (77%) with an average age of 45 years. The majority (78%) had at least some college education. Consistent with LGGs as church-based groups, all individuals claimed a religious affiliation, and 90+% identified as protestant Christian. Over 65% of the sample reported attending church at least once a week. Demographics for the full sample are presented in Table 2.

Most respondents indicated more than one primary diagnosis; therefore results describe participant report of any diagnosis given by a professional over their lifetime. The most commonly reported diagnoses were depressive disorders (63%) and anxiety disorders (60%), but a significant

Table 2. Demographics for the full Sample ($n = 78$).

Variable	Response	*n*	%
Age	Mean (SD)	45.1	(16.0)
Gender	Female	60	76.9
	Male	14	17.9
	No response	4	5.1
Racial/ethnic identity	Caucasian	57	73.1
	Hispanic	11	14.1
	African-American	2	2.6
	Multi-racial	4	5.1
	Other	2	2.6
	No response	2	2.6
Lifetime diagnoses	Depressive disorder	49	62.8
	Anxiety disorder	47	60.3
	Bipolar disorder	33	42.3
	PTSD	13	16.7
	Schizophrenia	7	9.0
	Personality disorder	4	5.1
	Substance use disorder	1	1.3
	Other diagnosis	10	12.8
Level of education	HS Graduate or less	17	21.7
	Some college	35	44.9
	College degree	13	16.7
	Any graduate work	13	16.7
Religious affiliation	Protestant Christian	71	91.0
	Catholic	6	7.7
	Jewish	1	1.3
Religious attendance	A few times a year or less	13	16.7
	One month	13	16.7
	Once a week	32	41.0
	2–3 Times a week or more	19	24.4
	No response	1	1.3

percentage also indicated they had been diagnosed with bipolar disorder (42%), Posttraumatic Stress Disorder (PTSD) (17%), or schizophrenia (9%). It appears that many individuals would be considered to have a psychiatric disability, but others were likely experiencing mental disorder that was not as disabling. Indeed these groups are designed to be able to help both groups together, without separating individuals on the basis of the intensity of their difficulties.

In a further indication of the severity of mental health issues in the sample, 44% reported that they had received inpatient treatment for their mental health issue at some point. Eighty-five per cent of the sample reported that they are currently taking medication for their mental health problem, while 59% were currently receiving psychotherapy. Only 10% of the sample reported receiving no assistance other than the LGG with their mental health issues over the last year. Both the mean and median date of first diagnosis was at least 12 years ago. These responses indicate that most of these individuals have been dealing with persistent difficulties.

R/S Survey questions

LGG members gave high ratings (four or above on a 5-point scale) to several questions of religious preferences in counselling (Table 3). On average, the presence of each of these religious factors was more than "somewhat important" to LGG members.

Table 3. Participants' religious and spirituality preferences in counselling.

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

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

Living Grace completer and dropout groups

Demographic information for LGG completers was compared to information for dropouts using chi-squared tests of independence. The LGG completer and dropout groups were not statistically different in any categories except for gender. Though women were the large majority throughout the groups, men who completed initial surveys were more than twice as likely as women to complete surveys at Time 2. Seventy-seven per cent of men who completed Time 1 surveys also completed surveys at Time 2, compared to only 37% of women ($\chi^2(1) = 8.07$, phi = .330).

In addition, the LGG completers were compared to dropout responses with regard to reported diagnoses and treatment services received. No significant differences between the groups were found. The completer group was further compared to dropouts on the three dependent measures at Time 1. The two groups showed no significant differences on any of the scales.

Outcome measures

Dependent samples *t*-tests were used for each scale and its component subscales to examine the difference between responses at Time 1 vs. Time 2. Results are displayed in Table 4. All outcome measures showed a significant change from Time 1 to Time 2, with all changes in the direction of clinical improvement. A medium size reduction was noted on the DASS-21, while a large increase was reported on the TSOS. The RAS showed the largest effect of any scale, indicating that participants were rating their recovery much more positively at the end of the group compared to the beginning.

Discussion

The results of the present study indicate that the LGGs are fulfilling many of their goals. They attract highly religious individuals with significant psychiatric difficulties who desire R/S integrated into their counselling and care. In addition, LGG participants report clinically meaningful improvement on measures of recovery and depression/anxiety during the course of the group. There are several implications that can be drawn from this initial evaluation. First, this study provides initial evidence that LGGs can be effective in promoting recovery and spiritual growth for individuals with a wide range of mental health struggles who value religious integration. Second, faith communities appear to be an appropriate venue for recovery-oriented efforts to serve those with serious mental illness. Additionally, present results begin to extend empirical support for R/S integrated treatments into the realm of peer-delivered community support.

LGG participants reported improvements on each of the three outcome scales. They described increases in spirituality on the domains of LG, LO, and moral self-acceptance. Given that spirituality, relationships with others, hope and a sense of meaning in life are aspects of recovery, it is not surprising that participants also reported large gains in self-rated recovery. Finally, even

Table 4. Comparison of pre- and post-group outcome measures.

	Pre-LGG		Post-LGG			
Outcome measure	Mean	SD	Mean	SD	*t*	*d*
DASS-21						
Total score	26.21	14.06	18.34	10.23	−4.02[c]	.70
DEP	9.79	6.48	5.43	3.84	−4.33[c]	.75
ANX	6.94	5.68	5.03	4.57	−2.37[a]	.41
STR	9.48	4.98	7.89	4.30	−2.40[a]	.42
RAS						
Total score	145.94	17.10	161.36	13.60	6.76[c]	1.18
PCH	30.06	5.14	33.52	3.79	5.57[c]	.97
HEL	10.91	2.67	12.12	2.37	3.57[b]	.62
GSO	18.39	3.39	19.85	2.98	3.00[b]	.52
ROO	15.39	2.83	16.67	2.03	3.68[b]	.64
NDS	8.76	2.45	10.79	2.09	5.30[c]	.92
TSOS						
Total score	54.70	11.09	62.06	9.19	4.61[c]	.80
LG	19.39	5.21	22.59	4.72	4.42[c]	.77
LO	20.48	3.89	22.32	3.68	3.14[b]	.55
LS	14.82	3.45	17.15	2.56	4.22[c]	.73

Notes:LGG, Living Grace Group; DASS-21, Depression Anxiety Stress Scales-21; DEP, Depression; ANX, Anxiety; STR, Stress; RAS, Recovery Assessment Scale; PCH, Personal confidence and hope; HEL, Willingness to ask for help; GSO, goal and success orientation; ROO, reliance on others; NDS, no domination by symptoms; TSOS, Theistic Spiritual Outcome Survey; LG, Love of God; LO, Love of Others; LS, Love of Self.
*$p < .05$.
**$p < .01$.
***$p < .001$.

reported symptoms of depression and both physiological and psychological markers of anxiety decreased. Taken together, during their time in the LGGs, participants described reductions in spiritual tension and conflict, improvements in their view of relationships with others, increased feelings of self-worth and self-acceptance, more hope and confidence in their ability to handle symptoms, all in addition to reporting fewer anxious/depressive symptoms.

The success of this type of group is not surprising: literature support for similar peer-led groups for mental illness is rapidly expanding (Cook, 2011; Repper & Carter, 2011). However, most previous work on peer-led groups takes place within the mental health system, as community mental health centres train peers and sponsor courses (Cook, Copeland et al., 2012; Cook, Steigman, et al., 2012; Fukui et al., 2011; Van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012) or consumer-run organisations provide leadership (Cook et al., 2010; Fukui et al., 2010). The LGGs are different – designed to be more independent and portable by relying on faith communities for support.

This is good news for individuals who prefer R/S integration in their mental health care. The reported data indicate that not only is the LGG approach acceptable, even preferable, to a highly religious population, but it is described as helpful by participants on well-validated standardised outcome measures. Present results further corroborate previous studies indicating that integrating R/S with established psychological principles of change is an effective strategy with appropriate populations (Hook et al., 2010; Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis, & McDaniel, 2011). As a quantitative outcome design, this study provides evidence regarding services that have rarely been empirically tested, and serves to begin to extend the positive findings regarding R/S integrated, professionally delivered treatments to peer-led, psychoeducational support groups.

Study limitations

The choice to study existing community groups carries both pros and cons. The intentional absence of direct group oversight by researchers protected confidentiality of participants, enabled inclusion of widely geographically distributed groups, and allowed a naturalistic description of the groups. However, it also resulted in less controlled research conditions. For example, one group's leader was sick on the last day of group, and though the group was run by a substitute, most of the group members did not attend (or complete outcome surveys). This and similar instances contributed to a lower survey completion rate, and the omission of those individuals increases potential error.

Other limitations of this pilot test of the LGGs include a lack of a comparison group, absence of follow up, and a relatively small sample size. Nevertheless, the larger size of the sample of initial LGG surveys is adequate to describe typical LGG participants, and the geographic diversity of groups contributes to external validity.

Clinical potential

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

Conclusions

The results of this study confirm that individuals with mental illness are present in faith communities, and that those individuals desire help from the church (Rogers, Stanford, & Garland, 2012). The LGG has brought psychoeducation to faith communities in an integrated format acceptable to religious individuals. The intensity and persistence of mental health issues reported in this sample further demonstrate that programmes run in faith communities may be ideally placed to intervene with individuals with persistent psychiatric difficulties and other mental health concerns. LGGs indeed are an "innovative programme" as called for by Koenig et al. (2001) that mobilises the internal religious resources of the participant and the community resources of the church to facilitate recovery in a supportive and caring environment.

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