

INTEGRATING RELIGIOUS AND SPIRITUAL PRACTICES WITH THERAPEUTIC LEISURE WITHIN THE RECOVERY PROCESS OF PERSONS WITH MENTAL DISORDERS

GERVAIS DESCHÊNES¹

Université du Québec à Chicoutimi, Saguenay, Canada

PAUL HEINTZMAN²

University of Ottawa, Ottawa, Canada

JACK REIMER³

Trinity Western University, Langley, Canada

ABSTRACT— This paper explores the therapeutic impacts of religious and spiritual practices integrated with the therapeutic leisure experiences with persons with mental disorders. A brief overview of these disorders and their symptoms is provided. Religious and spiritual dimensions of therapy are then presented. Thereafter, therapeutic approaches are discussed with a focus on evidence based recovery practices and conceptual models of recovery explained. Leisure experiences as a recovery strategy for social inclusion is addressed. Furthermore, the paper discusses leisure experiences as a recovery strategy and a meaningful pathway to spiritual well-being. Recommendations are proposed for future actions within psychiatric services.

RÉSUMÉ— Cet article explore l'influence du recours aux pratiques religieuses et spirituelles dans les expériences de loisir thérapeutiques chez les personnes souffrant de troubles mentaux. Il brosse un survol des troubles mentaux et des symptômes afférents et dresse un portrait des dimensions religieuse et spirituelle de la thérapie. On y traite des approches thérapeutiques en mettant l'accent sur des méthodes de guérison fondées sur des données probantes ainsi que sur les modèles théoriques de guérison. Puis,

¹ Gervais Deschênes is Part time teacher at the Université du Québec à Chicoutimi, 555 Boulevard de l'Université Chicoutimi, Saguenay, QC, G7H 2B1, gervais_deschenes@uqac.ca

² Paul Heintzman is an Associate Professor, Leisure Studies at the University of Ottawa, 125 University, Ottawa, ON, K1N 6N5, pheintzm@uottawa.ca

³ Jack Reimer is an Assistant Professor of Human Kinetics at Trinity Western University, 7600 Glover Rd., Langley, BC, V2Y 1Y1, jreimer@twu.ca

on présente les expériences de loisir comme moyen de guérison menant à l'inclusion sociale. Finalement, on aborde les expériences de loisir comme moyen de guérison conduisant au bien-être spirituel. L'article conclut en proposant des recommandations pour les soins en psychiatrie.



*“He who has a why to live
can bear almost any how.”*

— Friedrich Nietzsche

*“Man is not destroyed by suffering;
he is destroyed by suffering without meaning.”*

Viktor Frankl

This paper proposes a model for combining therapeutic leisure experiences with religious and spiritual practices for supporting the recovery process of those suffering from a mental disorder. It must be specified that leisure is about persons and as such a phenomenon of life (Arendt, 1972)⁴. Any attempt to define leisure faces a primary obstacle: the evolution of this phenomenon. The beneficial effects of leisure for recovery have long been known. Nimrod, Kleiber and Berdychevsky (2012) demonstrated the efficacy of leisure as a recovery strategy for persons with depression. These authors also pointed out the profound paradox for persons experiencing depression “[t]he more depressed they feel, the less they are able to participate in leisure activities... and the less involved they are, the more depressed they become” (p. 419). This paper aims to provide an argument that religious and spiritual practices can break this cycle of depression and provide strength for persons with mental disorders to participate more fully in their recovery process. Spiritual and religious practices contribute to a higher level of spiritual well-being and assist people to build greater resiliency (Jacobson & Greenley, 2001; Provencher, 2002, 2007; Lord & Hutchison, 2007). Leisure and its relationship with spirituality may also enhance the recovery protocols available to professional therapists.

This paper suggests a new relationship between spirituality and psychiatric services with a vision of therapeutic leisure for the field of rehabilitation services. It is divided into six parts: (1) a brief overview of mental disorders; (2) religious and spiritual dimensions of therapy; (3) evidence-based recovery

⁴ For some theorists, leisure is synonymous with free time, activity programming and/or a positive experience, usually characterized by feelings of freedom and intrinsic motivation. Kelly (1987) affirmed that leisure is an important historical and structural dimension of human life that is conditioned by culture, ethnicity, gender, social class, family, religion, and so forth. Leisure is a complex reality, plural, ambivalent, contingent on the many facets of human existences, which to be understood and involves a ‘state of becoming’.

practices utilizing religious and spiritual practices; (4) finding meaning through work engagement; (5) conceptual models of recovery; (6) pathways to recovery and spiritual well-being through leisure; and finally, (7) recommendations and future directions.

Brief Overview of Mental Disorders

According to the World Health Organization (2012), more than 450 million people worldwide suffer from a mental disorder, with 75% of persons remaining untreated in developing countries. Mental disorders such as intellectual disability, autism, schizophrenia, bipolar disorders, anxiety disorders, depressive disorders and neurocognitive disorders are mainly characterized by cognitive impairment, mood disorders and chaotic behaviours associated with distress and impaired functioning. The apparent symptoms of these biological and psycho-social diseases vary from mild to severe, depending on the category of the mental disorder, the individual, the family and the socio-economic environment. *DSM-5* provides definitions of the most recognized and personally debilitating mental disorders in contemporary societies, as shown in Table 1.

Mental disorders have a evolutive effect and the role of the *DSM-5* might only cause an escalation of 'new' diagnosis and a proliferation of the pathologization of everyday life (Micale, 2014). As Gilman (2014) affirmed:

Across the globe, societies see categories of madness as something that impinges on human activity, for ill or for good, and with a variety of meanings that generate a variety of interpretations. The realities of what constitutes madness in any given society or community or historical moments are constantly shifting: symptoms change and their meanings seem always in flux. (p. 442)

The task of accurately assessing and diagnosing mental disorders presents multiple challenges. Too often, patients who are living in a psychiatric facility have to demonstrate normative behaviour to a greater degree than individuals outside of the facility (Deegan, 2007). Society's moniker of 'mentally crazy' invokes a dehumanizing effect. Patients who feel vulnerable internalize their diagnosis telling themselves: 'I am a schizophrenic or I am a manic-depressive' thus becoming unable to see themselves beyond the boundaries of their diagnosis. However, persons with mental disorders are still a complete human being and able to experience spiritual health (Kehoe, 2009). They are nevertheless stigmatized as 'crazy persons' and may unintentionally receive a cognitive death sentence, *the death*

Table 1
Brief definitions of mental disorders

Diagnosis	Description
Intellectual Disability	[C]haracterized by deficits in general mental abilities, such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, and learning from experience.
Autism	[C]haracterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviours used for social interaction, and skills in developing, maintaining, and understanding relationship.
Schizophrenia	[D]efined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour (including catatonia), and negative symptoms.
Bipolar Disorders	[These disorders refer to] the modern understanding of the classic manic-depressive disorder or affective psychosis described in the nineteenth century,...the vast majority of individuals whose symptoms meet the criteria for a fully syndromal manic episode also experience major depressive episodes during the course of their life.
Anxiety disorders	[I]nclude disorders that share features of excessive fear and anxiety and related behavioural disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat....Sometimes the level of fear or anxiety is reduced by pervasive avoidance behaviours. Panic attacks feature prominently within the anxiety disorders as a particular type of fear response.
Depressive disorders	[I]nclude disruptive mood dys-regulation disorder, major depressive disorder,...persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depression disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder....The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.
Neurocognitive disorders (dementia and amnestic)	The neurocognitive disorders (NCDs) (referred to in DSM-IV as "Dementia, Delirium, Amnestic, and Other Cognitive Disorders") begin with delirium, followed by the syndromes of major NCD, mild NCD, and their etiological subtypes. The major or mild NCD due to Parkinson's disease, frontotemporal NCD; NCD due to traumatic brain injury; NCD due to HIV infection; substance/medication; NCD due to Huntington's disease; NCD due to prior disease; NCD due to another medical condition; NCD due to multiple etiologies; and unspecified NCD.

Source: American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*. (5th ed.). Washington, DC/London, UK: American Psychiatric Publishing, pp. 31, 31, 87, 123, 189, 155, 591.

before death (Deegan, 2007) or entrance into *the kingdom of shadows* (Robi & Leclerc, 1990). The psychiatric services can inadvertently act as a social punishment system where the patients are condemned with a diagnosis for actions that are outside of their control. At the beginning of their injury, patients with severe schizophrenia for instance are caught in a catatonic state where they are not in touch with their own reality. They often feel like strangers to themselves, guilty and oppressed by a psychiatric system (Secheyaye, 1950/1970) that tries to rehabilitate them quickly for economic, utilitarian and humanitarian reasons. Szasz (1974) declared in an ironic manner that “[i]f you talk to God, you are praying; if God talks to you, you have schizophrenia” (p. 113). He concluded that no person or group should have the moral authority “to ‘correct’ a human being; only God does” (p. 47). Psychiatric patients are full human beings, and from a Christian worldview are sons and daughters of God who need the profound love, care and protection available to all children of God. Morin (2004) observed that the medicine of love is critical to the recovery process. This medicine of love includes loving life, living to love, and loving the fragile and vulnerable persons of society, thereby reducing personal delusion and creating a more healthy and robust society.

Addressing the spiritual dimension in the treatment of those suffering from mental health disorders can offer new hope and possibilities, and expand the ways we approach and treat mental disorders “[t]he very fact that the spiritual dimension is beyond us —while within us— makes an essential part of the process of health and sickness beyond our understanding” (Balter & Katz, 1992, p. xviii). The spiritual approach can offer empathy, opportunity and time to understand the patient’s situation and to rediscover meaningful pathways to spiritual well-being.

Denny and Elgar (2013) affirmed that mental disorders are a social phenomenon and cannot be understood using only personal biological terms. Vulnerability is a social construction that creates an environment or context that causes persons to be discriminated (Lord & Hutchison, 2007). It is not the physical or mental disability that causes vulnerability, but social conditions and determinisms such as segregation, exclusion, isolation and loneliness. The problem of discrimination lies mostly in terms of the environmental factors and does not emanate from the persons with the disability. Social labels reinforce the internalized feelings of guilt as “[s]tigma describes a mark of shame, disgrace, or disapproval that results in an individual being shunned or rejected by others” (Carter & Van Andel, 2011, p. 335). Thus by creating and continuing to strengthen the negative social stigma and refusing to see persons with disabilities as human beings first,

our society contributes unwittingly to the creation of vulnerable populations. Importantly, the vulnerability results from a long period of prejudice, denigration or slander, exclusion, exaggeration or misdiagnosis which stigmatizes persons with physical or mental disabilities. These intensify social stereotypes. For Corrigan, Powell and Rüsç (2012), the persons are not responsible for their mental disorders. They are victimized by it. It should be stressed that a patient is stigmatized throughout his/her interaction with the psychiatric services. Instead, these services should be compassionate and supportive. This stigmatization contributes to the mental disorder epidemic in our society. The style of language used in this system may significantly affect the opportunity of recovery, which is not defined as cure but as building “a social identity through engagement in an active life. A positive social identity can be achieved by accessing mainstream facilities and activities that gravitates people away from being viewed as ‘mentally ill’” (Moxham, Liersch-Sumskls, Taylor, Patterson, & Brighton, 2015, p. 62). Barber (2012) explained that a patient is stigmatized with few alternatives from the beginning of his/her mental disorder by a prognosis which carries a life sentence that burdens his/her conscience. The therapeutic words used are relevant when a person receives a diagnosis such as schizophrenia. She suggested a new medical approach:

Traditionally, a psychiatrist told a patient with a new diagnosis of schizophrenia, ‘You will have to take medication for the rest of your life,’ comparing the illness to diabetes. Using our knowledge of current research findings, we could give a more hopeful prognosis: ‘You will have to take medication for several years and may need to be hospitalized at times. But over time, you have an excellent chance of recovery and of needing less or even no treatment’. (p. 278)

Abdel-Baki, Lesage, Nicole, Cosette, Salvat and Lalonde (2011) reported that the long-term outcome of schizophrenia has been less pessimistic than previously thought as “[a] significant proportion of treated schizophrenia incident patients achieve moderate long-term outcome, and stability of global functioning is certainly much more frequent perspective on schizophrenia patient outcome” (p. 100). Harding and Zahniser (1994) recommended that treatment programs be developed ‘as if’ patients will experience improvement of health and/or recovery for a quick return to normal life. Barber (2012) argued that if patients stop or reduce treatment and continue to recover, they would be more willing to report their success. This report of recovery is an opportunity to observe what clinicians rarely see—the full recovery of a patient. This does not mean that this new approach completely eliminates medications, which are one of many tools that might be required for the recovery process especially for patients with severe schizophrenia

(Deegan, 1995). Flaherty (2012) argued that a person-centered model is the corner stone for a new medical model based on a real sense of humanity that creates the possibility of reducing or even eliminating medication protocols in either the short or long term range⁵.

Finding hope is a way to support the recovery process. Religious and spiritual practices provide a significant pathway to instill hope and aid the journey to recovery. The following section describes such practices and how they are perceived by psychiatric services.

Religious and Spiritual Dimensions of Therapy

There is hesitation in tackling the subjects of religion and spirituality in the medical community. Too often, these aspects of human experience are viewed through the lens of a psychiatric symptom, something relatively pathological (Kehoe, 1999). This reluctance to engage religious and spiritual practices in the recovery process is due to their inherent amorphous nature and lack of specific empirical studies in the mental health field. Concerted attempts have been made to conceptualize and operationalize religion and spirituality.

Religion and spirituality have various meanings, but are often considered simultaneous or synonymous in contemporary societies (Peselow, Pi, Lopez, Besada, & Ishak, 2014). Religion is sometimes defined as a construct that is structured, outward, institutional, authoritarian, doctrinal, inhibiting, substantive and negative, as opposed to spirituality, which is personal, inward, emotional, relational, subjective and positive (Hill & Pargament, 2008). This distinction implies a restricted perspective that “[s]pirituality is more individualistic and self-determined, whereas religion typically involves connection to a community with shared beliefs and rituals” (Koenig, 2004, p. 1194). Some may argue that the communal nature of religion would be more desirable than the individualistic nature of spirituality, however individuals are sometimes alienated by the complex requirements of particular religious groups. During the painful experience of mental disorders, religion and

⁵ For instance, in Quebec, there is a wisdom in the protocol management of mental health through alternative resources which contribute to the field of psychiatric system. Thus minimum medical vocabularies such as diagnosis, diseases, symptoms and failures are not effectively employed. Far from being content to be hasty in giving a full diagnostic that labels the ill person for life, alternative practices of mental health resources prefer the comprehensive approach which avoids judging by appearances (Corin, Poirer, & Rodriguez, 2011), because a person is always much more than what we perceive about him/her; that what one understands from him/her (Bernazzani & Lacroix, 2014).

spirituality may play a role: “Whether it is as a new method of coping or a lifelong belief, religion becomes increasingly important as patients face the Goliath of illness” (Koenig, 2004, p. 1194). Religion and spirituality significantly contribute, in an indirect manner, to better global health (Frankl, 2009). Usually, they provide persons with a solid anchor, giving a person a sense of stability not found anywhere else. Religion and spirituality have something in common because both are driven by the quest for meaning and the search for the sacred. They are closely interconnected because “[s]pirituality can exist outside the boundaries of formal religion, but spirituality is also part of religion” (Folkman & Moskowitz, 2004, p. 760). From a holistic perspective, spirituality is an intimate journey that a person undertakes to find the meaning of his/her own life (Demers, 2008). When a person assumes his/her responsibility, then his/her spirituality takes form. Spirituality is an individualized journey characterized by experiential descriptors such as meaning, purpose, transcendence, connectedness and energy (Chiu, Emblen, Van Hofwegen, Sawatzky, & Meyerhoff, 2004). Reed (1991) defined transcendence as expanding the conceptual boundaries of the self beyond limits posed by the immediate, physical or environmental limitations.

Surveys indicate that 95% of mentally ill patients do believe in God, whereas 79% believe that spirituality is important for a healthy life (Lacombe, 2009). This data demonstrates the importance of religion and spirituality to persons with mental disorders. Many persons are involved in “religion specifically to help cope with the immediate demands of stressful events, especially to find the strength to endure and to find purpose and meaning in circumstances that can challenge the most fundamental beliefs” (Folkman & Moskowitz, 2004, p. 759). Bradshaw, Ellison and Flannelly (2008) discovered that “persons who hold more positive, intimate images of God—that is, as loving, caring, forgiving, etc.—will experience fewer symptoms of psychopathology....[Conversely] persons who experience or envision God as a more distant or remote figure will experience higher levels of psychopathology” (pp. 650, 653). Pargament, Smith, Koenig and Perez (1998) proposed that there are positive and negative patterns to cope with major everyday life stressors. The positive patterns include seeking spiritual connections and support, religious purification and forgiveness, collaborative religious coping and benevolent religious reappraisal, whereas the negative patterns consist of interpersonal religious discontent, punishing God reappraisals, spiritual discontent, reappraisal of God’s powers and demonic reappraisal. Nevertheless, through the personal search for the sacred, it is possible to cope with painful and overwhelming experiences. Even if physicians and professional therapists might have concerns about negative self-awareness, or worry about

spending additional time with patients, or over-stepping ethical boundaries, therapists should attend to the client's attachment to God.

The sense of connection to a higher power or religious entity is a unique predictor of life satisfaction. Specific components of spiritual belief systems have a direct and unique influence upon recovery outcomes (Waldron-Perriene, Rapport, Hanks, Lumley, Meachen, & Hubbarth, 2011). Spirituality can connect "the patient to a wholeness that exists beyond the presence of impairment, disability, or handicap" (Cotter, Spangenberg, Mulford, & Wilcox, 2003, p. 191). With changes in medicine that have occurred over the past decade, Koenig (2004) suggested that physicians can no longer ignore religion and spirituality factors. They should adopt whole-person medicine which "is the best kind of care both for those who receive it and those who give it" (p. 1199). The boundaries between physicians and patients are important and need to be constructed over time. As such, there is a unique point of equilibrium to each patient that requires an alliance of trust (Ricoeur, 2001a, 2001b) between patients and their physicians and also their professional therapists⁶.

Ultimately, religion and spirituality are important to many patients and seem to improve their quality and length of life as well as overall life satisfaction (Chally & Carlson, 2004). Coping behaviours might be facilitated in many religious or spiritual settings through prayer, meditation, worship and ritual (Carleton, Esparza, Thaxter, & Grant, 2008). The therapeutic effects of prayer and meditation produce spiritual healing through gratitude, grace, relaxation, hope, inner peace, tranquility, forgiveness and love which facilitate behaviours that promote a general calming effect (Levin, 1996) that is crucial for the recovery process. The literature points to the relevance of religion and spirituality in therapy and their potential positive effect on the recovery process of those suffering from mental disorders.

Evidence-Based Recovery Practices Utilizing Religious and Spiritual Practices

Neuro-imaging research and standard psychotherapy evaluative procedures have demonstrated the positive effects of religious and spiritual practices in treating various mental disorders (Beauregard & Paquette, 2006;

⁶ There are geographical and cultural variations in how physicians, professional therapists and patients interact and adapt to each other within psychiatric services in contemporary societies.

Bellamy, Jarrett, Mowbray, MacFarlane, Mowbray, & Holter, 2007; Kehoe, 2009; Miller et al., 2014). There is an emerging philosophy of recovery that is based on values beyond the destructive nature of psychiatric symptoms. It aims to support patients to redirect their lives to find meaning, rather than get stuck with the prejudice of these potential incurable diseases (McAll et al., 2012).

Neuroimaging studies have explored the neural mechanisms underlying mindfulness, meditation and prayer experiences with techniques such as electroencephalography (Davidson et al., 2007) and functional magnetic resonance imaging (Farb et al., 2007; Short et al., 2010). Mindfulness and meditation practices enhance the network density in the brain structure resulting in improved mental functioning (Hölzel et al., 2011; Lazar et al., 2005). By preserving cortical thickness, meditation might attenuate depression, dementia and the aging process (Xiong & Doraiswamy, 2009). More recently, Miller et al. (2014) have demonstrated that religious and spiritual practices have positive effects in the left and right parietal and occipital regions, the mesial frontal lobe of the right hemisphere, and the cuneus and precuneus in the left hemisphere, which may result in a reduction of depression symptoms. A thicker brain cortex is linked with high levels of religious and spiritual engagement and creates resiliency in depressive persons who have a high familial risk of deep depression. This expansion of cortical reserve possibly may counter some of the cortical thinning present in persons with a genetic predisposition to depression. Hence, “[t]he importance of religion or spirituality appears to confer a neuro-anatomical resilience in those who are otherwise predisposed to developing depressive illness” (Miller et al., 2014, p. 134). It appears that mindfulness and meditation experiences are significant factors in recovery and improvement within the quest for quality and meaning of life.

A multitude of psychotherapy approaches in North America include innovative group settings or personal encounters with professional therapists, who discuss religious resources; share values concerns, spiritual struggles, hope and forgiveness; and encourage prayer and meditation practices as an adaptive strategy to manage and cope with the stress associated with mental disorders (Corrigan, McCorkle, Schell, & Kidder, 2003; Kehoe, 1999, 2009; Lachance, 2009; Singh, Shah, Gupta, Coverdale, & Harris, 2012). For example, the Spirituality Matters Group (SMG) inside hospital settings “allow individuals with persistent psychiatric disabilities to explore positive emotion-focused coping” (Revheim & Greenberg, 2007, p. 310). Using this model, patients can progress at their own pace in a do-it-yourself spirituality (Corin, 2009).

Bellamy et al. (2007) discovered that patients with mental disorders who attended consumer-centered services found that religiousness and spirituality contributed to their psychological well-being with decreased psychiatric symptoms, and overall improvement in management of one's daily life. Religiousness and spirituality have been found to have beneficial outcomes including social inclusion, hope, personal empowerment and recovery (Corrigan et al., 2003); and also to have prevented possible future hospitalizations through the practices of religious coping methods, such as prayer, attending religious services, worshipping God, meditation, reading scriptures and meeting with a spiritual leader (Tepper, Rogers, Coleman, & Malony, 2001). These findings are theorized to be caused by understanding that “[r]eligion is meant to bind us to the external Creator and not to bind us internally with knots of fear, anxiety, and prejudice. Spirituality, with its root in spirit or breath, refers to the source of life” (Kehoe, 2009, p. 51). Hence, religion and spirituality encourage patients with mental disabilities to explore a more positive emotion-focused coping, which can create healing effect. Religion and spirituality represent a source of energy that needs more consideration by professional therapists working with psychiatric populations (Phillips, Lakin, & Pargament, 2002). Fallot (2007) proposed that psychiatric services need to be ‘spiritually-informed’ to enhance the quality of life of their patients who are suffering from these diseases. There is a need for more education for professional therapists and also a need to create more sacred spaces inside therapeutic facilities that provide psychiatric services.

Finding Meaning through Work Engagement

The work environment plays an important role in mental health. The practice of meaningful work is emphasized in the Bible as an important factor of living well. There is a profound connection between religious understanding and work displayed in God's declaration in Genesis 3: 19 “by the sweat of your face you shall eat bread” (NRSV-Catholic edition). Persons with mental disorders are trying to search for a healthy life, and work is definitely a pathway to creating meaning and aiding the journey to mental health recovery. However the unemployment rate for persons suffering from mental disorders is over 80% (Drake & Whitley, 2014). Unemployment reduces life expectancy, increases homelessness and hinders the pursuit of life, liberty and happiness (Whitley & Henwood, 2014). Psychiatric patients are faced with social stereotypes that significantly limit stable employment conditions (Lauzon & Lecompte, 2002). This leads to the broader question for society,

of why opportunities to participate in meaningful occupations are restricted for persons with mental disorders. Employment provides significant positive outcomes within the recovery process, as the work environment produces meaning for self-identity construction (Dunn, Wewioeski, & Rogers, 2008). This employment liberates and empowers persons with a mental disorders through renewed life purpose (Strickler, 2014). Disclosing mental disorders remains a dilemma for mentally ill persons in their occupational life. Employing vulnerable populations inside psychiatric services might promote positive role models for social inclusion (Deegan, 1988). Currently, in the province of Quebec, a practical rehabilitation program called “Peer Helping” exists for persons who have or have had mental disorders. Participants share their painful experience and recovery stories in order to give hope; serve as leaders; and provide inspiration, support and information to patients who come from similar situations (Association Québécoise pour la Réhabilitation Sociale, 2014). In addition, there is a need for a recovery mentor at work (Huddleston, 2012) in order to prevent problems associated with prejudice and social stereotypes.

Conceptual Models of Recovery

Roe, Rudnick and Gill (2007) argued that “the concept of recovery, and particularly the notion of ‘being in recovery’ or ‘recovery as a process’, has generated much hope and positive change” (p. 173). As such, the need to further develop and establish our theoretical understanding of these conceptual models is critical to diminish the negative and collateral impacts of mental disorders in the social world.

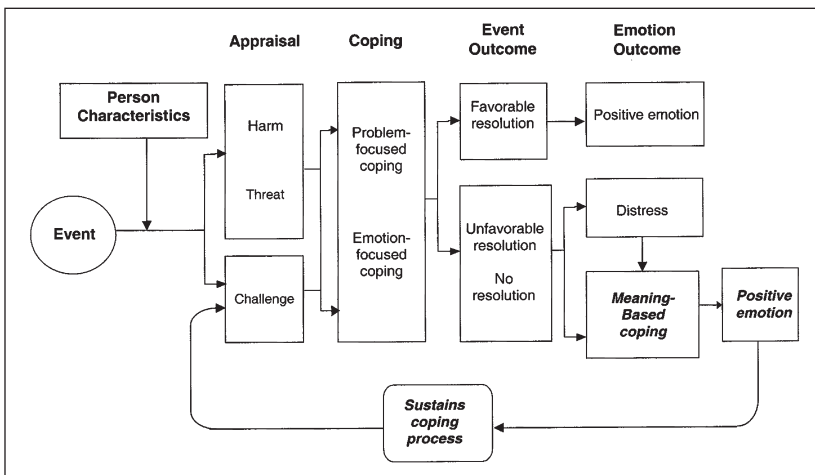
A theory that is useful to consider is the transactional theory (Lazarus & Folkman, 1984). It explains how people may adapt to stressful situations by thwarting personal goals and limiting their overall global health. This theory demonstrates how coping strategies may produce positive and/or negative consequences in physical condition, social functioning and psychological status. This theoretical framework developed originally by Lazarus and Folkman (1984) has revealed fruitful connections between the various factors in stress appraisal and management:

(1) feelings can shape thought and action; (2) actions can shape thought and feeling; (3) the environment shapes thought, feeling, and action; and thoughts shape feeling and action....Moreover, if one accepts the premise that how people act and react shapes the behavior of others toward them and how they feel, then by changing their behavior, people can also change the

environment and thereby create an entirely new relationship to the world. (pp. 345, 348)

The transactional model revised by Folkman (1997), and confirmed by Folkman and Greer (2000), has two processes: appraisal and coping. Appraisal involves the assessment of a person’s perception of significance of a particular event and the adequacy of personal resources to cope. This appraisal includes the emotions and leads to subsequent adaptation. The coping aspect refers to the thoughts and behaviours of a person to regulate distress (emotion-focused coping), to manage the problem solving distress (problem-focused coping), and maintain optimistic well-being (meaning-based coping), when confronting the influences of the outcome of the event and the person’s appraisal of it. This transactional model states that when the stressor is perceived negatively these two processes actually inhibit problem solving and positive changes within the relationship between the person and their environment, as shown in Figure 1:

Figure 1: Transactional model of appraisal and coping process



Source: Folkman, S. & Greer, S. (2000). Promoting psychological well-being in the face of serious illness: When theory, research and practice inform each other, *Psycho-Oncology*, 9, p. 12.

These transactional models of stress management may also benefit therapeutic programs that facilitate psychological well-being for patients with serious mental disorders. The following sequential stages could be applied in therapeutic settings: (1) create optimal conditions for challenge (find out

what matters to the patient/establish goals/emphasize opportunities for personal control), (2) encourage positive behaviour to achieve goals, and (3) maintain positive mood (Folkman & Greer, 2000). Gall, Charbonneau, Clarke, Grant, Joseph and Shouldice (2005) presented the basic principles (e.g., the dynamic process) and structural components (e.g., coping behaviours) of this transactional model by integrating spirituality within the recovery process. This recovery model can be enhanced when implemented by spiritual care workers and/or chaplains from multi-faith religious or spiritual backgrounds.

Jacobson and Greenley (2001) have offered a recovery-oriented model that includes both internal and external conditions. The internal conditions include attitudes, experiences, and processes of change for recovering individuals. The external conditions are comprised of the circumstances, events, policies and practices that support the recovery process. These internal (Table 2) and external (Table 3) components are critical for the success of 'being in recovery'.

Table 2

Recovery-oriented Model. Internal conditions

Hope: Gaining hope has something of the transcendent....The source of this grace is different for each individual. For one it will be the entity he or she knows as God. For another, it might be a spiritual connection with nature....By expanding the realm of the possible, hope lays the groundwork for healing to begin.

Healing: Recovery is in part the process of 'recovering' the self by re-conceptualizing illness as only part of the self, not as a definition of the whole....The second healing process is control—that is, finding ways to relieve the symptoms of the illness or reduce the social and psychological effect of stress.

Empowerment:...empowerment may be understood as a corrective for the lack of control, sense of helplessness, and dependency that many consumers develop after long-term interactions with the mental health system....A sense of empowerment emerges from inside one's self...and it has three components: [autonomy, courage, responsibility].

Connection: To connect is to find roles to play in the world. These roles may involve activities, relationship status, or occupation....the most powerful form of connection is helping others who are also living with mental illness....this means becoming a mental health provider or advocate; for others, it means bearing witness, or telling their own stories in public arenas. (Jacobson & Greenley, 2001, pp. 482-483)

Table 3*Recovery-oriented Model. External conditions*

Human right: ...a human rights agenda lays out a vision of a society in which power and resources are distributed equitably....equal opportunity is promoted through expanded access to care and services that might otherwise be restricted by poverty, stigma, or the law itself.

A positive culture of healing: this new order as 'a positive culture of healing...a culture of inclusion, caring, cooperation, dreaming, humility, empowerment, hope, humor, dignity, respect, trust, and love'. [It] begins with an environment characterized by tolerance, listening, empathy, compassion, respect, safety, trust, diversity, and cultural competence.

Recovery-oriented services: Recovery-oriented services address the range of these features and include services directed at symptom relief, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, and self-help. (Jacobson & Greenley, 2001, p. 484)

Kerr, Crowe and Oades (2013) pointed out that the recovery-oriented model involves the reconstruction and integration of one's self-identity in a changing social world. Corin (2002) suggested that recovery involves the ability to regain agency in a specific community, building a significant inner space and reorganizing one's relationships with others according to one's own rhythm. Recovery-oriented practice implies a new social status within the community.

The person engaging in the construction of new dimensions of the self is capable of projecting a re-defined meaning of the self into the future and therefore reinforces a sense of agency (Provencher, 2007). This growing sense of inner peace promotes a more inclusive rehabilitation. From this perspective, a disabled person becomes resilient when he/she presents and maintains improvement in outcome indicators (e.g., psychiatric symptoms). This growth also optimizes his/her potential within a global health context (e.g., psychological well-being). This improved resiliency creates a new self-efficacy for future challenges and even the potential to reorganize past painful experiences into meaningful growth. This pattern of resiliency is one of many which characterize the transformation experiences of fully 'being in recovery'.

Provencher (2002, 2007) established a multi-dimension conceptual model of recovery by specifying the characteristics of four specific dimensions of

recovery. This conceptual multi-dimension model is shown in Figure 2 below.

Figure 2: Multi-dimension Model: The four dimensions of recovery and their characteristics

<p style="text-align: center;">Redefinition and expansion of self</p> <ul style="list-style-type: none"> – Grieving process associated with the presence of a mental disorder – Discovery process of a new self – Complexity of self 	<p style="text-align: center;">Relationship with the temporal space</p> <ul style="list-style-type: none"> – Hope – Spirituality
<p style="text-align: center;">Empowerment</p> <ul style="list-style-type: none"> – Process and build up – Transformation of helplessness feeling – Empowerment level <ul style="list-style-type: none"> • Psychological level <ul style="list-style-type: none"> ◦ Intrapersonal component ◦ Interactional component ◦ Behavioral component • Organizational level • Communal level 	<p style="text-align: center;">Relationships with others</p> <ul style="list-style-type: none"> – Relationships with the family members – Relationships with peers – Relationships with the [professional] therapists – Relationships with health and support Services

Provencher, H. L. (2002). L'expérience du rétablissement: Perspectives théoriques. *Santé mentale au Québec*, 27(1), p. 48.

In the *redefinition and expansion of the self*, the person forgets his/her role as patient and applies his/her energy to new roles, which allow for re-building an improved self-esteem. In the *relationship with the temporal space*, the person searches for meaning in his/her potential future life, through the endeavor of hope and spirituality. The *empowerment* process is mainly characterized by the transformation from feelings of helplessness into an increased sense of agency in their environment and the building-up of proactive goals through intrapersonal, interactional and behavioural components at organizational and communal levels. The *relationships with others* are characterized by the establishment of authentic and reciprocal connections to family, friends, peers or professional therapists.

As Weinberg (2013) emphasized: “[i]t is helpful for people in distress to dream of something better, with hope supplying the motivation to explore valued life goals and learn new skills to navigate new roads” (p. 124). This should include the patient’s ability to articulate and implement values and belief systems that promote recovery and improve the quality of life through building positive self-identities without negative social stigmas.

'Being in recovery' incorporates parental, occupational, educational, leisure and other roles (Provencher, 2007). Leisure experiences have significant therapeutic outcomes for persons 'being in recovery' and their search for a better quality and meaning of life. Furthermore, religious and spiritual practices can expand and enhance the implementation of the transactional, recovery-oriented and multi-dimensional models in the recovery process.

Pathways to Recovery and Spiritual Well-being through Leisure

The integration of religious and spiritual practices within therapeutic leisure reduces and even minimizes the negative impact of mental disorders by supporting the meaning-making process (Iwasaki, Messina, Shank, & Coyle, 2015, Iwasaki et al., 2014). Leisure, in which the playful nature of a person may be fully in action, has a role in overcoming psychological problems through personal enhancement, self-actualization and escape perspective (Neale, 1969). Play has its own meaning as an ontological action which often results in emotional and physical improvements. Miller (1970) stated that play, which is the ultimate seriousness, has a definite therapeutic function because *purposelessness is the highest purpose*. Play is an existential element of leisure (Deschênes, 2007, 2011, Euvé, 2000; Moltmann, 1977). Research has consistently acknowledged the therapeutic function of leisure within the recovery process (Caldwell, 2005; Cassidy, 2005; Haworth & Lewis, 2005; Provencher, 2007; Trenberth, 2005). In order to achieve inclusion, diversity, creativity, meaning and growth, the practice of quality leisure experience should be viewed as an end in itself rather than as a simple means or medium for functional medicalized outcomes (Genoe & Whyte, 2015).

In addition, there is a task force considering the positive effects of leisure on those working with patients (Arai, Berbary, & Dupuis, 2015). The literature suggests that leisure is beneficial for care providers. Grafanaki et al. (2005) have found that: "[l]eisure itself can help counsellors and psychologists in becoming more present and emotionally available to their clients.... leisure seems to help mental health professionals expand their empathy and understanding of clients through becoming more connected with the deeper parts of their own selves" (p. 39). Leisure may very well improve the relationship between professional therapists and their patients thereby facilitating the journey to recovery.

Leisure is often associated with supportive social groups and positive inter-relationships that affect the integral development of the whole person. For vulnerable persons with mental disorders, leisure provides a robust social

component critical to the quality and meaning of life. Leisure also affects other aspects of life (i.e., work, family, politics, community lives, friendships). Iwasaki, Coyle and Shank (2010,) affirmed that “[l]eisure is a key context for active living and an important pathway toward recovery, health promotion and life-quality enhancement. Leisure represents broad aspects of human functioning including emotional, spiritual, social, cultural and physical elements” (p. 485). Persons with mental disabilities intuitively realize the benefits of leisure in the struggle for life and the capacity of leisure to be rehabilitative for the heart, mind, body and soul.

Haworth and Lewis (2005) affirmed the therapeutic function of leisure as a factor in well-being “...Participation in both physical and non-physical leisure activities has been shown to reduce depression and anxiety, produce positive moods and enhance self-esteem and self-concept, facilitate social interaction, increase general psychological well-being and life-satisfaction, and improve cognitive functioning” (pp. 72-73). In the past, people with disabilities have been assigned worth, not on their abilities, but on their inabilities which resulted them in being negatively labeled or stereotyped as less than normal. With the use of therapeutic objectives for leisure these negative stereotypes may be overcome (Stumbo, Wang, & Pegg, 2011).

The psychological concept of flow (Csikszentmihalyi, 2004; Elkington, 2011) has been linked to the therapeutic function of leisure resulting in a positive and energizing experience. Engaging in leisure, patients can experience a sense of flow that can promote better concentration, focus, and confidence which supports the recovery process. Through leisure, patients may connect with their soul that has its own purpose and which temporarily helps them experience happiness and creativity beyond the limitations of their diagnosis. Such experiences lead the patients to connect with the eternal and transcendent dimensions of life (Jasper, 1962).

Flow experiences during leisure have an existential impact, liberating and rejuvenating persons living with a mental disorder and bringing significant benefits for a patient’s recovery journey. Leisure helps patients feel more socially connected and reveals “flow’s distinctive boundary-transcending qualities” (Elkington, 2010, p. 350). The flow process through human interactions may create religious and spiritual understandings and multi-faceted personal meanings in the leisure context. The conceptual multi-dimensional model of Provencher (2002, 2007) explains how flow experiences during leisure allow for an integration of the religious and spiritual perspective in a hopeful life. Professional therapists are encouraged to support their patients, especially those struggling with life’s challenges and limitations, to engage with the healing effects of leisure. These experiences help persons to cope with negative

live events in ways that are self-protective, self-restorative and personally transformative (Kleiber, Hutchinson, & Williams, 2002).

Casual leisure that is defined as “immediately, intrinsically rewarding, relatively short-lived pleasurable activity requiring little or no special training to enjoy” (Stebbins, 1997, p. 18) can be helpful in the recovery process for persons with mental disorders. In cases of stressful circumstances, unexpected traumatic events and chronic stress, casual leisure activities such as watching a movie or a television program, strolling, napping, praying, meditating, reading, dialoguing, having conversation and playing board games are definitely stress reducers. In addition, listening to music has had positive effects for individuals with traumatic brain injury (Waldron-Perrine et al., 2011) that might produce mental disorders (Arciniegas, Harris, & Brousseau, 2003; Schwarzbold et al., 2008). Music therapy goes beyond just functionally rehabilitating the brain as it can also create a positive mood, which reduces the negative effects of the brain injury (Magee & Bowen, 2008). The practice of music therapy is a substantial asset for recovery. Through music therapy, the barriers of language can be eliminated by helping vulnerable persons with complex mental conditions to overcome their disability throughout their life, improve their emotional well-being and enhance their global mental functioning (Magee & Baker, 2009). Additionally, including art therapy in therapeutic leisure may restore spirituality, the search for the sacred, and the search for meaning in one’s life (Pelletier & Cournoyer, 2015). Hutchinson and Kleiber (2005) reported that casual leisure helped persons to cope successfully with stressful situations and negative life events. As such, it provided a source of pleasures by giving immediate enjoyment and prevent illness. This way of practicing leisure provides possibilities to be momentarily away from stressful events and to focus the attention on something else. Casual leisure provides for positive emotion, optimism and hope which results in improved global health.

Humanization occurs in a recreational environment through self-awareness and community building. Leisure offers a fundamental spiritual experience, where persons are deeply immersed in their social world and communities (Gallant, Arai, & Smale, 2013). Leisure increases self-confidence and hope (Moxham et al., 2015), which lead to rehabilitation and transformation of vulnerable persons (Kleiber, Reel, & Hutchinson, 2008). Inclusive leisure is critical in the process of self-definition for persons with mental disorders. Inclusive leisure refers to “the extent to which people with and without impairments engage in leisure ventures together” (Rossow-Kimball & Goodwin, 2014, p. 322). In some way, persons with a mental disorder build a new life story by learning as they go. They have opportunities to grow and change and gain a sense of positive social inclusion (Lord & Hutchison, 2007). For

adults with a mental disorder, meaning-making through leisure provides positive emotions, well-being, identity, self-esteem, connection with spirituality, social and cultural links, harmony, human strength, resilience, ways to learn new things and finally human development throughout the life span (Iwasaki, Messina, Shank, & Coyle, 2015). Leisure may even diminish the perception of boredom, and replace it with enjoyment, interest and excitement (Iwasaki et al., 2014). The therapeutic practice of leisure united with a compassionate pedagogy produces self-reflection, relational reflection and theoretical reflection that are significant factors in healing, meaning creation and well-being for persons in treatment (Briscoe & Arai, 2015).

Genoe (2010) has presented evidence that the social world of leisure is important for resisting the stereotypes of dementia and preventing stigma. In this regard, leisure is an efficient tool to resist personal adversity and reduce obstacles in society that affect persons with mental disorders and to open personal space for meaning. Research conducted with patients who suffered from dementia pointed out that through inclusive leisure patients could find ways to tackle the challenges of living with the disease “*by reconciling life as it is, battling through by being proactive, living through relationships, being optimistic, and prolonging engagement in meaningful activity to live their lives with hope*” (Genoe & Dupuis, 2014, p. 33). This resiliency function of leisure can be explained by the transactional model of appraisal and coping processes, when challenging conditions create motivation for behaviour change to achieve personal goals and maintain a positive mood (Folkman & Greer, 2000). This behaviour change involves the projection and the immersion of the self into the social world in spite of the challenges. Despite the difficulties faced in recovery through rehabilitation, there is a need to be able to look toward the future with the anticipation of “*having something meaningful to do and the opportunity to connect with others*” (Warner, Doble, & Hutchinson, 2012, p. 255). The therapeutic function of leisure is an alternative way to fulfill human needs, actualize our sense of self and produce authentic meaningful partnerships, while journeying with mental disorders.

The therapeutic practice of leisure facilitates change that can promote healing and may yield meaningful pathways to spiritual well-being. For Christians, leisure presents the freedom to experience a spiritual transformation of the inner life, which is exhibited in our actions towards the Lordship of Jesus Christ and all our fellow human beings (Spykman, 1994). Religious and spiritual practices have a specific recovery effect and they offer time for “*finding transcendence through the ordinary*” (Berglund, personal communication, June 10, 2015). The playful psychological state of escape can create

‘[l]eisure oases or leisure spaces’, that provide the opportunity of ‘being away’ from the stresses of daily life. Pleasure can encourage and enhance spiritual rejuvenation for those experiencing stress (e.g., Heintzman, 2009). To achieve transcendence, leisure must preserve each participant’s ability for spiritual exploration and growth within the group experience. The therapeutic practice of leisure can affirm the mutual interdependence, while providing learning and acceptance of various spiritual conceptions. This mutual experience often creates a space for both personal and interpersonal growth (Lyons & Lopez, 2015).

Promoting spiritual well-being has become increasingly accepted by the medical health community as evidenced by the World Health Organization’s interest in modifying their definition of health (Dhar, Chaturvedi, & Nandan, 2011). Spiritual well-being has been considered the inner life and its relationship to the broader environment. The medical community has recognized the necessity to address the broader human experience, in the pursuit of healing and wholeness (Puschalski, 2001). Burkhardt (1989) and Ross (1994) have described spiritual well-being as a journey of the lived experience, characterized by a greater sense of peace, meaning, purpose and connectedness. Chiu et al. (2004) described spiritual well-being as a quality of relationships; with self, with others, with nature, and with the transcendent. Spiritual well-being is the result of complex interactions within a group of multifaceted systems that are individually adaptive. These perspective result in multiple points of equilibrium because “in order both to survive as a species and grow in complexity, humanity must adopt a new image of what it means to be human... We need, and can demonstrate, cooperation, altruism, and even spiritual empathy with the universe at large” (Hanlon, Carlisle, Hannah, Reilly, & Lyon, 2011, p. 34). These internal relationships create the connections for integrative wholeness, linking the interior world to the exterior environment. Spirituality motivates and illuminates pathways to this integrative wholeness and spiritual well-being aids the recovery process.

It should be emphasized that “[t]here seems to be consistent conceptual and empirical evidence that leisure is capable of renewing the human soul and providing a free space for exploring the self and human connection” (Bouwer, 2013, p. 289). Thus, leisure may be highly connected to religious and spiritual practices. Leisure is ‘a mental and spiritual attitude’, ‘an attitude of the mind’, and ‘a condition of the soul’. It is also ‘an attitude of non-activity’, ‘of inward calm, of silence’ and ‘means not being ‘busy’, but letting things happen’ (Pieper, 1952). Leisure may also be seen as a psychological experience and a pathway to attain peace with ourselves and our environment. It is primarily a ‘state of mind’ (Neulinger, 1974) and a ‘spiritual state

of mind' (Livengood, 2009) where organic joy is possible in the course of ordinary life (Dubos, 1974). In turn, leisure commitment is closely related to psychological attitudes of optimism, perceived control and social support. These positive outcomes suggest leisure practices be employed "as a focus for interventions to improve health and to prevent illness" (Cassidy, 2005, p. 65; e.g., Min, Lee, & Lee, 2013). Leisure may provide pathways to connect with oneself and others, to create and find meaning, and to discover God (Karlis, Grafanaki, & Abbas, 2002). Schmidt and Little (2007) described how leisure affords persons the opportunity to experience spirituality. Leisure is not a frivolous experience, but is associated with notions of both creativity and freedom (Kelly, 1987). Ultimately, leisure experiences are fundamental practices of openness, independence and restoration of the human soul, all important dimensions for the journey to recovery.

The therapeutic use of leisure provides religious and spiritual resources for managing the traumatic effects of disease and disability (Deschênes, 2011; Heintzman, 2008, 2009). Leisure facilitates the material conditions for a positive contemplative state of mind (Béal, 1992; Deschênes, 2007; Dufour, 1980; Ouellette, Snyder, & Carette, 2011; Tremblay, 1961/1965, 1976, 1983). In that sense, this religious and spiritual reality allow a new manner to be free in the social world by becoming aware about eternal life signs through leisure experiences as the time go by. "[L]eisure is a way of knowing God, knowing what he has made me to be, and knowing, in the silence which follows when competitiveness is shut out, the God who has given free time as a gracious gift" (Neville, 2004, p. 147). Spiritually informed, leisure produces an enriching human experience and benefits all aspects of life.

As Joblin (2009) declared:

Leisure...needs to be linked to spirituality so that it provides a holistic path that embraces not just a segment of time or activities but all of time and all of human activities....the spirituality of leisure can once again awaken and alert people to be attentive to an engaged and responsible pursuit of freedom so they are fully and joyously alive in their work, play, and worship. (pp. 117-118)

The ultimate goal of the health care system is to foster healing of the human being. From this viewpoint, "spirituality often gives a sense of well-being, improves quality of life, and provides social support" (Bouwer, 2013, p. 280). Instead of focusing on resources, the therapeutic practice of leisure is facilitated through personal resourcefulness which allows programs to become more inclusive and also to enhance the capabilities for creative activity of those who have limited opportunities (Kelly, 2012).

Leisure experiences offer opportunities to look for optimal challenges which actualize one's full potential physically, emotionally, socially, intellectually and spiritually (Henderson, Kanters, Levine, & Yoder, 2010). When persons are captivated by leisure experiences, they are then motivated to repeatedly return to the experience. If the challenges in a leisure experience requires complete attention for success; there is potential for the emergence of inner peace and joy. Such experiences positively support recovery and empowerment.

Recommendations and Future Directions

The therapeutic use of leisure combined with religious and spiritual practices can reduce psychiatric symptoms and help rebuild a new social identity for vulnerable persons with mental disorders. We need to continue building our knowledge about the role of leisure and spirituality in the journey to recovery. Recommendations for psychiatric services are as follows:

- Promote empirical research on the beneficial clinical effects of religion, spirituality and leisure experiences as a natural place for treatment for persons suffering from mental disorders;
- Sensitize and train professional therapists working within psychiatric services to be 'spiritually-informed' by creating a learning culture in order to enhance the quality of life of their patients;
- Develop consumer-centered services and 'spirituality matters groups' (SMG) within hospital settings for persons with severe schizophrenia and for those with mental disorders who wish to attend such psychotherapy groups;
- Organize therapeutic leisure experiences focused on conflict resolution and stress coping activities;
- Continue applying the "peer helping" program within the social work services and education certifications.

Conclusion

Leisure and spirituality play an important role in the journey to recovery. The significance of treating patients as whole persons is the cornerstone in building the alliance of trust between a patient and his/her physician and/or professional therapists. While the recovery process is sometimes ambiguous,

it is not a magical process. Therapeutic programs should facilitate psychological well-being for patients with serious mental disorders, by creating suitable circumstances for challenge, encouraging constructive behaviours to accomplish goals, and promoting an optimistic attitude. Integrating religious and spiritual practices with leisure experiences can have a positive effect upon coping, adapting to stress, reducing psychiatric symptoms, supporting the management of a patients daily routine and reducing/preventing hospitalization. Therapeutic leisure can result in social inclusion that enhances life quality and meaning. Therefore, these spiritual and leisure practices are important factors in rehabilitation and self-transformation as they create greater personal resiliency, while reducing prejudices and social stereotypes. Persons with mental disorders have the opportunity to discover meaningful pathways to spiritual well-being through leisure and deliberately walk the path toward recovery and healing.

Acknowledgement

Our thankfulness is extended to Dr. Sotiria Grafanaki and the reviewers for their editorial and wise contributions throughout the writing process of this project.

References

- Abdel-Baki A., Lesage A., Nicole L., Cosette M., Salvat E., & Lalonde P. (2011). Schizophrenia, an illness with bad outcome: Myth or reality? *Canadian Journal of Psychiatry/La Revue canadienne de psychiatrie*, 56(2), 92-101.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*. (5th ed.). Washington, DC/London, UK: American Psychiatric Publishing.
- Arai S. M., Berbary L. A., & Dupuis S. L. (2015). Dialogues for re-imagined praxis: Using theory in practice to transform structural, ideological, and discursive 'realities' with/in communities. *Leisure/Loisir*, 39(2), 299-321.
- Arciniegas D. B., Harris S. N., & Brousseau K. M. (2003). Psychosis following traumatic brain injury. *International Review of Psychiatry*, 15, 328-340.
- Arendt H. (1972). *La crise de la culture*. Paris : Gallimard.
- Association québécoise pour la réhabilitation sociale (2014). Pair aidant réseau. Retrieved from <<http://aqrp-sm.org/pairs-aidants-reseau/role-du-pair-aidant/>>.
- Balter M., & Katz R. (1992). *Nobody's child [Sing no sad song]*. Boston, MA: Balter Institute.

- Barber M. E. (2012). Recovery as the new medical model for psychiatry. *Psychiatric Services*, 63(3), 277-279.
- Béal F. (1992). *De nos loisirs au loisir éternel*. Paris-Fribourg : Saint-Paul.
- Beauregard M., & Paquette V. (2006). Neural correlates of mystical experience in Carmelite nuns. *Neuroscience Letters*, 405, 186-190.
- Bellamy C. D., Jarrett N. C., Mowbray O., MacFarlane P., Mowbray C. T., & Holter M. C. (2007). Relevance of spirituality for people with mental illness attending consumer-centered services. *Psychiatric Rehabilitation Journal*, 30(4), 287-294.
- Bernazzani, O., & Lacroix, B. (2014). *Santé mentale, santé spirituelle. Dialogue entre une psychiatre et un théologien*. Montréal, QC : Mediaspaul.
- Bouwer J. (2013). Leisure as moderator for spiritual well-being? In H. Westerink (Ed.), *Constructs of meaning and religious transformation: Current issues in the psychology of religion* (Vol. 4, pp. 275-295), Göttingen, Germany: V&R Unipress.
- Bradshaw M., Ellison C. G., & Flannelly K. J. (2008). Prayer, God imagery, and symptoms of psychopathology. *Journal for the Scientific Study of Religion*, 47(4), 644-659.
- Briscoe C. L., & Arai S. A. (2015). Relational reflective process as an act of compassionate pedagogy in therapeutic recreation. *Leisure/Loisir*, 39(2), 193-214.
- Burkhardt M. A. (1989). Spirituality: An analysis of the concept. *Holistic Nursing Practice*, 3, 69-77.
- Caldwell L. L. (2005). Leisure and health: Why is leisure therapeutic? *British Journal of Guidance & Counselling*, 33(1), 7-26.
- Carleton R. A., Esparza P., Thaxter P. J., & Grant K. E. (2008). Stress, religious coping resources and depressive symptoms in an urban adolescent sample. *Journal for the Scientific Study of Religion*, 47(1), 113-121.
- Carter M. J., & Van Andel G. E. (2011). *Therapeutic recreation: A practical approach*. (4th ed.). Long Grove, IL: Waveland.
- Cassidy T. (2005). Leisure, coping and health: The role of social, family, school and peer relationship factors. *British Journal of Guidance & Counselling*, 33(1), 51-66.
- Chally P. S., & Carlson J. M. (2004). Spirituality, rehabilitation and aging: A literature review. *Archives Physical Medicine Rehabilitation*, 85(3), 60-65.
- Chiu L., Emblen J. D., Van Hofwegen L., Sawatzky R., & Meyerhoff H. (2004). An integrative review of the concept of spirituality in the health sciences. *Western Journal of Nursing Research*, 26(4), 405-428.
- Corin E. (2002). Se rétablir après une crise psychotique : Ouvrir une voie ? Retrouver sa voix ? *Revue de Santé mentales au Québec*, 27(1), 65-82.
- Corin E. (2009). La texture du religieux dans la psychose. *Le Partenaire*, 18(2), 7-17.

- Corin E., Poirel M.-L., & Rodriguez L. (2011). *Le mouvement de l'être : Paramètres pour une approche alternative du traitement en santé mentale*. Québec, QC: Presses de l'Université du Québec.
- Corrigan P., McCorkle B., Schell B., & Kidder K. (2003). Religion and spirituality in the lives of people with serious mental illness. *Community Mental Health Journal*, 39(6), 487-499.
- Corrigan P. W., Powell K. J., & Rüsich N. (2012). How does stigma affect work in people with serious mental illnesses. *Psychiatric Rehabilitation Journal*, 35(5), 381-384.
- Cotter A. C., Spangenberg V., Mulford G., & Wilcox J. (2003). Prayer, meditation, and spirituality in rehabilitation. In S. F. Wainapel & A. Fast (Eds.), *Alternative medicine and rehabilitation: A guide for practitioners*, New-York, NY: Demos Medical, 185-196.
- Csikszentmihalyi M. (2004). *Vivre : la psychologie du bonheur*. Paris: Robert Laffont.
- Davidson R. J., Kabat-Zinn J., Schumacher J., Rosenkranz M., Muller D., Santorelli S. F., Urbanowski F., Harrington A., Bonus K., & Sheridan J. F. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*, 65(4), 564-570.
- Deegan P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychological Rehabilitation Journal*, 9(4), 11-19.
- Deegan P. E. (1995). Principles of recovery model including medications. Retrieved from <<http://www.power2u.org/downloads/MedicationMeetingPacket.pdf>>.
- Deegan P. E. (2007). Le rétablissement en tant que processus autogéré de guérison et de transformation. *Le partenaire*, 15(1), 13-18.
- Denny K., & Elgar F. (2013). Mental health: Population perspectives. *Canadian Journal of Community Mental Health*, 32(1), 1-3.
- Demers P. (2008). *Élever la conscience humaine par l'éducation*. Québec, QC : Presses de l'Université du Québec.
- Dhar N., Chaturvedi S., & Nandan D. (2011) Spiritual health scale 2011: Defining and measuring 4th dimension of health. *Indian Journal of Community Medicine*, 36(4), 275-282.
- Deschênes G. (2007). *Le loisir : Une quête de sens*. Québec, QC : Presses de l'Université Laval.
- Deschênes G. (2011). L'anthropologie spirituelle du loisir : L'homo faber-religiosus-ludens. *Counseling & Spiritualité/Counselling & Spirituality*, 30(2), 57-85.
- Drake R. E., & Whitley R. (2014). Recovery and severe mental illness: Description and analysis. *La revue canadienne de psychiatrie*, 59(5), 236-242.
- Dubos R. (1974). *Choisir d'être humain*. Paris : Denoël.
- Dufour R. (1980). *Mythologie du week-end*. Paris : Cerf.

- Dunn E. C., Wewioeski J., & Rogers E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatric Rehabilitation Journal*, 32(1), 59-62.
- Elkington S. (2010). Articulating a systematic phenomenology of flow: An experience-process perspective. *Leisure/Loisir*, 34(3), 327-360.
- Elkington S. (2011). What it is to take the *flow* of leisure *seriously*. *Leisure/Loisir*, 35(3), 253-282.
- Euvé F. (2000). *Penser la création comme jeu*. Paris : Cerf.
- Farb A. S., Segal Z. V., Mayberg H., Bean J., McKeon D., Fatima Z., & Anderson A. K. (2007). Attending to the present: Mindfulness meditation reveals distinct neural modes of self-reference. *Social Cognitive and Affective Neuroscience*, 2, 313-322.
- Fallot R. D. (2007). Spirituality and religion in recovery: Some current issues. *Psychiatric Rehabilitation Journal*, 30(4), 261-270.
- Flaherty M.-T. (2012). A medical model for today. *Psychiatric Services*, 63(5), 510.
- Folkman S. (1997). Positive psychological states and coping with severe stress. *Social Science Medicine*, 45(8), 1207-1221.
- Folkman S., & Greer S. (2000). Promoting psychological well-being in the face of serious illness: When theory, research and practice inform each other. *Psycho-Oncology*, 9, 9-19.
- Folkman S., & Moskowitz J. T. (2004). Coping: Pitfalls and promise. *Annual Review Psychology*, 55, 745-774.
- Frankl V. (2009). *Nos raisons de vivre : À l'école du sens de la vie*. Paris : Interéditions.
- Gall T. L., Charbonneau C., Clarke N. H., Grant K., Joseph A., & Shouldice L. (2005). Understanding the nature and role of spirituality in relation to coping and health: A conceptual framework. *Canadian Psychology/Psychologie canadienne*, 46(2), 88-104.
- Gallant K., Arai S., & Smale B. (2013). Celebrating, challenging and re-envisioning serious leisure. *Leisure/Loisir*, 37(2), 91-109.
- Genoe M. R. (2010). Leisure as resistance within the context of dementia. *Leisure Studies*, 29(3), 303-320.
- Genoe M. R., & Dupuis S. L. (2014). The role of leisure within the dementia context. *Dementia*, 13(1), 33-58.
- Genoe M. R., & Whyte C. (2015). Confronting ageism through therapeutic recreation practice. *Leisure/Loisir*, 39(2), 235-252.
- Gilman S. L. (2014). Madness as disability. *History of Psychiatry*, 25(4), 441-449.
- Grafanaki S., Pearson D., Cini F., Godula D., McKenzie B., Nason S., & Anderregg M. (2005). Sources of renewal: A qualitative study on the experience and role of leisure in the life of counsellors and psychologists. *Counselling Psychology Quarterly*, 18(1), 31-40.

- Hanlon P., Carlisle S., Hannah M., Reilly D., & Lyon A. (2011). Making the case for a 'fifth wave' in public health. *Public Health, 125*, 30-36.
- Harding C. M., & Zahniser J. H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavica.*, 384, 140-146.
- Haworth J., & Lewis S. (2005). Work, leisure and well-being. *British Journal of Guidance & Counselling, 33*(1), 67-79.
- Heintzman P. (2002). A conceptual model of leisure and spiritual well-being. *Journal of Park and Recreation Administration, 20*(4), 147-169.
- Heintzman P. (2008). Leisure-spiritual coping: A model for therapeutic recreation and leisure services. *Therapeutic Recreation Journal, 42*(1), 56-73.
- Heintzman P. (2009). The spiritual benefits of leisure. *Leisure/Loisir, 33*(1), 419-445.
- Henderson K., Kanters M. A., Levine L., & Yoder D. (2010). *Dimensions of leisure for life: Individuals and society*. Champaign, IL: Human Kinetics.
- Hill C. P., & 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, 1*, 3-17.
- Hölzel B. K., Carmody J., Vangel M., Congleton C., Yerramsetti S. M., Gard T., & Lazar S. W. (2011). Mindfulness practice leads to increases in regional brain gray matter density. *Psychiatry Research: Neuroimaging, 191*, 36-43.
- Huddleston T. (2012). A recovery mentor at work. *Psychiatric Rehabilitation Journal, 35*(4). 349-350.
- Hutchinson S. L., & Kleiber D. A. (2005). Gift of the ordinary: Casual leisure's contributions to health and well-being. *World Leisure Journal, 47*(3), 2-16.
- Iwasaki Y., Coyle P. C., & Shank J. W. (2010). Leisure as a context for active living, recovery, health and life quality for persons with mental illness in a global context. *Health Promotion International, 25*(4), 483-494.
- Iwasaki Y., Coyle P. C., & Shank J. W., Messina E., Porter H., & Salzer M., Baron D., Kishbauch G., & Naveiras-Cabello R., Mitchell L. Ryan A., & Koons G. (2014). Role of leisure in recovery from mental illness. *American Journal of Psychiatric Rehabilitation, 17*(2), 147-165.
- Iwasaki Y., Messina E., Shank J. W., & Coyle C. (2015). Role of leisure in meaning-making for community-dwelling adults with mental illness. *Journal of Leisure Research, 47*(5), 538-555.
- Jacobson N., & Greenley D. (2001). What is recovery? A conceptual model and application. *Psychiatric Services, 52*(4), 482-487.
- Jasper K. (1962). Réponse à la question : Quelles forces vous font vivre ? *Essais philosophiques*. Paris : Petite Bibliothèque Payot.
- Joblin D. (2009). Leisure and spirituality: An engaged and responsible pursuit of freedom in work, play and worship. *Leisure/Loisir, 33*(1), 95-120.

- Karlis G., Grafanaki S., & Abbas J. (2002). Leisure and spirituality: A theoretical model. *Loisir et Société/Leisure and Society*, 25(1), 205-214.
- Kehoe N. (1999). A therapy group on spiritual issues for patients with chronic mental illness. *Psychiatric Services*, 50(8), 1081-1083.
- Kehoe N. (2009). *Wrestling with our inner angels: Faith, mental illness and the journey to wholeness*. San Francisco, CA: Jossey-Bass.
- Kelly J. R. (1987). *Freedom to be: A new sociology of leisure*. New York, NY: Macmillan Publishing Company.
- Kelly J. R. (2012). *Leisure*. (4th ed.). Urbana-Champaign, IL: Sagamore.
- Kerr D. J. R., Crowe T. P., & Oades L. G. (2013). The reconstruction of narrative identity during mental health recovery: A complex adaptive systems perspective. *American Psychological Association*, 36(2), 108-109.
- Kleiber D. A., Hutchinson S. L., & Williams R. (2002). Leisure as a resource in transcending negative life events: Self-protection, self-restoration, and personal transformation. *Leisure Sciences*, 24(2), 219-235.
- Kleiber D. A., Reel H. A., & Hutchinson S. L. (2008). When distress gives way to possibility: The relevance of leisure in adjustment to disability. *NeuroRehabilitation*, 23, 321-328.
- Koenig H. G. (2004). Religion, spirituality, and medicine: Research findings and implications for clinical practice. *Southern Medical Association*, 97(12), 1194-1200.
- Lachance G. (2009). Expérience spirituelle et itinéraire de rétablissement : Les phases d'un processus de transformation de l'Être. *Le Partenaire*, 18(2), 26-32.
- Lacombe H. (2009). Spiritualité santé : Le dilemme de la médecine moderne. *Le partenaire*, 18(2), 4-5.
- Lauzon G., & Lecompte Y. (2002). Rétablissement et travail. *Santé mentale au Québec*. 27(1), 7-34.
- Lazar S. W., Kerr C. E., Wasserman R. H., Gray J. R., Greve D. N., Treadway M. T., McGarvey M., Quinn B. T., Dusek J. A., Benson H., Rauch S. L., Moore C. I., & Fischl B. (2005). Meditation experience is associated with increased cortical thickness. *Neuroreport*, 16(17), 1893-1897.
- Lazarus R. S., & Folkman S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.
- Levin J. S. (1996). How prayer heals: A theoretical model. *Alternative Therapies in Health and Medicine*, 2(1), 66-73.
- Livengood J. (2009). The role of leisure in the spirituality of new paradigm Christians. *Leisure/Loisir*, 33(1), 389-417.
- Lord J., & Hutchison P. (2007). *Pathways to inclusion: Building a new story with people and communities*. Concord, ON: Captus Press.
- Lyons K. J., & Lopez K. J. (2015). Re-imagining inclusive, existential approaches to spirituality in therapeutic recreation. *Leisure/Loisir*, 39(2), 215-234.

- McAll C., Awad J., Desgagnés J.-Y., Gagné J., Godrie B., Keays N., Plante M.-C., & Stoetzel N. (2012). *Au-delà du préjugé : Trajectoires de vie, pauvreté et santé*. Sainte-Foy, QC : Presses de l'Université du Québec.
- Magee W. L., & Bowen C. (2008). Using music in leisure to enhance social relationships with patients with complex disabilities. *NeuroRehabilitation*, 23, 305-311.
- Magee W. L., & Baker M. (2009). The use of music therapy in neuro-rehabilitation of people with acquired brain injury. *British Journal of Neuroscience Nursing*, 5(4), 150-156.
- Micale M. S. (2014). The ten most important changes in psychiatry since World War II. *History of Psychiatry*, 25(4), 485-491.
- Miller D. L. (1970). *Gods and games: Toward a theology of play*. Cleveland, OH: World.
- Miller L., Bansal R., Wickramaratne P., Hao X., Tenke C. E., Weissman M. M., & Peterson B. S. (2014). Neuroanatomical correlates of religiosity and spirituality: A study in adults at high and low familial risk for depression. *JAMA Psychiatry*, 71(2), 128-135.
- Min J.-A., Lee C.-U., & Lee C. (2013). Mental health promotion and illness prevention: A challenge for psychiatrists. *Psychiatry Investigation*, 10, 307-316.
- Moltmann J. (1977). *Le Seigneur de la danse*. Paris : Cerf-Mame.
- Morin E. (2004). *La méthode, 6 Éthique*. Paris : Seuil.
- Moxham L., Liersch-Sumskls S., Taylor E., Patterson C., & Brighton R. (2015). Preliminary outcomes of a pilot therapeutic recreation camp for people with a mental illness. *Therapeutic Recreation Journal*, 49(1), 61-75.
- Neale R. E. (1969). *In praise of play: Toward a psychology of religion*. New York, NY: Harper & Row.
- Neulinger J. (1974). *The psychology of leisure*. Springfield, IL: Charles C. Thomas.
- Neville G. (2004). *Free time: Toward a theology of leisure*. Birmingham, UK: The University of Birmingham.
- Nimrod G., Kleiber D. A., & Berdychevsky L. (2012). Leisure in coping with depression. *Journal of Leisure Research*, 44(4), 419-449.
- Ouellette P., Snyder P., & Carette R. (2011). L'application de la spiritualité bénédictine au loisir des personnes âgées : Un modèle théorique du bonheur spirituel. *Studies in Religion/Sciences Religieuses*, 40(1), 21-44.
- Pargament K. I., Smith B. W., Koenig H. G., & Perez L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for Scientific Study of Religion*, 37(4), 710-724.
- Pelletier L., & Cournoyer M. (2015). Quand l'art-thérapie et la spiritualité se conjuguent. *Counseling et Spiritualité/Counseling and Spirituality*, 34(1), 91-116.
- Peselow E., Pi S., Lopez E., Besada A., & Ishak W. W. (2014). The impact of spirituality before and after treatment of major depressive disorder. *Innovations in Clinical Neuroscience*, 11(3-4) 17-23.

- Phillips R. E., Lakin R., & Pargament K. I. (2002). Development and implementation of a spiritual issues psychoeducational group for those with serious mental illness. *Community Mental Health Journal*, 38(6), 487-495.
- Pieper J. (1952). *Leisure: The basis of culture*. New York, NY: Pantheon Books.
- Provencher H. L. (2002). L'expérience du rétablissement : Perspectives théoriques. *Santé mentale au Québec*, 27(1), 35-64.
- Provencher H. L. (2007). Le paradigme du rétablissement : Une expérience globale de santé. *Le partenaire*, 15(1), 4-12.
- Puchalski C. (2001). The role of spirituality in health care. *Baylor University Medical Center Proceedings*, 14(4), 352-357.
- Reed P. G. (1991). Preferences for spiritually related nursing interventions among terminally ill and nonterminally ill hospitalized adults and well adults. *Applied Nursing Research* 4, 122-128.
- Revheim N., & Greenberg W. M. (2007). Spirituality matters: Creating a time and place for hope. *Psychiatric Rehabilitation Journal*, 30(4), 307-310.
- Robi A., & Leclerc C. (1990). *Alys Robi, Un long cri dans la nuit: 5 années à l'asile*. Montréal, QC : Edimag.
- Ricoeur P. (2001a). Autonomie et vulnérabilité. *Le Juste* 2, (pp. 85-105). Paris : Esprit.
- Ricoeur P. (2001b). Les trois niveaux du jugement médical. *Le Juste* 2, (pp. 227-243). Paris : Esprit.
- Roe D., Rudnick A., & Gill K.-J. (2007). The concept of 'being in recovery'. *Psychiatric Rehabilitation Journal*, 30(3), 171-173.
- Ross L. (1994). Spiritual aspects of nursing. *Journal of Advanced Nursing*, 19, 439-447.
- Rossow-Kimball B., & Goodwin D. L. (2014). Inclusive leisure experiences of older adults with intellectual disabilities at a senior centre. *Leisure Studies*, 33(3), 322-338.
- Sechehaye M.-A. (1950/1970). *Journal d'une schizophrène : Auto-observation d'une schizophrène pendant le traitement psychothérapeutique*. Paris : Presses de l'Université de France.
- Short E. B., Kose S., Mu Q., Borckart J., Newberg A., George M. S., & Kozel A. (2010). Regional brain activation during meditation shows time and practice effects: An exploratory fMRI study. *Evidence-Based Complementary Alternative Medicine*, 7(1), 121-127.
- Schwarzbold, M., Diaz T. M., Tostes M. E., Rufino A., Amante L. N., Thais M. E., Quevedo J., Hohl A., Linnhares M. N., & Walz R. (2008). Psychiatric disorders and traumatic brain injury. *Neuropsychiatric Disease and Treatment*, 4(4), 797-816.
- Singh H., Shah A. A., Gupta V., Coverdale J., & Harris T. B. (2012). The efficacy of mental health outreach programs to religious settings: A systematic review. *American Journal of Psychiatric Rehabilitation*, 15(3), 290-298.

- Stebbins R. A. (1997). Casual leisure: A conceptual statement. *Leisure Studies*, 16(1), 17-25.
- Schmidt C., & Little D. E. (2007). Qualitative insights into leisure as spiritual experience. *Journal of Leisure Research*, 39(2), 222-247.
- Spykman G. (1994). Toward a Christian perspective in the leisure sciences. In P. Heintzman, G. E. Van Andel, & T. L. Visker (Eds.), *Christianity and leisure: Issues in a pluralistic society* (pp. 53-60). Sioux Center, IA: Dordt College.
- Strickler D. C. (2014). Rebirth through supported employment. *Psychiatric Rehabilitation Journal*, 37(2), 151-152.
- Stumbo N. J., Wang Y., & Pegg S. (2011). Issues of access: What matters to people with disabilities as they seek leisure experiences. *World Leisure Journal*, 53(2), 91-103.
- Szasz T. (1974). *The second sin*. New York, NY: Anchor/Doubleday.
- Tepper L., Rogers S. A., Coleman E. M., & Malony H. N. (2001). The prevalence of religious coping among persons with persistent mental illness. *Psychiatric Services*, 52(5), 660-665.
- Tremblay J.-P.-M. (1961/1965). *Loisir et Loisirs, tome 1 et 2*. Québec, QC : Ministère de la Jeunesse.
- Tremblay J.-P.-M. (1976). *Vienne le temps du loisir*. Montréal, QC/Paris : Paulines/Desport.
- Tremblay J.-P.-M. (1983). *Chrétiens autrement*. Montréal, QC : Bellarmin.
- Trenberth L. (2005). The role, nature and purpose of leisure and its contribution to individual development and well-being. *British Journal of Guidance & Counselling*, 33(1), 1-6.
- Waldron-Perrine B., Rapport L. J., Hanks R. A., Lumley M., Meachen S.-J., & Hubbarth P. (2011). Religion and spirituality in rehabilitation outcomes among individuals with traumatic brain injury. *Rehabilitation Psychology*, 56(2), 107-116.
- Warner G., Doble S. E., & Hutchinson S. L. (2012). Successful aging in transition: Contemplating new realities. *World Leisure Journal*, 54(3), 255-268.
- Weinberg C. M. (2013). Hope, meaning, and purpose: Making recovery possible. *Psychiatric Rehabilitation Journal*, 36(2), 124-125.
- Whitley R., & Henwood B. F. (2014). Life, liberty, and pursuit of happiness: Reframing inequities experienced by people with severe mental illness. *Psychiatric Rehabilitation Journal*, 37(1), 68-70.
- World Health Organization (2012). Making a difference in the lives of people with mental disorders. Retrieved from <http://www.who.int/mental_health_health_flyer_2012.pdf>.
- Xiong G. L., & Doraiswamy M. (2009). Does meditation enhance cognition and brain plasticity? *Annals of the New York Academy of Sciences*, 1172, 63-69.