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Review

Integration of Spirituality and Religion in the Care of Patients with Severe Mental Disorders

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Abstract: Spirituality and religiousness (S/R) are resources for finding meaning and hope in suffering and have been identified as key components in the process of psychological recovery. However, religion may also be associated with psycho-pathology, suffering and non-adherence with psychiatric treatment. Based on a literature review, this paper examines how S/R can be integrated in the treatment of patients with serious mental illness. We implemented a pilot "Spirituality and Recovery Group" designed to (1) help patients to resort to S/R as a means of recovery; (2) work on resolving conflicts between S/R and life issues and treatment; and (3) provide information on S/R in the context of psychosis. Preliminary results are presented.

Keywords: spirituality; religious coping; psychotherapy; psychiatry; psychosis

Abbreviations

S/R: Spirituality and Religion

1. Introduction

Over the last decade, the interest in spirituality in psychiatric care has dramatically increased. Indeed, numerous studies demonstrated correlations between mental illness states and levels of spirituality or religiosity. Those relationships are mainly positive, but not always [1]. According to patients and mental health and religious professionals, spirituality and religion (S/R) often play a key

role in the recovery process from serious mental illness. S/R may strengthen a sense of self and self-esteem, may involve coping responses that alleviate distress, may be connected to important sources of social and community support and may be the basic sense of hope. However, S/R sometimes hinder recovery by increasing psychopathology (anxiety, depression, delusion) or by rejecting people with mental health problems from religious communities. Patients would like their S/R to be assessed and taken into account in their care [2].

Psychological recovery indicates the development of a fulfilling life and a positive sense of identity founded on hopefulness and self-determination. It has recently been recognized as an organizing principle in the systems of care for people who manage mental illness [3]. In psychiatric services oriented toward the promotion of recovery, a person-centered diagnosis is a crucial step for identification of disorders and helps to provide a treatment according to individual needs and values. Such a diagnosis includes both illness aspects (clinical disorders, disabilities and risk factors) and positive health status domain (remission/recovery, functioning and preventive factors). In the diagnostic process, the personal narrative of illness (such as suffering, values and cultural experience of illness and care) and of health (such as quality of life, values and cultural formulation of identity and context) are central [4]. A specific contribution from cultural psychiatry resides in the examination of the interaction of illness explanatory models of patients and clinicians in a clinical setting. Explanatory models are beliefs about the nature, the name, the cause, the expected course and the desired treatment for an episode of illness. Explanatory models are influenced by culture, but vary largely among individuals of the same cultural background. Indeed, explanatory models are ways of organizing reality, influenced by context, shifting over time, and often including more than one model [5]. The western explanatory models of mental illness are not universal concepts of psychopathology. It is probable that in all cultures, you can find the belief that malign spiritual forces cause psychiatric illness. Such beliefs influence patterns of help-seeking and adherence to treatment. According to the availability and cost-effectiveness of spiritual treatments, up to 70 percent of the patients will use one or more spiritual treatment before seeking professional help [6]. Moreover, it makes it difficult to disentangle positive symptoms from spiritual experiences (e.g., hearing voices, visions, ecstatic states, trances), especially for people with schizophrenia. Some religious coping behavior may be misdiagnosed as being symptomatic of psychopathology [7,8].

Cultural contexts also influence the integration or the exclusion of S/R into psychiatric services. For example, in England, religion has been considered as consoling and therefore chaplains have been systematically included in the staff of psychiatric hospitals since 1890; whereas in France, over the same period of time, religion has been considered as harmful, encouraging delusions and hallucinations, and therefore excluded from psychiatric hospitals [6]. Today, with increased knowledge about S/R and mental illness, it is time to overcome this dichotomous vision of religion as harmful or helpful toward an understanding of the complexity of relationships between various aspects of S/R and mental illnesses. Such differences also introduce specificities of the integration of S/R into treatment according to various mental disorders and various struggles encountered by the patients.

There is no consensus about what spirituality is. Religion is easier to define, as it refers to a social group. Religion involves affiliation and identification with a religious group, cognitive factors-beliefs, and emotional and experiential factors [6]. A literature review of medical and psychological journals produced four models of spirituality: 1. A traditional-historical version of spirituality which defines a

subset of deeply religious people; 2. A modern version of spirituality which includes religion but expands beyond it. Spirituality is as a general feeling of closeness and connectedness to the sacred, *i.e.*, divine being or object or a sense of ultimate reality of truth. However, people may search for the sacred outside of an established religious tradition, being "spiritual but not religious"; 3. An expanded modern version of spirituality which includes also positive psychological states (purpose and meaning in life, connectedness with others, peacefulness, harmony and well-being) and 4. A modern clinical version of spirituality which also integrates secular concepts like hope, in order to include everyone [9]. In that sense, based on the sacred object, four types of spirituality were defined: religious spirituality (a sense of closeness and connection to the sacred as described by a specific religion (e.g., Judaism, Christianity, Islam, Buddhism) a particular "God or Higher Power"; humanistic spirituality (a sense of closeness and connection to humankind, often involving feelings of love, altruism, or reflection); nature spirituality (a sense of closeness and connection to the environment or to nature) and cosmos spirituality (a sense of closeness and connection with the whole creation) [10].

The integration of S/R into mental health care needs to be especially sensitive and respectful to the cultural context. The first step is a systematic inclusion of a S/R assessment into the diagnosis process. Due to the vagueness of the definition of spirituality, this assessment has to be a clinical interview with open questions and not a standardized questionnaire. In this review, we will first present how to conduct a S/R assessment and then various models of integration of S/R into therapies, with an extended focus on group treatments. We will then present preliminary results of our pilot "Spirituality and Recovery Group".

2. Spiritual Assessment

The importance of S/R is a phenomenon that is poorly acknowledged by clinicians [11]. The assessment of spiritual needs and by whom and how the patient wants those needs to be addressed is an essential part of care management [12,13]. In a study evaluating the concordance between a psychiatric rehabilitation program and patients' goals, 22% of patients set S/R goals for the ongoing year, yet they perceived offered services as insufficient toward those goals [14]. Once a patient expresses spiritual concerns and wishes to discuss them with the clinician, a more extensive assessment has to be conducted. Numerous scales have been developed to investigate S/R, as it is a multi-dimensional phenomenon [15]. Topics of special interest are those related to mental health states, like relationship with the transcendent, religious orientation and motivation, religious support and religious struggle [16]. For example, in order to assess S/R among outpatients with psychosis in Geneva, Switzerland, we developed a semi-structured interview. The open questions were based on the "Multidimensional measurement of religiousness/spirituality for use in health research", focused on behavioral, psychological, and social mechanisms of S/R, which may have an effect on physical and mental health [17], the "Religious coping index" [18], and a questionnaire on spiritual and religious adjustment to life events [19]. This assessment tool was adapted to a variety of spiritual beliefs (pathological or not), linked to different religious traditions (Judaism, Christianity, Islam, Buddhism and minority religious movements), various types of spiritual/religious coping [20]. This clinical interview consists of two parts: 1- A part about the religious and spiritual history (family background and religious education; as well as changes of spirituality and religiousness, especially in relationship

with mental illness); the current spiritual and religious beliefs and practices (private and collective); and the subjective importance of spirituality in daily life and to give meaning to life. 2- A part that concerns spiritual/religious coping; *i.e.*, the subjective importance of S/R in giving meaning to the illness, to cope with symptoms, to get comfort, coping style, support from the religious community; and the synergy between S/R and adherence to psychiatric care (medication and psychotherapy). The second part does not concern patients for whom S/R is absent or marginal. For them, secular sources of hope and meaning are asked. This S/R assessment was well accepted by patients and elicits major spiritual themes which may be integrated into care: support positive coping; work on identity and values; differentiate delusion from faith and work on this issue; mobilize the patient toward clergy, chaplains, or a religious community; work on negative religious coping; and work on representations of psychiatric disorder and treatment from a religious perspective [21].

Spiritual assessment leads to elicit spiritual needs and the type of S/R intervention needed. In some spiritual groups, patients pray together [22,23], some groups are led by both mental health and religious professionals [22,24], some secular therapies use Buddhist principles [25,26], others are religiously oriented [27,28]. S/R is a very sensitive area; the patient has to be informed of the above-mentioned S/R characteristics before any referral.

3. Models of Integration of Spirituality and Religion into Psychiatric Care

Integration of S/R into psychiatric care ranges from referral to chaplain, exploration of spirituality in individual and group psychotherapies, bringing in spiritual concepts and practices into psychotherapies, to holistic care programs.

Mental illness and its treatment present different kinds of theological challenges to different religious traditions, and then spiritual needs to be addressed specifically [29].When a patient expresses spiritual needs and wants them to be addressed by a religious professional, the integration of spirituality requires a collaboration with the chaplaincy service or other relevant religious people. Religious professionals are not mental health professionals. Their mission is to help their community's members to know God. However, mental health and religious professionals share the same commitment toward alleviation of patients' suffering, with mutual respect for the distinctive resources each partner brings to the helping process.

Individual psychotherapies may be more easily tailored to meet the special needs of patients than group therapies. In order to integrate spirituality into the treatment, therapists need to be open, sensitive and willing to learn about the role spirituality plays in the life of their patients. Each theoretical model of individual psychotherapy may integrate spirituality. In the domain of cognitive behavior therapies, this integration is documented in protocols of treatment. For example, the Christian accommodative cognitive behavior therapy for depression is adjusted for Christian patients. This therapy retains the main features of the existing secular theory yet places the therapy in a religious context. Techniques such as cognitive restructuring and guided imagery depends on Biblical teaching and religious imagery. The effectiveness of this treatment was demonstrated by several studies with outpatients, for both religious and nonreligious therapists. Indeed, therapists do not need to share the same religious background. Christian accommodative cognitive therapy also exists for other disorders, such as anxiety and eating disorders [28]. Under the same principles, cognitive behavior therapy is also

accommodated for other religious traditions: Islam, Buddhism and Taoism [28]. In Saudi-Arabia, a Muslim accommodative individual Cognitive Behavior Therapy was also designed to help Muslim in-patients with schizophrenia to cope with their auditory hallucinations [30]. The cognitive behavior therapy for depression has also been augmented by a focus on existential issues (hope, meaning, acceptance and forgiveness) for patients of various beliefs systems [31].

Holistic programs for severe mental illness integrate psychiatric treatment with a religious tradition as a whole person care setting. For example, the Windhorse Therapy is based on Buddhist principles and Western psychology to create individually tailored therapeutic living environments, in order to reduce the chaos and confusion of mental disturbance and improve life functioning [32]. Another example is a Christian psychiatric hospital in Switzerland which offers spiritual individual and group treatments based on the belief that mental illness always implies an existential or spiritual dimension. The individual spiritual treatment goals are elicited for each patient by a spiritual assessment. Spiritual treatments include a psycho-educational group focusing on coping with life and mental illness, a spiritual singing and music group, spiritual art therapy, spiritual counseling and psychotherapy, pastoral care and patient libraries [33].

Psychiatric services, predominantly in the USA, attempt to integrate spirituality into group therapies. Group psychotherapies provide unique treatment resources for severe mental disorders. Indeed, sharing their experiences with other patients reduces isolation and offers invaluable social support that also facilitates recovery. Therefore, we will now focus on models of integration of spirituality into psychotherapy groups for severe mental illness.

4. Models of Integration of Spirituality into Psychotherapy Groups for Severe Mental Illness

In the domain of substance use disorders, there is a long tradition of including spirituality into treatment. The dependence on a substance includes craving and impaired control over substance-related behavior. Those aspects are the target of both Buddhist and theistic spiritualities, with some commonalities (compassion to self and others) and differences (development of meditation to deal with craving and dependence on substance *vs.* dependence on God). The twelve-step program Facilitation for Alcoholism, created in 1935, has been well studied and demonstrated its efficacy in numerous clinical trials [28]. This inter-faith program encouraged clients to view alcoholism as a spiritual and medical disease. Its goals are to foster acceptance of the disease of alcoholism, develop a commitment to attend Alcoholics Anonymous, and begin working through the 12 steps. According to the original founders, those steps include that the persons admit their lack of power over alcohol; believe in a greater Power that could restore their sanity; make the decision to turn their lives over the care of God as the persons understand Him; make a moral inventory; admit to God, to themselves and other their wrongs; be ready to let God remove their defects of character and shortcomings; list all persons they had harmed and make amendments to them; continue to make a personal inventory and admit when they are wrong; through prayer and meditation improve contact with God and His will and then carry this spiritual awakening to alcoholics and practice these principles in all their life domains. This program has largely been accommodated all over the world to other substance dependencies, as well as to specific monotheistic faiths (Judaism, Christianity and Islam) [34].

The spiritual self-schema (3-S) therapy, a spirituality focused cognitive-behavioral psychotherapy for the treatment of addiction disorders, integrates Buddhist psychological principles and practices [26]. Addiction is the result of over-learned maladaptive behavioral sequences that supplant almost all others, which frequently result in harm to self and others. In 3-S_ therapy, those behaviors are referred to as the *addict self*. The goal is therefore to help drug users to make a shift from the habitual activation of the maladaptive and potentially destructive addict self-schema to a self-schema that fosters mindfulness, compassion, and doing no harm to self and others, *i.e.*, the spiritual self-schema. This therapy does not impose or endorse Buddhism as an alternative religion, but rather, tailors the therapy to each patient's own S/R in defining the *spiritual self-schema*. Throughout the 12-session group therapy, patients practice mindfulness meditation and work systematically to develop the 10 traditional Buddhist qualities (generosity, morality, renunciation, wisdom, effort, tolerance, truth, strong determination, loving kindness, equanimity)—and four additional spiritual qualities (gratitude, courage, forgiveness, and serenity). With a great majority of Christian patients, this program demonstrates its efficacy for reduction of impulsiveness and drug intake, as well as an increase of spiritual and religious practices.

Another example is a theistic spirituality group for women hospitalized in a center for severe eating disorders [27]. The foundations of theistic psychotherapy are grounded in the worldview of the major theistic world religions, including Judaism, Christianity, and Islam. The core assumptions of this approach are that God exists, that human beings are the creations of God, and that there are unseen spiritual processes by which the link between God and humanity is maintained. It assumes that patients who have faith in God's healing power and draw upon the spiritual resources in their lives during psychological treatment will receive added strength to cope, heal, and grow. In that perspective, several of the core struggles in eating disorders have a spiritual nature. Almost all women with eating disorders have lost touch with their sense of spiritual identity and worth. They often feel unworthy, unlovable, and incapable. They may also struggle with negative images of God, fear of abandonment by God, guilt and shame. The major goal is to help women with eating disorders to affirm their spiritual identity and worth as creations of God. The thematic of the open group sessions concern faith in God, spiritual identity, grace, forgiveness, repentance and overcoming adversity.

For severe mental illness, especially psychotic disorders, spiritual groups in US psychiatric services emerged only several decades after spiritual groups for addiction. Indeed, even now, the prevalence of hallucinations and delusions with religious contents bias mental health professionals toward a reduction of S/R in psychopathology of patients with schizophrenia [35]. The groups reviewed are presented in Table 1.

The Nancy Kehoe's pioneering work initiated in 1980 had to wait almost 20 years to be published [24,36]. She is a nun and a psychologist, underlining that individuals are more than their mental illness. With a member of staff, she has leads an open group of discussion on spiritual issues for out and in patients with chronic mental illness for 25 years. The group offers a place where patients have the opportunity to explore ways in which their beliefs and practices help or hinder them in coping with mental illness. Membership is voluntary. The group is open to all, regardless of diagnosis or religious background. Patients have to accept the group rules of tolerance of diversity, respect and a ban on proselytizing. About a third of patients choose to participate in the weekly group (Christians, Muslims, Buddhists, Jews, and atheists). The average duration of participation is of two to three years. The

group fosters tolerance, acceptance of other's views, self-awareness, and thoughtful examination of belief systems, opportunities to apply spirituality and values to life questions. At first, the idea of having such a group generated anxiety, fear, and doubt among staff members. However, staff training and the long-term success of the group foster staff acceptance. Indeed, more than a hundred patients have attended the group without exacerbation of delusions and promotion of recovery. No empirical outcome data is available.

Table 1. Spiritual Groups for severe mental disorders.

Program	**Researchers**	**Patients**	**Therapists**	**Setting**	**Content**	**Ingroup spiritual practices**
Spiritual Beliefs and Values Group	Kehoe (1999, 2007)	Out patients with severe mental disorders	A nun and a mental health professionnal	Weekly open ongoing group	Discussion on beliefs and values	None
Spirituality Group	Wong – McDonald (2007)	Out patients with severe mental disorders	Two mental health professionals	Weekly open ongoing group	Discussion on spirituality and recovery	None
Spirituality Matters Group	Revheim and Grenberg (2007, 2010)	Inpatients with schizophrenia	A chaplain, a psychologist and a mental health prof.	Weekly open ongoing group	Structured group focus on recovery	Prayer and spiritual stories
The Spirituality Group Meetings	Galanter, Dermatis, *et al*. (2011)	In and out patients with severe mental disorders	A psychiatrist and a mental health prof.	Weekly open ongoing group	Semi-structured focus on coping with the illness	None
Spiritual Issues Psychoeducational Group	Phillips, Lakin *et al*. (2002)	Out patients with severe mental disorders	Two clinical psychologists	7-sessions	psycho-educational group	Prayer
Spiritual Coping Module	Weisman de Mamani, Tuchman, Duarte (2010)	Relatives of people with schizophrenia	Two cognitive-behavior therapists	3-sessions	psycho-educational group	None

In a psychosocial rehabilitation program of a community mental health center, patients choose each week to participate in the "Spirituality Group" or in a skill-training group [37]. Lead by two mental health professionals, this open group is aimed at enhancing the recovery process, defined as personal goal attainment. Each session focuses on one topic of interest determined periodically with participants. Spiritual interventions include discussing spiritual concepts, encouraging forgiveness, referring to spiritual writings, listening to spiritual music, encouraging spiritual and emotional support among the Spiritual Group members. The general purpose of the interventions were to: help participants to understand their problems from a spiritual perspective; gain a greater sense of hope; emotionally forgive and heal from past pain; accept responsibility for their own actions; experience and affirm their sense of identity and self-worth; encourage to connect with their faith communities for social and spiritual support. About half of the patients participate regularly in the group, essentially

Christians. All of the 20 participants reached their personal goals, in comparison to 57% of a group (n = 16) who did not participate. Indeed, when persons in recovery begin to conceptualize various aspects of life within a spiritual context, they often find a new orientation to the world and a new motivation and direction for living.

In a state-hospital inpatient unit, the "Spirituality Matters Group" is proposed for patients with schizophrenia [22,38]. This weekly group is open and lead by three professionals representing psychology, pastoral care and rehabilitation. The group lasts for several years, self-referred patients are from various religious backgrounds (Christianity, Islam, Judaism, other religions or without religion) and commit to attendance throughout their whole hospital stay (from 3 to 7 months). The group is recovery-focused on the use of spiritual beliefs for coping with one's illness and hospitalization, exploring nondenominational religious and spiritual themes designed to facilitate comfort and hope, while addressing prominent therapeutic concerns. The format of the group is highly structured in order to accommodate for cognitive deficits and limited social skills prevalent in persons with persistent psychiatric disabilities. Each session begins with members' presentation, reminder of objectives (using spiritual beliefs to cope with daily stressors and for support with behavioral changes) and the multi-religious and nondenominational nature of the group with a definition of spirituality (personal beliefs and values related to the meaning and purpose of life, which may include faith in a higher purpose or power). To foster respect and communication, a ritual of reading the covenant written by group members is instituted. Then, one leader, on a rotating basis, introduces a specific theme (e.g., loneliness, hope, forgiveness, patience), group members are encouraged to share how the topic has relevance to their own perception of illness, previous behavior patterns and treatments failures and future goals. When a situation cannot be changed, emotion-focused coping is attempted. One leader is familiar with the individual treatment plans, to insure integration with other clinical programming for goal attainment. The discussion is followed by pre-planned group activity relating to the topic (e.g., reading Psalms, spiritual stories from a variety of faith perspectives, narratives of spiritual struggle, reading and writing prayers). The group ends by a summary and a prayer for peace. The duration of the experience of leading this group and the satisfaction of patients suggest its therapeutic value. A cross-sectional comparison of 20 self-attendees to the spiritual group *versus* 20 non-attendees shows that attendees are more hopeful and report more positive religious and spiritual coping with their symptoms and disabilities [22].

The seven-session semi-structured "Spiritual Issues Psychoeducational Group" is designed for outpatients with severe mental illness, treated in a community health center [23]. The goals are to provide new information about spirituality to participants; to allow them to share experience and knowledge to present spiritual topics such as spiritual strivings, spiritual struggles and hope. Ten patients with severe mental disorders (schizophrenia, depression and personality disorders) participated and were satisfied. Before that, patients were interviewed to determine the fitness of the indication, and to accept the rules of respecting others' spiritual beliefs, not proselytizing, and not engaging in spiritual activities. All were religious Christians of various denominations, members of a religious community. The group was led by two clinical psychologists. Every session was organized in a psychoeducational format in which information on specific topics were presented, followed by a discussion on the issue. The themes of the session were (1) interactions between spirituality and mental illness; (2) personal and community spiritual resources; (3) the exploration of ways to create and achieve meaningful and

realistic goals related to their spiritual journey; (4) the expression of spiritual struggles with God and with Church, and active coping by a visualization of a Spiritual Being taking away their struggle; (5) forgiveness; (6) the exploration of spiritual strategies to keep hope alive (e.g., hymns, reading the Bible, trusting that God has a greater purpose, supporting each other) and suggestion of the serenity prayer; (7) review of the topics and feed-back.

For the relatives of the patients with schizophrenia, a three-session Spiritual Coping module has been added to a psycho-education program [39]. It is aimed at helping the family members of any religious backgrounds to tap into their spiritual or existential beliefs in functional ways. The group is led by cognitive behavior therapists. Handouts are used to facilitate the discussion. First, families explore their beliefs or disbeliefs about God, their community religious supports, their notions of morality, and meaning or purpose in life. Then the concepts of forgiveness, empathy, appreciation and peace are discussed. Lastly, family members are encouraged to engage in spiritual practices that are considered as meaningful and therapeutic for them.

Those experiences appear to be promising according to clinicians [23,36,39], as well as outcome measurements [22,37], and need to be implemented on a larger scale. Therefore, training of future psychiatrists and mental health professionals on S/R is necessary. In a teaching hospital, education about spirituality includes the animation of "The Spirituality Group Meetings", beginning with a teacher of the Spirituality Center Faculty, and subsequently with another mental health staff member [40]. The spiritual group is implemented in psychiatric units, as well as ambulatory centers for addiction, with 117 self-referred patients with severe mental disorders (65% psychosis, 21% affective disorders and/or 35%.substance use disorders). The open group is semi-structured aiming to encourage patients to discuss their own experience of spirituality and how it relates to their coping with illness. This is done by addressing one spiritual topic (importance of spirituality in daily life, S/R coping, S/R community, the role of spirituality in recovery, forgiveness, gratitude, and altruism) by brief information, followed by open questions and a reflecting period.

Some therapies integrate practices rooted in religious traditions, without integration of the spirituality of those traditions. For example, dialectical behavior therapy (DBT) combines acceptance and change through the principle of dialectical progress, with the use of standard cognitive-behavioral techniques for emotion regulation and reality-testing, as well as mindfulness and meditative exercises derived from Buddhism to treat borderline personality disorders. Those practices do not involve any religious concepts. They aimed to foster the capacity to pay attention, non-judgmentally, to the present moment; about living in the moment, experiencing one's emotions and senses fully, yet with perspective. DBT involved both individual and group therapy. The individual component focused on harmful behaviors to self or others, therapy-interfering behaviors and improvement of overall quality of life. In a group context, participants learn to use mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, and distress tolerance skills. DBT has been experimentally demonstrated to be generally effective in treating borderline personality disorders [41,42]. DBT appears to be effective also for post-traumatic stress disorder [43] and substance abuse [44]. The Buddhist meditation practice of mindfulness is also used as a therapeutic tool to cognitive-behavior therapies for psychotic disorders. It is even one of the six key components of the Acceptance and Commitment Therapy [45]. In order to alleviate the distress of positive psychotic symptoms, mindfulness was offered as an alternative response to complement existing coping strategies in a six-

session group format [46]. The Buddhist practice of loving-kindness meditation is used in the same way to cope with the negative symptoms of schizophrenia [25]. Those authors developed a six-session group therapy with a secularized version of the loving-kindness meditation practice to cultivate and focus attention on kindness toward self and others. The group is led by a psychotherapist with extensive meditation experience. An outcome evaluation of 16 outpatients showed an increase of positive emotions, self-acceptance, satisfaction with life and decrease of anhedonia. No information was available about the religious affiliations. This kind of use of religious practices is not considered as spiritual by their authors. However, it may be a challenge to use it with orthodox religious theist patients and need cultural sensitivity [47].

5. The Pilot "Spirituality and Recovery Group" in a Public Ambulatory Psychiatric Unit in Geneva, Switzerland

The integration of S/R in psychiatric care needs to be sensitive to the cultural context. The public psychiatric outpatients' facilities offer long-term treatment, primarily for patients with a diagnosis of schizophrenia, bipolar disorder, severe depressive disorder, or personality disorder. The multidisciplinary teams are composed of a first-line psychiatrist, who can be assisted by nurses, social workers, and psychologists, if necessary. Patients receive psychotherapy, somatic treatments, and rehabilitation as needed. Several psychotherapeutic groups are offered for patients with a specific focus on delusions, hallucinations, social skills, self-affirmation, and self-esteem. A chaplain service is offered for inpatients. Chaplains are not employed by the psychiatric service, but by their churches. They cannot therefore be involved as co-leader in spiritual groups, like some US spiritual groups [22,24]. Geneva, Switzerland, is an international and multicultural city, in our secular psychiatric service, 60% of outpatients with schizophrenia are Christians [48]. In such a context, there is no place for spiritual and accommodative group therapies linked with a religious tradition for religious patients. Some US interfaith spiritual groups introduce spiritual practices in their setting [22,23]. Based on recovery principles, we prefer to work on establishing bridges with chaplains and religious communities, rather than to annex spiritual practices. Indeed, on one hand each religious tradition has its unique specificity [29] and, on the other hand, people with severe mental disorders suffer too often from social isolation.

Given the clinical significance of S/R for patients with schizophrenia (*i.e.*, the salience of positive and negative spiritual/religious coping and its associations with psychopathology, psychosocial functioning, substance use, suicidal attempts, adherence to psychiatric treatment [20,49-51]; the reciprocal influences of the illness and the spiritual journey [52,53]; and the role of spirituality in recovery [20,35], we planned a pilot spiritual group for those patients.

The goals of this eight-session semi-structured group are to (1) foster leaning on spirituality to cope with the illness and to recover; (2) address potential deleterious aspects of spirituality; and (3) support social integration of patients in their religious communities. This inter-faith group has specific rules of respecting other people's spiritual beliefs, not proselytizing, not engaging in spiritual activities. These rules aimed to create a respectful climate of sharing between the participants.

Patients were referred by their psychiatrist for an assessment to determine whether their needs and expectations were an indication for the group. All participants considered spirituality of great

importance. They were from various religious traditions (Christians of diverse denominations, Muslims, Jews), yet seldom involved in a religious community. Their main objectives were predominantly to (1) decrease feelings of loneliness through sharing spirituality with others; and (2) clarify the confusing overlap between psychotic symptoms and spirituality. The group was led by two clinical psychologists who shared briefly their own religion and spirituality at the first session dedicated to personal spiritual history. The minimal therapists' disclosure was chosen according to our experience in conducting spiritual assessment of people with schizophrenia. Indeed, half of these patients asked the interviewer about his/her spirituality and religion, a brief answer fostered trust. Some leaders of spiritual groups took the same stance [22,23,36], while others gave no information. In each session, a topic was presented, followed by a discussion on the issue. The themes of the session were (1) the variety of spiritual beliefs and religious practices; (2) how spirituality and religion may help to alleviate or increase symptoms of the illness; (3) how to disentangle spiritual experience from psychotic experience; (4) how to conciliate spiritual meaning of the illness and psychiatric care; (5) other people's influence in spiritual journey and relationships with religious community members and religious professionals; (6) the interrelations between spiritual history and mental illness; (7) spirituality and recovery; (8) review of the topics and feed-back.

We conducted this spiritual group three times. All of the participants regularly attended the group except for one patient who dropped out after the first session because he was too suspicious to share this topic in a group format. The procedure of indication for the group, as well as agreement to group rules may explain this assiduity. Another factor was the intense nature of the group discussion with deep exchanges among all participants which included existential issues about the meaning of life and death, suffering, self-identity and relationships with God and other spiritual figures, as well as theological questioning. Each participant was acknowledged and sustained in his/her coping resources and knowledge. The group program consisted of seven sessions. In the first session, each member defined the meaning of S/R and conveyed the subject of representations of God or other spiritual figures as well as the relationship of the individual with those figures. This theme was then included in the two next spiritual groups. In the second session, topics as spiritual and religious coping were discussed and members exchanged views about changing coping strategies according to their symptoms levels. In their period of deepest suffering, they may feel abandoned by God, feel persecuted by demons, be in a great confusion, unable to discern psychotic from spirituality experience, or find in God or another spiritual figure the unique lasting comforting relationship. In the third session, the aim was to disentangle psychotic experience from spirituality. Interestingly, exchanges alleviated the intense loneliness felt by patients. Indeed, patients avoided talking about this topic with their psychiatrist, fearing increase of medication or imposed hospitalization, as well as with religious professionals, fearing stigma and rejection. Such thematic elicit deep emotions of fear, anger, guilt and shame. The fourth session aimed to explore spiritual meaning of the illness, the thematic of good and evil, sin and guilt. The discussion led to contemplate benevolent spiritual reappraisal. The fifth session was dedicated to the influence of other people on their spiritual journey. Some participants had experienced rejection and stigmatization by mental health professionals and/or religious professionals. However, those exclusions may also be due to lack of communication skills. It is noteworthy that some patients acknowledged the key role of religious professionals in helping them deal with suffering. The sixth session was planned to be dedicated to changes in religion/spirituality

over life, particularly in the context of one's psychiatric disorder which is a thematic already discussed in the earlier sessions. We expanded a tool designed to measure suffering by a pictorial representation of the self and the illness [54] in including S/R. Patients had to place the illness and S/R with regards to their self on a blank sheet representing their whole life. Representations were discussed in the group, increasing awareness of the interactions between the self, S/R and the illness. Then, in order to promote the recovery process, patients had to imagine where illness and S/R would be if they recovered. This introduced the seventh session dedicated to spirituality and recovery. The concept of psychological recovery and the key process (hope, sense of self, meaning of life, responsibility, and personal objectives) are discussed. We invited a patient for whom spirituality and religious involvement played a central role in his life and who recovered despite persistent delusions and hallucinations. His testimony instilled hope for the participants. During the seven sessions, theological questions emerged; hence we invited a theologian and psychologist to respond to these queries. This approach valued patients' questioning and fostered their curiosity to search how those issues are considered in their own religions. The group ended by an overview of the fulfillment of patients' goals and a feed-back about the group experience. Even though their goals were attained, patients wished the group to go on in order to elaborate addressed topics, as well as to discuss new ones, for example, sexuality and spirituality, theodicy, forgiveness. They appreciated the practical exercise of pictorial representation and they wished to have more written materials to sustain discussions. The group was well accepted by participants; they valued the freedom of expression, trust and confidentiality. Furthermore, they expressed a wish to have such a group during the turbulent episodes of hospitalizations. They especially appreciated guest interventions. The Spiritual and Recovery group was not at all aimed to replace the absence of involvement in a religious community, but rather to sustain mobilization toward the participants' religious communities. It was a time of reflection, development and exchange of the members' spiritual journeys. The personal appraisals of the group led some patients to adopt specific intervention according to their needs, *i.e.*, self-affirmation training group, reference to chaplain, cognitive group therapy for delusions, cognitive group therapy for hallucinations, individual psychotherapy, *etc.*

6. Discussion

This review on integration of S/R into psychiatric care of people with severe mental disorders, especially psychosis, shows promising results. However it also underlines obstacles and limitations that need to be addressed.

None of these spiritual groups appeared to induce worsening of psychotic symptoms, even with patients presenting delusions and hallucinations with religious contents, as commonly feared by mental health professionals. This fear is often an obstacle to the integration of S/R in psychiatric services. To overcome the reluctance of mental health professionals, training, including the experience of co-animation of spiritual groups, proves its efficiency [24,40]. The well-known under investment in S/R by mental health professionals is not an obstacle for this training, while non-religious therapists perform as well as religious therapists [28], and they usually bring strong values of compassion and openness into care, interested in training on spiritual assessment [11,21]. In that context, training and research on clinical outcomes of spiritual groups are crucially needed. Such research has to show its

efficacy (*i.e.*, the treatment works in more than one psychiatric service), its specificity (*i.e.*, the treatment works better than an alternative treatment for a particular disorder), its ability to produce clinically significant changes maintained over time, and its matching to patients characteristics [28]. No empirical research on the spiritual groups reviewed for severe mental illnesses met these criteria. All participants were voluntary in attending spiritual groups. Randomization would seem rather unethical for such researches, but it may be replaced by a waiting list protocol.

Most of the spiritual groups are open; participants can attend for several months or even up to several years [22,24,37,40]. Our eight-session spiritual group experience, points out the need for an ongoing group for patients with severe mental illness. Indeed, such a brief intervention initiates exchanges that patients wish to pursue, stimulates unexpected new topics to address; and only slightly touches the process of recovery. In order to improve the spiritual group, giving time to patients to explore and elaborate on spirituality and recovery is needed, as it deals with the whole person's identity, not only coping with symptoms. People recovered from severe mental illness underline that recovery involves the whole-person and place spirituality as the core of identity. Such a process needs time, effort, and the experience of loving relationships [55].

An ongoing spiritual group also leaves the opportunity to adapt the major spiritual approaches used to other mental disorders, similar to how long lasting experiences in spirituality and substance misuse was disseminated to severe mental disorders [40]. For example, in our spiritual group, some patients bring distressful representations of God (e.g., an over-demanding God, a punishing God, a terrifying, an abandoning God). A 14-session Spirituality Group, lead by a clinical psychologist and a chaplain, focused on this thematic in a psychiatric hospital unit for patients with borderline personality disorder. This group provides an opportunity to explore and discuss each other's representation of God, thus potentially facilitating modifications toward a more integrated and benevolent image [56]. About half of the people with severe mental illness experience childhood trauma [57]. Some spiritual groups target the specificity of abuse and trauma-related disorders, for example the inter-faith eight-session spiritually integrated intervention for female survivors of sexual abuse [58], and the interfaith eight-session spirituality group for veterans [59]. Trauma survivors have to deal with the evil acts, as a witness, a victim and/or a perpetrator. Evil may be seen as belonging to the nature of human beings, to the Divine, or as a singular entity (a demon, the Devil, Satan, *etc.*) [60]. Spiritually integrated interventions could help trauma survivors to more effectively use their spiritual practices and beliefs to make new meaning of the traumatic experience and thus foster recovery. Manualized spiritually integrated psychotherapies with specific targets (*i.e.*, severe medical illness, divorce, social anxiety, transgressions by others, *etc*.) [61] may be precious sources of inspiration to address the various problems encountered by people with severe mental illness.

Another adaptation lies in providing material that takes into account cognitive limitations often encountered in severe mental disorders.

7. **Conclusions**

Integrating spirituality into the care of people with severe mental disorders has to consider the cultural context of the psychiatric service, the characteristics of S/R of each patient as well as pathological specificities. Spiritual group therapies do not increase psychopathology and seem to

address patients' spiritual needs and foster recovery. However, wider implementations and clinical research are needed.

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