

## BRIEF REPORT

### **Spirituality Matters: Creating a Time and Place for Hope**



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*Individuals with serious psychiatric disabilities may become demoralized or hopeless consequent to longstanding disability and stigma. Potential antidotes are social support from the religious community and use of personal spiritual resources as coping mechanisms. The “Spirituality Matters Group” offers comfort and hope through structured and innovative exercises focusing on spiritual beliefs and coping. Activities facilitate verbal expression and appropriate social interaction, and build a sense of community. Activities and themes from selected group sessions are discussed within a recovery-oriented “emotion-focused coping” framework.*

**Keywords:** *schizophrenia, spirituality, coping, group treatment*

Addressing spiritual themes in therapeutic groups is an emerging modality that can promote spiritual and social support and improve coping resources for health-related issues (Lindgren & Coursey, 1995). Groups that focus on spiritual issues for persons with serious psychiatric disabilities have been shown to foster tolerance, self-awareness and nonpathogenic therapeutic exploration of value systems, and not increase delusional ideation or resistance to treatment (Kehoe, 1999). Religious beliefs and activities, such as prayer, worship, meditation, and reading scriptures, have also been found beneficial for symptom management and stress reduction, reducing symptom severity and hospitalizations (Tepper, Rogers, Coleman, & Malony, 2001).

We describe the structure and process of the Spirituality Matters Group (SMG), developed for hospitalized persons with persistent psychiatric disabilities, following the rationale that spiritual support fosters the recovery process. SMG is distinct from comparable groups (Philips, Lakin & Pargament, 2002) in its multidisciplinary leadership focusing on integrating spiritual/religious, psychological and rehabilitative perspectives over an extended treatment period.

#### **Structured Group Treatment Approach Addresses Spirituality**

SMG was established (2001) on the Clinical Research Evaluation Facility (CREF) of the Nathan Kline Institute for Psychiatric Research, a 24-bed state-hospital inpatient unit for persons in

clinical trials for refractory symptoms associated with schizophrenia. Staff were oriented to literature addressing spirituality groups and serious mental illness; their concerns about potential deleterious effects (e.g., increased psychopathology) were discussed in the context of the common occurrence of staff resistance encountered by proponents of this treatment format (Kehoe, 1999). SMG's purpose was described as strength-based, offering individuals personal choice, respect and peer support, corresponding to accepted core principles for mental health recovery ([www.samhsa.gov/news/newsreleases/060215\\_consumer.htm](http://www.samhsa.gov/news/newsreleases/060215_consumer.htm)).

SMG is composed of self-referred persons who join three group co-leaders (representing psychology, pastoral care and rehabilitation) in exploring nondenominational religious and spiritual themes designed to facilitate comfort and hope, while addressing prominent therapeutic concerns. The group leaders agree "spirituality" suggests transcendence over specific religious practices, underlining the group's non-denominational and inclusive nature, and supporting the perspective that spirituality and religiousness are both overlapping and distinguishable (Miller & Thoresen, 2003). CREF patients are told this group "focuses on the use of spiritual beliefs for coping with one's illness and hospitalization"; individuals with religious delusions rarely attended SMG sessions.

The 1-hour weekly SMG has had continuous enrollment over the last 5 years. Attendance ranges from 6 to 8 members, with participants making a commitment to the group for the duration of their CREF stay, typically 12 to 40

sessions. Group membership demographics during an evaluation period in SMG's second year included ( $n=20$ ): age 35 years, education 11 years, first hospitalization age 21 and current inpatient stay 255 days. Seventy-nine percent were male; 33% black, 42% white, 12% Hispanic; 72% diagnosed with schizophrenia, 28% schizoaffective disorder; 80% had past substance abuse and 5% a history of pathological religious ideation. Religious diversity prevailed, participants identified themselves as: Protestant 25%, Catholic 35%, Jewish 2.5%, Muslim 2.5%, Other 10%, Multiple 5% and None 20%.

The highly-structured group format accommodates cognitive deficits and limited social skills, prevalent in persons with persistent psychiatric disabilities. We employ a large-format pad and easel for note-taking during discussions, written handouts, large-print reading materials, frequent emphasis on paraphrasing content and eliciting participation from all members with encouragement, coaching and modeling. Co-leaders share personal experiences with discretion; reducing hierarchical therapist-patient distance.

During each session's *initial phase*, members are introduced, group's purpose reviewed, and seasoned group members orient newcomers on how the group can be used (e.g., using spiritual beliefs to cope with daily stressors and for support with behavioral change). The multi-religious and nondenominational nature of the group is affirmed. Spirituality is defined as "personal beliefs and values related to the meaning and purpose of life, which may include faith in a higher purpose or power." A covenant (written by group members)<sup>1</sup> is read to create ritual, cultivate re-

spect and establish an emotional tone. General group principles are adhered to, and the group structure allows for respectful limit-setting for members who are overly active or disruptive due to psychosis or destabilized mood. In the *middle phase*, a topic with a related group activity or exercise is introduced, with warm-up questions for personal sharing and reflection, followed by distribution of handouts, readings or other materials that are read aloud. Topics are selected by respective leaders on a rotating basis and carefully prepared so that both negative and positive emotions are addressed. For example, individual members' guilt, anxiety, intolerance or cognitive distortions resulting from previous religious/spiritual experiences are explored. Group members are encouraged to share how the topic has relevance to their perception of their illness, previous behavior patterns and treatment failures (e.g., medication non-adherence, re-hospitalization) and future goals (e.g., appropriate discharge planning, commitment to treatment recommendations). At least one group leader is familiar with the individual treatment plans, and offers such input into the group process when appropriate to insure integration with other clinical programming for goal attainment. In the *ending phase*, group members summarize the session's emergent themes and new learning that influences goals and future choices, followed by a formal closing with a prayer composed by group members (e.g., "CREF Prayer for Peace").<sup>2</sup> Topics for subsequent groups emerge from each week's discussion, which fosters continuity, repetition, and readiness for self-disclosure.

<sup>1</sup> "We seek to explore the healing power of our spiritual experiences. We promise to share our ideas with kindness and respect for one another. We agree to be open to one another's spiritual journeys."

<sup>2</sup> "Give me light and insight so that I may trust. Let me learn the way of peace so that I may grow....May those who find themselves off track, be guided. May those who are afraid, find comfort. And may we all find patience on our path."

### Structured Exercises Promote Using Spiritual Beliefs for Coping

Group activities and exercises highlight using spirituality as a coping mechanism during recovery. Selections from traditional and contemporary resources related to spirituality are chosen; and a curriculum developed appropriate for the group's characteristics. The principal group activities are reading Psalms (consistent with most participants having Judeo-Christian identification), reading prayers, writing prayers, and telling stories from a variety of faith perspectives.

*Readings from The Book of Psalms* (Weintraub, 1999/5760) evoke the full range of human emotions from thanksgiving and praise to anger, fear, desperation, despair, abandonment, hope and protection. Reading selected Psalms as a group, followed by personal sharing, emphasize the universal phenomena of experiencing conflicts and struggles in daily life, while focusing on elements of faith that maintain strength and perseverance during these difficulties.

*Reciting prayers* together that are familiar and common ("St. Francis Prayer") or those specific for personal needs (e.g. "prayers to start the day") reinforce individuals' extant religious/spiritual practices. Using congregated prayers with individuals with limited social discourse can enhance social support through focusing on a shared goal.

*Writing original prayers* helps improve self-awareness of one's needs and allows articulation of one's experiences in a setting that brings comfort and a

sense of closure. The use of templates or prayer formats (praise, thanksgiving, intercession) assist individuals in this creative and empowering experience.

*Reading spiritual stories, fables, allegories and personal narratives of others* allows group members to identify personal needs and values, and through identification, offers opportunities to express difficult emotions.

### Emotion-Focused Coping

Reviewing activity plans and group notes identified themes consistent with an "emotion-focused coping" model (Folkman et al., 1991). Emotion-focused coping includes cognitive reframing, social comparisons, minimization ("looking on the bright side of things"), and behavioral efforts to feel better (exercise, relaxation, meditation, support, religion, humor, talking). Emotion-focused coping is useful when a situation cannot be changed, and only the emotional response can be changed, which can be self-affirming and empowering. This coping style is congruent with both recovery and SMG goals, and can co-exist with problem-focused approaches.

### Examples of Session Content

Many group sessions focus on readings that portray a sense of abandonment, anger and disappointment in one's spiritual life, relevant to the alienation that hospitalized individuals can feel. The story "Footprints," describing a person who walks along a beach and feels alone at difficult times is used to posit the questions: "When have you felt lonely and abandoned? What support do you have or want?"

How can you give support?" These issues can also be elicited using Psalms that convey anguish ("Hear my prayer—do not hide your face from me in the day of my distress"). Discussion of painful emotions can lead to exploration of alternatives for coping, contrasting negative behaviors with positive emotional outlets. During such groups, participants have recognized the need to give up temptations or turn away from negative actions (smoking, drugs, alcohol, medication noncompliance). They can make the connection between deep emptiness (loneliness, isolation, confusion, boredom) and negative coping; and how they can use their spiritual strength to seek forgiveness, build social support and accept help. An example of an outcome from such a discussion is a prayer that expresses a need to accept medication.<sup>3</sup>

When addressing issues of patience and fortitude, readings that portray frustration, disillusionment, as well as solace and comfort are used to discuss the ongoing struggle of coping with illness. Poems that portray perseverance (D.L. Manning's "One Step Higher") reinforce constructive actions and hope. Members begin to see they can choose to focus on inner spiritual strength when the problem cannot be readily fixed or controlled. A group response to the struggles of persisting during recovery in spite of stigma was an adaptation of the poem "Anyway."<sup>4</sup> These affirming words allow individuals to shift perspective, from victimization to resilience in the face of obstacles, a recurrent theme for individuals using faith and spiritual strength during difficult life passages.<sup>5</sup>

<sup>3</sup> "Oh Lord, your medication has brought me a sense of peace....I am unable to cope with this illness myself....I ask for acceptance and continued renewal and strength."

<sup>4</sup> "People may be indifferent to your needs, treat them with kindness anyway; sometimes people will put you down and treat you like a child, express yourself anyway; in the face of much adversity and against all odds, believe in yourself anyway."

<sup>5</sup> "When I am turned away, help me to find the courage to stay on the path and to find my life's true journey...when I find myself living in difficult situations, help me to be brave and have the courage to keep on keepin' on and to accept my difficulties ...when I feel that people label me, give me the strength to peel it off!"

## Discussion

SMG format is congruent with recent studies on the healing aspects of spirituality and its integration into standard therapeutic practices. Examples above support the view that group activities using spiritual themes allow individuals with persistent psychiatric disabilities to explore positive emotion-focused coping. We plan future studies of psychological variables to examine characteristics of individuals who choose to attend SMG, to shed light on potential treatment mechanisms and outcome.

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## ACKNOWLEDGMENTS

WE THANK VERA HILL, COTA AND CHAPLAIN ARIEL VERDESI FOR CO-LEADERSHIP OF SMG; LESLIE CITROME, M.D. AND HENRY EPSTEIN, MSW FOR ADMINISTRATIVE SUPPORT, AND ACKNOWLEDGE THE INSPIRATION OF REV. AMY MANIERRE AND DR. GLEN MILSTEIN, CHAMPIONS OF SPIRITUALITY GROUPS IN PSYCHIATRIC SETTINGS.

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