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Integrating Spirituality Into Cognitive Behavioral Therapy in an Acute Psychiatric Setting: A Pilot Study

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Results from national studies in the United States suggest that spiritually integrated psychotherapy may be desired by and beneficial for a specific subset of patients. However, protocols to facilitate these aims within the context of evidence-based psychosocial treatments are few, and, consequently, the availability of spiritually integrated cognitive behavioral therapy (CBT) is limited. This article describes the development and implementation of a brief (50-minute), stand-alone Spirituality & CBT group piloted in an acute psychiatric setting. This novel treatment includes (a) psychoeducation about the relevance of spirituality to psychiatric symptoms, (b) the integration of spiritual beliefs into cognitive restructuring, and (c) the use of spiritual exercises in behavioral activation and self-care. We further report results from a brief survey of 45 patients regarding the perceived relevance of spirituality to symptoms and treatment and their subjective experiences in the group.

Keywords: spirituality; religion; culturally-sensitive treatment; diversity

National studies in the United States consistently highlight that spiritual beliefs and practices are part of daily life for most Americans (e.g., Gallup Poll, 2011; The Pew Forum on Religion & Public Life, 2008). Further, a rich body of empirical literature now ties spirituality and religion to psychological health in the general population. In one large-scale meta-analysis, 80% of 850 studies demonstrated a positive relationship between religious beliefs and practices and greater life satisfaction, and nearly two thirds of studies reported lower rates of anxiety and depression among more spiritual individuals (Koenig, McCullough, & Larson, 2001). Consistent evidence also indicates that spirituality and religion are vital resources for many individuals in times of psychological distress (Pargament, 1997). Consequently, it is not surprising that many medical and psychiatric patients report a desire for spiritually integrated care (Knox, Caitlin, Casper, & Schlosser, 2005; Lindgren & Coursey, 1995; Puchalski, Larson, & Lu, 2001).

In light of these findings, numerous spiritually integrated psychosocial treatments have been developed in recent years (Pargament, 2007). Spiritually integrated treatments are similar

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to conventional psychotherapy except the rationale for treatment can be presented in a spiritual framework, and patients are encouraged to harness spiritual resources and address spiritual concerns with the hope of ameliorating symptoms and enhancing motivation and treatment compliance. Numerous attempts to integrate spirituality into cognitive behavioral therapy (CBT) and rational emotive behavioral therapy have been met with success (see Rosmarin, Pargament, & Robb, 2010 for a discussion). In terms of treatment efficacy, although research on spiritually integrated treatments is still emerging, nearly 40 clinical trials have now been conducted and initial findings seem promising. Several prominent, randomized controlled studies have now demonstrated that spiritually based treatments can be effective for various symptoms, particularly for religious patients (e.g., Oman, Hedberg, & Thoresen, 2006; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010; Wachholtz & Pargament, 2009). Moreover, some research has indicated that spiritually integrated treatments might be marginally more effective than established secular therapies (Hook et al., 2009). For example, one recent meta-analysis (Smith, Bartz, & Richards, 2007) found that interventions with spiritual components produced a .51 greater reduction in symptoms than those without, across 16 experimental and quasi-experimental studies. Although the early state of literature and major methodological limitations in many previous studies make it difficult to speak conclusively about the comparative efficacy of spiritually integrated to secular treatments, more research and development in this area seems warranted.

Despite these developments, competency in addressing patient spirituality in clinical practice is still hindered by several formidable challenges (Aten & Worthington, 2009; Pargament, Murray-Swank, & Tarakeshwar, 2005). Because of potential tensions, many patients see psychotherapy as a secular enterprise and fear raising spiritual and religious issues in the course of treatment (Richards & Bergin, 2000). Furthermore, most practitioners are not explicitly spiritual in their practice and have no formal experience on how to assess for or address patient spirituality. A lack of graduate training is also a significant barrier because few American Psychological Association (APA)-approved academic programs and internship sites provide any coursework or practical training in this area (Schulte, Skinner, & Claiborn, 2002). Furthermore, the integration of spirituality into treatment in acute settings is a rarity because most existing work in this area has focused on outpatients, and replicable treatment protocols that have been implemented and evaluated are few in number.

Given the scant resources for spiritually integrated treatment in acute patient settings, we developed and piloted a brief, stand-alone Spirituality & CBT group in McLean Hospital's Behavioral Health Partial Program (BHPP). In this article, we provide background information of the setting for this project and describe the development and content of the Spirituality & CBT group. Further, we report descriptive results from a brief survey of 45 patients pertaining to the relevance of spirituality to treatment and their subjective experiences in this treatment. We conclude with recommendations for implementation of spiritually integrated CBT in other settings as well as directions for further study.

The Setting

McLean Hospital is a private, nonprofit psychiatric hospital located in Belmont, Massachusetts, a few miles west of Boston. McLean's BHPP offers comprehensive evidence-based treatment to patients presenting with symptoms across all major diagnostic categories (principally mood, anxiety, personality, and psychotic disorders). Treatment presents a complex array of challenges including acute symptom severity, high rates of comorbidity, and exceedingly short treatment durations (average length of stay is 7.2 days). As well, with more than 60 admissions and discharges each month and more than 800 per year, the BHPP patient population is constantly influx.

Despite these obstacles, the BHPP plays an integral part in McLean Hospital's mental health service because it provides an opportunity for patients with severe psychopathology to receive intensive care focused on the acquisition of cognitive behavioral skills and a comprehensive treatment plan following their discharge.

The BHPP uses a flexible approach to treatment that is informed by CBT principles and current evidence garnered from outpatient centers; however, it is adapted to the unique challenges faced in a naturalistic partial hospital setting (Neuhaus, 2006). To provide a structure for the delivery of skill-based treatment, the BHPP provides more than 100, 50-minute psychotherapy groups per week, of which individual patients attend approximately five per day. Groups provide a framework for basic CBT techniques including thought records, identification of cognitive distortions, cognitive restructuring, behavioral scheduling, chain analysis, and mindfulness. Specific treatment plans are tailored by clinical team managers who conduct initial intake assessments and oversee all aspects of treatment, including supervision of individual skills therapists, coordination of psychopharmacological consultations, and determination of appropriate therapy groups for patients to attend. Research conducted at the BHPP has indicated treatment efficacy regarding mood, anxiety, and personality disorders (Christopher, Jacob, Neuhaus, Neary, & Fiola, 2009; Neuhaus, Christopher, Jacob, Guillaumot, & Burns, 2007), and recent case reports with psychotic patients have been encouraging (Kuller & Björgvinsson, 2010).

Treatment Development

Development of a protocol for our Spirituality & CBT group commenced with consultation with known leaders in the field of spiritually integrated psychotherapy to identify pertinent literature to serve as a model for this endeavor. Despite the burgeoning empirical basis to integrate spirituality into CBT, we found a lack of available protocols germane to partial or inpatient settings. Such was the motivation for designing the present protocol.

Treatment development thus proceeded by identifying three principal areas to focus on in the brief intervention: (a) an introduction, including disclaimers and psychoeducation about the relevance of spirituality to patient symptoms; (b) the integration of spiritual beliefs and ideas into cognitive strategies; and (c) the integration of spiritual practices into behavioral strategies. We designed didactic, interactive, and experiential components mapping on these areas and developed an initial draft of the treatment protocol. Great care was taken to provide an open forum for broaching the subject of patient spirituality while conveying respect for diversity. Subsequently, extensive feedback was solicited from 40 or so mental health professionals, including the BHPP staff. The protocol and accompanying were then revised accordingly until consensus was reached among the study authors.

Selection of Patients

Recognizing that the integration of spirituality into CBT may not be desired by all patients and that participation in our group should be voluntary, the authors strategized with clinical team managers to determine an appropriate process for selecting patients to participate in the Spirituality & CBT group. In light of previous research, suggesting that spiritually integrated treatments may be helpful for nonreligious as well as religious individuals (Worthington, Kurusu, McCullough, & Sandage, 1996), criteria for inclusion is based on patients' interest in spiritually integrated treatments, not personal levels of spirituality or religion. Consequently, patients are screened by asking if they wished to attend a group involving "the integration of spirituality into treatment." Additionally, because our group builds on basic CBT skills and some background knowledge is required, clinical team managers are discouraged from including the group in patients' schedules

during the 2 days of treatment within our partial hospital program, barring patients' previous experience with CBT. Thus, patients are familiar with basic CBT principles, terminology, and practices prior to attending the group. Alternative groups are provided targeting CBT skill acquisition for individuals who do not attend the Spirituality & CBT group for whatever reason.

It should also be noted that some BHPP staff members raised concerns that inclusion of spirituality into treatment may be contraindicated for psychotic patients. This issue is beyond the scope of this article. However, it is worth mentioning that this concern was addressed by reviewing the available literature on this subject, which suggests that such fears are largely unfounded in the absence of active spiritual or religious symptoms, such as delusions or hallucinations with explicit spiritual/religious themes (see Weisman de Mamani, Tuchman, & Duarte, 2010 for a discussion). Further, this matter was discussed with the clinical director of McLean Hospital's Schizophrenia and Bipolar Disorder Program[1] who stated that the specific treatment being piloted posed low risk and added that integrating spirituality may be helpful for some psychotic patients. Nevertheless, clinical team managers did exclude patients, some of whom presented with psychotic symptoms, if the group was deemed to be a poor fit within an overall treatment plan for any reason.

Treatment Protocol

Timeline of Group

In the following section, we describe our treatment protocol. It should be noted, however, that depending on the number of patients present, the 50-minute time slot for this treatment group is often insufficient to cover, discuss, and practice the entirety of the protocol material. In such situations, priority is always given to the introductory segment to provide an overview of an evidence-based framework for integrating spirituality into treatment. Subsequently, group leaders poll patients to gauge their interest in learning about cognitive versus behavioral strategies and proceed to cover as much of the preferred material as possible. Additionally, patients who voice a particular interest in the subject matter have the option to follow up with their clinical team manager, individual skills therapist, and group leaders, and provisions are made to answer questions and review additional material as appropriate. Further, such patients may be given the option to participate in the group during subsequent weeks, barring discharge before this time.

Introduction: Disclaimers and Psychoeducation

The introductory segment of the group, which spans 12–15 minutes in total, sets a professional, inquisitive, and open tone to the integration of spirituality into treatment. At the commencement of the group, patients are welcomed and given the opportunity to introduce themselves by name (2–3 minutes). Patients are then informed that the purpose of the group is to identify spiritual resources that they may wish to integrate into their overall cognitive behavioral treatment plan. The group leaders state explicitly that the purpose of this group is *not* to convert anyone to any given faith or bring about an increase in spiritual activity but simply to explore the relevance of spiritual beliefs and practices to symptoms and how to incorporate these into treatment. Patients are also reminded that respect for different faiths, belief systems, and cultures is paramount because the group occurs in a diverse setting.

Subsequently, we engage patients in a discussion about how spirituality may be relevant to their own symptoms (5–6 minutes). During this discussion, each patient is encouraged to share his or her personal experiences, but patients are directed to comment specifically on how their own spirituality has or has not related to their symptoms. Almost invariably, patients identify several themes: (a) the use of spiritual resources as a protective factor against symptoms, including

coping with distress; (b) spiritual struggles that are associated with an exacerbation of symptoms; (c) behavioral and cognitive distancing from faith when symptoms worsen; and (d) symptoms that have specific spiritual themes.

Following this discussion, patients are provided with an overview of the current research on spirituality and psychiatric symptoms (5–6 minutes). Empirical findings are presented in layperson terms without reference to statistical terminology or jargon. Mapping onto patients' experiences, three areas of the literature are highlighted. First, it is underscored that many studies have found that general spiritual/religious practice is associated with lower levels of depression, anxiety, stress, anger, and risk-taking behaviors. Research suggesting that spirituality can be helpful in coping with life crises is also reviewed and discussed. Potential mechanisms by which spiritual resources can reduce the burden of mental health symptoms are explored (e.g., by increasing hope, gratitude, and other positive emotions). Second, patients are provided with an overview of three different types of spiritual struggles (Pargament, Murray-Swank, Magyar, & Ano, 2005): (a) interpersonal struggles that occur in a spiritual context, such as altercations or disagreements with clergy or congregation members; (b) intrapersonal struggles, involving fundamental spiritual/religious doubts or existential crises; and (c) divine spiritual struggles, such as a sense of mistrust in or anger toward God. Connections between all forms of spiritual struggle and physical/mental health and illness are discussed, and specific examples from current literature are provided where appropriate. The relevance of spiritual struggles to psychosocial factors such as a loss of community support, feelings of estrangement or alienation, and increased psychiatric symptoms is also mentioned. Finally, patients are provided with clinical examples in which spiritual and/or religious themes co-opt symptoms, such as religious grandiosity in the context of psychosis, and scrupulosity in obsessive–compulsive disorder. These examples are principally framed as culture-bound symptoms, not spirituality. They are further contrasted and compared with the use of spiritual coping, and the potential for overlap between these areas is discussed when relevant to individual patients in the group.

Integration of Spirituality Into Cognitive Strategies

The next segment of the group comprises a 15- to 20-minute module focused on identifying concrete ways to integrate spirituality into *cognitive* strategies. First, patients are provided with a handout entitled "Spiritual Beliefs and Reframes" (see Figure 1), which was created by group leaders. Thirty statements are presented across six main categories, which encompass various spiritual convictions and notions. Statements were informed by a diverse array of spiritual and religious traditions; however, in order to serve a range of patients, care was taken to avoid specifically religious language (e.g., God). As such, most phrases are implicitly spiritual (e.g., "Struggle makes us stronger"), although some are more explicit (e.g., "Even when danger is imminent, I may remain hopeful by trusting in my faith"). It is recognized, however, that leaving out the religious nature of spirituality can also serve to ignore that neglect human diversity. Furthermore, most spiritual individuals in the United States have a religious framework for their spiritual experiences and expressions, and it is common for patients to refer to religious idioms, concepts, and terms in the ensuing discussion about the handout (described subsequently). Thus, group leaders are careful to echo the extent to which patients' interpretations are religious whenever this occurs.

Prior to distribution of the handout, patients are informed that the list is not intended to be a comprehensive set of spiritual affirmations. It is further stated clearly that patients should not expect to personally concur or agree with all of the statements listed. Rather, the intention of providing this resource is to help patients identify *some* spiritual notions that may have personal meaning and can be used in the course of treatment. After the handout is distributed, patients are encouraged to read through the list while gauging their emotional responses to each statement. They are further encouraged to identify at least one statement that they find personally

1. We are never alone.
   - No matter how bad it gets, I am never alone.
   - Faith has no boundaries.
   - Wherever I am, my faith remains with me.
   - I am not the first person to ever go through this and I won't be the last.
   - My faith is always close by, even when I feel distant.
2. Nothing is impossible.
   - The truth is that I don't *really* know what will happen in the end.
   - Miracles *can* and *do* happen.
   - Even when danger is imminent, I may remain hopeful by trusting in my faith.
   - Help can come as swiftly as the blink of an eye.
   - Just as something can be taken away, so too can it be given back.
3. Life is a test.
   - Struggle makes us stronger.
   - The harder it gets, the greater opportunity I have to grow.
   - Faith can be demonstrated best in difficult situations.
   - This is just a test, and it will be over soon.
   - Suffering cannot completely take away my freedom of choice.
4. We can only control the process, not the outcome.
   - Success means trying my best, nothing more and nothing less.
   - It is not a failure if I truly do the best I can do.
   - My difficulties may not go away, but I can learn to handle them better.
   - My task is not to solve my problem—just to get through it without making it worse.
   - Life changes from day to day, but I can improve from moment to moment.
5. Everything happens for a reason.
   - There is meaning, I just have to search for it.
   - The universe is not out to get me.
   - Everything is for the best.
   - My difficulties are a gift; they are an opportunity for my faith to grow.
   - Even when life is difficult, it never ceases to have meaning.
6. Nothing is permanent.
   - There are good days and then there are bad days.
   - The only sure thing in life is that it's not going to last forever.
   - This too shall pass.
   - My problems cannot and will not last forever.
   - I have persevered through worse situations in the past.

Figure 1. Spiritual Beliefs and Reframes.

meaningful and comforting. After a few minutes, patients are engaged in an open discussion about how the statement/concept they have chosen may be helpful in reducing their symptoms. This typically results in a lively and engaging discussion. It should be noted that virtually, all patients are able to identify at least three to four meaningful statements but those who cannot are encouraged to augment one or more phrases from their provided list. If time permits, patients are also encouraged to identify at least one statement that lacks personal meaning or perhaps triggers increased distress, and their respective emotional responses are also explored in this regard.

Subsequently, the group leaders illustrate pragmatically how to use patients' spiritual statements in the context of cognitive strategies. Group leaders provide a brief review of two cognitive strategies: (a) cognitive restructuring involving the completion of thought records (i.e., identifying situations that precede a shift in mood and recording one's thoughts, emotions, and behaviors; recognizing cognitive distortions; and generating alternative ways of thinking) and (b) coping statements involving reviewing comforting declarations out loud and repeatedly during times of intense distress. It should be noted that most patients are familiar with these strategies from other groups attended at the BHPP, and so a concise description of these practices is typically sufficient. Regarding cognitive restructuring, it is common for patients in our program to report difficulty engendering alternative cognitions without therapist assistance. Patients are thus encouraged to use their chosen spiritual statements as a starting point when engaging in cognitive restructuring. This strategy is typically very well received. The relationship of spiritual statements to core beliefs is also explored where appropriate. Group leaders take care to punctuate the conversation with concrete examples, such as how to use the statement "Faith can be demonstrated best in difficult situations" as a reframe for individuals facing a specific crisis. Regarding coping statements, patients are encouraged to write down one or two spiritually salient sentences on an index card so it may be carried on their person and reviewed at will. Patients are encouraged to repeat this statement to cope with intense negative emotions as a strategy to reduce impulsive behavior such as self-harm, violence, or substance use.

Integration of Spirituality Into Behavioral Strategies

The final 15–20 minutes of the group focuses on the integration of spirituality into *behavioral* strategies. The group leaders first provide an overview of how spirituality may be relevant to self-care and behavioral activation. Regarding self-care, patients are typically familiar with the importance of medication compliance, engaging in regular physical exercise, eating a well-balanced diet, and sleep hygiene from their experience in other groups in the BHPP. Briefly reviewing these elements, we highlight that self-care can protect against symptoms in times of distress. We add that regular spiritual practice may also be an important part of many people's self-care regimen, and we state that many people report increased symptoms of aloneness, depression, and anxiety as they move further away from their spirituality. We further highlight that particularly in times of stress, it can be important to attend to both physical and spiritual self-care, such as regular spiritual practice. To this end, we provide patients with a chart to monitor their engagement with spiritual practices (see Figure 2). We suggest that patients try to practice in at least one spiritual behavioral strategy (described subsequently), as well as monitoring of their engagement and symptoms on a daily basis for at least 2 weeks because this will yield invaluable information regarding the relevance of spirituality to their treatment. We further highlight that the benefits of spirituality often come from consistent practice, despite fluctuations in mood.

Regarding behavioral activation, again it should be noted that BHPP patients attend multiple groups on this topic and are generally familiar with its overarching principles (e.g., action precedes motivation) and practices (e.g., behavioral scheduling). This enables group leaders to engage patients in a focused discussion of how specific spiritual exercises can be used to shift one's mood away from depressive and anxious states. Nevertheless, a brief overview is provided. Specifically, group leaders state that it is important to increase one's activity level and decrease avoidance behavior (e.g., staying in bed, procrastination) to facilitate engagement in rewarding activities and experience improved mood. More importantly, group leaders highlight that value-driven activities as well as those that are imbued with personal meaning and significance are particularly important to include in one's behavioral schedule.

Try to practice these exercises throughout your day, especially during times when you are feeling distressed. This may be difficult at first. However, if you miss a day, do not give up. Using these techniques can help you to build spirituality in your daily life.

Day	*Exercise #1: Prayer*					*Exercise #2: Counting Your Blessings*	*Exercise #3: Remembering Miracles*	*Exercise #4: Study*
	Thanks	*Praise*	*Conversation*	*Request*	*Silent*			
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

Figure 2. Spirituality exercises chart.

The remainder of the group offers pragmatic strategies to include spiritual activity into patients' lives to manage symptoms. Specifically, we (a) describe five types of prayer, (b) lead patients through two spirituality exercises (i.e., "counting your blessings" and "remembering miracles"), and (c) discuss spiritual study as an additional resource. Each of these is described next.

Prayer. We begin by stating that prayer can be an engaging and dynamic exercise to shift one's mood. We then state that there are many forms of prayer, and we add that prayer can also be spontaneous and free as well as structured or formal (e.g., part of religious liturgy). We then describe and provide examples of five different types of prayer: (a) thanks (e.g., giving verbal thanks for food, one's senses, or upon waking in the morning), (b) praise (e.g., uttering words to express awe and/or appreciation when faced with wonders in nature), (c) conversation (e.g., expressing one's emotions to one's faith entity), (d) petition/request (e.g., asking for assistance in times of need), and (e) contemplation/silence (e.g., mindfulness-based meditation, engaging in the *here and now* to break a ruminative cycle, silent thought about the divine). Specific examples of each form of prayer are provided to elucidate that prayer can serve as a diverse set of strategies.

We then engage patients in a discussion about the advantages and disadvantages of each form of prayer from the vantage of treatment. For example, it is often noted that thanks and praise can be very powerful ways of connecting to one's spirituality because they can lead to positive spiritual emotions such as gratitude, awe, and inspiration. However, efforts to voice thanks or praise may be difficult during challenging periods of life, and they may further seem disingenuous or empty at times. In such instances, it may be more fruitful to resort to conversational prayer, which allows one to connect with one's spirituality and simultaneously give voice to suffering, or petition/request that may be helpful in instilling hope. Regarding silence and contemplation, we highlight that this may be more suitable for individuals with nontheistic belief systems or for individuals experiencing acute or severe emotional distress. We further state that silent prayer can be a precursor to other forms of spiritual engagement. Time permitting, we invite patients to describe their personal experiences with prayer and how they understand the connection between prayer and their symptoms. In summary, we encourage patients to use various forms of prayer on an experimental basis for a time in order to gauge their utility as symptom management strategies. We further encourage patients to monitor their use of prayer alongside their symptoms and to share the data obtained with their treatment team.

Spirituality Exercises. Inspired by evidence from both experimental and treatment outcome research suggesting that regular use of brief spirituality practices can provide robust reductions in depressive and anxious symptoms even over a brief period of 2–6 weeks (e.g., McCullough, Emmons, & Tsang, 2002; Propst, 1980; Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010), we incorporated two spirituality exercises into the treatment group. We introduce these exercises to patients by stating that we would like to conduct an in vivo experiment to explore how engaging in two brief spiritual activities may impact emotions. We ask patients to try to remain aware of their emotions as they complete each exercise in order to inform a group discussion (described subsequently). We then lead patients through two exercises, entitled "Counting Your Blessings" and "Remembering Miracles." Patients are informed that each exercise is approximately 90 seconds in duration, and they are invited to close their eyes if they wish to do so. The exercises are read from a script and proceed as follows:

> *Counting Your Blessings.* Please start by thinking about something you value very dearly in your life. It could be your eyes, your sense of hearing, your legs, a spouse/child (*pause 10 seconds*). Now, this may be unpleasant to do, but please take a moment to picture what your life would be like without this thing you value. Try to think about how your life may be different without it (*pause 10 seconds*). Now, take another moment and try to think

of the item as a gift. Try to imagine that this item was given to you so your life would be more fulfilling and happy (*pause 10 seconds*). And that's the end of the exercise.

Remembering Miracles. Please start by thinking about a stressful time in the past when things turned out better than expected in the end. It doesn't have to be an overt miracle—any experience that you had when you felt that things turned out better than you expected will be just fine (*pause 10 seconds*). Try to think about how you felt before the situation was resolved. Recall what was stressing you out at the time. What were the anticipated consequences you were concerned about (*pause 10 seconds*)? Now, try to think about the situation was an opportunity for your faith to grow. Try to think about how you endured the "test" of this situation and are stronger today because of it (*pause 10 seconds*). And that's the end of the exercise.

After the completion of each exercise, patients are given an opportunity to share their experiences. Patients are asked to comment on what happened to their mood/emotions as they progressed through the practice. Patients are also encouraged to reflect on how they can use the exercises in the future to manage their symptoms. For example, many patients report an increase in gratitude, hope, and/or happiness over the course of one or both exercises. Such individuals are encouraged to continue to use these strategies on an ongoing basis to provide moments of spirituality throughout their day. Some patients, however, report experiencing increased distress having imagined the loss of something very dear (e.g., a family member) or a difficult life situation in the past, which was not fully resolved. Such patients are encouraged to pick a different valued entity going forward and/or to augment the activity such that they do not imagine their life without that which they value.

Spiritual Study. Finally, patients are encouraged to experiment with spiritual study. We provide patients with a single page list of "Spiritual Study Resources" that includes 17 book titles (see Figure 3). Titles are broadly spiritual, emerge from both Western and Eastern thought, and include several fiction books. Care was taken to choose resources that are not prohibitively expensive for most patients (current prices range from $9–$30 in U.S. funds). For patients who prefer electronic media or do not have the resources to acquire printed books, we also include a list of five Web sites. It is mentioned to patients that several of the Web sites provided offer free daily e-mails, which often contain inspiring anecdotes and readings.

Concluding the Group

During the final 2–5 minutes of the group, we underscore the potential utility of spiritually integrated cognitive and behavioral strategies with reference to research on cognitive biases in mood and anxiety disorders. We illustrate to patients that the nature of emotional disorders is to facilitate the selective abstraction of negative information from one's environment. For example, depressed patients are more likely than others to notice and be discouraged by barriers to success, and anxious patients are more likely than others to perceive and be alarmed by danger. By reminding oneself of spiritual beliefs and engaging in regular spiritual practice, one can reclaim positive and uplifting moments in one's day, and thus temporarily break free from thinking that is driven by emotional disorders. Spirituality, when used in the context of treatment, can thus lead to cognitive shifts and learning in a manner that is consistent with CBT. We further reference recent treatment outcome research suggesting that inclusion of spirituality into psychosocial strategies can be helpful in both reducing symptoms and increasing positive affect for many patients. We finish by thanking patients for choosing to attend the session and giving patients an opportunity to ask questions or provide comments. Subsequently, we describe a brief study we conducted to gauge patients' reactions to the group during its initial stage of operation within our program.

Books	
Author	Title
Jennifer Skiff	*God Stories: Inspiring Encounters With the Divine*
Squire Rushnell	*When God Winks*
Benjamin Blech	*If God Is Good, Why Is the World so Bad?*
Lawrence Kelemen	*Permission to Believe*
David Aaron	*The Secret Life of God: Discovering the Divine Within You*
Rabbi Shalom Arush	*The Garden of Emuna: A Practical Guide to Life*
Viktor E. Frankl	*Man's Search for Meaning*
The Dalai Lama & Howard C. Cutler	*The Art of Happiness, 10th Anniversary Edition: A Handbook for Living*
Ajahn Brahm	*Who Ordered This Truckload of Dung?: Inspiring Stories for Welcoming Life's Difficulties*
Eckhart Tolle	*The Power of Now: A Guide to Spiritual Enlightenment*
Jon Kabat-Zinn	*Full Catastrophe Living: Using the Wisdom of Your body and Mind to Face Stress, Pain, and Illness*
Stephan Bodian	*Wake Up Now: A Guide to the Journey of Spiritual Awakening*
Scott Kiloby	*Love's Quiet Revolution: The End of the Spiritual Search*
Mitch Albom	*Have A Little Faith: A True Story* (*nonfiction*)
Khalil Gibran	*The Prophet* (*fiction*)
Robin Sharma	*The Monk Who Sold His Ferrari: A Fable About Fulfilling Your Dreams & Reaching Your Destiny* (*fiction*)
Paulo Coelho	*The Alchemist* (*fiction*)
Web sites	
http://www.beliefnet.com http://www.spiritualityandpractice.com http://www.aish.com http://www.chabad.org http://www.sacred-texts.com	

Figure 3. Spiritual study resources.

Evaluation

Procedure and Participants

Over a 4-month period, at the end of Spirituality & CBT groups, patients were asked to complete a brief (one-page, two-sided), anonymous questionnaire on a voluntary basis. In addition to demographic items (age, gender, race, level of education, and religious affiliation), five questions assessed for importance of spirituality (both in general and in regard to symptoms/treatment), and three

TABLE 1. Participant Religious Affiliation

	Frequency
Catholic	$n = 18$ (40%)
Jewish	$n = 2$ (4.4%)
Protestant	$n = 6$ (13.3%)
Other	$n = 12$ (26.7%)
None	$n = 7$ (15.5%)

items evaluated the extent to which the group met its objective to integrate spirituality into CBT in a respectful manner using a 3-point Likert-type scale (anchors: *not at all*, *somewhat*, *definitely*). To provide an opportunity for patients to share qualitative feedback, we also included two open-ended items to assess for what patients enjoyed most in the group and solicit recommendations for change.

The group received 72 patient visits from 66 unique patients (6 patients participated in the group more than once). For various reasons (e.g., clerical errors), data could not be collected for the four groups in which approximately 16 patients participated. Thus, approximately 50 patients were solicited for participation, of which 45 patients completed the questionnaire. Reasons for refusal were not tracked but included having a previously scheduled appointment, severity of symptoms, and lack of interest in participating in research in general. It should further be noted that the naturalistic treatment context posed time constraints because only 10 minutes (at most) were available for patients to complete the questionnaire prior to the commencement of their next treatment group.

The distribution of demographic variables within our obtained sample was typical of BHPP patients in general. Participants ranged in age from 20 to 65 years ($M = 41.6$; $SD = 13.03$), and 52.2% were female. The sample was 84.5% White, 2.2% Asian, and 2.2% Hispanic/Latino. Most participants (72.1%, $n = 31$) reported having a college diploma or university degree. Religious affiliation for the sample is presented in Table 1.

Results

Participant responses to multiple-choice items are presented in Table 2. The overwhelming majority of patients reported that spirituality is *somewhat* or *definitely* important in their life (92.9%) and plays a central role in their mental health (87.9%). Similarly, virtually all patients stated that it is *somewhat* or *definitely* important to address spirituality in their treatment (95.3%) and that doing so is spiritually enhancing (92.9%) and would accelerate their recovery (93.0%). With the exception of only two individuals, all participants found the group to be *somewhat* or *definitely* helpful and respectful.

To provide further analyses of our results, we computed correlations between these individual items (Table 3). Self-rated importance of spirituality was highly correlated with perceived centrality of spirituality to symptoms ($r = .73$, $p < .01$) and importance of addressing spirituality in treatment (r ranged from .60 to .76, $p < .01$). This suggests that patients who report spirituality as being generally important are more likely to desire spiritually integrated treatments. However, it was also noted that patients' ratings of how helpful and respectful the group was did *not* correlate with levels of personal spirituality or perceived relevance to symptoms (r ranged from $-.07$ to $-.21$, *ns*), suggesting that high levels of personal spirituality are not a prerequisite for benefiting from spiritually integrated psychotherapy.

To provide an analysis of participants' qualitative feedback about the group, open-ended responses pertaining to what was enjoyed the most and recommendations for changing the

TABLE 2. QUANTITATIVE RESPONSE FREQUENCIES

	Not at All	*Somewhat*	*Definitely*
1. Spirituality is an important part of my life.	3 (7.1%)	16 (38.1%)	23 (54.8%)
2. Spirituality plays a central role with regard to my mental health.	4 (9.3%)	21 (48.8%)	18 (39.1%)
3. Addressing spirituality in my treatment is important.	2 (4.7%)	16 (37.2%)	25 (58.1%)
4. Connecting with my faith will accelerate the process of recovery.	3 (7.0%)	15 (34.9%)	25 (58.1%)
5. Integrating spirituality into treatment improves my ability to connect with my faith.	3 (7.1%)	18 (42.9%)	21 (50.0%)
6. This group clarified how spirituality can be integrated with cognitive behavioral treatment to reduce painful, negative emotions.	1 (2.3%)	15 (34.9%)	27 (62.8%)
7. This group help identify resources about spirituality that I can use to reduce my distress.	2 (4.7%)	10 (21.7%)	31 (72.1%)
8. This group was respectful of different faiths and belief systems.	1 (2.3%)	4 (9.3%)	38 (82.6%)

intervention were examined. Initially, participants' responses to each question were reviewed by the study authors and divided into several broad categories. Regarding what participants liked most about the group, four categories were identified relating to (a) the provision of an open forum for exploring spirituality/religion in the context of treatment, (b) psychoeducation about the relevance of spirituality to treatment, (c) specific exercises or materials, and (d) no response. Four categories were also identified regarding participants' recommendations for revision of the group protocol: (a) increased frequency/amount of similar groups, (b) more focus on specific religious practices, (c) "nothing" (i.e., the group is fine as is), and (d) no response. Subsequently, a research assistant was trained to code responses numerically. These codings were reviewed by the first author and any questionable responses were discussed until concordance was reached. It should be noted that some participants provided multiple responses to these items, and, in such cases, all responses were coded separately.

Frequencies of participants' qualitative responses are presented in Table 4. Nearly half of patients provided specific, concrete examples of what they liked about the group. Specifically, approximately one third of patients appreciated the specific spiritual strategies and/or treatment materials distributed in the group, nearly 18% felt they benefited most from psychoeducation, including a review of the empirical literature on the relevance of spirituality to mental health, and just more than 30% felt they benefited most from the simple provision of an open forum

TABLE 3. Correlations Between Questionnaire Items

Variables	1	2	3	4	5	6	7	8
1. Importance of spirituality	—							
2. Centrality of spirituality to mental health	.73**	—						
3. Importance of addressing spirituality in treatment	.65**	.53**	—					
4. Connection with faith important for recovery	.76**	.52**	.72**	—				
5. Integration of spirituality into treatment improves connection to faith	.60**	.60**	.47**	.61**	—			
6. The group clarified how to integrate spirituality into CBT	−.06	−.10	−.07	−.02	.23	—		
7. The group identified spiritual resources I can use to reduce distress	.11	.17	.18	.21	.48**	.59**	—	
8. The group was respectful of different faiths	−.01	−.09	.02	.01	.24	.60**	.51**	—

Note. CBT = cognitive behavioral therapy.
**$p < .01$.

TABLE 4. Qualitative Response Frequencies

	Frequency
What did you like the most about this group?	
Psychoeducation about relevance of spirituality to treatment	$n = 10$ (17.9%)
Exercises and/or handouts	$n = 19$ (33.9%)
Open forum for addressing spirituality/religion in treatment	$n = 17$ (30.3%)
No response	$n = 10$ (17.9%)
What would you change about this group?	
Expansion and/or extension of group	$n = 10$ (23.2%)
More focus on specific religious teachings/practice	$n = 9$ (20.9%)
"Nothing" or a generic positive response	$n = 6$ (14.0%)
No response	$n = 18$ (41.9%)

to address their spirituality in the context of treatment. Regarding patients' wishes to change the group, about one fifth of patients stated that they would prefer a more explicitly religious focus. Further, it was very encouraging that more than 50% of patients either provided no response or specified that they would change nothing about the protocol, and an additional 23.2% requested that the group be offered more regularly in the BHPP.

Discussion

The integration of spirituality into evidence-based practices and the development and description of replicable protocols is relatively rare, and practice of such treatments in partial and/or inpatient hospital levels of care is virtually nonexistent. Despite these limitations, we successfully developed and implemented a Spirituality & CBT group in an acute psychiatric setting. In the context of an intensive treatment program for patients with severe psychopathology, our protocol enables the delivery of respectful, skill-based, spiritually integrated CBT, serving an important patient need.

The treatment protocol described in this article is not seen to involve *new* cognitive or behavioral skills, per se. Rather it simply facilitates the integration of patient spirituality into *existing* CBT practices. Specifically, patients are encouraged to draw from personally meaningful spiritual beliefs and cognitions in the practice of cognitive restructuring and as coping statements. Patients are also encouraged to experiment by engaging in regular spiritual practices in the context of self-care and behavioral activation. Further, patients are provided with psychoeducation about current literature on the relationship of spirituality to symptoms. These strategies do not stem from specialized training or knowledge of patients' spiritual and religious perspectives but rather from an openness and willingness to coordinate care in a spiritually sensitive manner, as well as some degree of forethought and planning.

It is notable that more than 90% of participants in our study described spirituality as having personal importance and relevance to symptoms and treatment. Moreover, nearly half of patients who responded to our questionnaire found tangible efforts to integrate spirituality into CBT to be the most desirable aspect of the treatment, and another third enjoyed a forum for exploring their spirituality in the context of a greater program. Furthermore, when asked "What would you change about this group?" nearly 25% of participants in our study requested that the group be expanded and/or offered more frequently in the context of treatment. In combination, these findings are consistent with previous literature highlighting a strong desire for spiritually integrated treatments among a specific subset of patients. They further suggest that a skill-based approach to this subject matter can enhance treatment goals and provide for patients' experiential needs. Our protocol thus appears to be an important adjunct group for some patients presenting to an acute psychiatric setting.

This article has several important limitations that should be noted. First, as only one component in a larger treatment program, it was not possible to evaluate the clinical efficacy of the treatment provided. It is also important to note that about one fifth of patients stated that they would prefer a more explicitly religious focus in the treatment provided. This suggests that religiously oriented treatment may be more suitable for some patients than the inclusive and nondenominational approach that we have described. This is a conundrum for the practice of spiritually integrated treatment in diverse settings. On the one hand, it is important to provide an open forum for the exploration of patient spirituality in which patients do not feel compelled to relate to religion. However, it is simultaneously important to recognize that many patients' personal spirituality is in fact religious in nature, and failing to address religious themes can be tantamount to ignoring spiritual needs and patient diversity. Our solution to this problem was to use generic, nonreligious terminology in the preparation of written treatment materials but to allow for group

discussions to center around religion when appropriate. This approach may not be suitable for all patients, however.

Furthermore, our Spirituality & CBT group is not seen to be a suitable, stand-alone treatment for outpatient settings. Almost all patients entering the spirituality & CBT group in the BHPP context are knowledgeable about basic CBT skills (e.g., thought records, cognitive restructuring, behavioral activation, and scheduling) prior to entering this treatment module. This foundational knowledge is important for both comprehension of our protocol and utilization of the strategies provided. Nevertheless, elements from our treatment protocol may have utility for practitioners in other levels of care such as outpatient treatment. For example, some patients may benefit from being encouraged to draw from spiritual concepts in the process of cognitive restructuring. It may further be advantageous for some patients to schedule spiritual practices into daily life and monitor their level of engagement. To this end, the protocol handouts (e.g., the Spiritual Beliefs and Reframes handout, the Spiritual Exercises Chart, and/or the Spiritual Study Resources List) have been appended to this article. Practitioners are encouraged to experiment with these methodologies when consistent with patients' desires for spiritually integrated treatment. Moreover, given the interest and potential benefit of our brief treatment, it is hoped that future years will see the development of longer term group treatment, such as outpatient paradigms, to further the availability of spirituality integrated CBT.

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