Spiritual Psychotherapy for Inpatient, Residential & Intensive Treatment (SPIRIT)

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Tuesday, February 28th, 2023

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In the Beginning

*All of the patients described throughout this presentation have provided informed consent to have their material included, however names, images, and identifying details have been changed to protect privacy and confidentiality.

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In the Beginning

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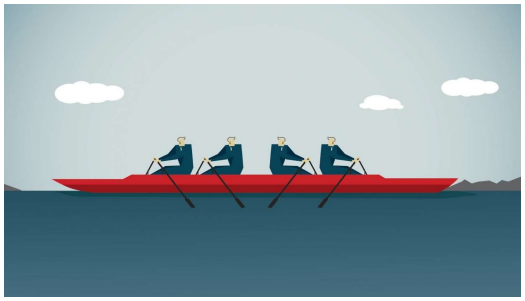
A Great Divide



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A First Foray

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A First Accomplishment

Journal of Cognitive Psychotherapy: An International Quarterly
Volume 25, Number 4 • 2011

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

David H. Rosmarin, PhD
Randy P. Auerbach, PhD
Joseph S. Bigda-Peyton, BA
Thröstur Björgvinsson, PhD
Philip G. Levendusky, PhD
McLean Hospital/Harvard Medical School, Belmont, Massachusetts

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S/R is not Uncommon!

Spirituality/Religion among McLean Hospital patients	
Religious Affiliation	60.5%
"Fairly" or greater belief in God	71%
"Absolutely Certain" belief in God	33.2%
Religion important	45.8%
Pray ≥ 1x/week	81.5%
Religious services ≥ 1x/week	48.2%

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Patients want Spiritual Psychotherapy

Journal of Consulting and Clinical Psychology
2015, Vol. 83, No. 6, 1149–1153

0022-006X/15/$12.00 http://dx.doi.org/10.1037/ccp0000046

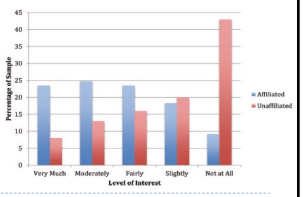
BRIEF REPORT

Interest in Spiritually Integrated Psychotherapy Among Acute Psychiatric Patients

David H. Rosmarin, Brent P. Forester, Daniel M. Shassian, Christian A. Webb, and Thröstur Björgvinsson
McLean Hospital, Harvard Medical School, Belmont, Massachusetts

Table 3
Interest in Spiritually Integrated Psychotherapy Among Acute Psychiatric Patients

Response	Frequency and percentage
Very much	44 (17.4%)
Moderately	51 (20.2%)
Fairly	52 (20.6%)
Slightly	48 (19.0%)
Not at all	57 (22.5%)



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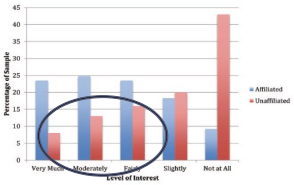

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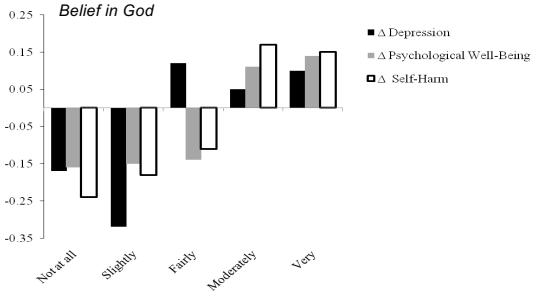
Benefits of S/R

Standardized Values of Symptom Change Across Levels of Belief in God



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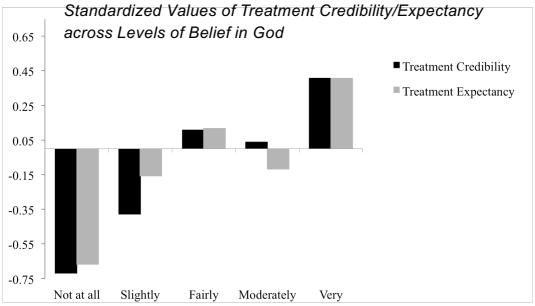
Benefits of S/R

Standardized Values of Treatment Credibility/Expectancy across Levels of Belief in God



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Benefits of S/R

Table 2. Effects of religion on suicidality among geriatric patients with mood disorders

Variable	Odds ratio	Test statistics
Affiliation	0.27	$\chi^2(1, 80) = 5.49$, $p = 0.02$
Importance of religion	0.23	$\chi^2(1, 80) = 6.85$, $p = 0.009$
Service attendance	0.18	$\chi^2(1, 80) = 6.67$, $p = 0.01$
Belief in God	0.33	$\chi^2(1, 79) = 4.24$, $p = 0.04$
Faith in God	0.23	$\chi^2(1, 78) = 6.94$, $p = 0.008$

Effects of religion on the course of suicidality among geriatric patients with mood disorders (Psychological Medicine, In Press)

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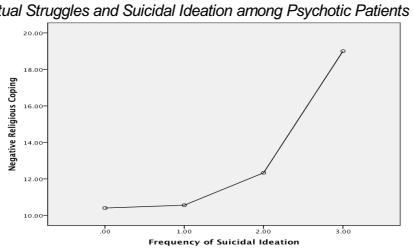
Risks of S/R

Spiritual Struggles and Suicidal Ideation among Psychotic Patients



Rosmarin DH, Bigda-Peyton JS, Ongür D, Pargament KI, Björgvinsson T. Religious coping among psychotic patients: Relevance to suicidality and treatment outcomes. *Psychiatry Res*. 2013;210;182-187.

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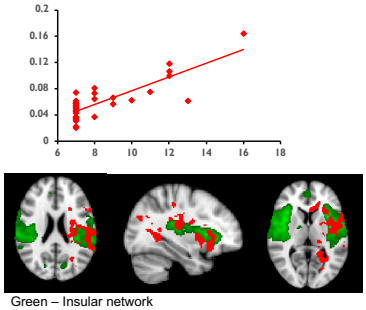
Risks of S/R



Green – Insular network

Red – Connectivity to Insular network

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A Big Step Forward

The Spirituality and Mental Health Program is a multi-faceted initiative to meet the spiritual needs of McLean patients by providing spiritually-integrated evidence-based care within multiple clinical units throughout the hospital.

SPECIFICS INCLUDE

Spirituality and Treatment Groups
- Weekly groups on most inpatient, partial, and residential units
- Helping patients harness spiritual resources in treatment
- Addressing spiritual struggles and resources

Spiritual Care Services (Chaplaincy)
- Providing 30 minute multi-faith chaplaincy visits on inpatient units
- Pastoral counseling, spiritual direction, and general spiritual support
- Coordinating patient spiritual/religious needs

Research/Training on Spirituality and Mental Health
- Discovering how spirituality can impact symptoms and patient care
- Clinical innovation of best practices in spiritually-integrated treatment
- Consultation for clinicians in addressing patient spirituality

McLEAN STAFF: To arrange for spiritual care services, please call 617-855-2320 or submit a request in Epic. Inpatient units only, please.

McLean HOSPITAL

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The Birth of SPIRIT

PSYCHOTHERAPY TOOLS

Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment

David H. Rosmarin, Ph.D., A.B.P.P., Sarah Salcone, B.A., David Harper, Ph.D., Brent P. Forester, M.D., M.Sc.

In this article, a clinical protocol for delivering a flexible, spiritually integrated cognitive-behavioral therapy, entitled spiritual psychotherapy for inpatient, residential, and intensive treatment (SPIRIT), is presented, and its implementation is described. The protocol, including general guidelines, materials, and training processes for clinicians, was developed and then implemented with 1,468 unique adult patients with acute psychiatric conditions presenting at 11 specialized clinical units of a large academic psychiatric facility. The authors have shown the feasibility and clinical utility of providing spiritually integrated psychotherapy to a heterogeneous patient population, by an equally diverse staff, within a large psychiatric center. SPIRIT holds promise in providing spiritually integrated care to patients with acute psychiatric conditions.

Am J Psychother 2019; 72:75–83;
doi: 10.1176/appi.psychotherapy.20180046

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What is SPIRIT?

Part I: How is S/R relevant to Mental Health?

Part II: Specific Strategies
1. Spiritual Beliefs/Reframes
2. Spiritual/Religious Coping
3. Spiritual/Religious Struggles
4. Meditating on the Psalms
5. Sacred Verses
6. The Power of Prayer
7. Forgiveness

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SPIRIT Clinicians

Clinicians (n = 22)	
Demographics	Mean Age = 42.1 (SD = 15.1) % Female – 68% (n = 15)
Training	Doctoral – 18% (n = 4) Masters – 45% (n = 10) CRC/MHS – 36% (n = 8)
S/R Affiliation	Protestant – 36% (n = 8) Catholic – 14% (n = 3) Jewish – 9% (n = 2) Buddhist – 14% (n = 3) Muslim – 4% (n = 1) SBNR – 14% (n = 3) None – 9% (n = 2)
Ethnicity	White – 64% (n = 14) Asian – 18% (n = 4) Hispanic – 9% (n = 2) Black – 9% (n = 2)

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SPIRIT Context

Level of Care	Total Unique Patient Visits	Psychiatric Condition(s)
Inpatient (3-10 days)	254	Mood/Anxiety Disorders
	218	Psychotic Disorders (Acute, higher functioning)
	199	Psychotic and other Chronic Disorders (Acute, lower functioning)
	293	Substance Use Disorders
	141	Posttraumatic Stress & Dissociative Disorders[1]
	98	Mood Disorders in Older Adults
Residential (2-6 months)	74	Eating & feeding Disorders
	34	Co-occurring Substance Use & Other Disorders
	31	Psychotic and other Chronic Disorders
Intensive/Partial (5-10 days)	92	Various Psychiatric Disorders[2]
	34	Posttraumatic Stress & Dissociative Disorders[1]
Total Patient Visits	**1468**	

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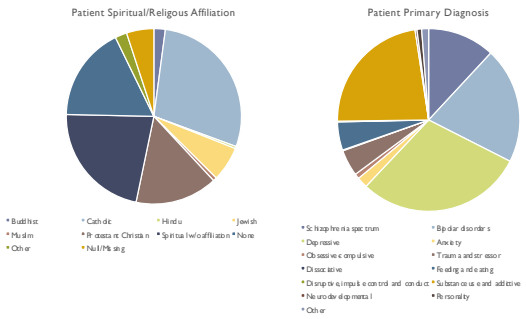
SPIRIT Patients



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SPIRIT Response

"This group helped identify spiritual/religious resources that I can use to reduce my distress."

Response	*n*	%
Not at all	143	10.5
Slightly	223	16.3
Fairly	**322**	**23.6**
Moderately	**341**	**24.9**
Very Much	**336**	**24.6**

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Predictors of SPIRIT Response

Predictors of Patients' Responses to Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment (SPIRIT)

David H. Rosmarin, Ph.D., A.B.P.P., Sarah Salcone, B.A., David G. Harper, Ph.D., Brent Forester, M.D.

Objective: Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment (SPIRIT) is a flexible clinical protocol for delivering spiritually integrated group psychotherapy within acute psychiatric settings. The authors evaluated SPIRIT's feasibility by examining patients' perceptions of its benefits and clinical and spiritual predictors of observed effects associated with this intervention.

Methods: Over a 1-year period, 22 clinicians stationed on 10 clinical units provided SPIRIT to 1,443 self-referred patients with a broad range of demographic, clinical, and spiritual and religious characteristics.

Results: Overall, patients' perceptions of benefit from SPIRIT were not associated with demographic factors. Clinical factors similarly did not predict treatment responses, suggesting that SPIRIT is equally suitable for patients with mood, anxiety, traumatic, substance use, psychotic, feeding or eating, or personality disorders and for patients with high levels of acuity. Patients with high levels of religious belief responded better to treatment, but patients with low levels of spiritual and religious identity also reported significant benefits. Patients responded better to SPIRIT when it was delivered by clinicians who reported not being affiliated with a religion than did patients receiving the SPIRIT intervention through clinicians who reported a religious affiliation.

Conclusions: Results indicate that SPIRIT is feasible in providing spiritually integrated treatment to diverse patients across multiple levels of acute psychiatric care.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.202000331)

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Patient Factors (demographic/clinical)

Predictors of Patient Response

Demographics	Perceived Benefit from SPIRIT (n=1443)
Age	r = -0.02; p = 0.29
Age 55+	F(1,1146) = 1.56, p = 0.21
Gender (F vs M vs Other)	F(2,1146) = 0.19, p = 0.83
Race (White vs People of Color)	F(1,1146) = 0.81, p = 0.78
Disability	F(8,1146) = 0.52, p = 0.84
College Student	F(1,1146) = 13.77, p = 0.07

Clinical Characteristics	Perceived Benefit from SPIRIT (n=1443)
Primary Diagnosis	F(12,1351) = 1.58, p = 0.09
Number of Diagnoses	F(3,1360) = 0.19, p = 0.90
Number of Medications	F(5,1382) = 1.05, p = 0.39
Antipsychotic Medications	F(1,1362) = 0.87, p = 0.35
History of ECT	F(1,1362) = 3.27, p = 0.07
Prev. Hospitalization (past 6 mos)	F(1,1339) = 0.22, p = 0.64

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Patient Factors (demographic/clinical)

Effects of Sexual Orientation on Spiritual Psychotherapy for Inpatient, Residential & Intensive Treatment

Eleanor M. Schuttenberg, M.A., Alana M. Johnston, M.A., Mia J. Drury, M.A., Jennifer T. Sneider, M.A., Marisa M. Silveri, M.A., David H. Rosmarin, Ph.D.

Objectives: Spiritual psychotherapy addresses mental health concerns by integrating spirituality/religion into treatment. There is scant research on how such approaches interact with sexual minority status. We sought to identify and compare how sexual minority and heterosexual patients respond to spiritual psychotherapy.

Method: We collected data from heterosexual (n = 66) and sexual minority (n = 15) patients who self-referred to participate in Spiritual Psychotherapy for Inpatient Residential & Intensive Treatment (SPIRIT), a spiritually-integrated, group-based, cognitive-behavioral treatment.

Results: We did not find significant differences between heterosexual and sexual minority patients across demographic/clinical variables, spiritual/religious characteristics, or effects of SPIRIT. Both groups reported notable perceived benefit of SPIRIT.

Conclusions: Although not specifically tailored for sexual minority patients, or intended to reconcile spiritual/religious conflicts around sexual identity, programs like SPIRIT may benefit sexual minority patients by providing a safe space to explore both sexual orientation and religious identity. In turn, this may help sexual minority patients develop frameworks to recruit spirituality/religion in the process of coping with distress, as a catalyst for clinical change.

Psych Res Clin Pract. 2022; 4:21–27. doi: 10.1176/appi.prcp.20210026

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Patient Factors (S/R)

Predictors of Patient Response

Spiritual/Religious Characteristics	Perceived Benefit from SPIRIT (n=1443)
Religious Affiliation (Religious vs SBNR & None)	**F(1,1287) = 11.35, p = .001**
Belief in God/Higher Power	**r = 0.28; p < 0.001**
Belief in God	**r = 0.16; p < 0.001**
Importance of Religion	**r = 0.21; p < 0.001**
Importance of Spirituality	**r = 0.27; p < 0.001**
Desire to discuss SR in tx	**r = 0.35; p < 0.001**

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Clinician Factors

Predictors of Patient Response: Clinician Factors

Clinician Characteristics	Perceived Benefit from SPIRIT (n=1443)
Clinician Age	**r = -0.98; p < 0.001**
Clinician Gender	F(2,1343) = 0.85, p = 0.45
Education (bachelors, masters, doctorate)	F(2,1343) = 1.25, p = 0.29
Clinician Religious Affiliation (R vs SR and None)	**F(1,1345) = 4.95, p = 0.02**

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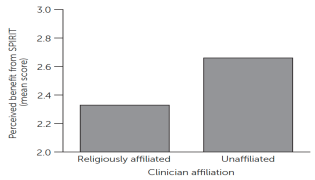
Clinician Factors

FIGURE 1. Patients' perceived benefit from Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment (SPIRIT), by religious affiliation status of clinicians delivering the intervention[a]



[a] The difference in mean scores, on a scale ranging from "not at all" (0) to "very much" (4), of patient-perceived benefit (i.e., identification of spiritual resources) from SPIRIT delivered by clinicians differing in religious affiliation (any affiliation vs. none) was statistically significant ($F=9.64$, $df=1, 1354$, $p=0.002$).

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Why do Unaffiliated Clinicians do Better?

Psychotherapy

ISSN: 0033-3204
https://doi.org/10.1037/pst0000400

Why Is Spiritual Psychotherapy for Inpatient, Residential, and Inpatient Treatment More Effective When Provided by Nonreligious Clinicians?

David H. Rosmarin[1, 2], Steven Pirutinsky[3], Eleanor M. Schuttenberg[1, 4], and Marisa M. Silveri[2, 4, 5]
[1] Spirituality and Mental Health Program, McLean Hospital, Belmont, Massachusetts, United States
[2] Department of Psychiatry, Harvard Medical School
[3] Graduate School of Social Work, Touro College
[4] Neurodevelopmental Laboratory on Addictions and Mental Health, McLean Hospital, Belmont, Massachusetts, United States
[5] Brain Imaging Center, McLean Hospital, Belmont, Massachusetts, United States

Previous research has suggested that patients receiving spiritual psychotherapy may have better outcomes when treatment is provided by nonreligious clinicians, compared to religious clinicians. We examined these effects within a large and clinically heterogeneous sample of patients ($N = 1,443$) receiving Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment (SPIRIT; Rosmarin et al., 2019) by a diverse sample of clinicians ($n = 22$). In addition to demographics, patients completed a brief measure of their experience in SPIRIT; clinicians completed measures of previous mental health training, previous training in spiritual psychotherapy, and attitudes toward spiritual psychotherapy, and also provided details regarding modalities, clinical interventions, and spiritual interventions utilized at each SPIRIT session. Mediating effects of clinician religion on perceived benefit were evaluated using correlations and multiple regression analyses. Of 26 potential explanatory factors, only 4 were significant, all of which related to the therapeutic process. Nonreligious clinicians were more likely to utilize dialectical behavior therapy (DBT), facilitate coping, encourage spiritual coping, and explore the relevance of spirituality to mental health, all of which also predicted better perceived benefit from SPIRIT. All four variables jointly, but not severally, mediated relationships between clinician religion and perceived benefit of SPIRIT. These findings suggest that DBT may be the most effective modality for delivering spiritual psychotherapy to acute patients, particularly in a group setting. Future research should further examine preferences for clinical modalities and techniques among religious and nonreligious clinicians, and effects of such preferences on perceived benefit, in a variety of settings.

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Why do Unaffiliated Clinicians do Better?

Why did unaffiliated clinicians outperform affiliated ones?

Clinician Differences in Practice between Affiliated and Unaffiliated Clinicians:	
Therapeutic Approach: Client centered	$t(1345) = 0.11$, $p = 0.92$
Therapeutic Approach: Cognitive	$t(1345) = 0.87$, $p = 0.38$
Therapeutic Approach: DBT	**$t(1345) = 2.35$, $p = 0.02$*** **
Clinical Intervention: Facilitating change	**$t(1345) = 2.31$, $p = 0.02$***
Clinical Intervention: Facilitating coping	**$t(1345) = 2.15$, $p = 0.03$*** **
Clinical Intervention: Facilitating insight	$t(1345) = 0.79$, $p = 0.43$
Clinical Intervention: Psychoeducation	**$t(1345) = 2.35$, $p = 0.02$***
Spiritual Psychotherapy Interventions: Exploring relevance of spirituality to mental health	**$t(1345) = 2.60$, $p = 0.01$*** **
Spiritual Psychotherapy Interventions: Facilitating spiritual coping	**$t(1345) = 2.11$, $p = 0.04$*** **
Spiritual Psychotherapy Interventions: Facilitating spiritual reframes	$t(1345) = 0.65$, $p = 0.51$

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Next Steps…

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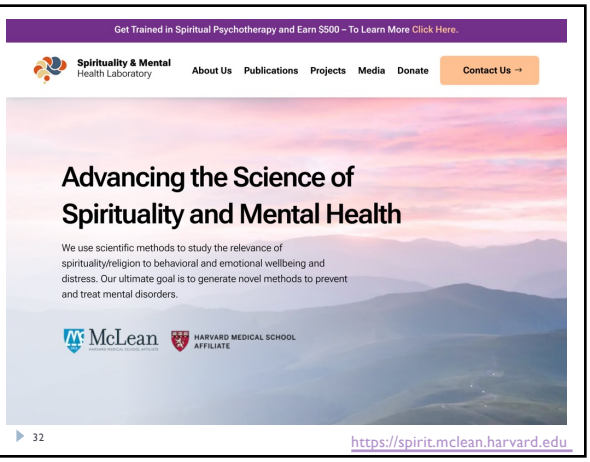

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Concluding Remarks

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Questions & Comments
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